MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 21, 2002
10:10 a.m.*

COMMISSIONERS PRESENT:

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RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: I'd like to welcome our guests.
3 As you know from our agenda, we will be spending today and
4 tomorrow working on our June report on the Medicare benefit
5 package.

6 As usual, we will have public comment period at
7 the end of the morning and afternoon sessions each. As
8 always, we'll ask you to keep your comments brief and to the
9 point. I know that sometimes we have multiple people
10 representing a particular point of view. I will ask you to
11 listen to the comments that went before you and, if you
12 don't have anything new to add, please exercise restraint
13 because we do have a number of people who want to get to the
14 microphone and offer their comments.

15 The first discussion will be led by Mae on the
16 introduction to a report on assessing the Medicare benefit
17 package.

18 DR. THAMER: In the next two days, you will be
19 hearing many presentations that are related to the June
20 report. In my introductory presentation here, I'd like to
21 give you a general sense of what you will be hearing, how
22 the presentations are related to one another, and to the

1 objectives of the June report, and basically the general
2 direction that we're embarking on.
3 To quickly review, the three objectives of the
4 June 2002 MedPAC report are to identify the major changes
5 that have occurred since the creation of the Medicare
6 program and the original design of the benefit package, to
7 assess their implications for Medicare beneficiaries, and
8 the adequacy of the Medicare benefit package, and to examine
9 the various options to modify the current benefit package to
10 possibly better meet the needs of the Medicare
11 beneficiaries.
12 First, I will review the major findings related to
13 three topics that were presented earlier to the Commission.
14 These topics include the changing beneficiary profile,
15 chronic conditions and care, and the use of preventive and
16 primary care services. The purpose of revisiting these
17 earlier presentations is that we would like the
18 commissioners to keep these issues and findings in mind when
19 they hear the subsequent presentations today and tomorrow.
20 After I review this earlier data, I will introduce
21 the new topics that will be presented to the Commission the
22 remainder of today and tomorrow.

1 In January, we presented a discussion on the
2 changing beneficiary profile from 1965 until the present.
3 I'd like to highlight the most salient findings. First of
4 all, in terms of demographics, the elderly population is
5 increasing in numbers with the greatest increase in the
6 proportion of persons that are age 85 and older. This is
7 reflected in Medicare's enrollment, which has increased from
8 19 million in 1966 to 40 million in the year 2000. The
9 number of disabled has also increased from 1.7 million in
10 1973, when the benefit was first enacted, to 5.2 million in
11 the year 2000.
12 Secondly, in terms of informal social support,
13 it's increasingly limited as the elderly age. Half of all
14 women over age 75 live alone in the year 2000.
15 Unfortunately, there's no comparable data from the '60s or
16 '70s to verify whether social support has been eroding among
17 the elderly during this time or not.
18 For men of age 65, life expectancy has increased
19 from 13 years in 1966 to 16 years in 2000, an increase of
20 three years. And for women at age 65, life expectancy has
21 increased from 16 years in 1966 to 19 years in 2000, also an
22 increase of three years.

1 The percent of elderly living below the poverty
2 line has decreased from 29 percent in 1966 to 10 percent in
3 the year 2000. The proportion of income spent on health
4 care is an interesting statistic. That's remained the same,
5 at approximately 20 percent in 1966 and 2000, although it
6 initially decreased to 11 percent after Medicare was first
7 enacted and has slowly risen back up.
8 Another presentation in January with important
9 implications for the June report that I'd like to review,
10 addressed chronic conditions and their care. There were
11 three important findings that I'd like to reiterate at this
12 point. One is that chronic conditions among the elderly are
13 highly prevalent, including multiple conditions. Depending
14 on the study prevalence rates for chronic conditions have
15 been cited as anywhere from 70 to 90 percent of all elderly.
16 Number two, effective care has been demonstrated
17 and includes the following elements: interdisciplinary team
18 assessment, early detection of functional impairments,
19 evidence-based treatments, patient self-management,
20 appropriate use of medications, and assistive devices for
21 mobility, hearing and vision.
22 The third point is that Medicare's ability to

1 promote quality chronic care is currently limited because
2 number one, Medicare doesn't cover or provides limited
3 coverage for certain services that are required such as
4 prescription drugs, case or disease management, and other
5 coordination of care activities.
6 Secondly, fee-for-service Medicare does not
7 generally promote coordination and continuity of care, since
8 there's no financial incentives to provide such care.
9 And third, providers are not reimbursed for
10 providing instructions on behavioral change or self-care, or
11 addressing emotional or psychological needs of patients.
12 The last presentation I'd like to review is
13 preventive services. In 1965 preventive services were not
14 covered as part of the Medicare benefit package, but they've
15 been added based on Congressional approval on an ad hoc
16 basis in subsequent years. Medicare covers some of the
17 preventive services that have been recommended by the U.S.
18 Preventive Task Force for the Elderly, such as flu and
19 pneumococcal vaccines and the pap smear, but not others,
20 such as smoking cessation and diet and exercise counseling.
21 Also, Medicare covers preventive services that aren't
22 recommended by the task force, such as bone density

1 screening and PSA.

2 Compared to private plans, Medicare's coverage of

3 preventive services is similar with the exception that

4 private plans cover annual physical exams and selected

5 counseling.

6 Finally, I want to say that coverage of preventive

7 services is only one determinant of their use. Other

8 determinants include the extent of cost-sharing, physician

9 recommendation, patient education and outreach efforts.

10 Today and tomorrow we'd like to present additional

11 evidence to the Commission to allow you to better assess the

12 Medicare benefit package. The new topics that we're going

13 to present include the results of an expert panel of

14 geriatricians, historians, public health experts, managed

15 care providers, bioethicists, technology experts and others

16 regarding the changes in the medical practice and delivery

17 of care since 1965, and its implications for the current

18 Medicare benefit package.

19 Second, we're going to have a guest lecturer

20 that's going to present the results of an analysis of

21 changing in the private sector benefit packages, including a

22 discussion of the relevance of private sector benefit

1 packages in serving as a role model for the Medicare benefit
2 package.
3 Third, we're going to have another guest lecturer,
4 along with MedPAC staff, that will present the trends in
5 beneficiaries' supplementation of the Medicare benefit
6 package, including a discussion of the stability of retiree
7 health plans, the availability and cost of Medigap coverage,
8 the availability and underuse of Medicaid benefits, and the
9 changing nature of the benefits offered by M+C plans.
10 Finally, MedPAC staff will discuss why
11 beneficiaries' out-of-pocket spending is a concern and we'll
12 present data showing the proportion of income that's spent
13 on health care, as well as show you that high out-of-pocket
14 spending often persists for years among certain
15 beneficiaries.
16 Second, MedPAC staff will present estimates of the
17 total pool of funds that are spent on beneficiaries for all
18 services, with the exception of long-term care. And we're
19 going to show you breakdowns by sources of funds, the amount
20 that's covered by Medicare as well as other payers and
21 what's purchased with this.
22 Finally, in tomorrow's presentations, we plan to

1 discuss three topics that will give you the general
2 direction, as well as the analytical framework, for the June
3 report. First, we're going to have preliminary findings of
4 what we anticipate to be the most significant, cross-cutting
5 findings, and their policy implications.
6 Second, I will introduce the criteria to both
7 evaluate the current benefit package as well as to evaluate
8 new proposals. The criteria are necessary to understand the
9 values and trade-offs in various approaches to changing the
10 benefit package.
11 Last, we're going to presenting a variety of
12 illustrative options on how to address the inadequacies and
13 limitations of the benefit package. We've modeled several
14 of these options to give the commissioners an idea of the
15 cost implications inherent in various proposals to modify
16 the benefit package.
17 MR. HACKBARTH: Any quick questions for Mae?
18 MR. FEEZOR: Not so much quick questions, but as
19 we think about our report, there are a couple of things that
20 I made note of as I was coming in that I guess I'd just like
21 to throw out for our thinking.
22 The first is to make sure if we're using some of

1 the normal benchmarks that they make sense, or are we simply
2 captured by how we have always categorized things? For
3 example, the over-85/under-85. Are there reasons we use 85
4 as a benchmark? Particularly with large loads of people
5 coming into the system, it may be breaking it up makes it
6 different. That's sort of one way of looking at it.
7 The issue of disabled, we probably need to spend a
8 little more time in terms of the disabled versus maybe
9 severely disabled and recognize there are some significant
10 differences in consumption and needs that might come about.
11 The life expectancy, by itself, is helpful to know
12 in terms of quantifying things, but some qualitative
13 measures and what that may mean that are associated with
14 that may be, in fact, more revealing in terms of the
15 resource consumption that that longevity factor does.
16 Then the issues like you talk about the average
17 income. Throughout the report there's some reference back
18 and forth in terms of disposable income may be, in fact, a
19 helpful measure.
20 I guess what I'm saying is instead of picking up
21 what is always assumed, that we've got to do some
22 rethinking. Going back to the first benchmark of the 85 as

1 sort of being one of the clear lines of break, and I'll come
2 back to this a little later as we start thinking about some
3 options, it very well may be that 85, 82, 75 or 15 years in
4 or whatever, that there is a significant change in
5 consumption patterns and it very well may be that one of the
6 social policy choices that we may want to put up is that, in
7 fact, Medicare have a stage level of benefits, that in fact
8 there is a different set of services that are available as
9 one progresses through that. Just conceptually.
10 So anyway, those are just some thoughts to
11 rethink, and part of it is dealing with my responsibilities
12 for the under and over-65, we're having to really do some
13 rethinking. And I found that many of the ways we've
14 categorized our statistics sort of helped guide us to some
15 of those same old conclusions. So that's a note of caution
16 for all of us, as well as for staff, in terms of when we
17 start grinding through those numbers.
18 DR. NELSON: Mae, I had a question with respect to
19 the Medicare Coverage Advisory Commission and whether it is
20 looking at the benefit package in a global sense, as we
21 intend to approach our task, or whether it's looking just at
22 specific new technologies that are presented to it a few at

1 a time?

2 So I guess what I'm asking is whether or not they

3 are proceeding on a parallel path or whether they're much

4 more isolated?

5 DR. THAMER: I'm sorry, are you referring to the

6 expert panel that we had?

7 DR. NELSON: Medicare Coverage Advisory

8 Commission.

9 DR. THAMER: They tend to look at new

10 technologies, I think, in general. New technologies that

11 are coming, not the whole program. That's my understanding.

12 MS. JENSEN: They evaluate coverage for services

13 that would already be covered under the broad guidelines of

14 the current benefits package, specific procedures, specific

15 -- they would be things that would already be covered

16 broadly.

17 MR. MULLER: Since we know that a lot of the costs

18 of any of these populations are in the very highly acute or

19 catastrophic or end-of-life cases -- I don't mean to use

20 those as determinants terms -- do we have any estimates or

21 can we derive any estimates as to if the benefit package

22 changed, what kind of effect that might have on our ability

1 to avoid some of those cases?

2 I know that in the common criticism of insurance
3 systems, at least the U.S. insurance system, is that in the
4 under-65 population, there's no incentive to take care of
5 people in the long term, because by the time the benefit
6 accrues to you, they're in some other insurance plan.

7 In the Medicare population, there's at least an
8 argument that you have these people for 16, 19, 20-some
9 years, and therefore the virtue of putting together a set of
10 services that could, at the margin at least, avoid some of
11 those highly acute costs. That might be beneficial to the
12 overall system.

13 Are we likely, or is it possible to make those
14 kind of estimates in this time frame, this period, as to if
15 one had a different benefit package that might have some
16 effect on avoiding some of these heavy costs at acute and
17 end-of-life stages?

18 DR. THAMER: That's an excellent question. We
19 have not done that kind of modeling yet, although we
20 possibly can. You'll see, tomorrow, the models that we've
21 done. But they haven't, to my knowledge, looked at avoiding
22 end-of-life costs or even avoiding acute exacerbations of

1 chronic conditions or costly outcomes. We haven't modeled
2 that, but that's certainly an excellent idea. Of course,
3 the modeling is a little bit more complex, but maybe we can
4 build that in.
5 MR. MULLER: That would be one of the policy
6 justifications for looking at that. I know most people feel
7 that no matter what service you have, every one is additive
8 rather than in some ways complementary. If we can't do it
9 in the next three months, I think looking at that time frame
10 may be something we look at in the long term.
11 MR. HACKBARTH: Thanks Mae, and let's move to the
12 first panel. Helaine, you will introduce it, I assume.
13 While they're taking their seats, let me publicly
14 thank all of the staff for the work done on this report. I
15 found the materials very educational and stimulating, would
16 be a good word.
17 I know this report is, in some respects, more
18 difficult than our typical report because these things are
19 all so intertwined. And so trying to put all of the pieces
20 of the puzzle together is very hard work and I appreciate
21 your efforts.
22 MS. FINGOLD: Good morning, I'm here to introduce

1 Dr. Marsha Gold and Dr. Bob Hurley, who we contracted with
2 through Mathematica Policy Research. Dr. Gold and Dr.
3 Hurley have helped us convene a panel to look at the context
4 of changes in medical practice and delivery of care since
5 the inception of program.
6 Staff thought we needed context in looking at the
7 benefit package, not just to recount the types of advances
8 that have happened in the interim, but really to look at
9 changes in technology and delivery, how it's impacted
10 beneficiaries, how they're treated, what kind of services
11 they receive. We wanted to look at the whole picture and we
12 help that would be helpful in assessing where the benefit
13 package has been and where it may go in the future.
14 Dr. Hurley is going to walk through what happened
15 at the panel, who was on the panel, give a summary. You
16 should each have a written summary of the panel that Dr.
17 Hurley prepared. We're sorry we couldn't get it to you
18 earlier. The panel was only a week ago and we actually
19 turned it around fairly quickly, and we thank them for that.
20 It's still in draft, but I don't foresee that it's going to
21 have major changes made to it.
22 So I will allow Dr. Hurley to proceed, and Dr.

1 Gold will be presenting subsequently. David Glass will be
2 here to describe that project afterwards.
3 DR. HURLEY: Thank you and good morning. This was
4 an expert panel that was held, as Helaine said, last
5 Wednesday, I believe it was. Marsha and I have done about a
6 dozen of these over several years for both this commission
7 and for PPRC. She has moderated this panel and I prepared
8 the summary and the report.
9 Because of the short time frame you have only a
10 draft summary, but I think it gives you a fairly good depth
11 of what was covered in the session. So let me take you
12 through the key points and highlights, if I might.
13 The panel membership, you just heard a bit about
14 them. The panel included a very diverse group of people
15 with expertise in chronic care management, geriatrics,
16 technology assessment, epidemiology, ethics, managed care,
17 integrated delivery systems, and Medicare policy. Further
18 indication of its diversity was the fact that one of our
19 panelists said he was caring for patients before Medicare
20 was passed, and another panelist said he was born after
21 Medicare was passed. So we covered the spectrum pretty
22 nicely.

1 The focus of the discussion was on four broad
2 areas: changes in care delivery and clinical practice, the
3 implications of these changes for the Medicare beneficiary
4 population, gaps in current Medicare benefits and you'll see
5 also related to some payment issues, and then advice for
6 improving the Medicare benefit package. So we'll talk about
7 each of these four areas in a little bit of detail right
8 now.
9 Obviously, the panel was very direct about the
10 range of expanded diagnostic and treatment possibilities
11 that have occurred, given advances in medical science and
12 technology. And they highlighted the fact that the changes
13 have occurred not only in terms of the range of
14 interventions, but also the pace of interventions which has
15 significant implications for providers, for patients, and
16 for the social systems of these patients.
17 Also, they talked about the fact and related to
18 the fact that many of these technological developments have
19 not been consistently subjected to cost-benefit and cost-
20 effectiveness analyses. They also reflected a
21 disproportionate interest in emphasis upon acute care and
22 suggested that that competes with the management of chronic

1 illness, which may not benefit the many beneficiaries who do
2 not benefit from those.
3 In addition, they commented on interest an
4 emphasis on prevention continues to lag the developments in
5 terms of acute care. And that again has significant
6 implications, as we'll see in a moment.
7 The second broad area they spoke to was the
8 changes in the rising patient needs and patient
9 expectations. Again, part of this was a function of the
10 success of acute care, in terms of prolonging life and, in
11 many cases, improving life. But also, leading to more
12 people living with chronic conditions.
13 They also emphasized the importance of rising
14 patient expectations that have accompanied these changes in
15 the sense that patients, and in many cases their physicians,
16 are operating under the assumption that any condition can be
17 treated if patients and physicians persist in seeking those
18 treatments, making it difficult to distinguish between
19 what's valuable and what's futile.
20 Growth in medical and health-related information
21 also was addressed in this area, in terms of how much more
22 patients know and also, to some extent, how much more

1 they're misinformed, which has significant implications for
2 the amount of time that their clinicians are having to spend
3 with their patients, in terms of education engaging them and
4 understanding these issues.
5 On a more positive side, this has had an
6 empowering effect for patients in improving their ability to
7 be engaged in the care delivery process.
8 In addition to these issues about information,
9 there was also a sense that racial and ethnic diversity is
10 confounding the ability of providers to be able to uniformly
11 communicate with their patients.
12 Broader social and demographic trends have altered
13 social systems in important ways that are particularly
14 pertinent in terms of persons who have disability or chronic
15 disease and have need for these support systems to keep them
16 in independence.
17 A third broad area that was highlighted was the
18 role and the importance of team-based care delivery. As one
19 of the panelists characterized it, the prototype of the
20 physician as captain of the team is giving way to the notion
21 of medicine as a team sport. And so consequently, the role
22 of the team-based delivery has become much more prominent

1 and has altered the relative importance of the various
2 participants on the clinical teams.
3 The degree to which teams are actually formally
4 structured and managed and organized varies greatly by
5 settings, and there's a sense that this is an area which
6 will have to see more improvement in order to really benefit
7 from the full fruition of team-based care.
8 But panelists pointed out particularly an
9 important irony that the ability to move in the direction
10 and to accommodate the pressure to move toward team-based
11 care delivery faces a significant impediment because of the
12 centrality of the one-to-one patient/physician relationship
13 which patients continue to assign enormous value -- some
14 panelists felt disproportionate value in light of the fact
15 that in many cases individual physicians are overmatched by
16 the demands upon them at this point in time.]
17 A fourth area is limited exploitation, concern
18 about limited exploitation of information technology and
19 decision support possibilities. The panelists remarked on
20 the revolutions that have occurred in communications and
21 information technology that have accompanied the medical
22 science and technology changes that have occurred, but they

1 noted there's a significant gap in the application of
2 information technology and health care, particularly given
3 relative to what is actually technically possible.
4 They attributed this slow and uneven pace of the
5 adoption of technology to under investment, lack of
6 resources for investment, lack of incentives for investment,
7 and structural impediments among providers and patients to
8 more ambitious adoption of information technology. They
9 suggested that this is an area where some of the most
10 important advances in care management will come in the
11 future of these impediments can be overcome.
12 The fifth point was, in some respects, a
13 reconsideration of the preceding four, in which the
14 panelists expressed the view that in many respects delivery
15 systems, in particular, have not fundamentally changed over
16 this period of time, partly because of the centrality of the
17 physician/patient relationship. Also, because of the
18 ability to achieve the clinical integration that many have
19 suggested would be coming, the inability to actually employ
20 more successfully administrative technology which exists but
21 is not applied in the health care arena.
22 Now if we go to the next slide, we'll talk

1 specifically and derive some implications for Medicare that
2 were highlighted. I think one of the panelists said
3 virtually everything that I just described to you is
4 intensified in the Medicare population. We have a program
5 that has a very strong acute care orientation. And in the
6 minds of the panelists, Medicare has generally kept pace
7 well with advances in clinical diagnosis and treatment,
8 particularly with respect to new technologies with the very
9 notable exception of outpatient pharmaceutical benefits.
10 On the other hand, Medicare -- like the acute care
11 system as a whole -- undervalues and under invests in
12 preventive care. That is compounded by the late onset of
13 eligibility for the program.
14 While it has been a bona fide innovator and
15 standard setter in payment methodologies for hospitals and
16 physicians and post-acute care, its methods have remained,
17 however, largely focused on process rather than outcomes,
18 rewarding effort rather than consequences.
19 The second point, in terms of the distinctive
20 needs and subsets of the Medicare population, if I might
21 just say a little bit about each of these bullets because
22 this is important for some of the subsequent comments that

1 we heard.

2 One of the panelists raised a distinction or

3 suggested there were three broad subpopulations of Medicare,

4 from his vantage point. There are the healthy Medicare

5 beneficiaries with occasional acute needs and routine

6 maintenance needs. The second subpopulation are the

7 seriously ill with multiple chronic conditions, dependency,

8 and at risk of further deterioration. And the third

9 population are those who are severely ill, perhaps

10 terminally ill, and have end-of-life care needs.

11 They drew this distinction by suggesting that, in

12 fact, the person population is well-served by the Medicare

13 program, with the exception of the outpatient drug benefit.

14 The third population is also reasonably well served because

15 of the hospice benefit. But the middle group, the seriously

16 ill with multiple chronic conditions, dependency and at risk

17 of further deterioration, is less well-served. That

18 distinction is an important one, in terms of some of the

19 recommendations you'll see in a moment.

20 A third point, in terms of the implications for

21 Medicare, and this is the mirror image of the team-based

22 care delivery, is a sense that Medicare has failed to

1 actually develop a care coordination and case management
2 compensation strategy. This care is particularly important
3 for this second population that I was describing a few
4 moments ago, and is also consistent with most prominent
5 models of chronic care that case management and care
6 coordination are central functions that have to be performed
7 in order to provide care effectively.
8 There is a sense that Medicare's payment systems
9 are simply out of sync with paying for coordinated care and
10 consequently, by not paying for this care, is relying on
11 this care to be delivered for free, if you will, or as a
12 byproduct of the service delivery process thus extracting
13 from providers a kind of forced contribution to make sure
14 that that care is, in fact, being rendered for those
15 patients who are in need of it, even though it isn't being
16 paid for.
17 A larger concern among the panelists was that
18 adding something only like care coordination in isolation
19 could possibly be inflationary, because it would mean
20 additional vendors and additional payment schedules and so
21 forth. And there was a suggestion that there needs to be
22 more serious consideration to sophisticated approaches to

1 paying for disease management and ideally basing these
2 payments on some kind of an outcomes basis rather than
3 effort or process.
4 A fourth issue in relation to Medicare, to follow
5 on the previous comments, a limited exploitation of
6 information technology, there was a sense that Medicare
7 payments and policies have not encouraged long-term thinking
8 and planning for information technology investment.
9 Patients are being seen by providers today who lack the
10 requisite information sets to render care at the highest
11 possible quality.
12 In addition, there are deficiencies in the
13 application of available technology that's been linked to
14 medical errors. So consequently, there is sound evidence to
15 support the benefits and the gains from further investment
16 in this area.
17 The last point in this regard, in terms of
18 Medicare implications, was a sense that there has been an
19 underdevelopment of systems of care for the Medicare
20 population, again something that flows from several of these
21 earlier points. This was a pervasive theme. Particularly
22 in light of the disappointment and experience in terms of

1 the Medicare+Choice, the marginal scale of the PACE and the
2 Social HMO programs, and the limited number of new
3 coordinated care demonstrations. All of these indicate that
4 most of the care for these chronically ill are still being
5 paid in conventional methods.
6 If I could go to the next slide, I'll give you two
7 slides here in terms of the identified gaps in benefits and
8 then payment issues that are influencing or related to the
9 gaps in benefits as identified by the panel. The first one
10 obviously is outpatient prescription drugs. There was a
11 complete consensus among the panel that this is the first
12 priority and such an omission would be inconceivable if the
13 Medicare program were being initiated today.
14 The physicians on the panel spoke to the fact that
15 in many respects the absence of this benefit is not
16 necessarily changing prescribing habits, it's changing
17 patient compliance habit with the likelihood of actually
18 getting the prescriptions and then using the prescriptions
19 that the physicians have prescribed.
20 At the same time the panelists endorsed this
21 strongly, they also suggested that the benefit must be
22 carefully crafted and thoughtfully implemented to ensure

1 that it is not exploited and that its contribution is not
2 diminished. By this they meant that safeguards have to be
3 put in place to promote appropriate use, careful monitoring
4 of prescription and consumption habits, systematic
5 evaluation of new products, and concerted efforts to educate
6 consumers.
7 In fact, the ethicist on our panel suggested that
8 the drug benefit might be a particularly useful opportunity
9 to cultivate a sense of the commonly situated circumstance
10 for Medicare beneficiaries to be sensitive to the fact that
11 appropriate use is necessary to ensure this benefit is
12 available to the most persons possible.
13 A second point, in terms of benefits, was care
14 coordination and case management. Specifically, the
15 importance of this benefit has already been identified.
16 It's noted as particularly important for beneficiaries with
17 multiple health problems, cognitive deficits and/or limited
18 social supports. So this is too critical a service to be
19 financed simply by cost shifting and cross-subsidization, as
20 it currently is.
21 There was on the panel some concerns about the
22 woodwork effect associated with covering a service like this

1 that previously has not been paid for, but the panelists
2 felt that this was worth the risk as long as the benefit was
3 carefully crafted and designed and implemented.
4 They also suggested that they believe that these
5 care coordination services are unlikely to produce savings
6 but they will improve quality because of substantial unmet
7 need in this area.
8 The next item on here was the package of enriched
9 benefits for complex chronic illness care. An idea
10 supported by several of the panelists was the program should
11 consider developing something that's analogous to the
12 hospice benefit that would be targeted to Medicare
13 beneficiaries who meet certain screening criteria in terms
14 of their being at risk for deterioration, the need for
15 maintenance services, and the need for a care coordination
16 strategy that would involve intensive multi-faceted
17 intervention that could be funded in a way to forestall
18 decline and debilitation.
19 Again, the issue of woodwork effects came up in
20 this same discussion in the potential for gaming a benefit
21 like this. But the panelists felt that a carefully
22 developed screening criteria, perhaps looking at functional

1 status and so forth as a basis for criteria, would be
2 effective.
3 Another item here was preventive benefits
4 enhancement, and just let me call your attention to it.
5 It's not captured entirely in the bullet that I have up
6 there. The preventive benefit expansion and coverage that
7 was discussed was actually extending preventive coverages to
8 the below 65 age, where there was interest, in fact, in
9 terms of exploiting available information about where early
10 intervention can, in fact, be effective. And as a
11 consequence of that, the Medicare program would encourage
12 investment in preemptive, if you will, as well as preventive
13 services or secondary prevention kinds of interventions.
14 The idea here would be that ultimately these are
15 persons who, when they become eligible, will have to be
16 consuming substantial amounts of services and so we should
17 use the best available knowledge to try to forestall and to
18 prevent the occurrence of those conditions.
19 Another item that was identified, in terms of gaps
20 of benefits, was mental health benefit improvement. This
21 was largely devoted to two specific issues. One of them was
22 the lack of availability of outpatient prescription drug

1 coverage, which is so central for the management of chronic
2 mental illness.
3 The second was, in some respects, a payment issue,
4 whether or not psychiatrists are adequately compensated at
5 this point in time in a way that Medicare beneficiaries have
6 access to them. This what was behind that suggestion.
7 The final point was expanding cost-benefit and
8 cost-effectiveness scrutiny of the benefits that are already
9 in the program, and those that may be advanced. Part of
10 this was because the non-linear nature in which new benefits
11 are actually being developed and non-sequential
12 decisionmaking that occurs. The consequence of that is that
13 there are conscious trade-offs that are not occurring
14 because the program is being drawn along by the coverage of
15 high-tech services, perhaps at the expense of more personal
16 kinds of care.
17 We have just a few items here under payment issues
18 and structures that were also related to the issue of
19 benefits package. They're not really payment policies as
20 much as facilitated of the provision of these benefits.
21 Payment methodology for care coordination. Recognizing that
22 this will be a challenge to be able to develop this, the

1 panelists felt that Medicare has an admirable track record
2 in terms of payment innovation and this is one in which some
3 ingenuity will be necessary to ensure that this doesn't lead
4 to proliferation of simply new providers or more
5 fragmentation in the system.
6 A second point was the payment for non-physicians,
7 which had its roots in the issue of team-based delivery.
8 There was a sense that Medicare is not as flexible in this
9 as it could be. It also, through physician-centered
10 payment, imposes significant accommodations to be able to
11 assure that both the appropriate person is being paid to
12 provide services and that the physician is in compliance
13 with whatever the extant payment policies are.
14 Payment for information infrastructure to
15 encourage investment was another area for consideration, in
16 terms of the fact that current methods do not adequately
17 target payments and encourage longer-term investments to
18 fully exploit the possibilities in terms of information
19 technology.
20 A fourth item in this area was that performance-
21 based compensation, again there was a sense that if
22 desirable to move in the direction of fee-for-outcome versus

1 fee-for-service, at the same time recognizing that there are
2 very significant impediments and technical problems to be
3 able to achieve that. But there was a feeling that more
4 could be done, given the progress that is occurring in terms
5 of outcomes measurement, risk adjustment, the understanding
6 of behavioral dynamics of incentives and related issues.
7 Counterbalancing this argument, however, was some
8 sense among panelists that the political context of Medicare
9 may not permit quality or outcome-based differential
10 payments, in terms of whether or not the program could, in
11 fact, engineer and implement something like that.
12 The last item on here, in terms of payments and
13 incentives, at system level structure and performance again
14 was reflecting this issue that we have not seen fundamental
15 change and we have not developed successful models, perhaps
16 sustainable models, for systems of care. They cited the
17 IOM's Quality Chasm Report of identifying clear criteria
18 that are associated with successful systems of care, and the
19 idea of possibly incorporating that into payment methods
20 would be worth exploration.
21 My last two slides are really kind of the rapid
22 fire closing round of issues of when Marsha asked the panel

1 to identify what would be the priorities they'd recommend to
2 the Commission and to Congress, they went through many of
3 these same things. But let me just quickly go through them
4 and see if there's any we didn't cover.
5 Covering outpatient drugs quickly but wisely.
6 Adding a care coordination benefit, perhaps as part of a
7 package of services for the seriously, chronically ill as we
8 talked about a moment ago. Devote greater attention to
9 cost-benefit, cost-effectiveness evaluation of current and
10 future benefits. Consider how a transition from process to
11 outcome-based payment methods might be engineered. Build
12 more flexibility into the program designed for future
13 adaptation. Again, the sense of the panelists was that the
14 Medicare program needs to be thinking about itself 30 years
15 from now, just as its been through the first 35 years. So
16 as we think about genomics and so forth, those kind of
17 emergent areas, the idea of building some kind of a
18 foundation to accommodate those seems important.
19 Devote more attention to provider and neutral
20 payments, which again was the notion of considering other
21 potential providers of services as qualifying for payment.
22 Avoiding increasing beneficiary copayments as the burden

1 falls most heavily on the sickest. This again was voiced by
2 several of the panel members. Assess the feasibility of
3 coverage for preventive benefits beyond the normal Medicare
4 program boundaries, as I mentioned a moment ago.
5 Incorporate federal prevention guidelines into
6 benefit and payment designs. The fact that those exist now
7 and have been accepted is a basis for more forthright
8 incorporation into payment methods.
9 And the last two were more general and sweeping
10 suggestions. Evaluate the implications of national versus
11 local coverage decisions on technology adoption and use.
12 Again, some of the technology assessment folks on the
13 committee raised that issue.
14 And the final point was the promotion of more use
15 of demonstration authority to encourage innovation, but
16 don't limit the program simply to demonstrations for the
17 purpose of finding and embracing new innovation.
18 The last slide, if I could, is just a summary
19 slide that highlights three key points. Medicare, like our
20 health system as a whole, remains strongly oriented toward
21 acute care in the minds of the panelists. That is certainly
22 emblematic of the program. They felt that Medicare has kept

1 pace well on technology adoption, except for the notable
2 deficiency in outpatient pharmacy benefits. And the benefit
3 improvements are most necessary for beneficiaries with
4 serious chronic conditions and multiple service needs.
5 DR. GOLD: If I can add one thing briefly, before
6 we start, one thing you see running through the panel
7 meeting, if I can step back, is we put together the agenda
8 and it focused directly on what your report is and benefits
9 and what we should do.
10 What was interesting, and we had some give and
11 take with the panelists about this, was to what extent you
12 could distinguish benefit decisions from payment decisions
13 from organizational decisions. The issue being they
14 understood that, but maybe as you're thinking about this,
15 how much of it is paying for each service versus putting
16 them together.
17 And then the other side of it, which is the
18 dilemma, I think, for the Commission is how much Medicare
19 and Congress can push ahead of where the rest of the health
20 care system already is and to what extent you can assume
21 that certain things would change. But I think a message
22 coming out of what they say is even though you're focused on

1 benefits, and we tried to keep pushing them back there, they
2 kept pushing back because they saw some of these things as
3 not unrelated, I think something which probably gave Murray
4 a headache.

5 DR. NEWHOUSE: Thank you for doing this. I have
6 several questions, let me just ask some about the
7 recommendations on paying for coordination and paying on
8 outcomes. On coordination, did the issue come up of how one
9 would verify effort? And what this would mean
10 operationally?

11 DR. HURLEY: No, we didn't get to that level of
12 detail. I guess I could have said one of the specific
13 suggestions was the idea of possibly paying a retainer of
14 some kind. That was about the most specific suggestion I
15 think we heard with respect to care coordination
16 methodologies.

17 DR. NEWHOUSE: I suggest there still is an issue
18 about what it is you're buying and how you can tell that
19 you've bought it.

20 On outcomes, this may have been what you meant by
21 the organization and delivery, but did the panel talk about
22 who was responsible for outcomes in the context of

1 traditional Medicare? That is, if a patient with a chronic
2 problem is seeing multiple physicians and there's going to
3 be some variation in payment based on what happens with this
4 patient, who takes the variation?
5 DR. HURLEY: The attribution issue didn't come up
6 at all, in terms of responsibility for care.
7 DR. NEWHOUSE: Did they get to the point about
8 whether the outcomes they mainly had in mind were prevention
9 of acute events or outcomes conditional on the events? Did
10 they have both in mind?
11 DR. HURLEY: I think some panelists had both of
12 them in mind. Certainly, there was a significant amount of
13 discussion within the panel itself about the degree of
14 difficulty associated with moving in this direction,
15 certainly. They were not naive about this, I think we can
16 say.
17 DR. NEWHOUSE: That brings me to my last question,
18 for the moment anyway. Did they talk about the selection
19 issue at either level? That is, if I'm paying on whether
20 the event occurs, I'm going to be not so interested in
21 people's whose lifestyle is not so great. And if I'm paying
22 on improvement conditional on event, I'm not going to be so

1 interested in the non-compliant patients?

2 DR. HURLEY: Absolutely, yes. We had a couple of

3 clinicians who were actually still seeing patients. In

4 fact, that was the point they said. If you went to a base

5 versus bonus payment, we would probably just get the base

6 because we get the sickest people. I think there was real

7 sensitivity about the degree of difficulty of that.

8 DR. ROWE: Let me echo Joe's gratitude to you, for

9 being our guest lecturer, one of our guest lecturers, and

10 for putting together this panel. I know some of these

11 people and think they're very able, very interesting mix of

12 experiences.

13 I have a couple of points. One of them is really

14 just for the record. I think it's self-evident to everyone

15 here, and it certainly was to you. But if you look at your

16 gaps in benefits, outpatient prescription drugs, case

17 management care coordination, preventive benefits

18 enhancement, mental health benefit. If we could develop

19 such a program like that with health plans we might call it

20 Medicare+Choice.

21 DR. HURLEY: We thought of that actually.

22 DR. ROWE: Just an idea. I don't know whether it

1 came up in your discussions at all.

2 DR. REISCHAUER: It doesn't seem to be working,

3 though.

4 DR. ROWE: Was there any discussion about that?

5 DR. HURLEY: Yes, there was. In fact, when we

6 talked about systems in care, and I think I mentioned this

7 simply in passing, that there was a sense that the

8 disappointing experience with the coordinated care program

9 under Medicare+Choice, as well as some of the other small-

10 scale demonstrations, have demonstrated the capability of

11 doing this but they've been troubled in terms of their

12 stability and sustainability.

13 DR. ROWE: But there is this grand experiment

14 here.

15 DR. HURLEY: Yes.

16 DR. ROWE: I have maybe four questions for you.

17 I'll just read them off and you can respond, either you or

18 Marsha can respond to these, or not at all

19 One is I was struck by the absence of the word

20 quality in any of your slides or in anything that you said.

21 I wondered whether or not the recent reports from the IOM

22 came up? Whether or not your panel was concerned about

1 whether this beneficiary population was disproportionately
2 at risk for errors, safety issues, et cetera? How they felt
3 about the general quality?
4 Secondly, with respect to access, you mentioned
5 that access for the first population seemed to be pretty
6 good, general needs. And that access to the end-of-life
7 population seemed good because of the hospice benefit, which
8 I was surprised to hear because I think we've seem some data
9 that while that may be increasing, it's rather heterogenous
10 in its use, et cetera, although use recently is improved in
11 minority populations.
12 I'd be interested in whether there was any
13 discussion of access with respect to that.
14 You also seemed to suggest that access was limited
15 for the seriously ill population and I just want to clarify
16 that, that that's the case.
17 The third question has to do with prevention. Mae
18 pointed out the discordance or dissonance between the U.S.
19 Task Force on Preventive Services recommendations and
20 Medicare's current coverage policies. I think you mentioned
21 with respect to bone density screening and PSA on the one
22 hand of things that Medicare pays for that aren't

1 recommended. And then there are things such as smoking
2 cessation and other things that maybe are recommended that
3 Medicare doesn't. I wonder whether you had any discussion
4 about, your panel had any recommendations with respect to
5 the concordance or lack of concordance of those and what
6 direction we should go in?
7 And I guess the last question I had was that the
8 only priority that I heard you say was that everyone seemed
9 to agree that the highest priority was an outpatient
10 prescription drug benefit. Stipulating that, I wondered
11 whether or not beyond that whether there was any discussion
12 amongst and between the panel members with respect to the
13 relative priority of some of these other recommendations
14 that are being made, all which would, of course, equaled the
15 national GDP here.
16 Can you give us any guidance beyond the outpatient
17 prescription drug benefit with respect to where they felt
18 the greatest opportunities were to enhance the program?
19 Thank you very much.
20 DR. HURLEY: Let me go back, your first question
21 had to do with the quality issue, and indeed there was
22 discussion of quality, although I guess we wouldn't say it

1 was a featured issue. There was several invocations of the
2 IOM's report. And as I suggested earlier, some of the
3 thinking that system level payments could, in fact, foster
4 adherence to some of the recommendations of the IOM report
5 in a way that they haven't necessarily done to date.
6 Also, the issue associated with outcomes-based
7 payment systems and methodologies was that those outcomes
8 bases would, in fact, include quality indicators and metrics
9 for inclusion in those payment methods. Although, that's
10 where I suggest that some panelists were concerned about
11 whether differential payment methods, in fact, would be
12 permissible that, in fact, implied that there was variation
13 in quality on which payment was forthcoming.
14 With respect to access, I think the idea -- we did
15 not talk very much about the hospice benefit, as I recall.
16 But let me just say a couple of things and then Marsha can
17 fill in this. I think the hospice was characterized as the
18 kind of package of benefits that is existing that would be
19 analogous to what another package of benefits might be
20 developed targeted toward that second group.
21 There wasn't a discussion about the accessibility
22 or the utilization of hospice in this discussion.

1 And then the third issue about the seriously ill,
2 I think the point, if I implied that there was concern about
3 access, the implication was that the care that they're
4 receiving is not adequately compensated in the sense that it
5 requires the care coordination that's now being rendered by
6 providers is actually contributed care by those providers
7 because it isn't separately paid. And so it's dependant
8 upon the willingness of the providers to make this
9 available.
10 There was a suggestion that because of the
11 apparent decline of cost-shifting and cross-subsidization
12 capabilities in the delivery system, this care might be at
13 risk.
14 DR. GOLD: On that second question, before Bob
15 goes on to the others, on the hospice one, there were I
16 think a number of practitioners who talked about the problem
17 of people not wanting to either admit that they're dying or
18 deal with that, and that was a barrier to using the benefit
19 because it's a six month period. And also, a concern that
20 you had to make a decision, palliative care or. And so
21 there were some issues, I think, that came up in the panel
22 where the end of life issues were there.

1 I think the main point, though, was just because
2 of the acute care focus of the benefit package, it does a
3 better job of dealing with people who have episodic needs
4 rather than that middle chronically ill population. And so
5 that was really where it came in. It wasn't that there
6 weren't things that could be improved for the people who
7 were terminally ill.
8 DR. HURLEY: The other two points you mentioned,
9 on prevention we had a limited discussion of the value and
10 the importance of adopting existing prevention guidelines in
11 the Medicare program. I believe that's as specific as we
12 got. We never got to the level that you were raising.
13 And your last point was other priorities. I think
14 the second priority on my list here was adding a care
15 coordination case management benefit was the other one that
16 was a fairly close second. Beyond that, we actually began
17 to see them spread out. And you can see on this list, some
18 of these are quite general without the same sort of benefit.
19 DR. ROWE: So that beat out prevention?
20 DR. HURLEY: Yes, indeed.
21 DR. ROWE: That's interesting. That's very
22 helpful, Bob. Thank you very much.

1 MS. ROSENBLATT: My question is on information
2 technology. It sounds like since it's coming up with
3 payment issues, there's almost a thought of paying
4 individual providers for the information technology. And it
5 would seem to me that a lot of what we're talking about does
6 require some kind of huge system to collect enough data to
7 see what's really going on.
8 So could you elaborate on that?
9 DR. HURLEY: I think there are two questions here,
10 or that there are two issues that fit together, I believe.
11 One of them was the information technology possibilities
12 that exist to actually provide the term decision support
13 systems for health care providers, particularly physicians.
14 They're there but they're not actually being implemented to
15 the degree possible because of difficulties or reluctance to
16 invest and to bring those systems up and put them in place.
17 Now whether or not individual practices or
18 individual small groups of physicians are likely to be able
19 to do that is another related issue. Part of the response
20 to that was the belief that systems of care, in the broadest
21 sense, organized delivery systems are going to be necessary
22 in order to have those kinds of platforms in place in order

1 to able to acquire the information technology and then put
2 it in use in such a way that it actually supports the care
3 that's being rendered by individual physician.
4 So there's really two levels to this. It's the
5 fact that there's information technology that could
6 contribute to better care, but in order to find a way in
7 which there's an enterprise that can invest and develop
8 those is the system of care concern.
9 MR. FEEZOR: First off, I found the categorization
10 of the three populations within Medicare to be very helpful.
11 And again, I think finding ways in a targeted fashion to
12 sort of separate out what might be the needs and designing
13 benefits to match that is very appropriate for us to give
14 some further consideration to.
15 Second, I guess I'd like to underscore something I
16 think I heard Marsha say right off the top. I think that we
17 ought to at least put the question out. That is Medicare
18 either is a change agent or, in fact, is a social security
19 blanket -- no pun intended -- that automatically inherently
20 sort of goes towards the status quo.
21 I say that, participating for instance in Pacific
22 Business Group on Health, aggregate spending in health care

1 in California and near areas is probably $8 billion. This
2 sense of well, we can't move on some of the things because
3 of the preponderant weight of government systems, and
4 particularly Medicare.
5 So I think that question ought to be framed
6 because I think our report will be coming out at a time
7 where even the private sector has renewed question mark
8 about whether we can sustain the current system and whether
9 it needs to be deeply changed.
10 The final comment quickly, is talking about gaps.
11 I think there is a gap in care coordination across the
12 current payment systems. Our panelists were asked to look
13 at Medicare by itself and yet, we know that, at least in
14 California, about two-thirds of the retirees have, for
15 instance, some form of pharmaceutical coverage.
16 I can tell you that I have tremendous exposure in
17 terms of our Medicare supplemental products and lines, or
18 Medicare+Choice. But I really don't have an incentive to
19 take that on, in terms of care management or care
20 coordination because I can't reach across that big barrier
21 that separates Medicare.
22 Again, I know that it's getting into a touchy area

1 of sort of private/public coordination, but I do think
2 that's something that we need to frame. And I'm not alone.
3 I've talked to other people in similar positions that just
4 say I really would like to take on some care coordination
5 and management and bring in some disease management to deal
6 with my retiree population. But it really just isn't worth
7 it, or I can't reach across to where so much of that is
8 being paid.
9
10 DR. HURLEY: There were actually two points that
11 were raised. Your comments remind me of two points. One
12 was that the idea that actually Medicare should be looking
13 at -- and the term that people used was transformational
14 payment methodologies, which would be the kind of change
15 agent beyond just simply static reimbursement methods.
16 On the other hand, there was an exchange early on
17 in the discussion as to whether or not Medicare could, in
18 fact, be perceived as a system financier or whether it's
19 simply a payment vehicle. So both of those issues were
20 present in the room.
21 DR. GOLD: We didn't really talk about, in the
22 panel, the supplemental issues. They are critical. I know

1 you have a session on it this afternoon. In other work I've
2 done, I think it's a very important point and is worth
3 thinking about.
4 MR. SMITH: Thanks, Glenn. And thank you, I found
5 this very helpful.
6 I have two questions. One, Allen's just asked, I
7 was interested in the question of coordination across
8 payment systems.
9 But let me come back to Jack's point. I think
10 many of us were struck, as you talked about gaps, about the
11 correspondence between the gaps and what we had hoped to get
12 out of health plans. I wonder if the panel had any
13 conversation about how else would you do it? Where else in
14 the system? What provider?
15 I know you talked, Bob, a little bit about the
16 anxiety on the panel about creating a new benefit and a
17 whole new layer of providers. But if not that, who? And
18 where in the system might that care coordination be
19 provided?
20 DR. HURLEY: There were a couple of responses.
21 One of them was there was a little bit of discussion about
22 packaged payments or bundled payments as another vehicle,

1 another way of actually pulling together clusters of
2 services or episodes of care, payment methods that actually
3 would achieve some of that integrative activity but not
4 necessarily do it at the health plan level, if you will.
5 The other point here, disease management. We
6 actually did have a representative from the disease
7 management industry participating in this. I think there
8 was some sense that this issue of looking across, or sort of
9 vertical strips of care, in fact is another means for
10 looking at payment methods that actually would encourage
11 linkage across and coordination of movement of patients
12 across the continuum of care.
13 But I believe that's about as far as we went. I
14 don't know if you recall anything else, Marsha, on that
15 realm.
16 MS. RAPHAEL: To follow up on that, your last
17 point was something that intrigued me, which is the main way
18 of testing change right now in the Medicare program is
19 through demonstrations. I think we would all agree that
20 that is a very elongated, and not necessarily successful
21 way, to promote and test innovation.
22 I was wondering if there was any discussion of any

1 other ways to try to test different ways of either changing
2 the benefit, targeting it differently, or testing different
3 ways of delivering or financing the service?
4 DR. HURLEY: I don't think there was and, as I
5 think I said at the end of my comments, that while there was
6 interest in and desire for greater flexibility to stimulate
7 more demonstrations and innovation, there was also a sense
8 that it would be bad policy to rely solely upon
9 demonstrations as a source of that innovation because of the
10 protracted period in order to get things from this.
11 But that really wasn't within the field of vision
12 for the panel.
13 DR. GOLD: I vaguely have a sense that there may
14 have been some sort of discussion of examples where you
15 could give flexibility to do things slightly differently if
16 it would be better within the regular program. But I don't
17 think it was an extensive part of the discussion, though I
18 think the point is very consistent with the general concerns
19 that the panelists talked about, about why are we doing all
20 these benefits? I mean, ultimately what are we trying to
21 achieve?
22 DR. HURLEY: I think probably the best example we

1 had in the discussion really was the idea of preventive
2 benefits to persons below the age of 65, so that actually
3 you stretch the boundaries of eligibility, in some respects,
4 based on the dictates of good science, as it were.
5 DR. NELSON: Was there discussion about what
6 happens to pre-Medicare patients who are in disease
7 management systems for diabetes or congestive heart failure
8 or whatever when they suddenly hit the Medicare wall and
9 they're no longer eligible? What do they do?
10 It seems to me that if I were a patient and very
11 pleased with my progress in an existing private sector
12 system and found out then that I couldn't continue to
13 participate under the Medicare program, I'd be unhappy.
14 DR. HURLEY: That actually did not come up. Of
15 course, it's a familiar concern with moving into a Medicare
16 health plan, as well, if you're in a commercial plan that's
17 not participating. But that did not come up in the
18 discussion.
19 MR. MULLER: Brief question. Given the increased
20 complexity of coordinating care over a lifetime, across
21 diseases with all possible interventions, a lot of people in
22 the under-65 population of increasingly using the patients

1 as individuals as a coordinator of care. In the Medicare
2 population, it's commonly hypothesized that that's just too
3 difficult to do.
4 As you look at those three populations that have
5 been identified, is it possible to consider at least the
6 first population as a group that might be more involved in
7 the coordination of the care? Or is it unlikely that we
8 could consider the population as a whole as one where the
9 individual becomes a coordinator of care?
10 DR. HURLEY: I think that the sense that part of
11 the differentiation among the three groups was that that
12 first group was, in fact, capable of and was much more like
13 the privately insured population, who is increasingly
14 empowered by more information and more actively engaged in
15 the care management process.
16 Whereas for the other populations, both the
17 hospice -- although, again end-of-life care is another form
18 of empowerment perhaps -- the other population was the one
19 in which a surrogate for care management, care coordination
20 was seen as necessary to really offset the deficit that
21 those patients might, in fact, be experiencing.
22 MR. HACKBARTH: Okay, thank you.

1 A theme that I've heard here, that I would like to
2 see included in the report, is that there are inextricable
3 links between benefits and system design and payment methods
4 and performance measurement. That is, I think, pretty
5 obvious. But I don't think it can be said often enough.
6 When you write a report that has benefits
7 somewhere on the cover, I think we have to early and often
8 remind people how linked these things are. And I think it
9 makes it very challenging to think about reforming the
10 Medicare benefit package, because there's so many variables
11 that need to come together to make it work to actually
12 improve care. Just a theme for inclusion.
13 Marsha, you're going to lead us through the
14 discussion about...
15 DR. GOLD: David was going to introduce me, and
16 Bob's going to stay up here because he's been a good
17 raconteur on the reports that I've done, that I'm
18 presenting.
19 MR. GLASS: Marsha is now going to lead us through
20 a discussion of the changes in the private sector benefit
21 packages. She's going to talk about how they've evolved and
22 what their current status is. We'll also compare it to the

1 Medicare benefit package.

2 And then we'll ask the Commission to think about

3 what are the implications of that for rethinking the

4 Medicare benefit package. To what extent does it make sense

5 to think of the employer group market as a model for the

6 Medicare population, given what the last panel just said

7 about how you have these different populations in Medicare.

8 Marsha, go ahead.

9 DR. GOLD: Thanks. I'm going to walk pretty fast

10 through what was a pretty extensive analysis. The

11 objectives were to review the historical trends in

12 employment-based health benefits -- although I should

13 emphasize this is for active workers -- and to compare the

14 results against trends in Medicare benefits, and then to

15 identify the implications for reforming the Medicare benefit

16 package. Although, some of that discussion is probably

17 going to be held over until tomorrow when you get a chance

18 to have more time with that.

19 You have the executive summary of that report.

20 You can get the full report, should anyone desire it, from

21 the staff. I'm not going to go into a lot of the methods.

22 We tried to go back as far as we could to what

1 employment-based benefits were like when Medicare was
2 started. There's some anecdotal information there but '77,
3 with the National Medical Expenditure Survey, was really the
4 first documentation nationwide.
5 What that showed was that basically people had a
6 single choice of health plan. It was an indemnity package
7 that had basic benefits and some major medical benefits.
8 There was limited preventive services. Pharmaceutical
9 services were included. Drug coverage was part of major
10 medical. We see, even back then, the disparity or the
11 distinction between the coverage for mental health and the
12 coverage for other conditions.
13 If you look over the 1980s, largely through the
14 BLS surveys, what you see is the integration of basic and
15 major medical benefits was occurring, which basically meant
16 there was more cost-sharing on the first dollar side of it.
17 At the same time, there was greater protection on
18 heavy expenses. That is, an annual limit on out-of-pocket
19 spending. Even in '77 that was about half of the people
20 with major medical, I think. It went up from there.
21 We started to see a growth in HMOs, though it was
22 still limited. Utilization review got added to indemnity

1 coverage. And you saw higher worker contributions to
2 premiums, especially for family coverage.
3 In the 1990s what you saw is more plan choice,
4 managed care options, and basically -- I have a slide I'll
5 show you next -- but the PPO replaced the indemnity product.
6 The worker's share of the premiums for coverage have
7 remained relatively steady from the mid-1990s.
8 Cost-sharing appears to have declined, but that's
9 a complicated topic and a lot of it is that there was the
10 growth of managed care and cost-sharing is different within
11 different forms of managed care. In the paper, there's some
12 good information on how that varies.
13 I noticed that there was just today a Health
14 Affairs web exclusive by Jamie Robinson on out-of-pocket
15 costs. I think within individual products, cost-sharing has
16 gone up. But cost-sharing, as a whole, hasn't gone up
17 because of the shift to managed care products.
18 There remain annual limits on out-of-pocket
19 expenses. Again, they've gotten more complex because
20 they're dealt with differently in different products, and
21 for in- and out-of-network benefits. Pre-tax spending
22 accounts, that is to pay for the cost-sharing, are more

1 common. But at least the data I saw, it seems like only a
2 minority of workers participate in those.
3 This is from the Kaiser/HRET data that's been done
4 on type of plan enrollment. What you can see, that yellow
5 bar shows the growth in PPOs against red, which is the
6 erosion of the indemnity benefit. That's both a reflection
7 of offering, because indemnity is less likely to be offered,
8 but just as much what people are selecting because there's
9 more offerings than there are people enrolled in indemnity.
10 Additional trends in the '90s, we've seen some
11 expansion in the SNF/home health/hospice benefits, although
12 they are still limited. Long-term care coverage may be
13 growing but it remains rare. Substance abuse benefits have
14 improved, but both they and mental health benefits still lag
15 general health benefits. Preventive coverage has expanded,
16 though it's still more common in HMOs.
17 In terms of what the pharmacy benefit looks like
18 in the employment-based coverage, virtually all workers who
19 have coverage do have pharmacy benefits. It's very rare
20 that there's any yearly maximum, as there has been in some
21 of the Medicare+Choice plans.
22 Tiered copayments are commonly used as a way to

1 control costs. As of the most recent year, three-tiered
2 copayments are now as common as two-tiered. So that you may
3 have a generic, a preferred brand, and another brand, or
4 there's various ways of structuring that. For the most
5 part, the pharmacy benefit is integrated with medical
6 coverage. It's not a separate stand-alone benefit.
7 In terms of looking to the future, and it's been
8 challenge and it will be a challenge for you, is that costs
9 are very cyclical. These are just the average health
10 benefit costs for active workers, so they're the costs that
11 the employer is paying.
12 What you can see is that in the late '80s, early
13 '90s, those increased a lot. People did some things. They
14 introduced managed care. Costs didn't go down a lot. Now
15 they're going up again. And so what the question is is
16 what's going to happen? I've just described where the
17 benefits are or as today as you get in these data. And I
18 think the Kaiser/HRET data are pretty current but it's still
19 lagging, and so what the future is.
20 There's a number of emerging pressures and
21 influences on that. Probably the dominant driver of all of
22 this is the tension between what employers face in terms of

1 growth and health care expenses, which relates to a lot of
2 the changes in medical technology, site of care, all the
3 things Bob talked about, and the need to -- you know, most
4 businesses are in business not to do health care. They're
5 in business to do something else. And so they need a labor
6 force for that. They may be willing to absorb some costs of
7 health care as a trade-off against not getting a good labor
8 force.
9 So we've had changing economic conditions over the
10 mid to late-1990s. It was a very strong economy. Aside
11 from the fact that health care costs weren't rising that
12 quickly, there also was not a lot of pressure to reduce
13 health benefits because there was greater interest in
14 getting labor force participation. The economy is a little
15 softer, health care expenses are higher.
16 And so one of the questions is how are employers
17 going to trade that off? They're obviously faced with some
18 regulatory constraints and negotiated contracts in doing
19 that.
20 I'm not a crystal ball thing and I think usually
21 people are wrong more than right. But when I looked across
22 the various consulting management reports and other things

1 and tried to give you a sense of what it looked like people
2 were saying, the concern is that cost pressures were going
3 to encourage change in health benefits. That is, ways of
4 keeping costs down. But the labor force concerns will
5 moderate it.

6 Most people expect increased cost-sharing on the
7 patient side. That was the focus of the Robinson article,
8 which I haven't read yet, that just came out. The data that
9 I looked at it's not very detectable yet. I don't know when
10 it will start showing up. There's probably people on this
11 panel who are more expert in that.

12 Most of the people that were writing when I was
13 looking at the things expected what I'd characterize as
14 evolutionary, not revolutionary change. That is, they see
15 changes at the margin rather than a total switch in how
16 benefits are defined. From the revolutionary side, if you
17 just looked at the defined contribution data, a few workers
18 are in them today. And the surveys that are there show
19 growing but still limited employer interest in those
20 products. And the products themselves, you have to be very
21 careful because they're very different and a lot of things
22 go by the same name and they're very different and they're

1 evolving.

2 There's more detail in the paper about that issue
3 if you're interested in it.

4 A key focus in the paper, and there's about three
5 page chart that tries to do it, is to compare Medicare to
6 employer group products then and now and look at what's the
7 same and what's different. What you can see if you
8 summarize it is that there are similarities across both of
9 those products. Both are medically focused with an emphasis
10 on acute care. Neither is strong in prevention, although
11 both have gotten better recently. Both have more limited
12 coverage for mental health services than medical care.

13 And this last point is a point one could debate,
14 but I think it's probably accurate, is that neither focuses
15 heavily on care management, though there is some activity
16 there.

17 In terms of the differences, there's no equivalent
18 in employer group coverage to the current Part A/Part B
19 split in Medicare. Medicare has more limited inpatient
20 coverage with more first dollar cost sharing. There's no
21 equivalent to that first day deductible in most employer
22 plans.

1 Employers cover prescription drugs and Medicare
2 generally does not. Employer group coverage provides
3 greater protection against high expenses because of the
4 annual limit.
5 I should indicate when I say this, though, that
6 some of the disparities are overstated because Medicare has
7 more protection because of balance billing limits than
8 private insurers do. Those out-of-pocket limits don't
9 affect any balance billing. So in some ways, they may give
10 a false sense of how much protection there is on the
11 employer side.
12 Differences. The basic employer plan is a PPO and
13 Medicare is still an indemnity plan. That means that
14 utilization review and a limited network are very common for
15 employers, not very common in Medicare. I think, this group
16 particularly being a group that deals with payment, will
17 appreciate that one of the ways of how to think about the
18 Medicare indemnity product, given administrative pricing.
19 To some extent, one could think about Medicare has getting
20 the benefit of PPO price negotiations without out of network
21 use. And if the pricing is better and there's less
22 participation, you might end up with a de facto PPO.

1 But some of the reasons employers go into PPOs is
2 to get price discounts and that may be less critical in
3 Medicare because of the administered pricing issue.
4 Second, contributions are really hard to look at
5 because of the A/B split and because on Part A you're
6 essentially -- or at least I think when I look at my
7 paycheck, that I'm paying for it each month when I get my
8 paycheck. But if you look at just the Part B, the Part B
9 contributions are at a par or higher than the contributions
10 for single coverage in groups. That is both absolute
11 dollars as a share of premiums, Medicare beneficiaries in
12 Part B are paying at least as much as single people in
13 employer groups.
14 Part A, there's no payment, but I don't know how
15 to deal with that because of the payments into the trust
16 fund. So I'm not quite sure how important it is to compare
17 that premium contribution, but I'm not sure what rules to
18 use.
19 The last point, which I think will come up a lot
20 when you talk about the supplemental market, which I would
21 encourage you to not ignore as you think about the benefit
22 package, because of the role of the supplemental market, is

1 that choices are much simpler for those with employment-
2 based coverage than Medicare. That's mainly because of the
3 choices that are involved in supplemental coverage, where
4 you have to know whether you're in an employer group or not,
5 and if there an HMO in your area or not? And are you
6 eligible for Medicaid or not? That varies in each state.
7 Those get quite complicated and I think one of the
8 risks, as one tries to figure out how to improve the
9 Medicare benefit package or address limits in benefits
10 through other areas with a limited budget constraint, is you
11 do make marginal changes in benefits but they have some
12 pretty nasty effects in terms of the complexity of choice
13 that it looks like to the beneficiaries as you go forward.
14 So good intentions can lead to a lot of complexity.
15 DR. ROWE: Can I ask you to clarify something,
16 Marsha? You said, on the last slide, Part B contributions
17 are at a par or higher than contributions for single
18 coverage in groups. Were you thinking about that in an
19 absolute dollar or as a percent of the health care cost?
20 DR. GOLD: Both.
21 DR. ROWE: Because the health care costs are so
22 much greater in this population.

1 DR. GOLD: It was both, but restricted for
2 Medicare side to only the Part B. So I didn't take into
3 account the Part A expenses. But both the absolute dollar
4 on Part B and the share of the premium it is is higher.
5 I was surprised at that. I actually frankly
6 thought it would be less. But again, because Part A is left
7 out, I don't know quite what to make of that.
8 DR. ROWE: Thank you.
9 DR. GOLD: Just the last slide, to summarize, I
10 think what you see is that Medicare and employment-based
11 benefits share some similarities but Medicare benefits are
12 generally more limited. And when I think you look over
13 time, the disparities are growing. So the question that the
14 Commission faces, not only today but tomorrow and over the
15 next few months, is what to recommend; how best to address
16 Medicare's current limitations; and especially what
17 principles should apply to any efforts at modernization.
18 I have, in the paper and in the executive summary
19 you have, a more extensive discussion of that. I'm not
20 going into it here, because that's really the focus of your
21 meeting tomorrow, but you might want to take a look at that
22 before then if that's of interest.

1 I'll take questions.

2 MR. HACKBARTH: Marsha, I have a question about

3 this one.

4 DR. GOLD: I was afraid somebody was going to ask

5 me about that slide.

6 MR. HACKBARTH: It's probably not what you're

7 fearing. Let me get your reaction to an observation, that

8 there is a correspondence between this pattern of declining

9 rates of growth in the early '90s -- very low rates of

10 growth in the mid-1990s, and then now more recently an

11 escalation -- with what's been happening in terms of the

12 organization and delivery of care and how that works with

13 health plans.

14 In the '90s there was a movement, not universal

15 but some movement towards people being in systems that were

16 more structured, organized, some would stay restrictive,

17 both for the enrollee and for the clinicians and providers

18 participating in them. Now by popular demand we're moving

19 more towards health plans and delivery systems that are

20 focused on maximizing choice.

21 Question number one is do you agree with that as a

22 general observation? Question number two would be maybe

1 what this presages is the pendulum swinging back again
2 towards more structured organized systems. That people are
3 slowly perhaps but inevitably learning the connection
4 between organization of delivery and the cost of care.
5 We may learn slowly but eventually we will learn.
6 DR. GOLD: Yes. I think I agree with that
7 observation. I want to sort of caveat it. It's clear that,
8 at least from the employer end, the shift to managed care --
9 I think at least in their minds and a lot of other people's
10 minds when they've looked at it -- has resulted in some of
11 the savings.
12 Some of that is overstated, I think, because the
13 underwriting cycle probably meant that the increases before
14 were higher and also some of that savings was because people
15 underestimated how much things would cost, and so they come
16 back up again. So there were some savings through managed
17 care.
18 As you know, I've sort of looked at managed care a
19 lot, and I think most people in the industry -- and
20 certainly, I would think, from a policy perspective -- would
21 agree that there are some fundamental issues of technology,
22 of coverage, of what people should have which just moving

1 from a fee-for-service system to a managed care system
2 doesn't resolve. In fact, that was probably some of the
3 biggest reasons there was a backlash, because people called
4 it managed care but we didn't change the underlying
5 infrastructure, nor did we deal with some of the ethical
6 issues as to who should have what.
7 So those dilemmas remain whether you move to a
8 managed care system or not. Now I don't know, one can say
9 it's half empty or half full. I remember Rashi Fine
10 teaching me in 1970, in my first health care course, do we
11 have national health insurance first or do we get costs
12 under control? I somehow sometimes think that everything
13 stays the same and nothing changes.
14 I do think a key -- I mean in my mind at least,
15 dealing with the issue of what is appropriate, what kind of
16 care people should get, and also what we expect of the
17 delivery system are the two fundamental things that will
18 affect costs of care, regardless of who's paying for it and
19 the fight over that. But what will happen with that, I'm
20 not terribly sanguine. I sometimes feel like we won't deal
21 with those things, instead we'll just have cost-sharing,
22 we'll go back to the '50s and we'll deal with out-of-pocket

1 costs. But that has a tough effect on people who are sick.
2 MR. HACKBARTH: Just for the record, I agree with
3 your point about this exaggerating the changes in trend
4 because of the underwriting cycle.
5 MR. GLASS: It might also show the provider push-
6 back. If most of those gains were because you were getting
7 providers to accept discounted rates and now providers are
8 not going to do that anymore, you see that pattern.
9 MR. HACKBARTH: Although I think that's a
10 function, in part, of network size and how inclusive the
11 networks are. Providers can push back a lot more if it's an
12 all-inclusive network and if the plan is willing to
13 restrict.
14 DR. GOLD: And also, in a backlash environment it
15 makes it easier for them to push back because all the press
16 has said how bad HMOs are.
17 MS. ROSENBLATT: I have quite a few points on what
18 you said. I thought this was very well done. Let me just
19 add to the discussion that just occurred.
20 I agree with you, although since I've had personal
21 experience back in the '70s, there's a feeling to me of
22 what's going on right now is sort of a back to the '70s.

1 But I do think, and this is my own opinion, not
2 that of my employer, not that of any actuarial academy. But
3 my own opinion is that the underwriting cycle caused a lot
4 of that, and the underwriting cycle was masked for several
5 years by the movement to managed care and the positive
6 selection that the HMOs created through that movement to
7 managed care.
8 And that by giving consumers the trade-off between
9 limited networks and more open access through a PPO, for
10 example, a lot of the savings that have been attributed to
11 managed care were due to that positive selection and that
12 the richer benefits were a cause of that because the richer
13 benefits were necessary in that trade-off choice. So there
14 are a lot of complicating factors there.
15 I think again, Glenn, your comment about the
16 trade-off between benefits and networks, it all fits
17 together.
18 DR. GOLD: That's helpful.
19 MS. ROSENBLATT: Was there any reason why you
20 looked at group coverage as opposed to individual coverage?
21 Because one of the things that I think a lot of people
22 always say is the cost of group coverage is so masked to the

1 individual because 80 percent of it is generally paid by the
2 employer, that those benefits are very different than what
3 you would see right now in the individual market where the
4 individual is bearing the full cost?
5 DR. GOLD: I looked at group coverage because I
6 was asked to. I think I probably was asked to because
7 people realize exactly what you said, and that the
8 individual products are -- the coverage is so much less at
9 so much more expense. And the idea was saying when Medicare
10 started, people -- I'm not sure this is exactly true because
11 I went back to try and find it. But it's common belief that
12 Medicare was modeled after the employer-based plans, and
13 certainly they are after some of the more common ones.
14 So the thought was let's look and see how it
15 compares now to what it was then because that might be a
16 precedent. And I think if my colleague, Debra Shallet, was
17 here, she could talk more about some of the limitations in
18 the individual market. But I think it's recognized there
19 are a lot. I didn't look at it because I wasn't asked.
20 MS. ROSENBLATT: Maybe that's something we should
21 consider. Because it is extremely different.
22 DR. GOLD: I think there's some good papers on

1 that already.

2 MS. ROSENBLATT: You'll probably find there's more

3 catastrophic coverage. It also gets to your parity question

4 because there is no employer funding, so to speak.

5 DR. GOLD: The paper does go into the issue of

6 just whether people have the coverage, if they are in an

7 employer group. So there's some data on that there.

8

9 MS. ROSENBLATT: The other point I wanted to make

10 is you've got that slide of what was covered in 1977, and

11 you mentioned that outpatient prescription drugs were

12 covered. You said it was part of major medical, and I'm not

13 sure everybody understands that.

14 Coverage for outpatient prescription drugs in

15 those days of indemnity plans put the prescription drug

16 benefit under the deductible. The deductible in those days

17 was typically $100. So if you were healthy and the only

18 expense you had was a drug, and the cost of drugs those

19 days, you very rarely got to have that as a benefit because

20 your drug costs never hit the deductible.

21 And again, if you look at individual plans right

22 now, there's a movement away from the copay and towards that

1 type of deductible product.

2 DR. GOLD: I'm not sure I saw the movement of the
3 deductible product, but I think that's otherwise right. The
4 paper does provide information on the size of the deductible
5 back then.

6 DR. REISCHAUER: I just have a footnote on that.
7 I was groveling around for information on what fraction of
8 prescription drugs were paid for by insurers around the mid-
9 1960s. It was only something like 5 percent, for exactly
10 this reason. It wasn't that many didn't have "coverage" for
11 prescription drugs but they never amounted to much. You
12 collected them, you had to send them in, you lost the slip
13 and all that.

14 MS. ROSENBLATT: One of the things you mentioned
15 that I haven't done research on, but it just strikes me as
16 being different in the industry. You said the pre-tax
17 spending accounts were not very common. You're talking
18 about FSAs, flexible spending accounts?

19 They're very common, from what I've seen.

20 DR. GOLD: What I was talking about, I think
21 they're commonly offered by especially the larger employers,
22 which is probably what you see. The take-up rates of

1 employees isn't as high. I'm referring to Bureau of Labor
2 Statistics data. It may be out of date.
3 Also, it's more common among the large employers,
4 which is probably what you're thinking of more. The take-up
5 rates and the amount are relatively low. It is higher for
6 higher income people or people in higher jobs, so probably
7 what you see is the higher share of that.
8 MS. ROSENBLATT: I also agree with the point that
9 you made that the data is lagging what's happening. Because
10 if you follow that curve where you saw three years of
11 increases, you ended in 2000 if I remember correctly? 2001
12 and 2002 continued that curve and my expectation is 2003
13 would continue it.
14 So I think that I agree that it's going to be
15 evolutionary not revolutionary. But the employers, from
16 what I see the employers are definitely increasing copays,
17 increasing deductibles, cost-sharing, looking for ways to do
18 things with networks that will save costs, and putting more
19 premium contribution on the employees. So there's a
20 definite trend.
21 DR. GOLD: If I can just clarify, the Kaiser/HRET
22 data was for 2001, but all the other data was earlier than

1 that.

2 MS. ROSENBLATT: And there is 2002 data available,
3 I think, because most of the large employers at least renew
4 new on January 1st, 2002. So there ought to be some data
5 available.

6 DR. ROWE: Let me just comment on that, Alice,
7 from another point of view. We saw, I think, in our book of
8 business contracting in January of this year, on average,
9 about a 3.5 percent buy-down with respect to reductions in
10 benefits on the part of employers in order to try to reduce
11 their expenses with respect to the contracts.

12 DR. GOLD: Can I ask you just in what form that
13 was translated to the employee, if you know? Is it mainly
14 cost, copays?

15 MS. ROSENBLATT: Buy-down would be benefits. Jack
16 wouldn't see the effect of the contributions.

17 I have only three more points, bear with me. I
18 also agree with your PPO point, that it's very similar to
19 what happens with some of the Blue plans back in the '60s
20 and '70s where the Blue plans were the only carrier out
21 there that had negotiated discount arrangements with
22 providers. In effect, they were very, very large PPOs.

1 Therefore, many of the Blue plans did not need to have PPOs
2 because their indemnity was similar to PPOs.
3 So I agree with your comment that Medicare could
4 be moving in that direction, as well.
5 MR. HACKBARTH: We're going to start to charge
6 copays for sequential comments, I guess, escalating copays.
7 [Laughter.]
8 MS. ROSENBLATT: I disagree with two. Choices are
9 simpler with employment-based coverage in the Medicare. I
10 think choices are pretty difficult with employment-based
11 coverage, as well. I don't think it's fully understood. I
12 mean if, in fact, people are not taking advantage of FSAs,
13 some of the things that you said, there are some pretty
14 complicated choices out there.
15 It's easier where the employer doesn't give
16 choice. But where the employer is giving choice, it's
17 tough.
18 DR. GOLD: I think the main issue I was concerned
19 with there was the supplemental market, if you overlay that.
20 I don't know that Medicare itself is more complicated than
21 employment based coverage, but that whole overlay of
22 different forms of supplemental coverage made things more

1 complicated to the beneficiary because they have to figure
2 out which of those they're eligible for. It may not be that
3 different for someone who's eligible for group-based
4 retirement coverage.
5 MS. ROSENBLATT: Absolutely, similar issue there.
6 My final point, I'm worried about the point Jack
7 asked you about the Part B premium. I didn't quite follow
8 it and I'm not sure that I'm there. So I might need to have
9 a side discussion on that one.
10 DR. GOLD: There's more data in the report.
11 DR. REISCHAUER: Can I offer something? It's
12 really quite simple. Premiums are 25 percent of Part B
13 spending by law, average employers charge 10 percent --
14 DR. GOLD: It's about 18 percent, I think, for
15 self.
16 MS. ROSENBLATT: Are we comparing Part B with
17 total?
18 DR. GOLD: That's what I said. And I say, I'm not
19 sure that's appropriate, but that's what it is. I was
20 trying to address whether the premium contribution was the
21 same, but I'm not quite sure how to do that.
22 MS. ROSENBLATT: I'm done.

1 MR. FEEZOR: One thing good about letting Alice
2 run on, she hit one of my points.
3 I do have to generally say that, first off, I do
4 think we need to work -- and I know the Foster Higgins now
5 is out and the 2001 figure I think was like 11.2 or
6 something like that. And I think early indicators will show
7 that 2002 are between 12 and 13 percent. So we are seeing
8 that curve go back up.
9 DR. GOLD: I can update that chart.
10 MR. FEEZOR: That gets to Alice's point. I guess
11 we almost ought to fall prey to what I call the actuarial
12 concern. Given the cost trends, and I would suggest that
13 since I'm one of the first in the barrel in 2002 and I hope
14 I'm atypical, but we will be looking at some trends that
15 begin to approximate what the late '80s, early '90s were,
16 every indication. I see Alice sort of nodding. Let's hope
17 it's a West Coast phenomenon, but I'm very worried about
18 that. I'm talking north of 15.
19 And there is the inevitable response, there's a
20 lag time between employers sort of grasping at, we'll take
21 it the first year, and I think we are on the cusp of a
22 significant erosion -- Jack pointed to it in his comment

1 just a second ago -- that will, in fact, begin to show up
2 and accelerate. I think Marsha is absolutely right. Most
3 of those changes, in looking at alternatives, whether it's
4 smaller networks, going back to tiered products not just in
5 pharmaceutical but tiered networks, to even less choice
6 which we've seen over the last couple of years in private
7 coverage, that those are going to be accelerating.
8 And I think our report needs to try to do the
9 actual route of maybe putting the greatest weight on the
10 last year or two's evidence, in terms of as we start to look
11 forward as opposed to saying well, in a 10 year picture it
12 really isn't great movement. So let's use the most recent
13 look back.
14 Particularly one area that I do think was not
15 captured because it's hard to capture, is that a fundamental
16 theme of employment-based coverages that they're not
17 executing too well on is greater enrollee engagement, not
18 just on the cost side, but in terms of their decisionmaking,
19 their responsibility for their own care coordination.
20 Whether or not that is something that could or
21 should be carried through to our aging population is a
22 question, but I think that is a trend that certainly the new

1 plans like Definity, that are enhanced by information
2 technologies and other profiling opportunities do come into
3 play that will be more evidenced in the private area.
4 DR. GOLD: There's additional detail on that in
5 the paper.
6 MS. NEWPORT: Thanks for coming today. It's very
7 helpful.
8 I was very anxious to hear what Allen had to say,
9 from his perspective as an employer purchaser group on
10 trend, so I won't go into that.
11 I would caution maybe as we look forward here is
12 looking at the nomenclature issue, understanding market
13 share between PPO, HMO, indemnity, point-of-service, for
14 example, in the complexity in choice that beneficiaries
15 have.
16 Our survey data shows that benes that are in the
17 classic HMO but think they're in a PPO have a higher
18 satisfaction rate than those that are in a PPO. And I think
19 that there's a real issue here. I was struck by -- can you
20 see this, my staff does this to me all the time.
21 This bar graph, in terms of the market share and
22 the movement towards freeing up choice but having members

1 really understand what is happening in terms of delivery of
2 care.
3 The other thing I think we need to bring out a
4 little more on the employer's side is the effect of the tax
5 benefit to providing this coverage, and acknowledge it in
6 terms of lining up what share of the costs is there.
7 Again, I would echo what Alice and Allen have said
8 about the trend data is looking more closely at the most
9 recent tend, although I know there's some limitations in
10 that, and really understanding what's happening. I think
11 that much of the rhetoric around managed care, in the
12 classic sense, we don't find we have a classic managed care
13 product anymore, in terms of our response to the
14 marketplace.
15 So I think that I would just like to urge, as we
16 look forward on this, that we are very careful about how we
17 categorize and define these products because it is
18 evolutionary, which is a point Marsha brought out. But I do
19 appreciate your thoughtful presentation.
20 DR. NEWHOUSE: I just have a couple rather picky
21 points. If I were a reviewer, this would be in the specific
22 comments, rather than the general comments.

1 The first is there's actually a couple of earlier
2 national household surveys than the National Medical Care
3 Expenditure Survey that were done out of the University of
4 Chicago by Odin Anderson and Ron Anderson.
5 DR. GOLD: Did they have insurance coverage on
6 there with the benefit package? A lot of times, Joe, those
7 household surveys that are done -- and NHIST was done I
8 think before then -- but you have to survey employers to get
9 at what the benefit package was.
10 DR. NEWHOUSE: That's right, but they do have what
11 percentage of various kinds of bills were paid. The point I
12 was going to make is that actually if you go back, it's not
13 only drugs where there's a very low coverage. It's also
14 office visits. Medicare in the '60s is actually in advance
15 of much of private coverage by covering office visits.
16 My recollection is actually different from Bob's
17 and yours. I don't think drugs are generally a covered
18 benefit in the policies in the '60s. I think it's not just
19 that they didn't satisfy the deductible.
20 DR. GOLD: Major medical was growing, so it may be
21 that major medical wasn't bigger in the '60s. It was
22 growing towards the '70s, which may be why it shows up in

1 NMES but not in --

2 DR. NEWHOUSE: One indicator of that is just, as I
3 recall -- I mean, I have some data from back then about the
4 proportion of drug spending that was covered by insurance.
5 As I recall, it's down in the fairly low single digits. Now
6 there's enough people with chronic disease that are going to
7 get above the $100 deductible to push it higher than that,
8 if it's generally covered.

9 The other quibble I have is I'm not sure I'm
10 comfortable with saying both Medicare and managed care have
11 more limited mental health benefits than medical. It's
12 clearly right for traditional Medicare, just on the copay
13 side.

14 In a world of managed care and utilization review,
15 I'm not sure how you would know it in private insurance.

16 DR. GOLD: Actually, I used to track that, as you
17 know, back when I was at GHAA. You're right, it's hard to
18 interpret what's equal, but there's more likely to be a
19 visit limit or a day limit on the mental health benefit
20 which doesn't exist on the other side.

21 DR. NEWHOUSE: I understand.

22 DR. GOLD: Now you may talk about appropriateness

1 or all the rest but --

2 DR. NEWHOUSE: What do you mean it doesn't exist

3 on the other side?

4 DR. GOLD: There's no general visit limit or

5 there's no general hospital day limit, but there is a limit

6 on mental health visits.

7 DR. NEWHOUSE: I understand that, but then I at,

8 as I say, in a world of utilization review, it's not clear

9 that that's the right test for assessing equal benefits.

10 DR. GOLD: I'm not sure it's the right test, but I

11 think we may disagree on the conclusion.

12 DR. NEWHOUSE: If I have a world of unlimited

13 benefits but I say gee, you don't really need care from XYZ,

14 and therefore I'm not going to pay for it on the medical

15 side, and I say you don't need this care on the mental

16 health side either, I'm not sure, as I say, how to say that

17 one is more equal than another.

18 If I'm a passive payer of whatever, bills come in,

19 as in traditional Medicare and I pay more for the medical

20 side than the mental health side, then the answer is clear.

21 DR. GOLD: I think that if you look at the

22 structures that are in place, there are a lot more hoops to

1 jump through on medical necessity for mental health and
2 substance abuse than there are in general medical care. And
3 so, it would seem to me that that makes the benefit more
4 constrained on the mental health/substance abuse side
5 because of the existence of more hoops in addition to -- you
6 just don't have that same level of review on the medical
7 side.

8 DR. NEWHOUSE: I agree with you about the benefit
9 limits, but we'll leave it at that.

10 MR. MULLER: In the charts we received before the
11 meeting showed the considerable drop in retiree coverage
12 over the period of years. I would assume that these charts
13 that Allen and Alice were talking about with the
14 considerable rise in premiums for employers, that that drop
15 would probably even accelerate as the population ages into
16 65?

17 DR. GOLD: No, I don't think so. If I can
18 understand what you're saying, I think these are on active
19 workers and their cost per covered individual. So I don't
20 think --

21 MR. MULLER: But the ones that age up from age 64
22 into Medicare, I would assume that one of the things that

1 employers do is even less likely to cover them.

2 DR. GOLD: In terms of the employer's total bill,

3 if they're covering less retirees and they have more people

4 aging into retirees, their total bill will go down. For the

5 active workers, they'd still be facing some of the same cost

6 pressures.

7 MR. MULLER: I'm talking about the ones that age

8 into retirement, because when I tie that together with

9 what's happening at the state level right now with a very

10 precipitous drop in state revenues, and looking at those

11 charts we have -- I don't have them memorized -- but

12 something like 30 percent of the people have that retiree

13 coverage. I think the Medicaid was a little less than 30.

14 You can see some considerable pressure, but states

15 act much faster than Medicare does to drop things, so you

16 can see some real dropping of coverage by the Medicaid

17 programs and the retiree programs, therefore putting

18 Medicare more into a spot of --

19 DR. GOLD: That wasn't the focus of what I looked

20 at, but I think it's a major policy that probably is

21 relevant to your session after lunch because you're looking

22 at the supplemental market. In fact, a lot of the sectors

1 of that supplemental market are diminishing in their
2 availability. There's less employer-based coverage. The
3 benefit for the M+C plans is less extensive than it was.
4 The price is going up on Medigap. I'm not sure what the
5 Medicaid trends are.
6 So that is an issue. I think one of the big
7 issues that the Commission faces is sort of what is
8 Medicare's role? To what extent should Medicare be
9 providing all of it? To what extent should there be a
10 supplemental market? And will there be a supplemental
11 market? So that factors in. But that's a real policy
12 issue, as opposed to an empirical thing.
13 MR. HACKBARTH: I think the copay is now, I think,
14 $35.
15 [Laughter.]
16 MS. ROSENBLATT: Talking about copays, Joe made a
17 point about prescription drugs and I think that prescription
18 drugs will receive a lot of attention it's very important
19 that we do an accurate job of what the historical issue of
20 prescription drugs is. I mentioned that my memory of the
21 '70s, being an actuary in this business in the '70s
22 unfortunately, I'm ashamed to admit, is that there was

1 coverage through the major medical plan. I worked for a
2 commercial carrier at the time.
3 What I don't know is there were Blue plans in the
4 '70s, that some had a base and then a commercial carrier
5 would come in with the major med. Other Blue plans had base
6 plus major med coverage. I'm much less familiar with that.
7 I don't know what those plans were in the '70s.
8 DR. GOLD: I didn't see that literature but, based
9 on this discussion, I think I need to go back and certainly
10 make the point about the major medical and look at some of
11 those spending things. And if there are any other data that
12 would shed any light on that, I'll incorporate that into the
13 report. I agree.
14 DR. NEWHOUSE: But the right date for this
15 comparison is the '60s.
16 DR. GOLD: If you can get it. Yes, I agree, if I
17 can get it.
18 DR. NEWHOUSE: Drug coverage starts to come in in
19 the '70s.
20 MR. FEEZOR: Just a quick comment, Ralph, on
21 yours. There are two retiree populations you have to worry
22 about, the pre-65 and the over-65, and what an employer may

1 or may not choose to do in either of those sectors is
2 important. Clearly, the retirement issue was driven on the
3 private sector in '92 -- when was FASB 106? '92.
4 The interesting thing, on the public sector side,
5 a FASB equivalent which basically said you've got to put on
6 your books somehow the expected cost of your retiree, is
7 about to happen for the public sector. The initial exposure
8 is this summer, June I think, at precisely a time when most
9 of those coffers are, in fact, depleted. It will be
10 interesting to see what that does also, in terms of state
11 bonds, local bonds, and so forth.
12 It will be interesting to see if there is a
13 similar acceleration of withdrawal by public employers.
14 Probably not, we tend to be less resistant.
15 The one other thing, Marsha I don't recall it in
16 the paper but it may be in the fuller edition, one of the
17 greater enrollee engagement issues that I think private
18 payers are trying to begin to push in a bit is removing the
19 insulation to the pricing or increasing price transparency,
20 I guess, is the current movement. Like Definity, the health
21 market models are built on that. It will be interesting to
22 see whether that persists.

1 DR. GOLD: I didn't see any of that. Part of that
2 was what I did in conjunction with the Commission staff is
3 not go through as much of the anecdotal literature and I was
4 relying mainly on the national surveys and what they're
5 tracking. I didn't happen to see that in any of the ones
6 that I looked at. But it wouldn't surprise me that that was
7 happening.
8 MR. HACKBARTH: I've been sitting here thinking
9 about the comments that Alice and Allen made earlier about
10 likely cost trends for employers in the immediate future.
11 I'm getting depressed right before lunch.
12 One interpretation of all of this is that the
13 apparent decline in the rate of growth in the '90s was not
14 real, it was an artifact of underwriting cycles and
15 selection and the stock market. You name it, a whole lot of
16 things. And we really have learned very little about how to
17 control costs and the evidence of that is about to hit us in
18 the face with rapidly escalating costs for employers.
19 Medicare is a little bit different by virtue of
20 its purchasing power. But in terms of controlling the
21 volume of services, no different and probably even worse
22 than the employer side.

1 If all of that is true, that has daunting
2 implications for any discussion of adding additional
3 benefits to the Medicare program, particularly in the
4 context of the major imbalances that exist just because of
5 demographics. So I'm depressed.
6 DR. REISCHAUER: I'll try and bring you back from
7 the depths of despair.
8 First of all, this period in the 1990s was one in
9 which we squeezed a great deal out of providers. I mean
10 sure, there was an underwriting cycle. Sure, there were
11 shifts of people from one form of delivery to another.
12 But look at hospitals now. Look at physicians'
13 relative incomes compared to investment bankers. Go down
14 the list. And a lot of it was real and it's here to stay
15 forever. Once you lower the level, it's here forever.
16 The second point that I think we all should be
17 aware of is the projections for Medicare's costs that CBO
18 and OMB have released for the next 10 years are the lowest
19 growth in per capita benefit expenditures in the program's
20 history.
21 Now some of that is due to the SGR.
22 MR. HACKBARTH: We know how good they are at

1 estimating --

2 DR. REISCHAUER: You can even add in our excessive
3 exuberance with respect to benefits and you would still get
4 a lower -- some of it is because there isn't a drug benefit
5 and drugs are what's driving a lot of the costs. But just
6 to go to your point, which is how can we be sitting here
7 talking about an expanded benefit package? I would say
8 we're talking about it at a time when the projections are
9 for the slowest growth in Medicare spending in the history
10 of the program.

11 So cheer up.

12 [Laughter.]

13 DR. ROWE: Let me suggest a solution for you
14 that's really going to drive you crazy.

15 If you're concerned about the numbers that you've
16 been hearing here about the inflation rates in the health
17 plans for Medicare costs, all of which are conservative,
18 then you should remind yourself of the reciprocity between
19 Medicare payments and commercial HMO payments, and increase
20 Medicare expenditures in order to help drive down the
21 medical trend in the health plans.

22 [Laughter.]

1 MR. HACKBARTH: I knew you would have a solution.
2 DR. WAKEFIELD: Give him a gold star.
3 DR. REISCHAUER: A statesman-like suggestion.
4 MR. HACKBARTH: We do need to go to lunch, but
5 before we go to lunch we will have a brief public comment
6 period, about 10 minutes.
7 MR. McCAMBRIDGE: My name is Peter McCambridge.
8 I'm a self-employed surgical technologist, first surgical
9 assistant. It's my pleasure to lend my working knowledge to
10 the Commission and answer any kind of questions.
11 I meet all the requirements for the Medicare Part
12 B services, it's reasonable and necessary, it's legally
13 authorized for me to perform the services, and it's
14 identical to the physician services.
15 I was enthused to see that this current care
16 coordination addresses the fact that you don't want me not
17 to be paid for my services, but you mostly just want to make
18 sure it's not going to fragment out to additional providers.
19 The one point I wanted to make is the Medicare
20 Part A and Medicare Part B. The surgical technologists now
21 get paid through Medicare Part A and I get paid through
22 Medicare Part B. I get paid by Medicare replacements. That

1 could be a test if you're looking to see if it would
2 increase the costs or not. I already now get paid by
3 Medicare C.
4 I think the main reason why the surgical
5 technologists haven't been recognized is that the profession
6 just came onto the -- the provider services that was out
7 there just after 1997 or just recently, the specialty didn't
8 exist when Medicare had its compensation rules made. But I
9 regularly get paid by all other insurance companies. The
10 only insurance company I don't get paid by is Medicare B.
11 Just to restate my point, I'm here to answer any
12 kind of questions. I have working knowledge and I hope that
13 I can answer some questions. Excuse me, I'm a little
14 nervous. Do you have any questions? Or later on this
15 afternoon, I think, is when the topic comes up of surgical
16 technologists.
17 MR. HACKBARTH: That's right. Thank you.
18 MR. YOW:
19 John Yow, Indian Health Service.
20 My question is primarily directed to Dr. Hurley,
21 with respect to the expert panel and the Medicare benefit
22 package. One of the biggest concerns that seniors have, I

1 believe, in this country of course is long-term care.
2 Currently or historically Medicare's benefits for long-term
3 care is very limited, as Dr. gold has pointed out, limited
4 to 30 days of SNF post-hospital discharge, and more recently
5 very limited home-based and assisted living type of
6 benefits.
7 The concern to both the first group and the second
8 categories of patients identified by the expert panel, of
9 course, is some kind of catastrophic illness or unforeseen
10 events that would lead to prolonged long-term care and the
11 wiping out of a senior's lifelong savings or assets because
12 right now, as it exists, very limited coverage in the
13 private sector and prohibitively expensive. The only
14 coverage thereafter is Medicaid, which of course has the
15 asset spend-down regulations.
16 So I'm just wondering whether or not it was off
17 the parameters or limits with respect to the panel's
18 discussion and recommendation? Or whether or not it was
19 just not being discussed with respect to the Medicare
20 benefits package?
21 Thank you.
22 DR. HURLEY: It was not part of the discussion.

1 MR. HACKBARTH: Any other comments? Hearing none,
2 we will reconvene at 1:00 o'clock.
3 [Whereupon, at 12:14 p.m., the commission
4 adjourned, to reconvene at 1:00 p.m.]

1 AFTERNOON SESSION [1:04 p.m.]

2 MR. HACKBARTH: Our next panel is on supplementing

3 the Medicare benefit package.

4 What I'd ask the commissioners to do is allow all

5 of our presenters to go before we start asking questions and

6 making comments, unless you have a very specific clarifying

7 question about a fact or figure or something like that.

8 They were suggesting, Jack, that I tell you

9 specifically that we're holding questions and comments until

10 the three presenters have presented.

11 [Laughter.]

12 DR. WORZALA:

13 At the last meeting, you discussed some of the

14 limits of the Medicare fee-for-service benefit package.

15 During this presentation, we want to provide you with

16 information about the ways in which beneficiaries are

17 obtaining coverage for cost-sharing requirements and also

18 for some uncovered benefits.

19 I want to start by introducing our guest lecturer,

20 Jeanne Lambrew. Jeanne is an Associate Professor of Health

21 Services Management and Policy at George Washington

22 University. Most of you probably know Jeanne. For those

1 who don't, she has considerable experience working on
2 Medicare, Medicaid, and other health policy issues.
3 She worked at the White House from 1997 to 2001 as
4 the Program Associate Director for Health at the Office of
5 Management and Budget. She was also Senior Health Analyst
6 at the National Economic Council. Prior to serving at the
7 White House, Dr. Lambrew taught at Georgetown University and
8 worked at the Department of Health and Human Services.
9 Turning to the topic at hand, I will begin the
10 presentation by discussing why the topic of additional
11 coverage is important. I'll then turn the discussion over
12 to Jeanne, who will discuss sources of additional coverage
13 and some of the recent trends in how beneficiaries are
14 filling Medicare's cost-sharing obligations and obtaining
15 additional benefits.
16 And then Scott is going to wrap up the
17 presentation with a discussion of the issues you may want to
18 consider when contemplating changes to the benefit package.
19 We know that fee-for-service Medicare has
20 significant cost-sharing obligations and limited coverage
21 for some items, such as prescription drugs. As Ariel will
22 discuss later, we estimate that the Medicare program

1 currently pays about 60 percent of beneficiaries' total
2 health care costs, if you exclude long-term care costs.
3 To help cover those costs that aren't borne by the
4 program, over 90 percent of Medicare beneficiaries obtain
5 coverage beyond the fee-for-service benefit. They do this
6 either by supplementing it with additional source of
7 coverage or by replacing it with a managed care plan.
8 On a semantic note, we tried to refer to sources
9 of additional coverage as a broad term that would include
10 Medicare managed care and use the term supplemental coverage
11 for those products that truly are a supplement to fee-for-
12 service Medicare. But we will probably slip in that, so
13 please bear with us if we use the terms interchangeably.
14 It's important to understand beneficiary sources
15 of additional coverage for a number of reasons. First,
16 beneficiaries without a source of additional coverage report
17 more coverage with access to care. For example, in 1998,
18 those with only fee-for-service Medicare coverage were more
19 than three times as likely as those with fee-for-service
20 Medicare and private supplemental insurance, to report
21 trouble getting care. They were nearly five times as likely
22 to delay getting care due to cost, and more than three times

1 as likely to lack a usual source of care.

2 In addition, they were more than 2.5 times as

3 likely to have not visited a doctor's office in the past

4 year, compared to those with private supplemental insurance.

5 In terms of the actual percentages, I'll only

6 elucidate one of those numbers. That is that 21 percent of

7 those with only Medicare fee-for-service coverage reported

8 delaying care due to cost, compared to 4.4 percent of those

9 with private supplemental coverage. That's from previous

10 MedPAC analysis of the MCBS access to care file for 1998.

11 We, of course, cannot infer that those with

12 private supplemental coverage have the optimal level of

13 service use, but the magnitude of these differences does

14 suggest that those without supplemental coverage are more

15 likely to have access problems.

16 Recent research has also suggested that having

17 supplemental coverage is associated with greater use of

18 medically appropriately therapies, and especially drugs, for

19 certain medical conditions. For example, beneficiaries with

20 coronary artery disease were more likely to take statins if

21 they had supplemental coverage that included drugs.

22 We plan to bring you new findings on the

1 associations between sources of additional coverage and
2 access to necessary care at the April meeting. So we'll
3 have 1999 findings, at least.
4 Finally, we want to look at supplemental coverage
5 in particular, and here I do mean those things that really
6 supplement the fee-for-service package, because they
7 complicate and distort the market. Studies have shown that
8 beneficiaries lack a basic understanding of the Medicare
9 program and they have considerable difficulty navigating the
10 many choices of how to obtain additional coverage.
11 In addition, the multiple sources of coverage do
12 increase administrative expenses in processing claims and
13 managing multiple systems. And for those purchasing private
14 supplemental coverage on an individual basis, that's simply
15 a very expensive way to get insurance.
16 Finally, some supplemental products provide
17 generous coverage of Medicare's cost-sharing requirements.
18 Most products do pay for the lion's share of beneficiaries'
19 deductibles and coinsurance, and some of the products cover
20 all of them. That's what we mean by first dollar coverage
21 because beneficiaries are protected from financial liability
22 from the first dollar of expenditure beyond their premium.

1 These products then eliminate the incentives for
2 judicious use of services that cost-sharing is meant to
3 provide. While studies of this effect vary on the
4 magnitude, there is general consensus that use of services
5 is increased when first dollar coverage is provided.
6 MS. ROSENBLATT: Excuse me, could we just mark
7 this slide. I have a lot of comments on this one later.
8 DR. WORZALA: If you'd like, we can address them
9 now. I don't have a problem with that.
10 This increased use of services results in higher
11 premiums for beneficiaries and higher costs for the Medicare
12 program. I do want to note that the literature has observed
13 this relationship but it doesn't identify how much of the
14 additional service use or, of course, which specific
15 services might be considered unnecessary. And in light of
16 the evidence that we have regarding access to care, it's not
17 clear that the level of services used by those without
18 supplemental coverage should be considered optimal in any
19 way.
20 At this point I'm going to turn things over to
21 Jeanne and she'll take it from there.
22 DR. LAMBREW: I think that, given the interest in

1 the other commissioners' asking questions, I'm going to try
2 to do a very quick overview of the different sources of
3 supplemental coverage, the differences across types of
4 supplemental coverage, and then the characteristics and
5 trends in the sources of supplemental coverage.
6 About 91 percent of Medicare beneficiaries have
7 some type of supplemental coverage for most of the year.
8 The most common source of supplemental coverage is employer-
9 sponsored insurance. For most Medicare beneficiaries, this
10 means retiree health insurance. For some, they're active
11 workers and they're included in this category.
12 The second most common type of supplemental
13 coverage is Medigap. About 28 percent of Medicare enrollees
14 in 1998 have Medigap health insurance, which is primarily
15 individual health insurance sold in the individual market.
16 Third, about 18 percent of Medicare beneficiaries
17 had Medicare managed care. I will not be politically
18 correct in this presentation and call it supplemental
19 coverage because it clearly was providing extra benefits and
20 reduced cost-sharing for Medicare beneficiaries.
21 Fourth, Medicaid covers about one in 10 Medicare
22 beneficiaries.

1 If you look at this pie chart, it's important to
2 note that this is the coverage distribution for where they
3 had coverage for the most part of the year. About 12
4 percent of Medicare beneficiaries had either different
5 sources of coverage throughout the year or multiple sources
6 of coverage. It's not uncommon that Medicare beneficiaries
7 will have Medicare managed care and Medigap, as well.
8 This is a fairly complicated table but what it
9 tries to do is compare the sources of supplemental coverage
10 across three major dimensions. First, who's eligible;
11 second, how much you pay; and third, what's covered?
12 Looking at eligibility, what's interesting about
13 supplemental health insurance for Medicare beneficiaries is
14 that virtually all types of coverage have some type of
15 eligibility and/or access restrictions. Clearly, employer-
16 sponsored insurance is restricted to those who work for the
17 particular firm, and even within those firms there's often a
18 length of service requirement. In the year 2001, the
19 average length of service that an individual had to work to
20 quality for retiree health insurance was 11 years.
21 With Medigap, all people joining Medicare at the
22 age of 65 have guaranteed access to Medigap for six months.

1 But afterwards, in most states, plans can both underwrite
2 those individuals and deny them coverage all together. In
3 addition, those non-elderly Medicare beneficiaries are at
4 larger disadvantage. There's only 19 states that guarantee
5 access to Medigap for the non-elderly Medicare
6 beneficiaries.
7 With Medicare+Choice, it probably has the least
8 access restrictions up front in terms of any individual in
9 an area can sign up for it. But, as you've heard in
10 previous presentations, those choices have become
11 increasingly restricted. About 40 percent of Medicare
12 beneficiaries lack the choice of a Medicare managed care
13 plan in the year 2001.
14 And finally, Medicaid has very strict eligibility
15 criteria, in part because of its generosity of benefits,
16 which we'll talk about momentarily.
17 Looking at the row on premiums, in addition to
18 Medicare's Part B premium, which is $54 in the year 2002,
19 what you see is that actually most beneficiaries pay
20 something for supplemental health insurance. The average
21 premium for employer-sponsored health insurance was $50 in
22 the year 2001.

1 Not all people in retiree health plans pay
2 premiums. About a third of them don't. But another one-
3 fifth of those beneficiaries in retiree health insurance pay
4 the full premiums, so this represents an average.
5 The Medigap premium in the year 2000 was about
6 $108 per month. That reflects premiums across all different
7 types of plans, including those with prescription drugs,
8 whose average premium was closer to $130 per month. In
9 addition to those types of variations across plan types,
10 there's significant variation by age and geography. In many
11 places, beneficiaries can be charged more based on their
12 age. So that the premium that they get charged in Medigap
13 at age 65 rises significantly when they turn 80 or 85.
14 That's called age attained rating. Similarly,
15 there's significant variation across area, in terms of
16 Medigap premiums. The Medigap premiums in California,
17 Indiana and Florida are, on average, 20 percent higher than
18 average and 75 percent higher than low cost states like New
19 Hampshire, Utah, and Montana.
20 Even Medicare+Choice has increasingly relied upon
21 premiums for their enrollees. The average in the year 2002
22 is $31. Again, some beneficiaries pay nothing for it. Some

1 pay higher premiums. That represents the average but it's a
2 increasingly trend.
3 With Medicaid, there is no premium for most
4 beneficiaries.
5 Turning to coverage, and we'll go through this
6 fairly quickly because again this is a complicated table,
7 virtually all types of supplemental coverage reduce
8 Medicare's cost-sharing to either nominal rates or nothing.
9 This represents a significant change in the out-of-pocket
10 burden for those beneficiaries.
11 The variation of coverage with benefits is much
12 greater. If you look at prescription drugs, most employer-
13 sponsored health insurance plans and most managed care plans
14 do offer prescription drugs to their enrollees. But in all
15 cases, we're seeing significant restrictions. The Medigap
16 drug benefit is availed of by only a third of its
17 beneficiaries, and it's a capped benefit with a $250
18 deductible, 50 percent copays, and a cap at $1,250 or $3,000
19 per year. In other words, once you have $6,250 worth of
20 drug spending in Medigap, you get no more coverage.
21 Similarly, as you probably heard in previous
22 presentations, the Medicare managed care benefit has grown

1 increasingly limited over time. In the year 2001, according
2 to some work that Marsha Gold has done, about 30 percent of
3 plans had no drug coverage and of those with drug coverage,
4 nearly half had caps at or below $1,000.
5 Finally, Medicaid does remain a major payer of
6 prescription drugs for Medicare beneficiaries. It does
7 cover the full range of drugs for most Medicare dual
8 eligibles.
9 Looking at the other benefits, Medicaid really is
10 the only program that has significant long-term care
11 coverage. Most of these sources of supplemental coverage
12 cover dental, vision and hearing services, although that
13 also is becoming more limited both in employer plans and in
14 Medicare managed care. And preventive services are often
15 covered by most of these sources of supplemental coverage.
16 These differences in eligibility and premiums and
17 access appear in the distribution of Medicare beneficiaries
18 across types of supplemental coverage. What this chart
19 shows is that there is a very big difference in who gets
20 what type of coverage based on income. Medicaid is the
21 primary payer or source of supplemental coverage for those
22 below poverty, whereas employer-sponsored coverage is the

1 primary source of coverage for those in the higher income
2 brackets, here defined as about $31,000 for a single and
3 $40,000 for a couple.

4 What's interesting about this chart is looking at
5 these people with medium income. About 26 percent of them
6 purchase Medigap coverage which, for individuals at the
7 lower end of that income spectrum, could represent about 15
8 percent of income not including the cost of drugs.

9 Turning to the next slide, we also see a variation
10 in coverage by geography. The patterns of coverage for
11 rural Medicare beneficiaries is quite different than that of
12 urban beneficiaries. Part of that relates to the lower rate
13 of employer-sponsored coverage in rural areas. Smaller
14 firms, self-employed individuals are much less likely to
15 have retiree health coverage than those in other types of
16 firms which are predominantly in urban areas.

17 We also see much managed care. These statistics,
18 remember, are from 1998 so this has changed since then, and
19 in fact worsened. But there are one-sixth fewer people in
20 rural areas in managed care as a proportion of population
21 than in urban areas.

22 This will help explain why 36 percent of Medicare

1 beneficiaries in rural areas are in Medigap. It's a much
2 more important source of care in rural areas than in urban
3 areas.
4 Finally, it's interesting to note that twice the
5 proportion of Medicare beneficiaries in rural areas lack any
6 type of supplemental coverage.
7 Now I'll very briefly talk about a couple of
8 characteristics of the four major types of supplemental
9 coverage, less on Medicare managed care, before we talk
10 about trends.
11 Looking at retiree health insurance coverage, not
12 surprisingly, in the same way that large firms are more
13 likely to offer active workers health insurance, large firms
14 are also more likely to offer retiree health coverage. As
15 this chart shows, 65 percent of those individuals with
16 retiree health insurance coverage were employed by firms
17 with 5,000 employees or more.
18 You also have within this, as I said previously, a
19 difference both in geography with firms in the Northeast
20 more likely to offer coverage than in the West, but also by
21 type of firm. Government is the most common type of firm
22 that offers retiree health insurance coverage. 61 percent

1 of individuals who work for the government have this option
2 versus 38 percent of those in financial services jobs, 27
3 percent of those in services jobs, and 9 percent of those in
4 wholesale or retail jobs.
5 But as discussed a little bit this morning, these
6 trends are changing. There has been a gradual decline in
7 the percent of firms offering retiree health insurance
8 coverage in the last eight years. Probably this isn't
9 gradual. There's been about a 40 percent drop since 1993 in
10 the percent of firms who offer this type of coverage.
11 Part of this may be due to the accounting changes
12 that occurred in 1992 that required for employers to account
13 for these costs on a different accrual basis. But there
14 also may be these other factors that were discussed this
15 morning, higher health inflation, the concern about
16 prescription drugs.
17 What's interesting about this, though, is that
18 it's not necessarily firms dropping those retirees who are
19 already in Medicare. What we think is going on is that it's
20 firms not offering their future retirees this type of
21 coverage. So what that means is that this reduction in the
22 number of firms offering coverage won't yet show up in the

1 Medicare statistics for several years. This is something
2 that's coming down the pipeline.
3 It is also important to note, in thinking about
4 the trends, that this is a dichotomous chart, whether
5 employers offered or did not offer. We've also seen a
6 significant decline in generosity. In the last two years 33
7 percent of the firms reported that they increased the
8 copayments for prescription drugs and 26 percent of firms
9 reported that they increased the retirees's share of
10 premiums.
11 Turning to Medigap and the next slide, what this
12 chart shows is the distribution of enrollment across
13 different Medigap plan types.
14 I'm sorry, there is an insert that was either
15 tucked into your packet or on the chair that you should be
16 looking at now. Actually, the insert, I think, began on the
17 previous slide.
18 What this chart shows is the distribution of
19 Medigap enrollees across plan types. Nearly 60 percent of
20 Medigap enrollees are in those standardized plans that offer
21 cost-sharing. It's important to note that individually
22 purchased Medigap policies have been around since the

1 creation of Medicare. But given lots of concerns in the
2 late '80s about people purchasing multiple types of plans,
3 overlapping coverage and general consumer concerns about
4 these plans, they were standardized in 1990. There are 10
5 plans, A through J. Basically A through G offer just mostly
6 cost-sharing and some preventive benefits. H, I, and J
7 offer prescription drugs.

8 Most people are in those plans that offer just
9 cost-sharing. A small fraction have purchased that coverage
10 that includes the limited prescription drug benefit. About
11 one-third of Medicare beneficiaries with Medigap are either
12 in plans that they purchased prior to the standardization of
13 these benefits in 1990 or are in states that have been
14 exempted from these laws.

15 Turning to the next slide, we also have seen a
16 decline in Medigap enrollment in the late 1990s. Sine 1991,
17 when 38 percent of Medicare beneficiaries were Medigap, it's
18 dropped down to 28 percent in 1998. In fact, the insurance
19 commissioner data suggests that the greatest drop in the
20 last several years are in those plans that cover
21 prescription drugs.

22 One explanation for this drop is that those people

1 who were paying those premiums for prescription drugs moved
2 to Medicare managed care. In many areas, it was an
3 affordable option with a generous drug benefit. However,
4 since 1998, with the changes in the structure of Medicare
5 managed care, it's much less clear what has happened in the
6 Medigap market. In fact, some work that Scott's done
7 suggests that there may actually be an increase again in the
8 number of people enrolled in Medigap since Medicare+Choice
9 has declined.
10 Turning to the next slide, it is actually
11 mislabeled. It's the distribution of beneficiaries enrolled
12 in Medicare and Medicaid in 1999.
13 What this shows you is what different types of
14 what are called dual eligibles get. Medicaid is a fairly
15 complicated program but basically you can think about it as
16 who gets what benefits. There's a subset of people who get
17 full Medicaid benefits, known as full dual eligibles. On
18 this chart it says that 57 percent of those people in
19 Medicare and Medicaid are full dual eligibles and get
20 prescription drugs, long-term care, and Medicaid's other
21 benefits.
22 About 11 percent are eligible only for premium and

1 cost-sharing assistance through what are called the
2 Qualified Medicare Beneficiary and SLIMB programs. What
3 that means is that you have income below 100 percent of
4 poverty, you get all Medicare's cost-sharing and premiums
5 paid for. And if you have income between basically 100 and
6 120 percent of poverty, you get your Medicare Part B premium
7 covered by Medicaid. Again, a small fraction of enrollees
8 are in those programs.
9 The third big other category partly is just states
10 reporting another category. So some of these people may be
11 fully dually eligible and be getting prescription drugs and
12 long-term care.
13 Some of them may also be in waiver programs.
14 There's a third category of Medicaid coverage which is
15 partial benefits. People in what are called 1915(c) waivers
16 get home and community-based care if they would otherwise be
17 eligible for nursing homes. We've begun to see at rend in
18 states of covering prescription drugs only through 1115
19 waivers, and we think that some state coverage also gets
20 captured in this category.
21 What's important to note is that this pie that
22 shows the enrollment represents only a fraction of those

1 people eligible. About 25 percent of Medicare beneficiaries
2 could be eligible for Medicaid assistance in one form or
3 another, but only a small fraction participate. Estimates
4 suggest that only 45 to 55 percent of those eligible for
5 full Medicaid will participate in that option. The
6 percentage drops precipitously when you just look at that
7 cost-sharing protections. One study found that only 15
8 percent of those eligible for Medicare's premium assistance,
9 Part B assistance, participated in that program.
10 These trends may change over time. In the 1990s
11 we saw basically a fairly steady component of Medicaid
12 spending accounted for by dual eligibles. In fact, it's
13 interesting to note that in 1998 the 17 percent of Medicare
14 beneficiaries who are dual eligibles -- those are both in
15 institutions and in the community -- accounted for 28
16 percent of Medicare spending. These are high users. But
17 projections are suggesting that we're going to see a much
18 greater increase in Medicaid spending associated with dual
19 eligibles.
20 A recent analysis found that over half of the
21 increase in Medicaid spending between the years 2000 and
22 2001 was accounted for by the aged and disabled. Part of

1 this may be long-term care as those costs begin to creep
2 into the system, but prescription drugs clearly accounted
3 for a lot of this increase, as well. Aged and disabled
4 Medicaid beneficiaries accounted for 80 percent of Medicaid
5 drug spending in the most recent year. And they have the
6 highest utilization of prescription drugs of all Medicare
7 beneficiaries. So a smaller proportion of population, but a
8 high cost population that's only growing over time.
9 Turning to the next slide, I'm going to just very
10 quickly talk about the Medicare managed care trends. As
11 you, I think, heard in your December meeting, we have seen a
12 peak and a decline in the percent of the Medicare population
13 enrolled in Medicare managed care. This has an
14 interrelationship between what happens in other types of
15 coverage. Where did these people go? We'll talk a little
16 bit about that in a couple of minutes.
17 Turning to the next slide, we also note in the
18 same way that employer-sponsored insurance is becoming less
19 generous. We also know that Medicare managed care plans are
20 covering less of beneficiaries' cost-sharing liabilities.
21 Premiums have increased, cost-sharing for most services has
22 increased, including that of prescription drugs. And there

1 are some plans that have discontinued covering brand name
2 prescription drugs at all.
3 In closing, what we do know is the good news, is
4 that most beneficiaries have some type of supplemental
5 coverage. For the most part, this supplemental coverage
6 does a good job at helping seniors pay for the cost-sharing
7 liability that's not covered by Medicare. But I think that
8 Marsha referred earlier to her crystal ball. I'm actually
9 more likely probably than Marsha to bet, but I am in this
10 case absolutely not going to predict what might happen
11 because there are very complicated trends going on in this
12 area.
13 Can those people losing Medicare+Choice coverage
14 get affordable Medigap coverage is an important question.
15 What will happen as those people who no longer are offered
16 retiree health insurance coverage enter the system? That's
17 another question. I think that the pressure on states,
18 there was a question earlier about whether or not states are
19 going to begin reducing their coverage for dual eligibles in
20 light of their state budget crises.
21 The good news there is that most states can't.
22 Most of these programs are mandatory and that's good news

1 from a federal perspective, I think. But the bad news is
2 that we do have abysmal participation in these Medicaid
3 programs. So the extent that that participation declines
4 even further because states are just not willing to sign
5 these people up, we may also see a diminution in that type
6 of coverage.
7 The bottom line is most experts do agree that
8 there will be a bigger share of Medicare beneficiaries who
9 lack any type of supplemental coverage. But beyond that, I
10 think it's guesswork.
11
12 DR. HARRISON: Given that so many beneficiaries
13 have one form or another of supplemental coverage,
14 policymakers should consider how the supplemental coverage
15 would affect the outcomes of any proposed benefit changes.
16 One set of issues would relate to how the proposed benefit
17 change would overlap with supplemental policy benefits.
18 Another set would relate to how the change would affect the
19 supplemental markets. In addition, there are administrative
20 issues that should be examined. For each set of issues here
21 we pose some questions and give brief answers for different
22 illustrative benefit changes.

1 My intention here is that we focus on the type of
2 questions that should be asked and on the type of analyses
3 that should be done, not on the particular responses that I
4 use here to illustrate the process.
5 Jeanne just told you how varied supplemental
6 coverage is and widespread. Almost any conceivable benefit
7 expansion will create an overlap with some existing
8 supplemental coverage. Let's look at overlap questions that
9 should arise when evaluating a benefit expansion proposal,
10 and I'll use outpatient prescription drugs as an example
11 here.
12 How many beneficiaries would have overlapping
13 coverage? I think in some of Jeanne's work she found that
14 close to 70 percent of Medicare beneficiaries recently had
15 some coverage for outpatient prescription drugs.
16 What are the characteristics of beneficiaries who
17 would tend to have duplicate coverage? For prescription
18 drugs, those beneficiaries who are eligible for Medicaid
19 have drug coverage, and those with employer-sponsored plans
20 usually have drug coverage. Those with Medigap and those in
21 Medicare managed care plans sometimes have drug coverage.
22 Some of this coverage may, in fact, be more comprehensive

1 than any proposed benefit. Medicaid drug coverage is
2 comprehensive with only nominal copayments. Some employer-
3 sponsored coverage is similar.
4 These overlap questions would be important to
5 policymakers that were concerned about benefit expansion
6 crowding out private coverage.
7 Before I move on, there's another question related
8 to overlap and how would beneficiaries respond to a new
9 benefit design that supplemental policies may overlap by
10 filling in copayments and deductibles? If a drug benefit
11 were designed with the idea that copays would help keep
12 beneficiaries from overutilization, and those copays were
13 effectively eliminated through supplemental coverage for
14 many of the beneficiaries, much of the rationale behind the
15 copayment structure would be defeated and Medicare costs
16 would rise more than expected.
17 Let's move on to the question of how a change in
18 the benefit packages might affect supplemental insurance
19 markets. For this set of questions, let's assume that the
20 proposed benefit change is to lower Medicare cost-sharing
21 for outpatient services.
22 How would the change affect the price of

1 supplemental insurance? If beneficiary copayment liability
2 were reduced, presumably the cost of policies that cover
3 these copayments would decline. Medicaid, Medigap, and
4 employer-sponsored plans might all become less costly.
5 Who would benefit from these lower costs? In the
6 case of Medicaid, the states would benefit from lower costs
7 while lower federal government costs for Medicaid would
8 probably be offset by higher federal costs to pay for the
9 benefit expansion.
10 Assuming that Medicaid markets are competitive,
11 the lower costs should be translated into lower premiums for
12 enrollees. Figuring out who realizes savings for the
13 employer-sponsored plans is much tougher. Employer savings
14 could go to their bottom line, or they could pass some or
15 all of the savings on to their retirees, or they could pay
16 current workers more since the cost of the future benefit
17 obligations would be lower.
18 How these changes in the cost of supplemental
19 products and the changes in the financial risk borne by
20 beneficiaries would affect the demand for supplemental
21 products is also uncertain. There would generally be some
22 trade-off between the lower prices and lower expected

1 beneficiary liability. The lower prices should increase
2 demand, but the lower threat of out-of-pocket costs could
3 end up lowering demand.
4 The last set of questions I'll mention today deal
5 with thinking about administrative issues. To illustrate
6 this series, we'll assume the proposed change would combine
7 the A and B deductibles and include a catastrophic cap. I'm
8 going to skip over all the implementation problems that
9 would arise from that, but try to look at it from the point
10 of view of the beneficiaries.
11 For beneficiaries and supplemental insurers, such
12 a change might produce a simpler system. Beneficiaries and
13 their insurers would only have to keep track of one
14 deductible and they would no longer have to keep track of
15 spells of illness. Some beneficiaries currently have
16 supplemental coverage that covers one deductible but not the
17 other.
18 If there were a catastrophic cap, then some
19 beneficiaries might feel that their risk was low enough to
20 forego supplemental insurance. If they had no supplemental
21 coverage, they would not have to worry about benefit
22 coordination and bill submission.

1 The system as a while might also be more efficient
2 for those who continue to supplement Medicare because once a
3 beneficiary reached the catastrophic cap, the supplemental
4 insurer would no longer have to process claims for that
5 beneficiary. Similarly, beneficiaries might not send Part B
6 claims to supplemental insurers until they had reached the
7 presumably higher deductible. Overall, there would be fewer
8 claims that would have to be submitted to multiple insurers.
9 Finally, would a proposed change affect the
10 ability of the supplemental market and Medicare to get a
11 fair selection of beneficiaries? With a catastrophic cap,
12 it is likely that the price of Medigap plans would decline
13 because the supplemental insurers would no longer be at risk
14 for beneficiaries with very high costs. A lower price means
15 that more healthy people might be willing to buy it because
16 they think they have more of a chance of recouping the
17 premiums.
18 On the other hand, if a supplemental plan covered
19 the combined deductible, a greater share of the total plan
20 expenditures would go for first dollar coverage. That could
21 increase the dollar trading nature of the policy and lead to
22 higher costs, which could make it harder for the plan to get

1 fair selection.

2 So I've just used a couple of different

3 possibilities as illustrations and now we're open for

4 discussion.

5 MR. HACKBARTH: Okay, Jack.

6 DR. ROWE: I defer to the distinguished

7 representative from Thousand Oaks, California.

8 MR. HACKBARTH: No, I'm looking away.

9 MS. ROSENBLATT: I have some real good points

10 here. First of all, on the introduction to this chapter,

11 I'm going to read it. It said comments should focus on tone

12 and content. So I am going to make some comments about

13 tone.

14 To illustrate the tone, could we see the chart

15 that says supplemental coverage complicates and distorts the

16 market? I believe that there's a heading in the chapter

17 that says the same thing. To me, that is a tone issue.

18 20-some-odd percent of individuals in the market

19 are buying these policies. I think that we need to change

20 the tone, so that we're not coming out with comments like

21 complicates and distorts the market.

22 Could we then go to the chart that has the

1 differences across sources of supplemental coverage?

2 DR. ROWE: What words would you choose? Why do

3 you feel, assuming that you or Murray or someone will

4 consider Alice's suggestion, why would you feel that it

5 complicates and distorts the market? Why would you feel

6 that way, Chantal? Even if we talk you out of using those

7 words, obviously that's the way you felt. Why would you

8 feel that?

9 DR. WORZALA: I would say that the word complicate

10 is mostly just a descriptive, as opposed to normative,

11 phrase. It's just complicated because beneficiaries have to

12 navigate all these difference choices and do a patchwork.

13 That's not necessarily something that's a characteristic of

14 supplemental coverage. And so ascribing it to supplemental

15 coverage is probably the wrong way to do it. The system as

16 a whole is complicated for beneficiaries.

17 So I wouldn't attribute that complication to

18 supplemental products, because they are clearly filling a

19 need for beneficiaries.

20 MS. ROSENBLATT: I agree with what you just said,

21 but what's in the text is making it sound like it's the

22 supplemental coverages that are doing that, that are causing

1 the complication and the distortion.

2 DR. WORZALA: I definitely appreciate that

3 comment. You can't always pick those things up when you're

4 writing it, so that's very important feedback. I don't mean

5 that it's those products that are complicating it. It's the

6 whole system that's complicated and they are, in fact,

7 filling a very important role, I think, in protecting

8 beneficiaries from out-of-pocket liability.

9 On the distorting the market, it sort of comes out

10 of the economic literature. What it's really referring to,

11 and again I'm happy to be more explicit in what I'm saying

12 and not use that word, I don't have any problem with it.

13 But it's this notion that you put in cost-sharing

14 obligations to give people incentives to use services

15 judiciously. And then you tweak those incentives by

16 offering first dollar coverage. That's the distortion

17 because you're distorting the economic incentive.

18 I don't mean it in a pejorative sense at all.

19 It's just sort of an economics term and I'm happy to change

20 it.

21 MS. ROSENBLATT: What you're talking about is a

22 well-known actuarial principle, that the richer the benefit

1 the greater the utilization you get, the less rich the
2 benefit the lower the utilization will be. And I would
3 agree with that.
4 But in terms of tone, the reason the products
5 exist the way they do today is due to OBRA. We've had over
6 10 years of no changes to the benefit structure. If there
7 had been a free market allowing changes to the benefit
8 structure, there might be totally different products out
9 there right now. So that's another tone issue, where I
10 think the OBRA law was intended to fix certain things and
11 had a whole bunch of unintended consequences that we're
12 seeing today.
13 MR. HACKBARTH: Perhaps a more neutral term would
14 be alters decisions that beneficiaries make. There is an
15 ambivalence in the presentation. On the one hand, we
16 observe that beneficiaries that have various types of
17 additional coverage use more services or are more likely to
18 receive appropriate care. Then you flip the page and we
19 begin talking about the other side of that coin, which is
20 overutilization, ta da, da da, da da.
21 So clearly we can say that it alters choices. The
22 subjective question is whether it's for the better or for

1 the worse.

2 DR. WORZALA: If I can just say one more

3 clarifying thing, I apologize. I'm hearing, Alice, in your

4 comments that you thought that this slide was really about

5 Medigap, and I didn't mean it that way. It's actually true

6 for all sources of supplemental coverage. We're talking

7 about employer-sponsored, Medigap, and Medicaid. They all

8 have these same impacts, and I forgot to make that point.

9 MS. ROSENBLATT: In my reading of the text, I

10 walked away with a definite impression that Medigap -- the

11 takeaway message for me, in reading that chapter, was

12 Medigap is bad. And I've got lots of paragraphs circled and

13 I'll give it to you. Since I've got eight other points, I

14 won't bother you all with the particular paragraphs.

15 Can I go on to the difference chart? The chart

16 that says differences across sources of supplemental

17 coverage.

18 Medigap eligibility restrictions. It says

19 affordability. Affordability is an issue for all of these

20 coverages. Somebody may turn down an employer-sponsored

21 plan because they can't afford the contribution. They may

22 not buy Medicare managed care because they can't afford the

1 contribution. So I don't think it should appear just on
2 Medigap.
3 Also, what's missing from this that was mentioned
4 verbally is that Medigap is subject to open enrollment at
5 age 65. In many states it's open enrollment all the time.
6 It looks like everywhere there are issues of health status
7 and disability. That's not true. There are also instances
8 where if your employer takes actions or your Medicare
9 managed care takes actions, there are laws that say you have
10 to open enroll. So I think that's misleading.
11 The next thing on this table that I'm finding very
12 confusing to understand is the comparison of premiums. I
13 was really shocked when I saw these numbers. I think what
14 may be going on here is we've got so much variation by
15 geography, by age, that we're getting lost in the averages
16 and may be drawing conclusions that are not appropriate.
17 So I would suggest that we do some more work here.
18 If we're going to compare across these different types of
19 plans, I think we need to look at it consistently by area
20 and age and see what that does.
21 DR. REISCHAUER: Do you really think these
22 patterns would be affected?

1 MS. ROSENBLATT: I do.

2 DR. REISCHAUER: If I said let's do it for 65-
3 year-old males in the Los Angeles metropolitan area, you
4 don't think that the Medigap premium would be higher than
5 the employer-sponsored and higher than the managed care? I
6 mean, they might be different.

7 MS. ROSENBLATT: I'm just amazed at the extent of
8 the difference. There's just something that doesn't look
9 right to me.

10 DR. LAMBREW: Just a comment about that? There's
11 been several places to go at this. One is looking at
12 National Association of Insurance Commissioner data, which
13 is where this particular number comes from.

14 MS. ROSENBLATT: I know, but it's national
15 averages. I'm not saying that you picked up the wrong
16 numbers. I'm just saying that sometimes averages are very
17 misleading. I would like to see some analysis done by area.

18 MR. FEEZOR: On the employment-based monthly
19 premiums, is that inclusive or non-inclusive of the Medicare
20 Part B?

21 DR. LAMBREW: It does not include it. What's
22 interesting is, I just learned this back in looking for it,

1 96 percent of employers do not cover that Medicare Part B.
2 It's very uncommon that they include the Part B. So that's
3 $50 on top of the $54.
4 MR. FEEZOR: Most of those plans, though, I would
5 think are written so that you have to have Medicare Part B?
6 DR. LAMBREW: Correct.
7 MR. FEEZOR: So the out-of-pocket for 2002 would
8 be another $54 up there? I was wondering if that would
9 clarify Alice's point.
10 DR. REISCHAUER: That's true of all of these
11 options.
12 MS. ROSENBLATT: The Part B would be left out of
13 all of them, I think.
14 DR. LAMBREW: The only one that wouldn't be is
15 Medicaid. Medicaid will pay for the Part B premium.
16 MS. ROSENBLATT: One of the things that you
17 mentioned that I didn't see in the text but Scott, when you
18 made the point that if Medicare is expanded, that might
19 shrink the benefits that are offered through Medigap, which
20 would lead to a decline in price. And I don't want to set
21 up false expectations because the thing to understand is how
22 does the trend compare to the decrease.

1 So you might not see the premium actually go down.
2 You'd see less of an increase. Just a point there.
3 The other tone issue I had with the chapter was on
4 the admin. It made it sound like Medicare is doing a great
5 job at 2 percent admin and these terrible carriers are
6 charging up to 35 percent. There are totally different
7 distribution methods. I wouldn't say Medicare is doing a
8 great job at 2 percent. I would say there's a lot of stuff
9 Medicare should be doing that it's not, and that's why it's
10 only 2 percent, like information systems and a whole bunch
11 of stuff like that.
12 Also, there are some carriers mention the
13 difficulty of the administrative interplay between the
14 Medigap and the Medicare. There are some carriers that you
15 only have to submit the bill once and that carrier takes
16 care of the interplay between Medigap and Medicare, and it
17 would be worth mentioning that.
18 Finally, I do agree with the issue that was
19 brought up about the future retiree issue. I think that I
20 agree, a lot of employers have taken the step to eliminate
21 coverage for future employees, and that we will be seeing a
22 more growing problem on that front.

1 Just a thought, we don't have any recommendations
2 in here, but I want to suggest one that has to do with OBRA,
3 because I think we've lived with that law for a very long
4 time. It has created unintended consequences, and maybe
5 it's time to make a recommendation about that.
6 I'm done.
7 DR. WAKEFIELD: I think this is for Jeanne, but if
8 I'm incorrect, of course, any one of you.
9 Table 1 that's in the papers that we received in
10 advance provides characteristics of Medicare beneficiaries.
11 Obviously, as always, of interest to me the rural residents
12 issue -- that shocks you, doesn't it Bob? You know, Bob,
13 I'll stop raising rural the day you start raising it.
14 [Laughter.]
15 DR. WAKEFIELD: Or the day somebody else does.
16 DR. REISCHAUER: I need a site visit.
17 DR. WAKEFIELD: We've got one for you. It's 12
18 degrees below zero out there right now. You think about
19 those little 82-year-olds bundled up in 12 below. They're
20 tough.
21 I'm looking at residents, and it was my sense of
22 this anyway, but it's interesting to me of course to see

1 that really high reliance on Medigap. I guess I wouldn't
2 have expected it to be quite that much difference between
3 rural and urban. And also, the difference in terms of much
4 higher numbers of rural residents relying on Medicare only.
5 And then that higher Medicaid percentage.
6 So I guess I want to see if I'm drawing the right
7 conclusions here. It seems to me that we've got far fewer
8 choices across supplemental options, we always knew that,
9 related to M+C for rural beneficiaries. You've got your
10 employer-sponsored insurance column in here now, so that
11 gives us some sense of what's happening there.
12 Fewer choices for Medicare beneficiaries, would it
13 also be the case that it's likely we've got higher out-of-
14 pocket expenses for rural Medicare beneficiaries, compared
15 to their urban counterparts, when we think about what
16 they're paying for in terms of their supplemental insurance?
17 And then isn't that an important issue to be
18 paying some attention to, given lower average incomes of
19 rural beneficiaries versus urban beneficiaries? So I'm
20 trying to get a sense of how serious a problem this
21 represents, and difference, for rural versus urban
22 beneficiaries.

1 DR. LAMBREW: I'm going to let Scott and Dan
2 comment on the very explicit question about out-of-pocket
3 spending, rural versus urban. But just two notes. You
4 mention the lower income of rural beneficiaries. That, in
5 part, explains why their disproportionately covered by
6 Medicaid. That's a good thing in a way because there's
7 drugs in Medicaid.
8 The bad news in this is that this chart is just
9 about supplemental coverage. There have been studies done
10 about prescription drug coverage among elderly and there
11 also is this very large disparity because most of that
12 Medigap coverage that these folks have does not have
13 prescription drug coverage.
14 So that would suggest, since there's less
15 prescription drug coverage and prescription drugs cost so
16 much that there is a disproportionate hit. But these guys
17 know the data.
18 DR. HARRISON: I think one factor on the employer-
19 sponsored is that you tend to get smaller employers out in
20 rural areas. I know we've been on site visits and we were
21 told there's no employer-sponsored, there's no employers out
22 there. So that's that answer.

1 DR. ROWE: There aren't any people out there,
2 either.
3 [Laughter.]
4 DR. HARRISON: Dan, you're going to be doing this
5 tomorrow, right?
6 DR. ZABINSKI: Here's what I know about urban
7 versus rural out-of-pocket. On pure out-of-pocket spending,
8 including out-of-pocket on premiums, rural and urban are
9 almost identical on average. As far as percentage of
10 income, I don't know. If rural beneficiaries have lower
11 incomes on average, then if they have the same out-of-pocket
12 then they're spending a higher share of their income on out-
13 of-pocket. But I'd have to look into the data to see if
14 that's true or not.
15 That's what I can tell you right now.
16 DR. WAKEFIELD: So your comment on out-of-pocket
17 expenses being roughly the same equivalent between rural and
18 urban beneficiaries, that's in terms of Medigap coverage?
19 In terms of all supplemental coverage?
20 DR. ZABINSKI: Right, includes all premiums that
21 they pay out-of-pocket, including the Part B premium, plus
22 their out-of-pocket on services.

1 DR. NEWHOUSE: MedPAC actually has a history in
2 this domain. As I recall, in our first year of existence,
3 we recommended something called full replacement insurance
4 only. Yes, you could sell supplemental insurance, but then
5 you had to take the whole ball of wax. That fell like a
6 tree in the forest with nobody in the forest, as far as I
7 could tell. So let me try another potential option.
8 DR. REISCHAUER: Why don't you try another
9 analogy?
10 [Laughter.]
11 DR. NEWHOUSE: I was going to suggest that we talk
12 about an option -- Alice, as I hear her, wants to get rid of
13 the OBRA '90 standardization all together. I think the OBRA
14 '90 standardization was put in probably for good reason.
15 The supplementary market was hopelessly muddled, I think,
16 at that point. But the issue goes to what are the options
17 that OBRA '90 allows. A decade has passed.
18 One option that I think is a little surprising to
19 me that isn't there is a catastrophic only option. So you
20 would buy a stop-loss policy. On the one hand, one could
21 say that's going to promote selection, but there already is
22 a ton of selection.

1 My objection to the premium numbers was not the
2 premium numbers, just that they suppressed the tremendous
3 amount of variation that's out there by geography, as you
4 brought up. I agree with Bob's comment, that the same
5 ordering would almost surely come through but it's really
6 the variation that's out there.
7 But any event, the point I was going to make about
8 the variation, is if you take a geographic area -- the data
9 I've seen suggests that the premium difference between plans
10 H and I -- let me say this. There's three plans that cover
11 drugs, H, I, and J. H and I pay 50 percent to a $1,250 cap
12 and J pays 50 percent to a $3,000 cap.
13 So we're talking about the benefit -- and there's
14 very little other difference, I would say no material
15 difference between those plans. So the extra benefit to
16 somebody, at most, from picking J is 50 percent of $1,750.
17 The premium differences that I've seen actually exceed
18 $1,750.
19 MS. ROSENBLATT: Do you know why?
20 DR. NEWHOUSE: Tell me why. One answer has to be
21 selection.
22 MS. ROSENBLATT: It is, and the law is forcing the

1 rating to look plan by plan.

2 DR. NEWHOUSE: I would think the insurer would

3 price that way anyway.

4 MS. ROSENBLATT: No, not necessarily. Some

5 insurers were looking at their whole pool.

6 DR. NEWHOUSE: Then they could be undercut by an

7 insurer that didn't offer all the plans. Going back to the

8 catastrophic option only, this suggests that there's already

9 an extreme amount of selection, even within the drug

10 benefit, let alone the plans that offer drug benefits and

11 the plans that don't.

12 Let me stop there and we can talk about that as a

13 possible direction to head.

14 DR. LAMBREW: If I could just make a quick

15 comment. The Balanced Budget Act of 1997 did create within

16 plans C and F high deductible options. I think this is an

17 old number -- those deductibles would be 15/80 -- in

18 addition to the usual F plan which basically covers most of

19 Medicare's cost-sharing, and the J plan which includes the

20 $3,000 prescription drug benefit.

21 As far as I know, there's been very, very few

22 plans who have offered it and fewer people who have taken

1 it, but those plan options do exist.

2 The second point I would just like to say quickly,
3 on the issue about access to these Medigap plans, there
4 haven't been that many states that have actually gone beyond
5 what the OBRA standards are, in terms of guaranteeing access
6 and doing any sort of rating reform. What we do know is
7 that about 10 states have prohibited what's called attained
8 age rating where you basically increase the premiums very
9 rapidly with age. Six states have prohibited what's called
10 entry age rating, which is a different way of rating that
11 causes problems for some seniors. And only eight states
12 have a version of community rating that are in place.

13 So it's not actually that common that you have
14 these guarantees. And whereas BBA, the Balanced Budget Act
15 of 1997, did provide some limited -- I call it transitional
16 -- protections for people losing employer-sponsored
17 insurance, going in and out of Medicare+Choice, unless their
18 plan is open, the plan that they came from in Medigap, they
19 often can only go back to a limited number of plans and
20 can't get back into those plans with prescription drugs.
21
22 MS. ROSENBLATT: You also need to look at whether

1 the rates are subject to prior approval.

2 DR. LAMBREW: Virtually all of the prescription

3 drug options in Medigap are underwritten.

4 MS. NEWPORT: I found some of this very

5 interesting. I've heard, and I think it's accurate, which

6 may be reflected in the June report, that CMS is looking at

7 plan K and L. I don't know much beyond that.

8 DR. REISCHAUER: The president suggested two

9 catastrophic plans with drug benefits.

10 MR. FEEZOR: It's going to be called plan W.

11 [Laughter.]

12 MS. NEWPORT: I just want to make sure that when

13 this comes out, if that's available, we should make sure

14 it's in the report, in terms of what they are and what

15 differences they may make.

16 I would like to know, if possible, on your graphs

17 on the below poverty, medium income, and high income, what

18 are the numbers of benes that are below poverty? What are

19 we looking at, in terms of -- if it was in the text, I

20 missed it.

21 DR. WORZALA: Table 1, I have 15 percent poor, 9

22 percent near poor.

1 MS. NEWPORT: Of all beneficiaries. Okay, I can
2 do the math after that thank you.
3 I think that the assumption that changes in the
4 scope of med sup coverage, lessening the scope of it would
5 automatically lead to a reduction in premium. I don't think
6 that's a direct line conclusion. I would bow to Alice on
7 that one, I think that's absolutely right. And I think it
8 has to do with all sorts of interactions, including amazing
9 regional variability in just the types that are available.
10 You may have two plans available in an area, particularly
11 probably rural. Just helping you out.
12 DR. WAKEFIELD: Thank you.
13 MS. NEWPORT: I think the pre-ex condition, too,
14 as Medicare+Choice has exited markets over the course of the
15 last few years, there's no opportunities to automatically
16 have a guaranteed issue. And those that are there, the pre-
17 existing condition and the premiums and just a general
18 availability of choice amongst med sup is diminished. So
19 these are important points that have to continue to be
20 brought out.
21 DR. ROWE: Just a couple of minor points. With
22 respect to this monthly premium average that alarmed Alice.

1 This $108 on Medigap, is that the average of A to J? Or is
2 that a weighted average for the distribution of the
3 beneficiaries in the different plans?
4 DR. HARRISON: It is weighted across all plans,
5 including pre-standard plans.
6 DR. ROWE: So it is the actual average that the
7 average person was paying in that year?
8 DR. HARRISON: Yes.
9 DR. ROWE: Secondly, each of these figures has a
10 number on them or a year. I think we would all agree, if
11 there's anything we would all agree on, that this is a
12 fairly rapidly changing situation. And you started on
13 unnumbered page number seven by telling -- and it would be
14 helpful to number some of these once in a while for us.
15 This says source of coverage. This is a wheel.
16 And you said that employer-sponsored coverage was the
17 largest at 33. Then you said that Medigap was increasing as
18 Medicare managed care was decreasing. So maybe that's
19 higher than 28.
20 Then when you go to unnumbered page number 11,
21 where it says percent of employers offering health coverage
22 to Medicare eligible retirees has gone from 28 to 23 in two

1 years.

2 DR. NEWHOUSE: This is employer-weighted.

3 DR. ROWE: I know. And my guess is that 2002 is
4 lower than 23, which means that 33 is lower than it was.

5 DR. REISCHAUER: That's future. Most employers
6 grandfather.

7 DR. ROWE: I understand, but I think it's lower
8 and there are employers that don't grandfather everyone, et
9 cetera.

10 So I think what would be very helpful, given the
11 uncertainty with respect to a lot of this, is if you could
12 draw a picture for us of what you estimate to be your
13 current best guess of the distribution of this. '98 was a
14 long time ago in a very rapidly changing set of variables.

15 DR. LAMBREW: I can just speak for myself
16 personally, I'm not sure you all pay me enough to do that.
17 That's a hard task.

18 DR. ROWE: Maybe one of our staff could, then.

19 [Laughter.]

20 DR. LAMBREW: I should actually say, before we
21 leave, we did actually did spend some time thinking about
22 this and we did some work that's implicit in some of the

1 analyses you'll see subsequently. What we did was basically
2 if you look at that decline in managed care enrollment
3 between 1998 and 2002, it's about 1 million people.
4 There was a survey done in 1999 about what happens
5 when people leave Medicare+Choice? Where do they go? This
6 is something that Marsha Gold has done in her tremendous
7 work on this topic. What they found was that 45 percent of
8 those who don't go into another managed care plan go to
9 Medigap. About 12 percent go to employer sponsored
10 insurance. And what we think that is people who were both
11 in employer-sponsored insurance and Medicare+Choice, so it's
12 a reporting issue. About 18 percent go to some unnamed
13 other source, probably also including Medicaid, and 24
14 percent of them become uncovered. They lose supplemental
15 coverage.
16 So we took all of that and mushed it into the
17 system. What you see is a small increase in the people
18 without any type of coverage, from 9 percent to like 11
19 percent, and an increase in Medigap from like 28 to about 30
20 percent.
21 MR. HACKBARTH: So in all likelihood, Medigap will
22 overtake employer-sponsored?

1 DR. ROWE: It doesn't really matter who's number
2 one and number two. It's just that it would be nice to have
3 a best estimate of what it looks like now for...
4 MR. HACKBARTH: I thought you were leading to some
5 profound point.
6 DR. ROWE: No. Aetna is no longer interested in
7 who or what is the largest. We're out of that business.
8 [Laughter.]
9 DR. ROWE: The other thing is I wanted to provide
10 what I'm sure Alice meant with respect to Medigap reform.
11 One of the things that seems to be distorting the market is
12 the legislated standardization of Medigap during a period of
13 time in which the market has changed a lot and Medigap
14 hasn't been able to evolve, as I think was implicit in some
15 of Alice's exceptionally excellent comments.
16 I do want to, in this little book that some of us
17 have, Cliff's Notes on Medicare 2002, it says here in
18 paragraph 640, under Medigap insurance, that Congress felt
19 that Medigap insurance needed to be regulated because
20 evidence indicated the companies marketing these policies
21 often were guilty of unethical sales practices and other
22 abuses. Furthermore, it was found the policies themselves

1 often contained ineffective coverage, duplicated coverage
2 already provided in Medicare, et cetera.
3 There was a reason why this bill was passed. I'm
4 confident we would all agree that many of the aspects of the
5 law that prohibit the sale of duplicated coverage, pre-
6 existing condition limitations, suspension of Medigap
7 premiums during Medicaid eligibility, et cetera, are all
8 good things. We're not suggesting, I'm confident, that we
9 want to get rid of any of those things.
10 Before anybody pushes back and says you can't get
11 rid of that law because of all of these conditions, it
12 really is the issue of the standardization of some of the
13 nature of the benefits and premiums and things that has been
14 restricted.
15 MS. ROSENBLATT: Thank you for the wonderful
16 clarification, Jack.
17 DR. ROWE: Before you get in trouble.
18 DR. BRAUN: One of the things I wanted to mention
19 was that we need to remember that there's medical
20 underwriting in most of the plans, but particularly in the
21 drug plans. That cuts down on the adverse selection,
22 because actually if you don't take it in the first six

1 months then when you really need it you can't get it. So
2 I'm sure there would be a lot more adverse selection if it
3 were open.
4 The other thing is that not all the plans are in
5 all of the areas. In fact, very few areas now are even
6 offering the drug plans at all.
7 There was one other thing I did want to bring up,
8 though. That was in the chapter -- fortunately I haven't
9 heard the words this afternoon so you haven't seen flames
10 coming out -- is risk averse. I think if we use the term
11 risk averse, it's gotten a pejorative sense. I think that's
12 very unfortunate.
13 But the fact is that the risk of expensive illness
14 increases dramatically as one ages. Because the cost-
15 sharing in Medicare is so irrational, prudence dictates that
16 one recognize the high risk of incurring high expense and be
17 prepared by carrying supplemental insurance. If the
18 benefits were comprehensive and the cost-sharing were
19 rational, as is the case with usual employee health
20 benefits, this added insurance would be unnecessary.
21 It's really not first dollar coverage. I think
22 that's the problem, risk averse and first dollar coverage

1 get tied in together. It's not first dollar coverage as
2 desired but protection from the high cost-sharing which is
3 really high for inpatient hospitalization, for outpatient
4 surgical and radiological procedures, SNF stays beyond 20
5 days, and so forth.
6 So Medicare beneficiaries who purchase Medigap are
7 not risk averse consumers seeking first dollar coverage.
8 They're simply prudent consumers who acknowledge the very
9 high odds that they will experience an expensive illness or
10 suffer from a chronic condition in the no longer distant
11 future. And I count myself in that group.
12 [Laughter.]
13 MR. FEEZOR: Bea's observations did underscore one
14 thing. I think Alice is right, that the market is working,
15 and particularly given the restrictions it's working on, in
16 terms of the supplemental market. I think as we get into
17 this market we have moved from an insurance market to more
18 of a prepayment or a budgeted plan of dealing with what is
19 an increased certainty, as Bea points out. That's why I
20 think we have a little different market dynamics than we
21 have otherwise.
22 One of the things, just as an observation, and

1 again this probably would not have been a part of this
2 panel's study, but we're trying to deal with some of the
3 creative things in our employment-based plan. And we look
4 at the issue of maybe having the enrollee engage in payment
5 out of, whether it's a spending account or personal care
6 account.
7 One of the dynamics that drives us when we get to
8 the retiree population is the fact that the current tax laws
9 require active income and an employment base. Whereas,
10 those of us who are still employed and have active income
11 can, in fact, pay for some of our out-of-pocket cost and so
12 forth on a prepayment basis, a pre-tax basis, and get the
13 tax advantage.
14 And in the main that is not available to retirees.
15 I would just simply put that out in terms of a policy
16 reality. If we're talking about trying to refathom or
17 reshape this thing, that's a significant barrier to some
18 creativity.
19 DR. ROWE: There are a number of issues that limit
20 the application of some of these products across the entire
21 spectrum of beneficiaries, be they Medicare beneficiaries,
22 pre-Medicare, medical, retiree, et cetera, that adjustments

1 would open the market up considerably.

2 MR. SMITH: I assume that we need to wrap this up,
3 so let me be very brief. Scott, I was struck in the
4 criteria, in the discussion in the chapter, that there
5 wasn't some attention paid to how the financial burden would
6 be reallocated. If we change the benefit package, what ends
7 up being paid by beneficiaries, what ends up being paid by
8 government? Clearly, as you think about the effects on
9 utilization, if we shift the utilization from something that
10 is paid for by Part B or we shift utilization from something
11 that's paid for by privately paid Medigap, the distribution
12 of who pays for what -- both public and private, is going to
13 change.

14 And as we think about the benefit package, I'm not
15 sure what the principles are. Do we want to keep all the
16 money that's in the system in the system? That's where I
17 think I would start, but I'm not sure that that is the right
18 principle. But we don't want to drive money out of the
19 systems, I suspect.

20 So we ought to think about the impact of changes
21 in the benefit package and the interaction between the
22 public benefit package and the supplemental, in terms of

1 where that money goes, and think about -- I would offer as a
2 principle how do we keep that money in the system? But at
3 least take account of that set of questions.
4 DR. HARRISON: I think you'll see some of that
5 tomorrow.
6 MR. HACKBARTH: Chantal, were you trying to...
7 DR. WORZALA: Yes, I have more of a direction
8 question, so maybe after Carol's comment.
9 MR. HACKBARTH: But she's not next.
10 [Laughter.]
11 DR. REISCHAUER: I'm concerned that Alice's
12 initial eloquent salvo in defense of supplemental insurance
13 is going to steer us away from what I think should be the
14 very clear message of the report that we put out in June.
15 And that is that an inadequate benefit package by Medicare
16 leaves beneficiaries with two options. One is to be exposed
17 to an unacceptable level of financial risk. And the other
18 is to seek some form of supplemental insurance.
19 Most take that second option and inevitably,
20 having two or more sources of payment adds costs,
21 complexities, and inequities to the system. And there's no
22 way around it. It's not Alice's fault. It's not the

1 employer's fault, in any sense. The original sin lies with
2 the inadequate benefit package and there's no way to fix
3 that.
4 I mean, you can screw around the edges and reduce
5 the extra administrative costs a little bit and remove a
6 little bit of the complexity, but it will always be there.
7 It's why employers don't offer you six add-on insurance
8 policies. They give you the choice of one. And that's
9 where we should be going, especially when you find that
10 virtually everybody has certain additional coverages.
11 90 percent have, through one form or another of
12 supplemental insurance, have the hospital deductible
13 covered. If that's true, why shouldn't we wrap it into
14 Medicare, even if that means raising the premiums to do it?
15 They're paying for it in a different way now.
16 MS. ROSENBLATT: I just want to respond to that.
17 I don't entirely disagree with what you said, but I disagree
18 with the payment issue. I disagree with the payment issue
19 because you said they're paying for it anyway. In fact,
20 they're not paying for it. They are paying for their
21 supplemental insurance, but you have cross-generational
22 funding going on for the basic Medicare package. So you

1 have to be --

2 DR. REISCHAUER: They meaning -- somebody meaning

3 the beneficiary is paying the Medigap premium. The employer

4 is paying, probably by reducing the wages over time of the

5 employees for the other. The general taxpayer is paying

6 Medicaid. It's not, in a sense, new money that we would

7 need. It's a redistribution of existing money, which is a

8 very difficult thing to do, which is what Dave is going to

9 talk about because you don't want it to be a windfall for

10 employers.

11 MR. SMITH: Bob's exactly right, that's part of

12 it. You don't want it to be a windfall for employers. One

13 of the questions about a prescription drug benefit is

14 there's a substantial amount of money already in the system,

15 probably paid for by workers during their working lifetime,

16 that a universal prescription drug benefit paid for by

17 taxpayers would displace. That's irrational in an overall

18 health system that is crimped for money.

19 I do think, Bob, you open up the right question

20 but it is more complicated, I think, than saying that

21 because Medicare beneficiaries are prepared to pay money for

22 a supplemental benefit, that we ought to make that part of

1 the basic benefit. It really does raise the sort of moral
2 hazard issue that Chantal and Jeanne talked about, that if
3 we make it part of the basic benefit what kind of
4 Commissionutilization shifts do we get? How much of that is
5 overutilization? How much of that is sensible and
6 reasonable good health care policy?

7 But we shouldn't start with the presumption that
8 because people are prepared to buy Medigap A, that it ought
9 to be part of the benefit package.

10 DR. REISCHAUER: That's precisely why the example
11 I used was the hospital deductible, because I don't think
12 there's a big utilization problem there.

13 MR. SMITH: Right, but the hospital deductible is
14 not the only thing that's covered by the supplemental stuff.

15 MS. RAPHAEL: I just wanted to make one point. If
16 we look at supplemental as a way to offer financial
17 protection as way as a way to possibly offer additional
18 benefits for those who want to perhaps pay for it, I think
19 that one of the things that I see is that as you put private
20 and public dollars together, the private marketplace is a
21 very unstable marketplace as you've described it.

22 And I think that that is important, for people to

1 not have predictability. And it's on all of the dimensions.
2 We have the Medicare+Choice program not offering stability,
3 the employee retiree benefit is not a predictable benefit
4 and it's subject to change. Medicaid clearly, in different
5 states, is beginning to restrict and change eligibility.
6 And the Medigap market, as well, is not to me a stable
7 market.

8 I see that as an important factor in terms of
9 trying to put this all together.

10 DR. ROSS: I don't want to distract the
11 conversation, but I did want to give Jeanne the chance to
12 answer a question that we are paying her enough to do an
13 estimate for.

14 You mentioned on Medicaid, enrolled as a fraction
15 of eligibles around 50 percent. Of that remaining 50, could
16 you sort of parse that into what fraction you think is maybe
17 measurement error, state unwillingness to cover, and
18 people's unwillingness to enroll?

19 DR. LAMBREW: There have been some studies that
20 have tried to delve into that, but the data limitations are
21 huge. You basically can figure out what are the
22 characteristics of those people. We do know that the people

1 who do sign up are disproportionately minority, married and
2 older. So we kind of know who's in and who's out of the
3 group who's eligible.
4 But there are basically three reasons that are
5 posited as to why this happens. One is lack of awareness,
6 not that many people know that these benefits are out there.
7 And there's been a stepped up effort in the last few years
8 to increase that, but it still is fairly low in terms of
9 awareness.
10 A second issue is states' willingness to really
11 make this easy. Fewer than half of states actually have a
12 simplified application, meaning it's not the 20-page
13 application, it's a two-page application. Only about a
14 third of states allow people to allow at sites other than
15 welfare offices. We only have a few states, a handful of
16 states, who have applications in any language other than
17 English.
18 Those sorts of barriers make it difficult even for
19 those people who know about the program to actually get into
20 it. There are actually just two major reasons.
21 There's a third, which is the stigma issue, those
22 who know about it but worry about being on welfare and will

1 it be there for them, has been a named reason but not very
2 well studied amongst the elderly.
3 MS. RAPHAEL: Murray, just one point. In New
4 York, after 9-11, there was a disaster Medicaid program put
5 into effect where you could get Medicaid for four months.
6 They reduced the application to one page. And within one
7 week like 40,000 people enrolled. It made a huge
8 difference.
9 DR. LAMBREW: Over the four month window, 380,000
10 people enrolled. And they actually have done a lot of
11 studies saying that the simple ability to go in, sign up and
12 get the card at the spot when you actually do this, rather
13 than going through an application process, having your
14 income verified, and waiting for the state to get back to
15 you makes an enormous difference.
16 MR. HACKBARTH: I'm trying to think through where
17 we might be headed, in terms of the changing dynamics of the
18 supplemental market, employer-sponsored coverage, and the
19 like. We start having -- and I may be getting in the way of
20 Bea's flame thrower here -- too much of the wrong type of
21 coverage for people. But now the prices are going up,
22 whether the beneficiaries are paying it out of their own

1 pocket for supplemental coverage or employers are paying on
2 their behalf the prices are rapidly escalating.
3 Is it too much to hope that something good may
4 come out of that and people may say well, as opposed to
5 paying rapidly escalating premiums for the wrong type of
6 coverage that pays small front-end sort of expenses, that
7 they'll say well a way to reduce the cost of this is to not
8 pay for that stuff that makes little sense from an insurance
9 standpoint and move towards more catastrophic sort of
10 coverage?
11 Joe's point about the selection issues would
12 actually augment the move in that way because the
13 catastrophic coverage tends to be underpriced relative to
14 the other stuff because of selection issues.
15 So I'm searching through this pile of manure for
16 the pony. Maybe some of these things will push us in the
17 right direction. Am I totally off the mark?
18 DR. NEWHOUSE: Of course, you could do
19 catastrophic through Medicare itself, which is where I
20 thought Bob was headed, which takes us back to 1988. Or you
21 can do it in the supplementary insurance market and we could
22 lay those both out as options.

1 DR. REISCHAUER: I guess I have a problem with the
2 discussion about the wrong kind of coverage. I mean, what
3 Bea is saying, I think, and I agree with is that a lot of
4 elderly people want to budget routine expenses that they
5 know they're going to have, and 80 percent of them meet the
6 Part B deductible, and they choose the supplemental way of
7 going about doing it. I mean, it's like a Christmas club
8 layaway plan or something like that. Each month you put a
9 few bucks into it and it's better than having the $100 bill
10 come in on January 11th, or whatever it is each year, and
11 having to pay it.
12 MR. HACKBARTH: Although, to the extent it affects
13 utilization patterns, that can be a more expensive way of
14 paying for the services.
15 DR. REISCHAUER: But we're already in that
16 situation at this point, and people want it. Is it the
17 greatest sin in the world to swallow hard over this when we
18 don't have immense amount of evidence about the induced
19 utilization associated with this and we know that there's no
20 way we're going to end wraparound policies by businesses for
21 some important chunk -- 25 percent or so -- of the
22 population? And it would be very inequitable to have the

1 chosen few have this and nobody else be able to access it.

2 And so, even as an economist, I'd just swallow

3 hard and give the people what they want.

4 DR. BRAUN: I don't believe they want first dollar

5 coverage, but with these 10 plans they don't have much

6 choice. If the plans were set up differently, I really

7 think you might get a different response. I really think

8 it's a very high coinsurance problem.

9 DR. REISCHAUER: They aren't buying plan A or plan

10 B, which are the ones that don't give them the first dollar

11 coverage. So I think they do want it.

12 MR. HACKBARTH: Jeanne's going to have the last

13 word and then we're going to move on.

14 DR. LAMBREW: Chantal and I have a joint comment.

15 First of all, I think it's important to recognize

16 with Medigap it was not Congress that set those Medigap

17 plans. It was the National Association of Insurance

18 Commissioners. And they did that trying to reflect what was

19 common at the time and what might be good policy.

20 They have reconvened a working group to begin to

21 reexamine these issues, although their major recommendation

22 or concern is how do we do this in the absence of a Medicare

1 drug benefit? Ten years later, when there's a lot of
2 discussion about what do we do about prescription drugs,
3 they're I think at a loss for what to do on that. And
4 that's just reflecting the conversations that have been out
5 there.
6 But to the point about the forced change, and
7 going back to the fact that I was paid enough to do this so
8 I will say it. Medigap inevitably is going to be an
9 increasingly source of coverage for these folks, or there
10 are going to be more people uncovered because we do know
11 employer-sponsored insurance is going down. We do know
12 Medicare+Choice is going down, although there's arguments
13 about how much and how fast. Medicaid is just not going to
14 expand much beyond where it is today, given its cost burden.
15 So it's going to be an inevitable choice. Either
16 there's going to be more reliance on Medigap, maybe with
17 changes, or there are going to be more people uncovered
18 unless there's some sort of policy change like what Bob
19 Reischauer was talking about.
20
21 MR. HACKBARTH: We need to move on to our next
22 panel on total spending and sources of payment. Thank you,

1 Jeanne. Fire when ready.

2 MR. WINTER: I will be talking about total

3 spending and sources of payment for beneficiaries' health

4 care, and then Dan will be talking about out-of-pocket

5 spending by beneficiaries and their financial liability.

6 Spending on beneficiaries' health care, including

7 long-term care, is estimated to be about $450 billion in

8 2002, or over $11,000 per beneficiary. This estimate was

9 developed by us in conjunction with Actuarial Research

10 Corporation.

11 A couple of important points to make about this

12 spending, spending by Medicare is estimated to be about 60

13 percent of the total. This leaves a significant portion of

14 spending that is covered by other payers.

15 Total resources spent on health care could be

16 viewed as a budget constraint in redesigning benefits. That

17 is, existing Medicare and non-Medicare spending may be

18 adequate to finance a comprehensive benefit package. Total

19 resources could be spent more efficiently. In other words,

20 we could provide better benefits at the same or lower cost.

21 This slide and the next one present preliminary

22 estimates of total spending, excluding long-term care, and

1 how that spending is distributed by payer and type of
2 service. While Medicare accounts for the majority of
3 spending, almost $270 billion, other payers are responsible
4 for a significant portion, almost $190 billion.
5 Private supplemental, which includes Medigap,
6 employer-sponsored insurance, and Medicare+Choice benefits
7 paid for by additional beneficiary premiums accounts for
8 about 15 percent of the total. Beneficiary out-of-pocket
9 spending accounts for about 18 percent of the total. And
10 the remainder, about 7 percent, is accounted for by
11 government supplemental, which includes Medicaid acute care
12 spending, and VA and DOD spending.
13 The spending figures for each payer include both
14 payments for services and administrative costs. If
15 administrative costs were shown separately, they would
16 account for about 5 percent of total spending. One-third of
17 this amount would come from Medicare and two-thirds comes
18 from all supplemental. As we discussed earlier,
19 administrative costs are much lower for Medicare than for
20 supplemental insurance, particularly private supplemental.
21 Here we show spending by type of service,
22 excluding long-term care and administrative costs. Spending

1 on Medicare covered services is about three-quarters of
2 total spending, about $330 billion. This includes both
3 Medicare payments and cost-sharing that is paid for by
4 beneficiaries and supplemental coverage. Medicare payments
5 are about 80 percent of this spending.
6 Spending on non-covered services is about one-
7 quarter of total spending, or about $100 billion. Most of
8 this spending, almost $90 billion, is on prescription drugs
9 not covered by Medicare. The other non-covered services
10 category includes vision, dental, and some equipment.
11 The last point I'd like to make is that total
12 resources could be reallocated to purchase better benefits
13 at the same or lower cost.
14 A couple of main sources of inefficiency in the
15 current system are supplemental coverage which, as we've
16 discussed earlier, has high administrative costs.
17 DR. REISCHAUER: Could you hold that until Alice
18 comes back?
19 MR. WINTER: I want to get it out before some
20 comes back.
21 It also provides first dollar coverage, which
22 leads to higher total Medicare spending.

1 Another source of inefficiency is the existence of
2 duplicate sources of coverage among beneficiaries, such as
3 Medicare+Choice and Medigap, which we also discussed in the
4 previous presentation.
5 I can either take questions now or we can move on
6 to Dan's presentation on out-of-pocket spending. Any
7 questions? Okay, so we'll move on to Dan.
8 DR. ZABINSKI: Just one comment, Murray, I like
9 these new microphones. I don't know if you had a hand in
10 it.
11 Ariel discussed national level spending and I'm
12 going to move down to the beneficiary level and focus on
13 their out-of-pocket spending on health care. First, I'll
14 discuss sources of beneficiaries' out-of-pocket spending.
15 In this diagram, we illustrate total spending on
16 beneficiaries' health care use broken into sources of
17 payment. The very top rectangle is the portion of total
18 spending paid by Medicare. The remaining four rectangles
19 comprise the portion of total spending that is not paid by
20 Medicare.
21 As you can see, I've divided the portion not paid
22 by Medicare into two broad parts, cost-sharing on services

1 covered by Medicare and the cost of non-covered services.
2 The diagram indicates that part of cost-sharing and part of
3 non-covered services are paid out-of-pocket by
4 beneficiaries. In addition, part of cost-sharing and part
5 of covered services are paid by supplemental insurance,
6 which includes private sector coverage such as Medigap and
7 employer-sponsored insurance, as well as public sector
8 coverage such as Medicaid.
9 However, beneficiaries often have an out-of-pocket
10 expense associated with private sector supplemental
11 insurance because they typically pay at least part of the
12 premium.
13 In addition to these sources of out-of-pocket
14 spending, most beneficiaries pay out-of-pocket for the Part
15 B premium. So if you combine all of the sources of out-of-
16 pocket spending, we have that a beneficiaries' total out-of-
17 pocket spending is the sum of their out-of-pocket spending
18 on cost-sharing, non-covered services, private sector
19 supplemental insurance premiums, and the Part B premium.
20 In the following slides, we're going to analyze
21 out-of-pocket spending for a sample that's drawn from the
22 Medicare Current Beneficiary Survey that includes non-

1 institutionalized beneficiaries who participated in fee-for-
2 service Medicare in 1998.
3 Beneficiaries' total out-of-pocket spending is a
4 concern to many and one likely reason is that may
5 beneficiaries have income that are below or at least close
6 to poverty, as indicated on this slide. This diagram
7 separates beneficiaries by their income relative to their
8 poverty and shows that more than 20 percent of beneficiaries
9 in our sample have income below 125 percent of poverty.
10 These beneficiaries with low incomes are going to be more
11 financially strained by high out-of-pocket spending than
12 would beneficiaries with higher incomes.
13 Some might think that out-of-pocket spending might
14 not be an issue for poor beneficiaries because they might
15 believe that poor beneficiaries almost always have Medicaid,
16 but as you just found out we know that only about half of
17 beneficiaries below poverty actually participate in
18 Medicaid. Consequently, I think one key point is that there
19 is substantial variation in income and that contributes to
20 differences in the financial strain that beneficiaries feel
21 from out-of-pocket spending.
22 Now, not only is there substantial variation in

1 beneficiaries' income, there is much variations in
2 beneficiaries' out-of-pocket spending. In this diagram, we
3 have ordered beneficiaries from the lowest to the highest by
4 the amount of total out-of-pocket spending. We found that
5 beneficiaries with the 5 percent largest values of out-of-
6 pocket spending have 20 percent of aggregate out-of-pocket
7 spending, as indicated by the bar furthest on the right in
8 this diagram. In contrast, beneficiaries with the 5 percent
9 smallest values of out-of-pocket spending have essentially 0
10 percent of the aggregate.
11 The combined effect of large variations in income
12 and large variations in out-of-pocket spending is
13 substantial differences between beneficiaries and the
14 percentage of their income that goes to out-of-pocket
15 spending on health care. The average of this measure in
16 1998 was 18 percent. But half of beneficiaries spent less
17 than 10 percent of their income out-of-pocket on health
18 care. At the same time, 10 percent of beneficiaries spent
19 at least 33 percent of their income out-of-pocket on health
20 care.
21 Among beneficiaries who are below poverty, this
22 measure can be very high with 10 percent of poor

1 beneficiaries spending at least 82 percent of their income
2 out-of-pocket on health care.
3 I hope that I can get this diagram clear. The
4 burden a beneficiary feels from out-of-pocket spending
5 depends not only on how much of their income is spent on
6 health care, but also on the persistence on their out-of-
7 pocket spending. For example, if a beneficiary has high
8 out-of-pocket spending that lasts a number of years, the
9 burden is likely greater than if it lasts only a short term.
10 We explored the persistence of total out-of-pocket
11 spending and the results are illustrated in this table,
12 which is comprised of beneficiaries who participated in
13 Medicare -- or I should say fee-for-service Medicare -- from
14 1996 through at least 1998. What we did is we ordered
15 beneficiaries from their lowest to highest value of total
16 out-of-pocket spending in 1996 and placed them in one of
17 five percentile rages. These 1996 percentile ranges are the
18 very first column on this table.
19 I'd like you to focus on the very bottom row.
20 These are the beneficiaries who are above the 90th
21 percentile of out-of-pocket spending in 1996. What we've
22 done is we've determined their percentile rank for their

1 out-of-pocket spending in 1998. What we found is that their
2 level of out-of-pocket spending tends to be fairly
3 persistent. For example, for these beneficiaries who are
4 above the 90th percentile in 1996, 41 percent of them were
5 still above the 90th percentile in out-of-pocket spending in
6 1998.

7 Now I'd like to refocus your attention to the very
8 top row of numbers. These are the beneficiaries who are
9 between the zero and 25th percentile in 1996. 74 percent of
10 those beneficiaries were still between the zero and 25th
11 percentile in 1998.

12 The bottom line issues for out-of-pocket spending,
13 at least from my perspective, are how it impacts
14 beneficiaries financially and whether it impedes their
15 access to care. We examined the effect of out-of-pocket
16 spending on financial status with two measures. First, we
17 found that 11 percent of beneficiaries with income greater
18 than poverty spend down to poverty. Second, we wanted to
19 know how many beneficiaries have a high level of out-of-
20 pocket spending, and we defined high out-of-pocket spending
21 as $5,000.

22 That's somewhat arbitrary but what it is is

1 comparable to the out-of-pocket spending limit in the
2 Federal Employee Health Benefit Plan Blue Cross-Blue
3 Shield's standard option. We found that about 6 percent of
4 beneficiaries in 1998 were over the $5,000 threshold.
5 In regard to access to care, survey data indicates
6 that about 10 percent of beneficiaries say they delayed care
7 due to costs and 3 percent say they have trouble getting
8 care. I'm not going to stick my neck out and say whether I
9 think these access numbers are big or small, but I will say
10 that research from several sources indicates that Medicare
11 beneficiaries report fewer access problems than do the non-
12 Medicare adult population. This may be a reflection that
13 Medicare beneficiaries have some coverage, that is Medicare,
14 but 18 percent of the adult non-Medicare population is
15 uninsured.
16 Finally, to the extent that policymakers are
17 concerned about how the cost-sharing or the benefit package
18 affects beneficiaries' out-of-pocket spending, I think it's
19 helpful to know which goods and services account for the
20 largest share of beneficiaries' out-of-pocket spending, at
21 least on average. In this diagram we break the 1998 per
22 capital total out-of-pocket spending into several service

1 components. Each bar indicates the per capita out-of-pocket
2 spending amount within each specific component. For
3 example, the category with the largest per capital out-of-
4 pocket spending is supplemental insurance premiums, which
5 averages $733 per beneficiary. As you can see, the next
6 largest categories are Part B premiums, prescription drugs,
7 and medical providers.
8 I'd like to emphasize that these are averages and
9 that some people pay much more than the amounts displayed
10 and others pay much less. For example, as I said, the
11 average beneficiary pays $733 in supplemental premiums. But
12 people, for example, who purchase individual Medigap
13 insurance typically pay much more. For these people, the
14 average out-of-pocket spending on premiums is about $1,440
15 in 1998, and 5 percent of them paid more than $3,000 in
16 premiums in that year.
17 Thank you.
18 MS. ROSENBLATT: I have fewer comments on this
19 one, but I have the same comment on the tone of this. I
20 mean, the tone does appear to say, as in the previous
21 section, that Medigap is not good. Again, I've got lots of
22 paragraphs circled so you can take a look at it.

1 Can you tell me how income was derived?

2 DR. ZABINSKI: Are you saying when I'm talking

3 about out-of-pocket spending relative to income how I derive

4 it?

5 MS. ROSENBLATT: Yes.

6 DR. ZABINSKI: As reported on the MCBS. They're

7 supposed to report, as I say, all sources of income on the

8 MCBS. Does that answer your question?

9 MS. ROSENBLATT: Yes, that does. Thank you. And

10 I thought those percent of income and the three year things

11 were very well done.

12 There's also a chart in here on admin costs for

13 med sup. How were those admin costs estimated?

14 MR. WINTER: For that question, I'd like to invite

15 up Jim Mays, who was our contractor on this. I can give you

16 the broad outlines and Jim can fill in any details. Jim is

17 from Actuarial Research Corporation.

18 What he did for Medigap is he used the required

19 loss ratio under the various state laws. For M+C and ESI,

20 I'm not quite sure how you derived that, so I'm going to

21 defer to you.

22 MR. MAYS: Alice, you may have noticed, I don't

1 know if it's in the tables, but the loading we were using
2 for Medigap, I think you would consider it an illustrative
3 loading. We used 0.4, rather than 0.3 or 0.5. We were not
4 trying to be tremendously precise on that, but we thought
5 that was consistent with what was probably observed with the
6 range of compliance with respect to loss ratios.
7 Does that strike you as high?
8 MS. ROSENBLATT: It does strike me as high because
9 I would say that since the bulk of Medicare supplemental is
10 AARP or Blue plans, which was also mentioned in the text,
11 they have I think lower admin costs, higher loss ratios,
12 than is required by law. So I think you'd find Blue plans
13 and AARP may be in the 10 to 15 percent range.
14 I'm concerned that it's misleading.
15 MR. MAYS: We'll certainly review that. Thank
16 you.
17 MS. ROSENBLATT: Thank you.
18 MR. MAYS: The other issue with respect to
19 employer-sponsored insurance, we were using 15 percent there
20 assuming that, based on national health accounts, employer-
21 sponsored insurance in general appeared to be quite a bit
22 lower, 10 percent or somewhat less. Our presumption was

1 that if you did assign the administrative costs to the
2 retiree medical, perhaps not just on average, but presumably
3 reflecting the somewhat more complexity to the
4 administrative cost. We went with a higher number, but
5 again a fairly round 15 instead of 10.
6 MS. ROSENBLATT: The 15 sounds right. The
7 individual 0.4 sounds high.
8 One other comment, there's a comment in here on
9 the second page of the text, total resources spent on
10 beneficiaries' health care, excluding long-term care, could
11 be viewed as a budget constraint in redesigning the Medicare
12 benefit package.
13 I think that gets into a lot of the issues we've
14 been talking about today, where there are a lot of different
15 things going on, employers, beneficiaries, and I'm just
16 worried that's a dangerous statement.
17 DR. ROSS: Could I just interject one thing for
18 sort of guidance to commissioners? The issue of tone and
19 description of the individual market keeps coming up. But
20 in fact, there's a real policy question here that staff have
21 tried to bring to your attention to reflect some of the
22 points that Bob has brought up, and I think Alice fairly

1 represents the opposing point of view.

2 It would be very helpful for staff for

3 commissioners to weigh in on what you think of this. One of

4 the issues here is what do we make of having this -- I don't

5 want to use a loaded word like fractured insurance market

6 that's out there, but we need to hear from you. This goes

7 beyond a tone issue. There's some real policy questions

8 here.

9 DR. REISCHAUER: I presume you don't want to hear

10 from me yet again.

11 Ariel and Dan, I think this is really good stuff.

12 I commend you on these calculations. And having said that,

13 that sup premium column and the total out-of-pocket spending

14 by component seems awful high and doesn't really seem to

15 jibe with the other numbers.

16 Dan, you just said well, it's a $1,400 average for

17 Medigap, I think you said in your presentation. When that's

18 '98 and we have, in the previous tab, a $1,200 average for

19 2001. I just am sitting here doing my weighted average and

20 assuming that Medicaid is zero, the uninsured is zero,

21 Medicare+Choice back then 70 percent of the people were zero

22 and the others were very small.

1 And I go it and I can't get a number that's much
2 above $400.
3 DR. ZABINSKI: First, there are no Medicare+Choice
4 in here. The reason why I left them out is because in the
5 MCBS I don't think their data are reliable. In the MCBS
6 they cross-reference with claims information to make sure
7 the beneficiaries' use reporting is complete and thorough
8 and there's no claims to cross-reference with the
9 Medicare+Choice.
10 By their own admission, CMS believes that the use
11 rates for the Medicare+Choice are severely understated in
12 the MCBS.
13 DR. REISCHAUER: So I take 17 percent out and I
14 still have a hard time coming up with a $750 number. You
15 and I can argue it out.
16 DR. ZABINSKI: Just a couple of points. When I
17 talk about Medigap, I'm talking about people who have -- you
18 know, most of these people who have Medigap are Medigap
19 only. But some also have Medigap and employer sponsored.
20 But that drives up their average of that $1,440.
21 I know that the General Accounting Office for 1998
22 has an average for people who are pure Medigap of something

1 like $1,350. So I took that as pretty much in the ballpark,
2 being pretty close there. We can talk about it.
3 Also, for the people who have employer-sponsored,
4 their average is $569.
5 MS. ROSENBLATT: Is there a spouse coverage issue?
6 If you have employer coverage and you're paying for yourself
7 and your spouse?
8 DR. ZABINSKI: That could be. I'm not sure how
9 much that would drive that up, but that might be an issue if
10 that's going on.
11 MS. ROSENBLATT: Could you check that?
12 DR. ZABINSKI: Yes, no problem.
13 DR. REISCHAUER: It's not a problem if your spouse
14 is on Medicare, too.
15 MS. ROSENBLATT: It is, if you're counting it two.
16 If you're counting it as a per capita when it's really two.
17 DR. REISCHAUER: But presumably your spouse is in
18 the denominator and a numerator with a zero, because you've
19 paid her or his bill. But it's possible that it's people
20 with younger spouses, which would be a big effect. Even 4
21 or 5 percent of the people could really...
22 DR. BRAUN: I just wanted to bring up, in the text

1 in a couple of places we have -- I think on page three and
2 page 10 -- researchers say out-of-pocket spending generally
3 is not an obstacle to beneficiaries getting the care they
4 need. That care they need, I'm presuming you're not
5 thinking about prescription drugs, which I'm sure is one of
6 the things for the out-of-pocket spending that really is a
7 problem with access to care.
8 And I guess both of those places I wondered if we
9 shouldn't make some reference to the fact that that does
10 interfere with getting care.
11 DR. ZABINSKI: I really agree with that and I
12 think there's some good -- for example, I think there's a
13 good JAMA article to cite on that particular point.
14 DR. BRAUN: Thank you. The other thing I wondered
15 is do you have any information on what percentage of federal
16 poverty level gives you Medicaid benefits in the various
17 states? Because I think a lot of people have the idea that
18 you're on Medicaid if you're federal poverty level. And
19 you're not on full Medicaid, you're on QMB. Or you can be
20 on QMB, but you're not on full Medicaid. And I think a lot
21 of people have the wrong idea on that. Really it's a much
22 lower percentage than federal poverty level that puts you on

1 full Medicaid.

2 DR. ZABINSKI: We can add that. Just one other

3 thought on that is that there's also these resource

4 requirements that I don't think a lot of people think about

5 when they're thinking about Medicaid eligibility. Maybe I

6 can add that discussion in there, as well.

7 MR. HACKBARTH: Remind me, for QMB and SLIMB, are

8 there any asset tests or are those just income?

9 DR. ZABINSKI: QMB there's an asset test, I know.

10 I'm not sure about SLIMB.

11 MR. HACKBARTH: Jeanne, is there an asset test for

12 both?

13 DR. LAMBREW: On Medicaid, to the question of

14 eligibility, states do have an option to extend coverage,

15 full Medicaid coverage to 100 percent of poverty. About 16

16 states have availed themselves of that option.

17 Otherwise, you're looking at the SSI levels, which

18 is about 75 percent of poverty. So in the vast majority of

19 states, you're only eligible for full Medicaid up to 75

20 percent of poverty unless you have high health care costs

21 that impoverish you.

22 On the second question, yes, there is asset tests

1 that are basically twice the SSI levels, which is $4,000 for
2 a single and $6,000 for a couple. There are excluded things
3 like a house and other expenditures that get excluded.
4 But Dan's absolutely right, if you just look at
5 income, there are maybe one out of 10 people who may look
6 eligible by income, but they get excluded because of assets.
7 MR. FEEZOR: Just a question. Dan, one of the
8 exhibits that was attached to the paper had distribution of
9 income across beneficiaries basically broken into $5,000
10 increments and then $40,000 and above. Is that a fairly
11 static distribution? Or is that changing? In other words,
12 do we have a different kind of Medicare or different, maybe
13 a more affluent Medicare eligible coming on line? Is there
14 any way of judging that up or down?
15 DR. ZABINSKI: I don't know. I have the
16 information available to do that, but I don't know. My
17 guess is that it's pretty static, but I'm not certain.
18 MR. FEEZOR: Static by the time you count cost of
19 living and other issues?
20 DR. ZABINSKI: Yes, adjusted for price level
21 differences between years.
22 MR. FEEZOR: And then the second question, on the

1 last exhibit in the materials that was part of the overhead
2 slides, the percentile of out-of-pocket spending by
3 percentile rank in 1998. Fair interpretation would be that
4 75 and above, that's about 50 percent of the out-of-pocket
5 spending?
6 DR. ZABINSKI: What are you looking at? Now that
7 I have the diagram, what's your question?
8 MR. FEEZOR: If you drew a line at 75 and above, a
9 rough interpretation would be about 50 percent then of the
10 out-of-pocket spending occurs at 75 and above?
11 DR. ZABINSKI: Yes, that's about right.
12 MR. HACKBARTH: Any others?
13 Okay, since we are making a pretty significant
14 change in focus here, why don't we take a five minute quick
15 break. We're a little bit ahead of schedule.
16 [Recess]
17 MR. HACKBARTH: Next on our agenda is a series of
18 issues related to the coverage of non-physician
19 practitioners and payment for non-physician practitioners.
20 Mary, are you going to lead the way?
21 DR. MAZANEC: This next session is on Medicare
22 coverage of services provided by non-physician

1 practitioners.

2 In BIPA, Congress asked MedPAC to conduct a study
3 to determine the appropriateness of providing Medicare
4 coverage for services provided by surgical technologists,
5 marriage counselors, marriage and family therapists,
6 pastoral care counselors, and licensed professionals
7 counselors of mental health.

8 Upon further examination we learned that marriage
9 counselors do not represent a distinct professional
10 category. Therefore, we have not included them in our
11 analysis. A member of Congress requested MedPAC to include
12 clinical pharmacists in this study, so they have been added
13 to our list.

14 MedPAC's report is due this June. At this
15 meeting, the staff asks the commissioners to discuss the
16 pros and cons of recognizing additional Medicare providers
17 and to indicate their preferred policy directions.

18 As you can see, we have divided this list into
19 three groups based on the specific issue or question raised.
20 And I have divided my presentation accordingly, into three
21 parts. So Glenn, with your approval, I'll stop after each
22 part for commissioner discussion.

1 MR. HACKBARTH: Okay.

2 DR. MAZANEC: I will begin with the surgical
3 technologist issue. Surgical technologists would like to be
4 paid under Part B when they function as first assistants at
5 surgery. Current Medicare payment policy permits
6 physicians, physician assistants, nurse practitioners and
7 clinical nurse specialists who perform first assistant
8 duties to be paid on a fee-for-service basis under Part B.
9 Payment for surgical technologists and certified registered
10 nurse first assistants, however, remain in the prospective
11 payment.

12 In your mailing materials, I have included a chart
13 that compares and contrasts the education and training of
14 these different providers, state licensure and certification
15 requirements, and the scope of their patient care
16 responsibilities.

17 Again, the issue that the Commission has been
18 asked to address is should surgical technologists who
19 function as first assistants be paid under Medicare Part B
20 for their services. In approaching this issue, there are
21 two questions that the Commission should consider.

22 First, how should Medicare pay for services of

1 first assistants? Specifically, should first assistants be
2 paid on a fee-for-service basis? Or should payment be
3 included in the prospective payment? And second, who has
4 the adequate training to function as first assistants?
5 MedPAC staff identified two policy options for the
6 Commission to discuss and consider. Option one proposes to
7 have Medicare cover the costs of all non-physician first
8 assistants through the hospital prospective payment system
9 or the physician surgical fees. This option would
10 essentially rebundle the cost of non-physician first
11 assistants that are currently allowed to bill under Part B.
12 Again, those are physicians assistants, nurse practitioners,
13 and clinical nurse specialists.
14 Staff considered including payment for physician
15 first assistants into the bundled payment but for several
16 reasons opted not to take this approach and limited this
17 discussion to non-physician providers.
18 The advantages of option one include maintaining
19 the integrity of the prospective payment system which would
20 encourage hospitals to conscientiously manage resources and
21 control costs. But a disadvantage of option one might be
22 that hospitals would have a financial incentive to use the

1 least expensive first assistants.

2 In addition, option one may disrupt current
3 practice arrangements since all non-physician first
4 assistants are employees of hospitals or surgeons.

5 Option two would have Medicare pay for all first
6 assistant services provided by qualified practitioners on a
7 fee-for-service basis. Option two might eliminate the
8 financial incentives that might place certain categories of
9 first assistants at an unfair market advantage.

10 MR. DeBUSK: Excuse me. That is as it is now,
11 right?

12 DR. MAZANEC: No, it would essentially provide for
13 fee-for-service payment to all qualified first assistants.
14 If you decide to go with option two, then the next question
15 is who are qualified first assistants, which I'm getting to.

16 As I started to say, option two might increase
17 program costs unless the prospective payment is
18 appropriately reduced to account for the wage component of
19 first assistants. Option two may further unbundle hospital
20 prospective payments if surgical technologists or certified
21 RN first assistants are determined to be qualified providers
22 of first assistants duties.

1 Finally, if additional categories of non-physician
2 providers are recognized, the volume of billings would
3 increase. And this may have some cost implications.
4 If the Commission decides to pursue option two,
5 then there is a secondary question, which is who should be
6 eligible to receive Part B fee-for-service payments for
7 first assistants duties? Again, there are three possible
8 options or choices. The first one would be to restrict
9 payment to practitioners that are currently covered under
10 the current payment policy. The second one would allow
11 payments to surgical technologists that meet training
12 requirements and then adjust the base payment rate
13 accordingly. Or finally, if the Commission feels that this
14 is not an issue that they have enough information or the
15 appropriate expertise to decide, they can opt to make no
16 recommendation at this point.
17 I'm going to stop here and answer questions and
18 entertain discussion.
19 MR. DeBUSK: Exactly how are they paid at present?
20 The first assistants? If it's a physician I understand it's
21 20 percent.
22 DR. MAZANEC: A physician first assistant is 16

1 percent of the physician fee schedule, and they bill
2 directly. Nurse practitioners, clinical nurse specialists
3 who function as first assistants receive -- and NPAs --
4 receive 85 percent of what a physician would receive as a
5 first assistants. Nurse practitioners and clinical nurse
6 specialists can bill directly. PAs bill through their
7 employer but their employer can bill directly.
8 MR. DeBUSK: 85 percent?
9 DR. MAZANEC: 85 percent of the 16 percent.
10 DR. LOOP: I think the issue here is -- I don't
11 know the prevalence of the percentage of surgery assistants
12 employed by the hospital versus the private surgeon hiring
13 the surgical assistant. Because the issue is that the
14 private surgeon wants to have their own personal assistant,
15 which may be good for safety and efficiency. But are the
16 great majority of them already employed by the hospital?
17 I don't have a problem with paying for a licensed
18 person to assist, but I think we ought to know the scope of
19 the issue because if you have a surgery assistant that
20 belongs to a surgery group rather than a hospital, you're
21 going to put a lot more surgery assistants into the Medicare
22 program that weren't there before.

1 DR. MAZANEC: We can try to track down that
2 statistic or that number for you. It still raises the issue
3 of whether the payment should be bundled in with the
4 surgeon's fee, even if the first assistants is employed by
5 the surgical group, or whether it should be a charge that
6 can be billed directly and separately.
7 DR. NELSON: I had the same question as Floyd.
8 Can you give us a ballpark? Can you give us an idea of the
9 size of the universe of those that are currently either
10 independently employed outside of the hospital or employed
11 by a physician outside the hospital?
12 DR. MAZANEC: I wouldn't want to misspeak. We
13 actually probably have representatives in the audience who
14 might have that number in their head. I will track that
15 down for you, though.
16 MR. HACKBARTH: Other questions or comments?
17 MR. DeBUSK: The whole dynamics of assisting a
18 physician today is changing. You know, you go to get a
19 defibrillator or you go to get a pacemaker. And Medtronics,
20 what they have out now is you've got a device that has to be
21 programmed. You've got someone coming in from the
22 manufacturer who's doing this for you.

1 You know, the spinal surgery where a neurosurgeon
2 is involved today, they hardly do a back procedure without
3 someone even from the manufacturer to assist them, because
4 that thing can take so many different shapes and forms as to
5 what's needed to do that procedure. I think this thing is
6 far more complicated than we realize.

7 Some of these people coming with these physicians
8 into these hospitals are well trained in multiple things. I
9 think there's a big issue here.

10 DR. LOOP: But we're talking about licensed
11 surgery assistants. We're not talking about sales people or
12 manufacturer's representatives.

13 MR. HACKBARTH: Although, as I understand it,
14 they're not necessarily licensed. Didn't I read that this
15 particular category of clinical assistants is only licensed
16 in two states?

17 DR. MAZANEC: That's correct, but there is a
18 formal process to become certified as a first assistants if
19 you're a surgical technologist which requires additional
20 training and education.

21 MR. HACKBARTH: I'm troubled by option one,
22 basically going back and rebundling everybody other than the

1 physicians. I'm troubled by that, in that it seems to me
2 that it provides a very strong incentive to favor a
3 physician assistant at surgery, since that's the only one
4 where you get the second payment. I'm not sure that, based
5 on what I've heard, that there is any clinical reason to say
6 we should only have physicians doing this, as opposed to
7 various other types of practitioners.
8 I'd like to hear from Floyd and others.
9 DR. LOOP: I think that it's not necessarily a
10 move that would favor the physician assistant. It would be
11 a move to have hospitals employ all the surgery assistants,
12 because those would be -- if you bundled it, they would be
13 the only ones that would be part of the DRG.
14 MR. HACKBARTH: The question I have about that
15 then is, if you're a hospital with limited resources how do
16 you respond to that? You can say okay, I'm going to take on
17 all these people and hire them with no corresponding
18 increase in my DRG payments. Or I can say to surgeons, if
19 you want a first assistant, bring your own.
20 DR. REISCHAUER: Why wouldn't you increase the
21 DRG? If you were bundling them back up you'd increase the
22 DRG.

1 MR. HACKBARTH: But you'd still have the same
2 incentive. Even if you did rebundle, you can get an
3 additional payment. There's more money that flows into the
4 system if you use a physician. If it's rebundled, you're
5 going to get the dollars whether you hire a nurse
6 practitioners --
7 MR. MULLER: Glenn, just on a factual basis, you
8 generally don't have these physicians around who want to be
9 first assistants at 16 percent versus 100 percent. I'm sure
10 here and there there's a possibility, but I think Bob's
11 point, if one were willing to increase the DRG and then you
12 have skepticism whether that would happen. But if one would
13 increase the DRG then that policy could make sense.
14 I think I also share the sense of a number of the
15 comments before, that most of it has gone towards increasing
16 the number of categories rather than rebundling. So this is
17 obviously a theme in this next hour we're discussing, with
18 more and more groups wanting to be a part of that.
19 DR. MAZANEC: Can I just give you some numbers?
20 Of all surgeries where a first assistant is billed, 57
21 percent of those first assistants are physicians, 25 percent
22 are PAs, 1.5 percent are nurse practitioners or clinical

1 nurse specialists.

2 MR. HACKBARTH: What was the first one?

3 DR. MAZANEC: 57 percent are physicians.

4 DR. ROWE: Of the physicians, when a physician is
5 a first assistant, do they have to be a licensed or board
6 certified surgeon?

7 DR. MAZANEC: No, they do not. They can be a
8 family practitioner. They can be any physician.

9 DR. ROWE: One of the things that sometimes I used
10 to see if somebody was referred to a surgeon for an
11 operation, the primary care physician, who was not
12 surgically trained or qualified, would sort of show up and
13 be there for the operation and therefore be "first
14 assistant" when they were really in the vicinity of the
15 operation. Now we're getting into the residency training
16 issue, which I know is a dangerous issue so late in the day.

17 Floyd, maybe you can comment on that. Is that
18 prevalent, do you think? And is that something that's
19 germane to this?

20 DR. LOOP: Yes, I think it's germane, but how old
21 is that data that you quoted?

22 MR. LISK: It's actually 57 percent are surgeons

1 and 27 percent are physician assistants, 2.7 percent are
2 family physicians, OB/GYNs are a little under 5 percent, and
3 it's other physicians who make up the remainder.
4 MR. DeBUSK: How old is the data?
5 MR. LISK: That's 2000 data. Now the people who
6 didn't bill, these are the people who are billed as first
7 assistants.
8 MR. SMITH: So what share of surgeries was a first
9 assistants billed? 57 percent of what?
10 MR. LISK: I don't know.
11 DR. MAZANEC: I don't have that.
12 DR. NELSON: I have two questions. Do hospitals
13 bill for the services of residents as first assistants in
14 surgery?
15 DR. MAZANEC: No.
16 DR. NELSON: The second question is if we created
17 a new category of folks who would be paid independently for
18 assistant services, that is if we unbundled it and they were
19 paid fee-for-service, would that require construction of a
20 bunch of additional codes determining relative values?
21 MR. HACKBARTH: As I understand it, it's adding to
22 the list that are already unbundled.

1 DR. MAZANEC: That's correct.
2 MR. HACKBARTH: It's not like this would be the
3 first one that we've taken out of the bundle. We've got a
4 bunch of others. The question is whether we add still
5 another to the list.
6 MR. DeBUSK: What I'm seeing is a lot of physician
7 surgeons who will take a physician's assistant. Now the
8 trend is toward them taking a physician's assistant to the
9 hospital with them that works within that practice. I've
10 seen a lot of that.
11 So this technology that I'm speaking of, these
12 people are learning more and more about the specific way
13 that doctor practices medicine and does surgery. And that
14 seems to be the model of where it's moving to. Now this is a
15 separate issue from the surgery assistant.
16 DR. LOOP: I think there has to be a little more
17 data on the prevalence of the independent assistant who
18 would bill Medicare separately. The whole cost of the
19 surgery assistant, whether it's physician or whether it is a
20 technician, I think we need some cost data before we decide
21 how much the independent payment would add to that.
22 MR. HACKBARTH: Whether they're independent or not

1 today, isn't that, in part, influenced by how Medicare pays?
2 They wouldn't be independent today because they can't be
3 paid independently.
4 DR. LOOP: They can't be paid today, but the
5 surgeon who is in a private group often wants to have their
6 own assistant follow them to the hospital.
7 MR. HACKBARTH: So when you say independent,
8 you're including employed by the physician or the surgical
9 group?
10 DR. LOOP: Exactly. Not paid for by the hospital
11 in the DRG.
12 DR. REISCHAUER: A couple of questions. One is
13 what do private insurers do?
14 DR. MAZANEC: My understanding is -- and I can't
15 say they all cover the first assistant payment separately,
16 but some do. I can get you more specific data on that.
17 DR. REISCHAUER: Alice, do you know?
18 MS. ROSENBLATT: I don't know for sure, but I
19 think in general it is paid.
20 DR. REISCHAUER: But what kinds of people are
21 paid? Anybody?
22 MS. ROSENBLATT: No, I don't know.

1 DR. REISCHAUER: And am I right, that there are
2 only a certain number of surgeries for which an assistant is
3 an allowable expense?
4 DR. MAZANEC: That's correct.
5 DR. REISCHAUER: So you can come back with data
6 saying of the total amount of surgeries, 35 percent is this
7 a billable item. Within that 35 percent, it's broken down
8 by surgeon, car mechanic, whatever else.
9 MR. MULLER: Since up to about five years ago only
10 the physicians could bill, so some sense of growth of that
11 as the new categories were allowed to bill gives you a sense
12 of what the curve might be if one added others to it.
13 There's always a little lag time by the time people get
14 licensed.
15 DR. REISCHAUER: But also the way the fraction of
16 eligible surgeries that have an assistant is growing, as
17 well as who are the assistants.
18 DR. ROWE: I think it would be helpful to have, if
19 you haven't already been asked to do this or thought to do
20 it, have some data that shows the relationship between the
21 proportion of surgeries in an institution in which there's
22 an assistant paid and the number of residents in the

1 institution.

2 That is, I can imagine that if there are no
3 residents or surgical residents or very few to go around in
4 a given institution, that a surgeon might request assistant
5 from a colleague more frequently than if there are residents
6 who could be there to assist during the procedure. And to
7 see what kind of a relationship there would be there might
8 be helpful, as well.

9 DR. NELSON: I presume that when the first
10 assistants, the non-physician first assistants, are working
11 within the hospital they have to receive privileging by the
12 hospital. They have to be certified. So they're
13 credentialed and also privileged.

14 My question deals with what happens in the free-
15 standing surgical center? I would think that that would be
16 a bigger application for this category of practitioners
17 rather than the hospital. So then I'm not certain about
18 what the payment rules are with respect to the free-standing
19 surgical center.

20 DR. NEWHOUSE: Are those procedures eligible?

21 DR. NELSON: A lot of procedures that are done in
22 free-standing surgical centers require some assistant, I

1 would think. But my question relates to the setting in
2 which they would operate.
3 DR. NEWHOUSE: This is for Floyd, or anyone who
4 knows. Is the trend toward microsurgery affecting the
5 demand for assistants at surgery?
6 DR. LOOP: I don't know.
7 DR. NEWHOUSE: I guess the data, as somebody said,
8 would reflect the ramping up of the coverage which would, I
9 guess, make the trend not that...
10 DR. LOOP: I was going to say we've sort of
11 skirted this issue of certification versus licensure. If
12 you're going to pay this independent payment for assistants
13 who come with the surgeon, travel with the surgeon, should
14 they be licensed by some formal state body? Or who
15 certifies them? Are they just a nurse that travels and
16 assists, or should they be formally certified by some body
17 or licensed by the state? I don't have any idea.
18 DR. MAZANEC: The professional society, the
19 Association of Surgical Technologists, has a formal
20 certifying procedure and a certifying exam.
21 MR. HACKBARTH: Does Medicare require
22 certification or does Medicare simply require that people be

1 acting within state law when they do this?

2 DR. MAZANEC: For the most part, they have to act

3 within the scope of their practice, as defined by state law.

4 MR. HACKBARTH: That doesn't mean licensing.

5 They're not necessarily licensed by the state.

6 DR. MAZANEC: Not necessarily, no.

7 DR. WAKEFIELD: Craig, could you comment one more

8 time. I'm sorry, I know you said it twice and it just takes

9 me three times. You said 57 percent of all first assistants

10 -- wherever you are.

11 MR. MULLER: As a rural add-on?

12 DR. WAKEFIELD: Ralph wants to know what the rural

13 add-on is? See how I attributed that to you? No, I'm

14 actually not going to ask a rural question. You're shocked,

15 aren't you? I'm letting Bob ask those questions from now

16 on.

17 MR. LISK: 57 percent of the first assistant

18 services billed in Medicare were done by surgeons.

19 DR. WAKEFIELD: Were done by surgeons. And then

20 when you drop in the rest of the physicians...

21 MR. LISK: 27 percent were physician assistants.

22 DR. WAKEFIELD: Right. I'm trying to get a sense

1 of how many first assistants are MDs? About 60 percent
2 total?
3 MR. LISK: About 70 percent.
4 DR. WAKEFIELD: About 70 percent.
5 MR. LISK: Of the ones who can bill. These other
6 people you're talking about extending it to are not
7 included.
8 DR. WAKEFIELD: But of those who can bill right
9 now, about 70 percent are physicians and the rest are NPs,
10 CNS, PAs, et cetera.
11 MR. LISK: And in teaching hospitals, in many
12 cases, it's residents and there is no billing, they can't
13 bill for the service of residents, if surgical residents are
14 available to provide the first assistant service.
15 DR. ROWE: Give us the rest? It's 57, 27, go
16 ahead. What's left?
17 DR. WAKEFIELD: Chicken feed.
18 DR. ROWE: That's all that rural chicken feed.
19 [Laughter.]
20 MR. LISK: 27 percent are physician assistants or
21 PAs. 1.5 percent were NPs or clinical nurse specialists.
22 The rest are other physicians. Family physicians was 2.7

1 percent, OB/GYNs was 4.6 percent.

2 DR. ROWE: OB/GYN you would include as a surgeon,

3 also.

4 DR. WAKEFIELD: Can I just make a second comment?

5 On the report, regardless of where we go with the options, I

6 guess I'd raise the same comment about this particular

7 piece, as Alice did about previous ones. That has to do

8 with tone, although we weren't asked to comment on tone.

9 I think that somebody needs to go back and take a

10 look at how we're casting some of this commentary. The

11 statement requirements for first assistants prescribed by

12 certain professional societies must be judged objectively by

13 uninterested parties. I'm not sure which those certain

14 professional societies are that we're casting concerns

15 about. But there's a little bit of that that gets threaded

16 through here that I think is a bit problematic. Maybe

17 somebody could take a look at the tone when this thing is

18 finally written.

19 DR. MAZANEC: I wanted the commissioners to get a

20 sense of some of the controversies.

21 DR. WAKEFIELD: I guess what bothered me about

22 that was the word certain professional societies, as opposed

1 to others. Name them.
2 Actually, I don't want the names. I guess what
3 I'm saying is we might be trying to -- that statement seems
4 to suggest that some professional associations are more
5 suspect in their positions than others. That's how I read
6 that. Maybe I'm the only one who read it that way.
7 Apparently I am.
8 DR. MAZANEC: I think there have been allegations
9 about the objectivity of the certifying process by different
10 professional societies.
11 DR. WAKEFIELD: I'll be happy to look at your next
12 go round on this, or somebody's next go around, but I'm
13 going to say again that we can put the facts out there and I
14 don't think we should attach value -- at least I'd rather
15 not do that in text -- to different organizations. Let
16 their rhetoric stand as it is, whatever it happens to be.
17 But from my perspective, casting aspersions on one
18 organization versus another, I don't want to get into that
19 dogfight in text if we can avoid that.
20 MR. HACKBARTH: Pete, and then we've exhausted the
21 time we've got for this particular topic today. Pete, make
22 a comment and then I want to try to get a sense of where we

1 are in this issue to help the staff move ahead.

2 MR. DeBUSK: Here we're addressing the surgical
3 technologists and maybe a break out to include payment, a
4 separate fee-for-service as exists with some of the
5 physician assistants and some of the other professionals at
6 present that are being paid for this.

7 What's bringing this up? Access comes into play.
8 Right now, as I understand it, there's a tremendous shortage
9 of people to help in the surgical procedure? Is this what's
10 driving this?

11 DR. MAZANEC: There are shortages in surgical
12 assistants. I think this is driven by professional issues,
13 by an issue of equity across the different providers that
14 function as first assistants, why certain categories are
15 paid on a fee-for-service basis versus folded into the
16 bundle, if there's any rational basis for that.

17 MR. HACKBARTH: Could you put up the previous
18 overhead, that has the two basic options? Option one being
19 to rebundle, with the exception of physicians. And option
20 two being to unbundle and pay separately for all qualified
21 practitioners, including new categories.

22 DR. ROWE: Is there an option to bundle the whole

1 thing?

2 MR. HACKBARTH: There is conceptually a third

3 option, I guess it would be 1A would be to rebundle

4 everybody, including the physicians.

5 What I'd like to do is get a sense of where people

6 are among those three options. I know we've got some

7 outstanding questions that people have asked, but at the

8 same time I have a feeling people have a general notion of

9 where they are across those three options and I want to find

10 out where.

11 DR. LOOP: How far do we want to go in

12 understanding what constitutes a qualified practitioner and

13 do we want to tighten up the standards for that while we're

14 trying to figure out the payment?

15 MR. HACKBARTH: I think that's something we can

16 do. For current purposes, let me ask that you say I want to

17 do the unbundling, but I may want to tighten up the

18 criteria. Obviously, the operative word is qualified

19 practitioners in option two, and different people might have

20 different ideas about who constitutes a qualified

21 practitioner.

22 MR. MULLER: By and large, the hospital and

1 physician group is held liable under state law for the
2 quality of services provided in the institution. Therefore,
3 the more the one can go towards bundling and having them
4 take the responsibility for assessing the appropriateness of
5 the people involved, the better off one is.
6 Since some of option two has happened and it's
7 been unbundled, it's a little hard to go back to Jack's
8 suggestion. But I think if I could start from scratch, I'd
9 say bundle it all, understanding that the politics of
10 putting the physicians back in would be pretty intense
11 politics.
12 In terms of the quality movement, one is better
13 off having it under local control rather than trying to do
14 this from Baltimore. So in general, I'm inclined to not
15 open it up a lot more.
16 MR. HACKBARTH: Ralph, if Medicare says we will
17 pay, can't the hospital still say in order to be eligible to
18 be a first assistant here you've got to meet our test?
19 MR. MULLER: Yes.
20 MR. HACKBARTH: So I think they are separable
21 questions, the Medicare payment policy and who decides who's
22 eligible to practice in a particular institution with a

1 particular surgeon.

2 MR. MULLER: I'm just saying that the question of

3 -- I take it we have four categories right now and this

4 might be a fifth and there might be a sixth or seventh to

5 follow. And the question of how one has appropriate

6 standards for that, which could vary quite a bit by state,

7 by locality, and so forth. Some of them, like physician

8 training, obviously is many years. Others, I take it from

9 some of the material we received before, might be as little

10 as in the months. So that has quite a big of variation in

11 terms of who are qualified providers.

12 MR. HACKBARTH: I really do want to -- we've got

13 lots of issues coming up. So right now I'm not asking

14 anybody to make a definitive vote, but I just want to get a

15 sense of where people are. If option one is described here,

16 option two is the complete rebundling including the

17 physicians.

18 DR. ROWE: Can I ask a question about that? This

19 is budget neutral, right? You would take the payments there

20 are now distributed to them and throw them in the DRGs?

21 It's budget neutral?

22 MR. HACKBARTH: Right. And then option three

1 would be what's described here as option two.

2 DR. ROSS: Can you go with 1, 1A and 2?

3 MR. HACKBARTH: Okay, one, 1A and two. Number one

4 here, 1A being rebundle everybody, and two being unbundle

5 everybody.

6 DR. LOOP: Before we decide to unbundle, wouldn't

7 it be good to know the estimated cost of unbundling?

8 MR. HACKBARTH: We are not deciding. If people

9 really feel uncomfortable with --

10 DR. REISCHAUER: Why wouldn't they do that budget

11 neutral, too? I mean, we'd lower the DRG.

12 DR. LOOP: Assuming there would be more people as

13 assistants then when it's unbundled you would have to cut

14 the payment as a percent to the physician, paid to the

15 surgery assistant. The non-physician would get less money

16 than they're currently getting now as a first assistant if

17 it became budget neutral unbundled.

18 MR. DeBUSK: I'm missing something. It's

19 unbundled already.

20 MR. HACKBARTH: It is. The immediate question is

21 whether to add another category.

22 MR. SMITH: But in some cases, it's not.

1 DR. ROSS: Could I interject? The staff will try
2 to come back to you with some of the data you've asked for
3 and to be able to at least hand wave to a cost kind of
4 number. But while we're pursuing that, we'd also like to
5 have some kind of philosophical guidance from you all on
6 bundling, super bundling, and then expansion of the provider
7 list. Can you just stipulate to we'll try and bring you
8 back some of the data and information you've asked for?
9 We're not asking for a binding commitment today.
10 MR. HACKBARTH: We will revisit this at the April
11 meeting.
12 DR. STOWERS: Just a quick comment. CMS has
13 already kind of set a level of unbundling in the hospital
14 setting or whatever, in that all of the people now that are
15 paid separately for assistant surgery are masters level and
16 above. It's not at the RN level or different levels down
17 the line.
18 So I think what we would be doing is deviating
19 from the qualified licensed in that state type
20 qualification. So it's just a thought in the process, are
21 we wanting to change that line that they've drawn at this
22 point. Because as of this year, 2002, that requirement is

1 across the board for all of those other categories.

2 MR. HACKBARTH: Option 1, as presented here. At
3 this point, who's inclined in that direction? Three people
4 that I see.

5 Option 1A, rebundle including physicians. Floyd,
6 you would support that?

7 Option 2, add another...

8 DR. NELSON: The important question before us was
9 whether or not this category should be able to bill
10 independently. And by and large we're saying no.

11 MR. HACKBARTH: In fact, it's not this category
12 we're saying. We're saying even ones who previously,
13 currently are able to bill separately need to be put back.

14 DR. REISCHAUER: But in our report, we are asked
15 the specific question, which is a narrow one for which there
16 is a preliminary no answer. We can say that and talk about
17 philosophically there's sentiment for doing in the other
18 direction. But we don't necessarily have to recommend
19 rebundling in whatever -- to be responsive to the Congress.

20 DR. ROWE: Didn't we just decide whether or not we
21 want to do that?

22 DR. REISCHAUER: We can. What I'm saying is we

1 don't have to go that far. We can talk about it, but not
2 recommend it.
3 MR. HACKBARTH: We've worked on this enough for
4 today and we'll have another chance in April.
5 DR. LOOP: Can I just ask one question? Pete said
6 that everything is already unbundled. I don't see it that
7 way. The surgical technologist is often included in the
8 hospital and included in the hospital payment bundle.
9 MR. DeBUSK: With the exception of that one.
10 MR. HACKBARTH: Physician assistants and nurse
11 practitioners are unbundled already.
12 Thank you, Mary.
13 DR. MAZANEC: I'm doing more.
14 MS. LOWE: And if you thought that was easy, wait
15 until you get to the next one.
16 DR. MAZANEC: The second category of non-physician
17 practitioners that the Commission has been asked to make
18 recommendations for are providers in mental health services.
19 Currently, Medicare Part B pays for mental health
20 services provided by certain categories of non-physician
21 practitioners, including psychologists, clinical nurse
22 specialists, nurse practitioners with the equivalent of a

1 master's degree in psychotherapy, and licensed clinical
2 social workers.
3 Marriage and family therapists, licensed
4 professional counselors in mental health and pastoral care
5 counselors would like to be recognized as providers of
6 currently covered Medicare mental health services. This
7 would allow them to bill under Part B.
8 In your mailing materials, you received a table
9 that outlines the education and training, licensure or
10 certification status, the scope of practice, and the private
11 sector payment policy for both covered and non-covered
12 providers of mental health services.
13 In approaching this issue, the staff has
14 identified three major considerations. First, do
15 beneficiaries have access to needed mental health services?
16 It is unclear whether Medicare beneficiaries have difficulty
17 getting mental health services solely because of a lack of
18 providers. There are other equally important reasons why
19 beneficiaries may not seek mental health services besides an
20 insufficient number of providers. These include
21 transportation difficulties, cost of mental health services,
22 especially psychotropic medications, beneficiary denial of

1 psychiatric problems, and avoidance of treatment because of
2 the stigma attached to mental illness.
3 That being said, there may be certain geographic
4 areas, such as rural areas, where access to mental health
5 providers is a problem. There is no guarantee that
6 increasing the number of providers will eliminate access
7 problems in these areas.
8 A harder question to answer is which categories of
9 non-physician practitioners have the appropriate education
10 and training to provide mental health services to Medicare
11 beneficiaries? From the table in your mailing materials,
12 the different categories of non-physician providers of
13 mental health services, all at least have a master's degree
14 in counseling with the exception of some pastoral care
15 counselors who have a master's level degree in another
16 discipline such as divinity or theology but have
17 concentrated course work in counseling.
18 As I pointed out in your mailing materials, the
19 focus of the education and training of the different
20 categories of non-physician providers vary. For example,
21 marriage and family therapists are trained in psychotherapy
22 and family systems and diagnose and treat mental health and

1 emotional disorders within the context of marriage and
2 family relationships.
3 Pastoral counseling integrates behavior therapy
4 with the spiritual dimension. Licensed professional
5 counselors have a wellness orientation and use a
6 developmental and preventative approach and focus on the
7 individual within the environmental context.
8 A third issue to consider is the cost of adding
9 provider categories to the Medicare program. Expanding the
10 pool of mental health providers may increase Medicare costs
11 because of increased utilization of services. Some have
12 asserted that by treating mental illnesses, such as
13 depression and anxiety, there will be a reduction in the
14 number of physician visits and thereby save money for the
15 Medicare program. Others have argued that it is more
16 important to spend limited resources on addressing the
17 structural deficits in the Medicare coverage of mental
18 health services, such as the 50 percent copay and the
19 lifetime 190 day limit on inpatient care.
20 This slide lists three options for the Commission
21 to consider. Option one states that Medicare should
22 recognize marriage and family therapists, licensed

1 professional counselors and pastoral care counselors with
2 the appropriate education and training as providers of
3 mental health services for Medicare beneficiaries.
4 Option two recognizes that there are differences
5 in the focus of the education and training of non-physician
6 providers of mental health services, and that expanding the
7 pool of Medicare providers may increases costs. And
8 therefore states that marriage and family therapists,
9 licensed professional counselors and pastoral care
10 counselors should not be added to the list of Medicare
11 providers.
12 Finally, if the Commission believes that it does
13 not have information or the appropriate expertise to address
14 this issue, option three provides that the Commission is not
15 in a position to make a recommendation at this point.
16 I'll stop now for discussion.
17 DR. ROWE: Has there been a specific determination
18 of what kind of services would be provided? For instance,
19 if someone providing pastoral care, be it a priest or a
20 rabbi, said mass or presided over a religious service for
21 200 patients at a hospital that provided them with solace
22 and general counseling, would that be a billable service?

1 DR. MAZANEC: I don't think so.
2 DR. ROWE: I know you may not think so. But I'm
3 just...
4 DR. MAZANEC: The issue is being able to bill for
5 diagnosis and treatment, specifically psychotherapy. Again,
6 this would be within the scope of practice as defined by
7 state law.
8 DR. NELSON: Mary, in the key points discussion,
9 you indicate that one of the reasons to consider adding
10 these practitioners would be that it may improve access to
11 mental health services for beneficiaries. Is there evidence
12 that there's an access problem in getting these kinds of
13 mental health services?
14 And my second question is what's the distribution
15 of these practitioners? Specifically, are they largely
16 localized in just a few states like California, Texas or
17 something? Or are they broadly distributed nationally?
18 DR. MAZANEC: Let me answer your second question,
19 first. They are broadly distributed nationally, but there
20 tends to be a concentration of certain categories in certain
21 parts of the country, such as pastoral care counselors in
22 the Southern states. Marriage and family therapists are

1 very prevalent in California and the West Coast.

2 Your first question, as far as evidence of access

3 problems, I think in general there isn't good evidence

4 except in certain geographic areas such as rural areas.

5 DR. REISCHAUER: Do we know the extent to which

6 private insurers reimburse these providers? Alice, Jack and

7 Janet?

8 DR. WAKEFIELD: Did you see it on the table?

9 Payment policy in private sector and other government

10 programs. Far right-hand side of that.

11 It says marriage and family therapists, covered by

12 CHAMPUS and TriCare, generally covered by private payers.

13 For example, pastoral care counselors, various private

14 coverage varies by region. Covered by CHAMPUS, Tricare,

15 FEHB. Licensed professional counselor or mental health

16 provider, generally covered by private payers. Covered by

17 VA, Tricare, Head Start, DOD.

18 DR. NEWHOUSE: I think the problem with

19 interpreting that, private insurance is generally managed

20 behavioral health care and that's not the context we're in

21 here.

22 DR. ROWE: We're talking in the hospital as well

1 as out of the hospital, right?

2 DR. WAKEFIELD: Out, wouldn't it primarily be out?

3 DR. MAZANEC: Primarily in the outpatient area.

4 Part B.

5 MR. HACKBARTH: Let's do the same thing here. The

6 formal vote will be at the next meeting in keeping with our

7 general policy of wanting to have two looks at something

8 before we make a final decision. But I would like to get a

9 sense of where people stand. Joe?

10 DR. NEWHOUSE: Do we have a ballpark estimate of

11 cost here? This presumably should have a longer run time

12 horizon, but we sure have a problem with physician payment

13 at the moment. What kind of number are we talking about

14 here? Is this $3 million? $30 million? What is it? $300

15 million?

16 DR. MAZANEC: We really don't have an accurate

17 cost estimate. I think it depends on if you think that

18 provision of mental health services will actually reduce

19 other types of services, such as physician visits, which may

20 actually lead to a savings.

21 MR. MULLER: Can I ask a variation of Bob's

22 private question? Does this, in the private sphere, fall

1 into the alternative and complimentary category? Or these
2 categories don't fall into that?
3
4 MR. HACKBARTH: We've got a bunch of questions
5 here. Cost, to what extent is access a problem, that we
6 don't know the answer to. I'm not sure if we'll know the
7 answer to them at the April meeting, either, with all due
8 respect to our esteemed staff.
9 So I think we're either going to have to just deal
10 with the uncertainty or the staff has offered an option
11 three, which is to punt and say we simply don't have the
12 information necessary to make a recommendation here.
13 One clarification for me, Mary. I understand
14 there's some precedent of saying we will pay for categories
15 of providers in the circumstance where there is a clear
16 demonstrable access problem. Is that true? And if it's
17 true, is that an approach that's worked in the past?
18 DR. MAZANEC: It used to be true in the past for
19 nurse practitioners, clinical nurse specialists, and PAs, up
20 until the BBA, where they were paid in rural areas. But the
21 BBA lifted that geographic restriction and they're now
22 eligible to bill in all areas.

1 DR. STOWERS: I just want to make a comment.
2 There's a little bit out there about cost savings. We make
3 an example of the patient that has depression and therefore
4 we can avoid or maybe save physician visits as a cost
5 savings. But one of the top things listed as new technology
6 is medications for depression and other things which have
7 consequently considerably reduced the number of counseling
8 and otherwise visits. So it may be that the most cost
9 effective way of treating some of these things is with a
10 physician visit and appropriate medication.
11 So I don't think we should just directly write
12 that off as a cost savings and totally take out new
13 technology and new breakthroughs in medical treatment. I
14 think there's stuff in the literature about that that may be
15 worth looking up.
16 MR. FEEZOR: I participated in several state
17 debates around this issue, and I haven't looked at the
18 distribution effects but I found that many of the categories
19 we're talking about here have a very similar distribution to
20 that of psychiatrists or to existing mental health treatment
21 centers.
22 To the extent that makes greater availability,

1 that reimbursement would perhaps induce that to be more
2 stable that's one thing. But to the extent we're thinking,
3 I guess along your line Glenn, would that cause people to go
4 out into underserved areas, I think there's a real question.
5 Unless there is the ability, as you said, which is in the
6 absence of other practitioners in underserved areas that's
7 something we ought to consider.

8 MR. HACKBARTH: Bea, I'm going to give you the
9 last word, since you're our resident expert on mental health
10 issues.

11 DR. BRAUN: I think the pastoral counselors are a
12 tremendous help to people. I don't question that at all.
13 But I guess I do question whether it's a mental health
14 benefit or it should be paid for as a mental health benefit.

15 Mental health practitioners can become pastoral
16 counselors. There's no question then because they can bill
17 as mental health practitioners. But I'm not at all sure
18 that the education of those who are not already mental
19 health counselors really gives them the type of education to
20 diagnose and to treat mental illnesses. That would be a big
21 concern to me. I really don't think that they have those
22 qualifications.

1 MR. HACKBARTH: Again, I'd like to get a sense of
2 where people are on the three options currently on the
3 screen. Who, at this point, subject to change, favors
4 option one?
5 Option two?
6 Option three?
7 Thanks.
8 DR. BRAUN: Might you give us an option of
9 possibly paying for one or more of them only in the specific
10 areas that we were talking about earlier? I don't know
11 whether it would be worthwhile having that recommendation or
12 not.
13 MR. HACKBARTH: Is there a particular category
14 that you're interested in? Or are you saying add a category
15 where there's a demonstrable unmet need.
16 DR. BRAUN: Where there's a professional shortage
17 of mental health professionals.
18 DR. ROWE: I wonder whether or not it might be
19 helpful to get some sense of the Commission's priorities
20 with respect to these different categories. We're lumping
21 all three together in all of these recommendations. I think
22 that Bea made a very good point about some of the MFTs who

1 happen to be PCCs can bill as MFTs, but the PCCs who aren't
2 -- you know, it seems to me I have preferences within these
3 categories as to which ones would seem to be to be more
4 appropriate to be paid by Medicare, if any are, than others.
5 There should at least be some text about that, if
6 we don't want to get a sense. My own preference would be
7 that pastoral counselors would be the lowest priority for
8 me, with respect to that. Not that pastoral counseling
9 isn't good or spiritual help isn't good, it's just that I
10 think every single patient, every single patient -- whether
11 they're sick or not -- can probably benefit from it. It
12 would be hard for me to understand what the specific
13 requirements would be. And I don't know whether one minute
14 would qualify or 10 minutes or an hour.
15 And I'm concerned about all the uncertainty there
16 and what that would result in. Even the credentialing which
17 is, according to this table, much less clear than it is in
18 these other areas.
19 So that seems to me to be an area of potential
20 uncertainty which I would want to avoid.
21 MR. HACKBARTH: Any reactions to what Jack says?
22 Concurrence?

1 MR. SMITH: I share Jack's concern except I guess
2 I would extend it a little bit. I couldn't tell from the
3 text or from this discussion whether or not -- the reason to
4 do this is apparently a shortage. But I have no confidence
5 from what I've read, or the little bit I understand, that
6 option one responds to a shortage. Is there a clinical
7 need that's not being met which could be met by these
8 categories of counselors?
9 That case has not been made and I'd be very
10 uncomfortable with option one or even a truncated option
11 one, as Jack suggests, unless we make that case more
12 clearly.
13 DR. MAZANEC: Can I respond? The shortage
14 argument is only one argument. There's also an equity
15 argument. These category of non-physician providers assert
16 that they can provide psychotherapy and that they have
17 similar training and education to provider categories that
18 are currently recognized, such as the licensed clinical
19 social workers.
20 DR. NEWHOUSE: I am going to echo David. I
21 interpreted Allen to say these people locate where other
22 mental health professionals locate and absent some evidence

1 to the contrary, I'm reluctant to play much with the
2 shortage argument.
3 The equity argument, it seems to me we have to
4 take the stance of what we think is best for beneficiaries,
5 in light of overall budget constraints, pressures on
6 Medicare. In principle, I could think of potentially lots
7 of groups that might come in and say you're not treating us
8 this way.
9 MR. SMITH: In fact Joe, it's a sure thing if we
10 go down this road.
11 DR. WAKEFIELD: One point. The University of
12 Southern Maine is working on, or they're close to completing
13 a study on access to rural mental health services. I think
14 they're including 30 or more states. So if they're closer,
15 if they've got some preliminary findings, it might be worth
16 looking at that.
17 I can't tell you, however, whether or not they
18 include these particular categories. But at least it would
19 give us a sense of access to mental health services in rural
20 areas, if they're anywhere near done with that.
21 The second issue, I'd like to be able to think
22 more about the equity argument. I don't just dismiss that

1 out of hand. I think of that as an issue from my
2 perspective. But related to that, I found the OIG study
3 that was identified on page three kind of interesting in
4 that 22 percent of reviewed medical records showed that
5 currently, based on that study, Medicare beneficiaries were
6 receiving currently mental health services beyond what was
7 medically indicated or necessary.

8 I think it's part of a bigger picture of how you
9 fashion payment policy in a way that doesn't incentivize
10 overutilization or incentivize stinting on care. That's a
11 bigger issue here, and it's not unique to adding in just
12 these providers. And I think that little study makes that
13 point.

14 So here's this bigger issue about crafting payment
15 policy that's a little bit more accurate in terms of getting
16 the right service at the right time.

17 MR. HACKBARTH: I think that I'm in much the same
18 position as Joe described, maybe with one qualification. I
19 think that, given the overall situation of the Medicare
20 program, I think that there needs to be a very compelling
21 case to add new providers given the likely cost
22 implications. And if we add new ones, I would prefer that

1 it be as targeted as possible to where there's a true need.

2 What's nagging at me is if I'm trying to figure

3 out whether our stance here is consistent with what we just

4 did on the previous issue. In the previous issue we had

5 this equity question of are we treating various categories

6 of providers fairly. A number of people, and I would

7 include myself, say we've got to do that so let's rebundle

8 everybody including the physicians so that there's a level

9 playing field there.

10 Here, however, if we just say no to the add-ons,

11 yet we keep all of the other that are already in, it at

12 least raises the question in my mind of have we achieved the

13 same equity in the playing field?

14 DR. NEWHOUSE: The cost implications are quite

15 different.

16 DR. NELSON: You can't bundle dogs and cats.

17 Clinical social workers don't necessarily perform the same

18 services that these folks do. Nor are they trained to or

19 are capable of it.

20 If you have a trained general surgeon who refers a

21 patient to a cancer surgeon and scrubs first assist, to

22 provide that service and still provide continuity, that's

1 different from a nurse practitioner.

2 MR. HACKBARTH: That's helpful. In the case of

3 assistants at surgery, we are talking about a very clearly

4 defined task for which differently credentialed people might

5 be able to do it, but they're doing the same thing. Here

6 we're talking about different services. That is a

7 legitimate basis for distinguishing.

8 Okay, I think we've examined this one enough for

9 today. What's next, Mary?

10 DR. MAZANEC: One more. This may be the easiest

11 of the three.

12 The last group of non-physician providers that

13 MedPAC has been asked to examine for coverage is clinical

14 pharmacists. Clinical pharmacists would like to be paid by

15 Medicare for collaborative drug therapy management services.

16 Collaborative drug therapy management services is an

17 approach to care where drug therapy decisions and management

18 are coordinated collaboratively by physicians, pharmacists,

19 and other health care professionals and patients.

20 33 states currently permit physicians and

21 pharmacists to enter into a voluntary written agreement to

22 manage drug therapy for a patient or a group of patients.

1 In practice, these arrangements tend to be disease specific.
2 For example, a clinical pharmacists may run an anti-
3 coagulation clinic or manage the drug or insulin treatment
4 of diabetics.
5 In examining this issue, the staff has identified
6 three considerations. First, there is the issue of quality
7 of care. Some studies have shown that involving pharmacists
8 in patient care has reduced drug errors and improved patient
9 outcomes. The second consideration is the cost of adding a
10 collaborative drug therapy management benefit. In some
11 studies, selective costs were reduced. However, many of
12 these studies did not take into consideration the cost of
13 the pharmacist services when evaluating savings.
14 In addition, we don't know the cost of a more
15 generalized collaborative drug therapy management benefit,
16 or for that matter the best way to structure such a benefit.
17 Finally, as discussed in your mailing materials,
18 there is some disagreement between physicians and
19 pharmacists as to the scope of their respective
20 responsibilities under such an arrangement. Although
21 physicians recognize the value that pharmacists bring to
22 patient care, physicians believe that they should be

1 responsible and be in control of a patient's care.
2 Pharmacists see a much greater, expanded role for
3 themselves. They believe that after a physician makes the
4 diagnosis and initiates treatment, they should then be
5 permitted to select, monitor, modify and discontinue
6 medications as needed to optimize outcomes.
7 The staff has outlined two possible options for
8 this issue. Option one would create a Medicare
9 demonstration to determine the optimal construct of a
10 collaborative drug therapy management benefit and the
11 projected cost of this service to the program.
12 Option two would reconsider a collaborative drug
13 therapy management benefit after the creation of a more
14 generalized Medicare drug benefit.
15 I'll stop here.
16 MR. HACKBARTH: Questions, comments?
17 DR. LOOP: I think the clinical pharmacist has a
18 big role to play as drug treatment becomes more complicated,
19 but I think also that the first sentence under conclusion on
20 page five sort of sums up where we are. The problem with
21 demonstration projects is that they take a long time. And
22 this one would have to be totally designed. There's a

1 couple going on, I guess, in Medicaid in Iowa, Mississippi
2 and Minnesota. What's the status of those?
3 DR. MAZANEC: The last time I checked we had no
4 preliminary information or data on those demos.
5 DR. STOWERS: I think too, and I could not agree
6 more that the pharmacists have a lot to add to the quality
7 of care and in joint management. There is some concern,
8 especially in the managed care environment, these
9 collaborative agreements are used to decrease the number of
10 visits when payment is under a capitation system. I think
11 it's what we looked at earlier in the day. Many of these
12 patients have very significant, complicated multiple
13 diagnosis things going on and a lot of these arrangements
14 particularly will work to manage one component of that. So
15 let's say diabetes and insulin, is just taking one narrow
16 look at the patient's total care.
17 So I think we have to be careful here that these
18 automatically improve the overall care of the patient, where
19 we may develop an entity where there's a less comprehensive
20 care of the patient being taken on that might occur in the
21 physician's office.
22 So I'm a little concerned about this agreement of

1 segmenting out managing the Lanoxin or the Protyme or the
2 diabetes. And that changing over here in an independent
3 environment when all of these other chronic medical
4 problems, it seems to me almost to be exactly the opposite
5 of what we were talking about earlier, where we're trying to
6 have a collaborative care agreement and management that
7 looks at the whole patient.

8 DR. REISCHAUER: I, like Ray and Floyd, think this
9 is a very important service, but I think Medicare getting
10 into it would be premature because we don't really know what
11 the structure of a drug benefit within Medicare will be.
12 And it's not at all clear to me that creating a separate
13 payment stream like this wouldn't preclude some structures,
14 like having this function within PBMs or within plans, when
15 we try and reform the system.

16 What we would be doing is creating, in a sense, an
17 interest group that would then affect what structures could
18 be considered in a political sense. And so I think until we
19 resolve the issue of the form of the drug benefit, we
20 shouldn't even get into a demonstration program on this.

21 DR. ROWE: I concur with that, and I would also
22 add that I think that, in the in-hospital setting at least,

1 application of this expertise, which is substantial and real
2 value added, in my experience, should really be considered
3 to be included in the hospital payment. This is associated
4 with reduction in medication errors, reduction in
5 complications and length of stay, reduction in drug/drug
6 adverse interactions, greater use of generic rather than
7 private label medications that reduces cost to the hospital.
8 Since the cost of medicines is bundled into the hospital
9 payment, the cost of managing the medicines should be
10 bundled into the hospital payment.
11 So I think, at least on the inpatient side, that
12 really should be in there already. It's in the hospital's
13 best interest to have these capacities there.
14 With respect to the outpatient issue, I think the
15 fact that an outpatient drug benefit is not yet available
16 and the structure of it is not yet available, is a good
17 rationale for holding off.
18 DR. WAKEFIELD: Actually, when I read this
19 section, I was thinking more about care delivered on the
20 outpatient side of the equation, so it's interesting to hear
21 Jack's take on it.
22 MR. MULLER: Yes, it's really more Part A.

1 DR. WAKEFIELD: Yes, because I thought more about
2 this on the outpatient side, in terms of care coordination.
3 It also reminds me of some of the comments that were made by
4 the panelists early this morning where they were talking
5 about gaps in benefits focusing on payment methodology for
6 care coordination. I mean, I see these areas sort of coming
7 together. There's a lack of information that probably helps
8 us get as far as we need to. But they certainly talked
9 about that and talked about devoting attention to two or
10 three coordinated care actions and recommendations that I
11 think sort of tie back into this piece.
12 Just from a personal perspective, I personally
13 think that pharmacists are one of the most underutilized
14 clinicians available to just about anybody. And they are a
15 key provider of services in rural areas, for example. I
16 mean, if you've got a drug store there, you've got access to
17 some health care provider.
18 The difficulty I have is a shared one. I guess
19 I'm not even so concerned about tying it to understanding a
20 drug benefit as I am trying to figure out how you would
21 structure this particular provision of services. How would
22 that benefit be constructed? I don't have a sense here, in

1 reading this text, about what that care really looks like at
2 a fairly detailed level and then what the benefit associated
3 with that would be separate and apart even from a drug
4 benefit that gets included in the Medicare program.
5 So what's holding me back is exactly back. How
6 would you construct that benefit? And around what? It just
7 seems like we're a little bit shy of information, although
8 from my perspective this absolutely moves us in a direction
9 that I think that I would want to go.
10 DR. MAZANEC: Let me just make a comment. The
11 American Association of Clinical Pharmacists envisioned this
12 mostly on the outpatient side. They would see this as maybe
13 anywhere from four to six visits a year where they would sit
14 down with the patient, go over the different medications,
15 the interactions, actually maybe make recommendations about
16 changes.
17 But there is a lot of play in this because it
18 would be a totally new benefit and we could basically
19 recommend to build it any way we wanted to. But they see
20 this as a regular visit in the outpatient arena.
21 DR. NELSON: There's a lot to be said for the
22 advantages of collaborative relationships between these

1 professions, but there's also hazard in unlinking diagnostic
2 capability from management because the diagnosis can change
3 on a daily basis. And I worry about the diagnosis being
4 made and then a subsequent series of management decisions
5 being made by another practitioner without adequate
6 communication. And I'm worried about that fragmentation of
7 care being hazardous.

8 So until we have some way of structuring it in a
9 way that we can clearly have confidence that there will be
10 proper communication between the diagnostic side and the
11 management side, we need to be careful.

12 MR. HACKBARTH: Didn't I read that the norm
13 outside of Medicare is that there exists an agreement
14 between the physician and the pharmacist about how they're
15 going to work together to manage the patient?

16 DR. MAZANEC: That's correct. 33 states allow a
17 voluntary written agreement, and the elements of that
18 agreement can be fashioned any way the two parties want to,
19 as long as they're practicing within their scope.

20 DR. NELSON: That may be allowed, but I don't
21 think that's standard.

22 MR. HACKBARTH: I have all of the concerns that

1 you have about just saying now we've got a new category of
2 people who, independent of the physician, can start
3 regulating the drugs that they're taking, et cetera. That,
4 to me, doesn't seem right at all. But if it is in the
5 context of a defined relationship between the physician and
6 the pharmacist it's a bit different.
7 Although right now I think this question is
8 premature, given that we don't have a drug benefit or lots
9 of the administrative details.
10 DR. LOOP: Could you, Mary or maybe Bob, tell me
11 exactly how this links with a drug benefit? I got the key
12 word drug there, but I don't understand the clinical
13 pharmacist link to a drug benefit.
14 DR. MAZANEC: It doesn't necessarily have to be.
15 I think some people feel that with limited resources you
16 might want to put them into creating a drug benefit rather
17 than this type of service.
18 DR. REISCHAUER: I would argue that it is very
19 important to coordinate this with the structure of your drug
20 benefit. If you're going to run your drug benefit through
21 competing pharmacy benefit management companies, the
22 pharmacy benefit management company might want to contract

1 with pharmacists and we might want to pay through that
2 mechanism, rather than to pay pharmacists individually.
3 What I'm saying is if you start a system which --
4 I don't know, maybe that will turn out to be a crazy idea.
5 But if you start something like this, you can be sure you
6 won't consider that as a possibility.
7 MR. HACKBARTH: Foreclose future options for
8 restructuring.
9 DR. ROWE: The PBMs themselves often do some of
10 this, and they'll send an alert to a patient saying go to
11 your physician because this medicine interacts with that
12 medicine, or we have you as a diagnosis of having this. And
13 if you're an African-American with hypertension, it's often
14 that you take this medicine, not that medicine, et cetera.
15 A lot of this is done by PBMs already, and this
16 would be potentially duplicative of that.
17 MR. HACKBARTH: Let's again do a straw vote.
18 Who's leaning towards option one at this point?
19 Option two?
20 Is that it Mary?
21 Next we have payment for non-physician
22 practitioners.

1 MR. LISK: Good afternoon. Today Marian and I are
2 going to discuss another of the mandated reports we have.
3 This one is on Medicare payments for services provided by
4 non-physician providers. The report is due in June of this
5 year.
6 Today we are going to review the Congressional
7 mandate for this study, provide some background information
8 on the characteristics of these practitioners included in
9 the study, go over Medicare's current payment policies for
10 these providers, and discuss some of the key issues that
11 will need to be considered by the Commission. And finally,
12 consider some potential options for changing current policy.
13 At this meeting, you will need to make some
14 preliminary indication of the direction you would like to
15 take in making recommendations for this report.
16 The Congressional mandate requires the Commission
17 to study the appropriateness of current payment rates for
18 four different non-physician practitioners: certified nurse
19 midwives, nurse practitioners, clinical nurse specialists,
20 and physician assistants. In our presentation, we will
21 sometimes refer to these as non-physician providers, but
22 again it's not necessarily the same group of non-physician

1 practitioners that Mary was discussing in her earlier
2 discussion.
3 As part of this study, the commission is also
4 required to examine whether orthopedic physician assistants
5 also should be paid separately, and whether current payment
6 rates for these other non-physician practitioners would be
7 appropriate for these providers. Again, to remind you, this
8 study is due in June of 2002.
9 So Marian will now discuss some of the
10 characteristics of these providers, although we'll focus on
11 the orthopedic physician assistants towards the end of the
12 presentation.
13 MS. LOWE: Thank you. Very quickly, I just wanted
14 to give a little bit of background on who these providers
15 are, what their educational requirements look like. In
16 brief, there are over 200,000 nurse practitioners, midwives,
17 physician assistants and clinical nurse specialists
18 recognized in the U.S. Most of these providers are prepared
19 at the master's level, the notable exception being the
20 physician assistants that basically have an expectation that
21 they have two years of college or higher education, as well
22 as patient care experience. About 27 percent of PAs have a

1 masters, 40 percent of them are bachelors or less.
2 Nurse practitioners seeking Medicare recognition
3 after January 1, 2003 will be required to hold a master's
4 degree to bill the program.
5 Next, the scope of these practitioners is based
6 largely on the relationship with the physicians that they
7 work with, and is very vaguely defined in state law, the
8 specificity of which varies significantly. In general, the
9 laws are very permissive. There are very few prohibitions
10 on what types of services these people can provide.
11 Clinical nurse specialists are a little bit
12 different in their utilization. There are nine states in
13 which these providers are only recognized to provide mental
14 health services.
15 Licensure for the advanced practice nurses is
16 based primarily upon their recognition as a registered nurse
17 and then on either secondary recognition or additional
18 licensure as an advanced practice nurse. And they are
19 regulated by the Board of Nursing at the state or jointly by
20 the Board of Nursing and the Board of Medicine in the case
21 of midwives. Physician assistants, on the other hand, are
22 regulated by the state Board of Medicine, in general.

1 Where there is tremendous variation across the
2 states is in the area of prescriptive privileges for these
3 providers. Most of them have some level of prescriptive
4 privilege. About 60 percent of the states recognize nurse
5 practitioners and nurse midwives to prescribe controlled
6 substances. About 80 percent of states recognize PAs for
7 this authority.
8 Additionally, there's about 12 states that have
9 granted prescriptive privileges independent of physician
10 involvement for nurse practitioners and nurse midwives.
11 A final note, the clinical nurse specialists are
12 limited by their unique education and master's preparation
13 in the specific area, in terms of what they're involved in,
14 and their prescriptive privilege is far more limited than
15 the nurse practitioners and the nurse midwives.
16 As a final note, in terms of how these providers
17 came into the program, as was discussed a little bit earlier
18 with Mary's section, these were first recognized by Medicare
19 starting in 1997 in rural areas with exceptions. And then,
20 of course, the Balanced Budget Act of 1997 expanded that to
21 remove the site restriction on where these individuals could
22 practice.

1 At that point, I will turn it back over to Craig
2 to discuss how that reimbursement now works.
3 MR. LISK: Thank you. Services provided by these
4 non-physician practitioners can either be directly billed by
5 the practitioner or their employer, or billed by a physician
6 as incident to. Under direct reimbursement, certified nurse
7 midwives are paid at 65 percent of the physician schedule.
8 In contrast, nurse practitioners, clinical nurse
9 specialists, and physician assistants are paid at 85 percent
10 of the physician fee schedule.
11 The BBA, which expanded payments for this later
12 group of providers did not change payments for services
13 provided by certified nurse midwives who did not face the
14 same restrictions on practice reimbursement as these other
15 providers did at that point in time.
16 Also, as a matter of comparison, in terms of
17 reimbursement rates for other non-physician providers who
18 can independently bill, certified nurse anesthetists are
19 reimbursed at 100 percent of the physician fee schedule if
20 they independently provide the service. If they are
21 provided under the direction of an anesthesiologist, they
22 receive 50 percent and the anesthesiologist receives the

1 other 50 percent of the fee. Psychologists are reimbursed
2 at 100 percent, and social workers at 75 percent.
3 With incident to billing, the supervising
4 physician or the physician is paid at 100 percent of the
5 physician fee schedule for the service provided by these
6 practitioners in office or physician clinic settings.
7 Incident to billing, though, does not apply in hospital
8 inpatient or outpatient settings. Incident to rules require
9 that physicians be in the office suite immediately available
10 for consultation if needed.
11 Incident to billing is also limited to established
12 patients not presenting a new problem for treatment in that
13 case. So there's incident to for these practitioners, where
14 100 percent billing is limited to these cases.
15 The physician therefore must have provided direct
16 personal professional services to initiate the treatment and
17 must first furnish subsequent treatment and show active
18 management in the course of the treatment of the patient
19 over time. Though the physician is not required to see the
20 patient at each office visit.
21 We don't have any indication on the patient bill
22 when services are provided incident to that the services

1 were, in fact, provided incident to one of these
2 practitioners. So we unfortunately can't provide much
3 information on how extensive these services are provided
4 incident to, rather compared to direct billing.
5 Finally, on orthopedic physician assistants, they
6 are not recognized by Medicare for direct reimbursement for
7 the services they provide to Medicare patients.
8 So moving on to the questions for direct
9 reimbursement that we wanted to look at, the principal
10 question we have here for direct reimbursement are are the
11 inputs used by physicians and non-physician practitioners
12 the same in terms of the care provided for when we're
13 determining what difference there should be? And should
14 there be any difference in the payments rates between
15 services provided by physicians and non-physician
16 practitioners given your answer to that question?
17 Finally, because we also see a specific issue
18 where the certified nurse midwives are reimbursed at a lower
19 rate relative to the other advanced practice nurses, should
20 they be paid at a rate that is different from those other
21 advanced practice nurses?
22 What I want to next turn to is our analytic

1 framework in terms of how we might look at this. If we
2 determine that the inputs used by these non-physician
3 provider services are the same as physician services, we
4 might conclude then that there should be no payment
5 differential. If however, we conclude that there are
6 differences, we need to look at what is different. And here
7 we can focus on the different inputs to the patient care.
8 That would be the work, the practice expense, and the
9 professional liability insurance, and look at each of those
10 components to determine how much of a difference there is.
11 Work is the time, effort, skill and stress
12 required to provide a service. Practice expense is the
13 support staff, office space, supplies, equipment, and other
14 inputs in a physician's office. And professional liability
15 insurance is to provide coverage for the cost of malpractice
16 litigation.
17 I want to next talk then about what might be
18 different between physicians and these non-physician
19 practitioners in the work, practice expense and professional
20 liability insurance. We discussed in the paper some of the
21 differences in the services provided, and showed that these
22 non-physician practitioners tended to provide more

1 evaluation and management services, and within those
2 evaluation and management services provided those services
3 tended to be of lower complexity on average.
4 Beyond those evaluation and management services,
5 these non-physician practitioners tended to provide other
6 primary care diagnostic and treatment services, services
7 that appear to be within their scope of practice. In
8 general, when a non-physician practitioner provides a
9 service within their scope of practice, we don't know
10 whether that service would be, from the patient bill or even
11 from other things, whether that service would be different
12 if it was provided by an MD, in many cases.
13 In many cases, the time, effort, skill and stress
14 involved in providing the service would be the same for
15 someone who presents with a simple upper respiratory
16 infection, care for wound care for ulcers for many patients
17 who are in nursing homes with bedsores that need to be
18 treated, or for follow up care for monitoring many chronic
19 conditions.
20 But there may be other cases where there are
21 differences. But then again, when a patient presents with
22 more complicating conditions that are outside the non-

1 physician practitioner scope of practice, the services
2 provided would likely be different, but the services
3 potentially would be also billed at a higher rate within,
4 let's say, even the evaluation and management codes if
5 provided by the MD, if that is what is inputted in there, if
6 that's involved in the inputs because such conditions would
7 likely require greater skill and work by the physicians in
8 that case.

9 Unfortunately, we really don't know because we
10 don't know within a specific service what really ends up
11 going into it for the individual service going in.

12 One piece of information we do know from the
13 research is that nurse practitioners do tend to spend more
14 face-to-face time with patients, whereas physicians tend to
15 spend more pre-prep time and post-prep time with the
16 patients. Some of this is probably related to some of the
17 differences in characteristics of how these clinicians are
18 trained, as well.

19 Another component under work is where these
20 services are provided. NPs and PAs seem to be more common
21 in rural areas in terms of relatively -- an office is the
22 most common location for services provided by most of these

1 practitioners, although NPs and clinical nurse specialists
2 provide a substantial share of their services in nursing and
3 other custodial care services. For nurse practitioners it's
4 28 percent of the services, and for CNSs it was 39 percent.
5 So that's a substantial portion of their services are being
6 provided in these other settings. Whereas, for PAs, a
7 substantial portion of their services are being provided in
8 hospitals, 31 percent.
9 The research available on outcomes and quality
10 generally show comparable outcomes and quality of care. But
11 again, there hasn't been substantial research done in this
12 area. But what research has been done show comparable
13 outcomes.
14 The biggest difference between physician and these
15 non-physician practitioners is in their education and
16 training. The models of training are different, leading to
17 qualitative differences in the course content and the
18 clinical experience between these providers. The total
19 length of post-undergraduate training also differs
20 substantially. For physicians it's four years medical
21 school training plus a minimum of three years of residency
22 training compared to two years of master's level training

1 for advanced practice nurses. But again, for the advanced
2 practice nurses, if we consider total health care related
3 training, they also receive health related training, though,
4 at the undergraduate level to receive their RN training.
5 Now again, the models of training are different,
6 but in terms of what training is going into a health related
7 profession, it's not as different as the seven to two number
8 would show.
9 Medicare, however, does not currently recognize
10 for physicians differences in training between physicians in
11 the fee schedule for evaluation and management. So a
12 thoracic surgeon who provides a level I evaluation and
13 management service would be paid the same as a general
14 practitioner for that service. Now, of course, the
15 distribution of services is going to be different between
16 those providers but we don't differentiate currently on
17 those.
18 So the issue is whether we believe that there is a
19 difference between these practitioners and work, whether the
20 education and what goes into that in providing care
21 contributes to some difference in work.
22 It is probably reasonable to assume that the

1 practice expense for given services are similar across these
2 providers. For an office visit, for example, rent,
3 supplies, equipment and clerical support are likely similar
4 whether the service is provided by a non-physician
5 practitioner or a physician. In many cases, these are being
6 provided within the same office.
7 The limited data we have shows that nurse
8 practitioners have lower professional liability insurance
9 rates than primary care physicians, quite a bit lower.
10 Certified nurse midwives, however, appear to have rates for
11 professional liability insurance that are similar to, if not
12 higher than, primary care physicians in general, but lower
13 than rates for the people who they most likely practice with
14 in terms of OB/GYNs.
15 One consideration here on professional liability
16 insurance, though, is that the RVUs account, to some extent,
17 for malpractice risk associated with a given procedure. So
18 it's not clear that professional liability insurance would
19 want to be adjusted fully for these differences between
20 these practitioners or not.
21 Let's go what the options are on direct
22 reimbursement for you folks to consider. The Commissioners

1 could conclude that there should be no differential in the
2 payments for these services, that a service is a service if
3 it's provided by a qualified practitioner and that we make
4 no differential payment. So pay for the service at 100
5 percent of the physician fee schedule for services that are
6 within the scope of practice of these providers.
7 Alternatively, you could continue to have a
8 differential. And here essentially you have three choices
9 to consider. That is to keep the current differential with
10 certified nurse midwives at the lower rate; raise payments
11 for certified nurse midwives to 85 percent of the physician
12 fee schedule, consistent with other of these non-physician
13 providers; or calculate a new differential, essentially a
14 number that's different than the 85 percent. In that case,
15 you'd be conclude a number different than 85 percent would
16 be appropriate.
17 Now, some considerations in that later option is
18 if a new differential were calculated, there are a number of
19 different approaches you could take. The differential could
20 apply to only certain components of the physician fee
21 schedule, for instance work and professional liability
22 insurance. The differentials could apply to just certain

1 services, such as assistants at surgery services when there
2 may be a clear distinction between what let's say a surgeon
3 provides in that services versus what these non-physician
4 practitioners provide.

5 An example of that is a surgeon could close the
6 case or finish the case if the other surgeon, for some
7 reason, is incapable of doing so.

8 Or three, an overall adjustment like the current
9 one could be made, just the percentage would be different.

10 I'd like to stop here and then, depending upon
11 what your discussion leads to, it may affect the discussion
12 on incident to.

13 MR. HACKBARTH: Comments?

14 DR. STOWERS: I have several comments, most of
15 which I'll get to you a little later. I think it would be
16 important here to talk about, where you talk about
17 distribution of rural versus urban, the last things I've
18 been reading says that there's really not much difference in
19 the distribution because of the PAs being heavily numbered
20 doing surgery in the more urban areas. And that when you
21 look at the total numbers, it's pretty well equal with what
22 the family physicians --

1 MR. LISK: It's more for the office visits.
2 DR. STOWERS: I think we need at the overall
3 picture here and not separate out the E&M services, which
4 are more popular, I think, in the rural versus urban. But
5 overall, it's almost equal.
6 And looking at that, I think we also need to note,
7 I think, in the chapter about rural health clinics and other
8 underserved areas, where all of these practitioners already
9 receive 100 percent of the physician fee schedule, as
10 opposed to the 85 percent. Because in the rural health
11 clinic systems that we had, the reimbursement in nursing
12 home visits, as well as office and hospital visits, are all
13 the same for these practitioners as what it is for the
14 physicians. So that rural thing has kind of been taken care
15 of there a little bit.
16 The other thing on tone was under this education.
17 I think the way that paragraph was written on page 10 is
18 still very misleading and kind of totally discounts the pre-
19 med years and so forth that go in. So we still have a
20 difference of a max of six years versus 11 years and,
21 counting years only, that's still almost a two-to-one in
22 years and investment out of high school. So I think we need

1 to look at that. I don't think that paragraph comes across
2 with that very well.
3 One other thing is that to look at just years of
4 training and not talk intensity, not look at equivalent
5 college hours and that kind of thing, I think also is more
6 in what the current discussions are going around about that.
7 So those are just some of the things.
8 Some of the things on PA training, and so forth,
9 I'll talk with you about later.
10 DR. REISCHAUER: Was there any analytical
11 background to the 85 percent number? Or was it just sort of
12 pulled out of the sky?
13 MR. LISK: From my understanding, the 85 percent
14 was a negotiation when it came to, in terms of BBA. If you
15 go back to the old PPRC report in '91, that did something
16 for physician assistants, if you assume physician assistant
17 -- if you did the educational investment approach and you
18 assume that these other physician assistants had a return on
19 their educational investment similar to other professionals
20 -- not physicians -- you'd get a number close to 85 percent,
21 84 percent on average, for instance.
22 I don't know whether that had anything to do with

1 where the 85 percent came from.

2 DR. REISCHAUER: Do we have any idea how much of

3 the total E&M work is done by non-physician?

4 MR. LISK: It's less than 2 percent.

5 DR. WAKEFIELD: I think it's fine, of course, to

6 further expand, as accurately as possible, educational

7 background and providing a context like that. I also say I

8 think it's probably worth making the point in here -- I'm

9 not sure, maybe it was and I glossed over it -- but the

10 point strongly from my perspective that the whole RBRVS

11 payment methodology was based on a service is a service.

12 And our thinking through about drawing distinctions in terms

13 of payment between physicians, we're not drawing

14 distinctions in payment policy across types of physicians.

15 But we are here, as payment policy currently exists, drawing

16 distinctions between physicians and non-physician providers.

17 I think if we had more information about the

18 extent to which that 85 percent accurately reflects inputs -

19 - so one of my points is I think it's fine to discuss

20 education. I don't think education applies when we look at

21 physicians providing -- a neurologist treating me for my

22 migraine versus an internist providing me services for my

1 migraine. But we are talking about a difference in payment
2 for a nurse practitioner or a PA who treats me for my
3 migraine, for example.
4 I want to make sure that that point is captured
5 here, that payment policy was paying for the service being
6 delivered, not directly tied to the type of physician
7 providing that service, if I understanding from reading
8 about that correctly. So that's one point. I want to make
9 sure that, just like education, that's captured adequately.
10 Having said that, to me the issue is is there a
11 difference in some of the other inputs, like malpractice
12 liability insurance. You talked a little bit about that
13 between CNMs and their OB/GYN counterparts. But some of
14 that is picked up in adjustment for risk and underlying
15 payment policy.
16 So I guess the question I have is are there
17 distinctions that make sense to be made based on inputs like
18 liability or work effort, overhead, et cetera, that you were
19 able to capture beyond what you've shared with us here.
20 MR. LISK: No, it's difficult to say what other
21 differences there really are for a given service when you
22 look at an individual service that's being billed. On the

1 liability side, there are differences in terms of what may
2 be the underlying overall responsibility of the physician in
3 caring for patients. For nurse practitioners and the
4 advanced practice nurses are not necessarily supervised by
5 physicians but need to work in collaboration with
6 physicians. PAs, though do have to be supervised by
7 physicians. I don't know whether you think there's a
8 distinction within that responsibility that the physician
9 has when these practitioners are going independently versus
10 not.

11 DR. WAKEFIELD: I guess just on the surface, and
12 the last comment from me, the reimbursement for the CNMs
13 seems to be -- that 65, I think it was 65, percent seems to
14 me to make about the least amount of sense. But it's hard
15 to know what that level should be, thinking about the other
16 related inputs.

17 My guess, however, is that this is an awfully
18 small, tiny piece of set of services provided to Medicare
19 beneficiaries by that provider. Would it be just a
20 microcosm of --

21 MR. LISK: What was billed was about 8,000 or
22 9,000 services in 2000, though because there's a 65 percent

1 rate, there's probably greater incentive to be billing
2 incident to because of the lower reimbursement. So how many
3 services are being provided and wouldn't necessarily be
4 provided incident to.

5 And then some of the maternity care is really a
6 bundled service. For the limited amount of maternity care
7 that Medicare provides is generally a bundled payment for
8 the labor, delivery, and all the prenatal care and postnatal
9 care.

10 DR. WAKEFIELD: So it's really hard to get a cost
11 implication.

12 MR. LISK: It's hard to.

13 DR. REISCHAUER: This is a comment on Mary's
14 opening statement, which I agree with. But I think it leads
15 you in a different direction. I believe, like probably many
16 of you, that people who are capable of providing the same
17 service should be paid the same amount. But that amount
18 doesn't necessarily mean the amount we pay physicians,
19 because if a particular service can be delivered adequately
20 by somebody with less human capital that the market doesn't
21 pay as highly to, an efficient payment system would say
22 whoever provides that service we should pay that amount to.

1 We have a plasma physicist teaching elementary
2 algebra, you don't pay him plasma physicist rates, you pay
3 him school teacher rates.
4 Now given that you said a tiny fraction of total
5 services are provided by these folks, it's probably not a
6 relevant comment at this point. But at some point, where 50
7 percent of these services are provided, it could.
8 MR. HACKBARTH: Arguably, that's the principle
9 that's built into the system currently. We don't pay more
10 to the more highly credentialed specialist for doing the
11 same service. So we level down, if you will, as opposed to
12 level up. So if you apply the same thinking here, and
13 they're truly equal in every dimension, you may say well we
14 need to level down to...
15 DR. NEWHOUSE: I'd like to know if we're talking
16 about changes in a budget neutral context or not. This last
17 set of comments suggests we may be putting on reverse
18 thrusters.
19 I think maybe for purposes of discussing certainly
20 some of the changes like the 65 versus 85 percent, it would
21 be helpful to just postulate budget neutrality. I didn't
22 see in the draft that that was done.

1 DR. LOOP: The services provided by non-physician
2 practitioners will increase in time, and maybe I missed it
3 in here, but we probably should find somewhere in here an
4 estimate of the growth in the complement of the various non-
5 physician practitioners if we're going to talk about
6 reimbursement and budget neutrality.
7 DR. NELSON: I'd like to make the point that two
8 individuals treating the same diagnosis aren't necessarily
9 providing the same service. I don't know whether it's still
10 true or not but 10 years ago nursing organizations were
11 saying that they provided nursing care, not medical care.
12 So a nurse providing care for Mary's migraine may very well
13 be providing a different service from a physician taking
14 care of Mary's migraine, just the same as a tribal
15 practitioner taking care of an Indian child with pneumonia
16 is providing a different service from the Indian Health
17 Service person. And yet the individual has pneumonia.
18 So we have to be careful to not make assumptions
19 that the services are the same just because the condition
20 being treated is the same. Part of that involves not only
21 additional years of training but different kinds of
22 training, without making any value judgment about which is

1 best. Clearly both have a role. But you can't justify
2 paying them the same just because they're treating the same
3 condition.
4 MR. SMITH: As I read this material over the
5 weekend, I actually had a conversation with myself that
6 sounded like Mary and Alan. But I began with the principle
7 that Mary articulated, and I think she's right, that we
8 ought to pay the same for the same service. And then we
9 ought to try to figure out what the best way to deliver that
10 service is. But there's no particular reason to prefer Alan
11 providing it to me providing it, even though he's better
12 educated, if I can provide that service.
13 But then I wondered is the same thing going on?
14 The question that Alan just raised. I guess I ended up
15 thinking if the same thing isn't going on, we need better
16 codes. Because there's no way to distinguish between the
17 presentation of your headache and how Alan reacts to it or
18 how Joe reacts to it, getting me back to your principle.
19 It does seem to me here that we need to conclude
20 that if it's evaluation and management, it shouldn't make
21 any difference to us whether it's a nurse practitioner or a
22 physician's assistant or a doc who provides it. Your

1 principle ought to trump the suspicion that the better
2 educated among us are doing something different than those
3 who didn't stay in school as long.
4 That's a suspicion rather than a sound argument, I
5 think.
6 MR. HACKBARTH: Any other comments?
7 MR. DeBUSK: I don't see how we can keep from
8 differentiating the quality of care. I mean, it looks to me
9 like the whole system comes apart if we don't differentiate
10 the incentive to have the education to treat the patient in
11 a better manner.
12 MR. HACKBARTH: The question is whether, in fact,
13 the care is better. At least some measures in some studies,
14 the care is as good or better, although you wonder whether,
15 in fact, you're seeing exactly the same sort of patients or
16 not. I don't know the answer to that.
17 DR. NEWHOUSE: One comment. In the original
18 proposed RBRVS -- you may know the answer to this, since you
19 were at HCFA at the time -- there was to be a differential
20 for difference in education within physicians. And that was
21 dropped as it went through the legislative process.
22 Was there a reason for that?

1 MR. HACKBARTH: Actually, I left just before --
2 RBRVS was really just getting started as I was leaving HCFA.
3 DR. NEWHOUSE: The follow-on comment I was going
4 to make is if it really is the same service, this implies
5 that the return to the additional years of training is zero
6 within the MD community.
7 MR. HACKBARTH: Craig, did you have something you
8 wanted to add?
9 MR. LISK: No, I just wanted to see whether there
10 was a direction that you think the Commission -- like you
11 did for the others, a direction that you want to head on
12 this?
13 MR. HACKBARTH: Could we have the overhead with
14 the options, please? What I'm thinking about is whether we
15 need to add additional options here to reflect the
16 discussion. I guess one would be an A1 to reflect Joe's
17 suggestion that we do no differential, pay 100 percent, but
18 do it on a budget neutral basis. That would be a variation.
19 DR. NEWHOUSE: I would postulate that for all the
20 options, not just A.
21 MR. LISK: Actually, estimates could be done to
22 change the conversion factor slightly to make the whole

1 thing budget neutral.

2 MR. HACKBARTH: So it would only be relevant for A

3 and B2 is what you're saying, Joe, right? Because those are

4 the only ones that result in increased payments?

5 DR. NEWHOUSE: B3.

6 DR. ROWE: You're aware of what that would do in

7 large organizations who hire a lot of [inaudible], some of

8 whom are physicians and some of whom are nurses. Say all

9 those people are salaried and all the bills are submitted on

10 their behalf to Medicare and they pay the nurses much less

11 than they pay the doctors. But now they would get paid the

12 same, for both the doctors and the nurses? Is that what

13 you're suggesting?

14 DR. NEWHOUSE: No, that's A, as opposed to B.

15 What I was suggesting is just that whatever we do here, it's

16 done in the context of budget neutrality.

17 DR. ROWE: I'm just interesting in making sure

18 that I understand this right, that people have to think

19 about this not just from the point of view of individual

20 providers are getting paid the payments. In fact, their

21 employers are getting these payments, and this will provide

22 very strong -- in fact, irresistible -- incentives to reduce

1 the number of physicians and increase the number of lesser
2 paid providers within an organization where they are
3 employed. Just so everybody understands, that would be the
4 implication of A, unless I got this wrong.
5 DR. ROSS: Which will in turn lead to a rise
6 presumably in the cost of those now lesser paid individuals.
7 DR. ROWE: Exactly, particularly during a nurse
8 shortage.
9 MR. MULLER: But Jack, by and large, these are B
10 payments. And so those wouldn't be going to the employer
11 anyway in most places. Most places don't have A and B done
12 by the same employee, the way it is in certain select parts
13 of the Northeast.
14 DR. ROWE: That might change abruptly.
15 DR. WAKEFIELD: Do you have any idea at all about
16 how it cuts on Part A versus Part B? Do we have any idea?
17 I mean to these two points?
18 Then what's Jack talking about?
19 DR. ROWE: I'm talking about a large multi-
20 physician group that has about 40 physicians in a practice
21 plan. The Department of Endocrinology at the University of
22 Chicago is going to wind up with one endocrinologist and 15

1 endocrinology nurse practitioners.

2 DR. WAKEFIELD: Reimbursement would drive the way

3 they're choosing to deliver their care?

4 DR. ROWE: I'm just trying to understand the

5 implications. I want to put that on the table as one of the

6 implications of this, so people shouldn't think that these

7 are all physicians in the fee-for-service situation. Many

8 of them are employed and it will influence the structure of

9 those organizations. I believe, maybe I'm wrong.

10 MR. HACKBARTH: I don't think there's any

11 question. Let's work through the options. Anybody object

12 to Joe's suggestion that we look at each of these in the

13 context of budget neutrality?

14 DR. REISCHAUER: We're getting religion after our

15 March --

16 [Laughter.]

17 DR. ROWE: Bob, if it was religion, we'd be

18 reducing expenditures. We'd be saying that the expenses

19 should fall.

20 MR. HACKBARTH: So with that proviso added to

21 each, who is leaning towards A?

22 Who is leaning towards B1, keep the current

1 differentials?

2 B2, which I read as keep the current differentials

3 for everybody but for the nurse midwives increase it to 85

4 percent?

5 And B3?

6 DR. ROWE: Alice always votes for the option that

7 says calculate.

8 [Laughter.]

9 MR. HACKBARTH: Murray says it's two, five, three,

10 three is the vote. We've accomplished enough for today on

11 that subject.

12 DR. NEWHOUSE: I think the practical difference

13 between B1 and B2 is very small.

14 MR. HACKBARTH: Fair enough. Shall we move ahead

15 to incident to?

16 MR. LISK: The next issue then, if you had taken

17 option A, we wouldn't talk about incident to because that

18 implicitly would imply 100 percent. But since you didn't,

19 we will talk briefly about incident to.

20 Under current policy physicians are paid 100

21 percent of the physician fee schedule for services provided

22 by these non-physician practitioners. The original intent

1 of the incident to provision was to pay for services not
2 traditionally performed by physicians and services performed
3 under direct supervision of physicians. As the role of non-
4 physician practitioners has expanded, interpretation of this
5 provision widened to include coverage of evaluation and
6 management services delegated to these non-physician
7 practitioners.

8 So the options essentially here apply to payment
9 differential when services are provided by a non-physician
10 practitioner -- so essentially, how provides it determines
11 what the payment is -- or continue to pay 100 percent of the
12 physician fee schedule under retaining current policy. So
13 basically the question is, is there a need to reexamine
14 current policy? If so, then you have these options to
15 consider.

16 DR. NELSON: Persuade me there's a need. Why is
17 there a need to reexamine current policy?

18 MR. LISK: One of the reasons why we were bringing
19 this up is when PPRC examined this issue back in 1991 they
20 concluded that non-physician practitioners should be -- that
21 there should not be 100 percent reimbursement. It should be
22 based on the practitioner who's providing the service. So

1 they concluded that it should be based at the non-physician
2 practitioner rate rather than the 100 percent physician
3 rate.
4 There are issues about what incentives the
5 incident to provision may provide or also some issues of
6 whether there's too much incentive to -- it's part of the
7 incentives of --
8 DR. NELSON: I don't know what's broken. That's
9 what I don't understand. Why do we have to fix this if it's
10 not broken?
11 MR. LISK: It's one of the issues of how these
12 providers are paid currently, so that's the only reason why
13 we're bringing it up. So the question, if it's not broken,
14 then we go on.
15 DR. REISCHAUER: I gather from what I read and
16 what you said we don't know if it's working well or if it's
17 broken.
18 MR. LISK: That's true.
19 DR. REISCHAUER: There's an equity issue. You're
20 saying to us, you don't know how much of it there is, right?
21 MR. LISK: That's correct.
22 DR. REISCHAUER: So we don't know if it's 70

1 percent or 7 percent.

2 MR. LISK: And what the role of the physician --

3 DR. REISCHAUER: Not to use the word tone, but
4 that seems to be what we're -- there was a tone about this
5 that in a way maybe it was a sham. That the physician had
6 to be in the same airspace but really would provide no input
7 at all. I could see saying, if you want to bill at 100
8 percent, at least the non-physician provider has to discuss
9 the results of whatever it was with the physician, as
10 opposed to just having the physician four rooms away
11 examining another patient while --

12 DR. NELSON: That's a process in the relationship,
13 not a payment issue.

14 MR. HACKBARTH: What makes it a payment issue is
15 that you're paying more money. So if you're going to pay
16 more money, you have a right to expect something different
17 to happen, as opposed to hope that something different will
18 happen.

19 MR. LISK: What Bob described is what's supposed
20 to actually happen when a service is billed incident to in
21 terms of the collaboration. It may be that in an individual
22 case that if no problems arise when the non-physician

1 practitioner is seeing the patient then they don't
2 necessarily -- it's marked in the record and when the
3 physician next time sees the patient that's fine. But if
4 some other complication arises then they would be obligated
5 to consult with the physician.
6 DR. REISCHAUER: But what I was suggesting is if
7 they consult you get 100 percent. If they don't they get
8 the 85 percent. That would be the equitable way to do it.
9 MR. HACKBARTH: That makes sense to me.
10 DR. REISCHAUER: If there were a service rendered,
11 it should be paid for. Otherwise, no.
12 DR. NEWHOUSE: But not necessarily while the
13 patient is there?
14 MR. HACKBARTH: No.
15 DR. STOWERS: I think this, if I remember right,
16 was consistent with what's happening in the rural health
17 clinics where it's a place where Medicare has mandated a
18 certain supervisory relationship as they did in the rural
19 health clinics. Therefore, because of the physician
20 involvement -- and it's that relationship that you're paying
21 for that put it back to that level. So it's 100 percent
22 rural and it's 100 percent here where there's a supervisory

1 definition, so to speak.

2 MR. HACKBARTH: Regardless of whether anything
3 actually happens with regard to a particular --

4 DR. STOWERS: It was viewed then, in the rural
5 health clinics the same as here, that it's not each
6 particular encounter that you're paying for, but you're
7 paying for an environment in which the two are interacting
8 and practicing together in collaboration in a team approach
9 as opposed to independent practice. Because of that added
10 value that the physician is adding to the non-physician
11 practitioner's ability to work with patients and diagnose
12 them, it had greater value.

13 DR. ROSS: Craig, is there any limit to the number
14 of these simultaneous relationships that can go on? How
15 many people could I have billing incident to under my
16 supervision?

17 MR. LISK: I'm not aware of anything that limits
18 that. Again, the practitioner has to be available. I think
19 there may be an IG issue here in some cases of whether the
20 practitioner really is available for immediate consultation
21 when the patient is being seen by one of these providers.
22 That's one of the requirements, and I think that's probably

1 one of the concerns with the incident to is that could be
2 something down the road.
3 If we think about the PATH audits, this is
4 something that if the IG ever took up, who knows what you
5 would see. I think there are probably very legitimate
6 cases, the physician thinks that they're available and the
7 IG looks, you were having this complicated case; you didn't
8 bill us. So I think there's that aspect to it too to
9 consider as well here of what to do.
10 DR. NELSON: But the rule is clear.
11 MR. LISK: The rule is clear, but you never know
12 where that interpretation could go. It's a type of thing
13 when someone else presents with a new illness, the nurse
14 practitioner saw them and the physician wasn't able to see,
15 whether realistically there's a judgment. I think that's
16 another case where there may be some cases where there may
17 be some issues there where the service is billed incident to
18 because there's the higher payment for that. There is an
19 incentive to try to bill the higher payment in that case.
20 MR. HACKBARTH: To qualify for incident to, there
21 has to be a supervisory relationship; is that the language?
22 Does it mean employment?

1 MR. LISK: It's an employee relationship.
2 MR. HACKBARTH: So it has to be employer-employee.
3 MR. LISK: It can be a contract employee but it
4 has to be an employee. But there has to also be though, for
5 the patient it has to be an established patient and it can't
6 be a new presenting illness.
7 DR. STOWERS: I might add on the number, that's
8 determined by state law. Most all states limit two non-
9 physician practitioners to each physician, so there is a cap
10 of two per physician. There are a few states that do not
11 have that particular requirement, but that's the norm.
12 MR. HACKBARTH: Any other comments on this?
13 DR. WAKEFIELD: Just out of curiosity, although
14 somebody might say so what to me, just like they did to Jack
15 when he asked a parallel question, do you have any idea what
16 -- on the payment differential, do we have any idea what
17 that might incent the organization to do in terms of
18 utilization of nurse practitioners? If, for example, you
19 chose option A -- and again I might beg the so what question
20 -- but just out of curiosity, do we have any idea how that
21 might change or incentivize the organization differently?
22 MR. LISK: There would be slightly less

1 reimbursement, although if you had everybody at 100 percent,
2 then on the other side you wouldn't have any distinction.
3 So if you get slightly less reimbursement, you might have
4 slightly less incentive to have those folks.
5 MR. HACKBARTH: Shall we get a sense of where
6 people stand on this question? Who's leaning towards A at
7 this point?
8 Does that mean everybody is leaning towards B?
9 How about B?
10 MR. LISK: Okay, last issue. This is dealing with
11 orthopedic physician assistants. The questions we have
12 here, should orthopedic physician assistants be reimbursed
13 by Medicare in a manner similar to these other non-physician
14 practitioners? To answer this question we need to consider
15 how equivalent is their education, training, and
16 accreditation process to that of these other non-physician
17 practitioners.
18 The first question you might ask is, why are we
19 being asked to look at OPAs? First of all, they're not
20 currently reimbursed by Medicare for their services, so in
21 some sense this is similar to the questions that Mary was
22 going over before. But one little difference for these

1 folks is they were included in proposed regulations when the
2 BBA expansion for the nurse practitioners and physician
3 assistants was made. In regulations HCFA included the
4 orthopedic physician assistants in the regulations in the
5 proposed rules. But then they were taken out in the final
6 rule and not included as being a covered provider.
7 So what do they do? They work with patients
8 preoperatively. They're employees generally of orthopedic
9 physicians. They work with patients preoperatively, perform
10 pre-surgical histories and physicals. They make the proper
11 equipment is available in the surgical suite at the time of
12 surgery, and they serve as first assistant at surgery during
13 the service. And they provide post-operative care and
14 rehabilitation care in the hospital for the orthopedic
15 physicians. They also help in seeing patients in the
16 orthopedic physician's office as well.
17 So how are they trained? At one time there were a
18 many as 10 OPA programs in the country. Accreditation for
19 these programs though ended in 1974. The last program
20 though in terms of operating, AMA withdrew its accreditation
21 for a number of reasons. Originally the orthopedic
22 physician assistants were supporting these program but

1 didn't have the manpower to help support the accreditation
2 process. At the same time, the physician assistants program
3 were being supported by AMA, so the AMA withdrew its support
4 without a specialty society support for the program.
5 The last program closed in 1990. So in terms of
6 students attending accredited programs we're talking about
7 actually a fairly narrow window from the late '60s to '74.
8 Those students can receive training by working basically in
9 an apprenticeship model with orthopedic physicians for five
10 years and then sit for the certifying exam. So
11 certification and licensure, there's a national certifying
12 exam. No states license these providers, and there's only
13 limited recognition in some states. That's Tennessee and
14 California for those who attended an approved orthopedic
15 physician assistant program in California during those years
16 that program was open, and in New York they can serve as
17 first assistants at surgery.
18 So the options here for you to consider for the
19 orthopedic physician assistants is to continue current
20 policy; essentially do not recognize OPAs for coverage;
21 treat OPAs like physician assistants since they kind of
22 serve as that role for orthopedic physicians; or allow

1 payment for a limited set of services such as assistant at
2 surgery, consider them along with the other providers that
3 Mary considered in serving as first assistant at surgery.
4 MR. DeBUSK: Let me talk about this just a second
5 here. There's about 2,500 to 3,000 of these OPAs that are
6 caught out there in no-man's land and the American Academy
7 of Orthopedic Surgeons are back there wanting to reactivate
8 this school. They're wanting to get some recognition for
9 these people because the demand for human resources today,
10 we all know what's going on there.
11 So how do they get started again? With this many
12 of them caught in no-man's land, and to start up a school
13 they need some recognition by Medicare, of course. I don't
14 know how to put it. They're there. Do you grandfather
15 these people? Do you try to give life back to this program
16 which now they really want back because of the need? But
17 that's where they're caught at.
18 DR. STOWERS: I'm sympathetic to what Pete is
19 saying. I think my old CPT RUC days come back a little bit
20 where all of the services that you named off, history and
21 physical prior to surgery, post-op inpatient visits, follow-
22 up visits in the office are all included in the global fee

1 that goes with that surgical payment to the orthopod. I
2 think not to mention that here is leaving out a valuable
3 piece of payment policy.
4 MR. LISK: That's a very important point.
5 DR. STOWERS: So the only thing that is not
6 already being paid for by Medicare here in these services is
7 the assisting at surgery, which is a separate billable item.
8 So I think that we can't have it in both worlds. We either
9 have to go back and make an adjustment to the global fee for
10 these surgeries if we're going to pay in addition for these
11 other services so that we're not paying twice. Or the
12 simplest thing here would be just to move this group back
13 into the other questions of assisting at surgery. Otherwise
14 we've totally created an unlevel playing field.
15 This was discussed at great length at the RUC
16 through many, many meetings about these individuals who are
17 assisting and taking over duties that are within the
18 surgical global and then creating other people to do that.
19 So I think that discussion is very germane to this point.
20 DR. LOOP: I agree. If they have a legitimate
21 scope of care that they provide and they're certified, it's
22 going to be a while before they get their own training

1 program back so I think to categorize them under surgery
2 assistants is probably the best way to do it.
3 MR. SMITH: I think I agree with what's just been
4 said, but we argued an hour ago that we ought to rebundle
5 all of those non-physician practitioners who might provide
6 first assistant services. That would seem to me ought to
7 apply to this group of non-physician practitioners. Ray's
8 point about the bundle already including the other
9 functions, it seems to me that this is a question that
10 doesn't need to be answered. We've answered it. We've
11 answered the extant part of it in our recommendation that we
12 rebundle.
13 MR. HACKBARTH: I can't remember what the vote was
14 on that question, but to the --
15 DR. REISCHAUER: Preliminary.
16 MR. HACKBARTH: The preliminary vote; the straw
17 vote.
18 DR. WAKEFIELD: Yes, preliminary. We didn't all
19 vote that way.
20 MR. HACKBARTH: But I agree with your logic, that
21 to the extent that you buy the, let's rebundle everyone, it
22 would seem to apply here.

1 Any other comments?

2 MR. DeBUSK: Let me reiterate on the nursing
3 shortage and the shortages of all professions. Orthopedic,
4 the assisting an orthopedic surgeon or a neurosurgeon, that
5 gets to be more and more complicated every day. With this
6 need growing and what have you, if there's a possibility
7 that they can reactivate -- and I happen to know that
8 there's some schools already willing to step forward if they
9 can get some Medicare recognition and start up programs from
10 the ground up to do this. The curriculum and everything is
11 in place.

12 So I think with that being an opportunity, I think
13 it would certainly be a good direction for us to move into
14 if we can increase access to better care or supportive care
15 to the orthopedic surgeon and neurosurgeon going forward.

16 DR. WAKEFIELD: Just on your earlier point, Glenn,
17 or I guess yours, David, it was that was the majority
18 preliminary vote for rebundling all first assistants, not
19 non-physician providers separated out from other providers,
20 from physicians, right? It was all. So those of you who
21 voted for that, you voted for all of them.

22 MR. HACKBARTH: We do need to move ahead because

1 we have one other item. I don't think we need to do the
2 straw vote for this one.
3 So that takes us through all of the other non-
4 physician practitioner issues and the last item of the day
5 is access to hospice care.
6 DR. KAPLAN: Good afternoon. We're going to talk
7 about access to hospice in this session, as Glenn said. In
8 BIPA, the Congress requested we study to access to and use
9 of hospice. They asked us to pay special attention to delay
10 in the use of hospice, and urban and rural differences in
11 use. The BIPA language is in an appendix to your mailing
12 material.
13 As you know, access is a multidimensional concept.
14 In this study we used two indicators of access:
15 beneficiaries use of services and supply of providers. We
16 also hired a contractor, Jay Mahoney, to interview
17 individuals knowledgeable about hospice so we could learn
18 about access problems not detected by these two indicators.
19 As you also know, hospice has a relatively rich
20 group of services, some of which Medicare does not pay for
21 in other settings. For example, Medicare does not pay for
22 drugs or homemaker services under home health care. To be

1 eligible for hospice services beneficiaries must have two
2 physicians certify that their life expectancy is six months
3 or less, and beneficiaries must give us curative care for
4 the terminal condition.
5 As promised in your mailing material, we have
6 updated most of the data to 2000 thanks to the hard work of
7 Chris Hogan. We'll update the rest for April's meeting. At
8 the end of the presentation we'll ask you for your comments,
9 and of course, questions.
10 As you can see from the figure on the screen and
11 in your handouts, the number of beneficiaries using hospice
12 tripled from 1992 to 2000. During this time period the
13 number of hospices almost doubled. In 1998, 20 percent of
14 Medicare decedents used hospice. In that year, cancer
15 patients using hospice accounted for 51 percent of all
16 beneficiaries who died of cancer. Cancer patients are the
17 lighter part of each bar in the figure.
18 The beneficiaries with the greatest growth in
19 hospice use were those with non-cancer diagnoses -- the
20 black part of each bar in the figure -- those living in
21 nursing homes or living in rural areas. Only 2 percent of
22 beneficiaries lived in areas with no hospice services

1 available in 1998.

2 The empirical evidence shows that minority
3 beneficiaries use hospice less than their white
4 counterparts. It also shows that beneficiaries without
5 supplemental insurance coverage use hospice less than those
6 with any type of secondary insurance, including M+C. These
7 findings could indicate access problems for these two
8 groups, but the lower use could be due to other reasons.

9 The literature suggests that cultural differences
10 are largely responsible for lower use by minorities.
11 However, no simple explanation exists for beneficiaries
12 without secondary insurance, especially because there is
13 very little cost-sharing for hospice services. People
14 without secondary insurance are disproportionately low
15 income and non-white. But Chris controlled for income and
16 race in the regression analysis, so this is an independent
17 effect.

18 The hospice community believes that four other
19 groups of beneficiaries have difficulty accessing hospice,
20 but there may be other explanations. Two of these groups,
21 nursing home residents and beneficiaries with non-cancer
22 diagnoses, experienced the greatest growth in hospice use,

1 as we said before. Older-old beneficiaries frequently do
2 not have caregivers and some hospices will not admit
3 individuals without them.
4 Regarding patients using chemotherapy, radiation
5 or surgeries, on the one hand we here that some hospices
6 won't admit these beneficiaries. On the other hand, some
7 patients using these interventions may not have accepted the
8 proximity of their death or be willing to give up curative
9 care.
10 Some believe that short hospice stays are also an
11 indicator of access problems. The fraction of hospice
12 patients dying within one week of admission increased from
13 21 percent in 1992 to 30 percent in 2000. We're not sure
14 what this increase means given the change in the population
15 during this period.
16 Main causes of late referrals, however, appear to
17 be difficulty of making prognoses, beneficiaries
18 unwillingness to give us curative care, and the greater
19 availability of non-toxic therapies. The literature
20 documents the difficulty that physicians have making
21 prognoses of death within six months. Only 20 percent of
22 the diagnoses are accurate. Sixty-three percent over-

1 estimate survival time.

2 Even when physicians identify patients as eligible
3 for hospice, patients may choose to continue curative care.
4 The greater availability of therapies that are not
5 debilitating may result in more beneficiaries delaying
6 election of hospice. As you heard this morning from Dr.
7 Hurley, patients have greater expectations that cures can
8 happen if the patient and physician will just persist.

9 We conclude that short stays do not appear to be a
10 result of Medicare policies. We also conclude that the
11 rapid growth of hospice in the 1990s indicate that overall
12 beneficiaries do not appear to have difficult accessing
13 hospice.

14 To preserve access without financially
15 overburdening beneficiaries or taxpayers, Medicare payment
16 rates must be adequate. The rapid growth in providers and
17 service use suggests that rates are not too low on average.
18 However, the industry says rates are too low. We don't know
19 whether the rates are right, too high, or too low. They're
20 based on the hospice demo that was conducted in the early
21 1980s. The only way to resolve this issue is to reevaluate
22 the rates.

1 While reevaluating, several payment issues can be
2 addressed. For example, CMS can determine whether rural
3 hospices have higher costs than urban ones. They can also
4 determine whether payment is adequate for shorter lengths of
5 stay. This research could help determine whether case-mix
6 adjustment is needed.
7 Now we turn to the draft recommendations. Draft
8 recommendation one is on the screen. The Secretary should
9 evaluate hospice rates to ensure care consistent with
10 efficient providers' cost of providing care. We understand
11 that cost reports will be available in June -- of course,
12 just after our report is due at Congress. And we understand
13 that CMS' staff is chomping at the bit to get at it.
14 Draft recommendation two, the Secretary should
15 research differences in resources and care needs of
16 patients, and whether a case-mix adjusted payment system for
17 hospice care is feasible.
18 We welcome your questions and comments.
19 DR. NEWHOUSE: I think the recommendations are
20 fairly easy to agree with. I would propose, however, an
21 additional one, which is that the Secretary investigate an
22 outlier system. We have considerable heterogeneity in

1 payment at the case level. I guess I should ask Sally
2 whether she considered bringing that recommendation forward
3 or not.
4 DR. KAPLAN: Yes, we did consider bringing it
5 forward. I think part of the thing that we were concerned
6 about is it seemed like before you reevaluated the rates --
7 that you didn't want to go jump into an outlier policy until
8 you did that.
9 DR. NEWHOUSE: Really? I don't see the
10 connection. They're really two different issues I think.
11 The outlier really goes to heterogeneity across patients and
12 the adequacy of the rate just goes to the level of the rate
13 given what the hospice needs to purchase.
14 MR. HACKBARTH: Would the outlier be an adjunct to
15 a new case-mix system are you saying even --
16 DR. NEWHOUSE: I see those as independent also. I
17 support investigating a new case-mix system. But it's
18 really inconceivable to me that a new case-mix system could
19 be so good that you would get rid of the heterogeneity
20 across patients.
21 DR. STOWERS: I just wonder if you have any data -
22 - I would love to have asked Carol this. In my experience,

1 a lot of the non-cancer hospice admissions came out of the
2 home health care system because you take care of that
3 congestive heart failure patient and then they become
4 homebound, and then only at the final stages do we deal more
5 with the hospice. Do you have any data of where the
6 referrals come from, or what track they're coming from?
7 Because I'm wondering with the proliferation of
8 home health care over the decade that you're talking about,
9 how much substitution here has occurred and might be
10 affecting that short stay in the hospice. I know there's an
11 interaction there because I see it happen every day, but I'm
12 just trying to quantify that somewhat.
13 DR. KAPLAN: In your mailing material, one of the
14 indicators that predicted short stays -- by short stays,
15 we're changing the definition a little bit: admission within
16 two weeks of death. That indicated that having home health
17 services was a significant predictor of short stays. That
18 also came up among the experts, the people knowledgeable
19 about hospice as well.
20 The thought was that that might have changed
21 because with the new payment system going from basically a
22 cost-based system where you paid for as many services as you

1 delivered, to an episode-based payment system, that there
2 might have been a change. Also on the OASIS there is a
3 requirement that the home health agency actually make a
4 prognosis about death. So there's the thought, or at least
5 anecdotally a thought that there's more awareness among home
6 health agencies that people are eligible for and might
7 benefit from hospice.

8 As far as being able to tell where the folks who
9 are referred to hospice come from, I don't think we can do
10 that in time for April, to tell you the truth. The data is
11 there. It's not the most reliable variable on the claims
12 data, and I think you'd have to do a link-up of home health
13 claims and hospice claims and I don't think we can do that
14 by April.

15 DR. WAKEFIELD: Actually, it struck me as good
16 news, the statement that we've got fewer than 2 percent of
17 beneficiaries live in areas with no access to hospice care
18 available. I would be interested, however, in knowing how -
19 - and you don't need to tell me now but I'd like to look at
20 how the investigators determined whether or not an area had
21 hospice coverage.

22 A little bit of what I hear back in my state is

1 that the -- notice I didn't use the word rural, Bob. Back
2 in my state, is that there have been hospice closures but
3 driven in large part by very few patients needing this type
4 of service, long distances to travel to provide it. So I'm
5 trying to reconcile that anecdotal feedback with how they
6 determined what on the face of it is really good news in
7 terms of access to hospice care.

8 DR. KAPLAN: Chris used various ways of
9 determining that, and I can actually speak to North Dakota.
10 There is a hospice provider who provides services statewide.
11 Chris, first of all, use in a county, any beneficiaries
12 using hospice services in a county, which indicates those
13 services are available. He also used various other
14 indicators. I can't remember what they were, but it was a
15 pretty sophisticated analysis to come up with whether you
16 have hospice available or not in a county.

17 DR. WAKEFIELD: If I could still see it, that
18 would be just great. Because the person I spoke with is the
19 CEO of a 17-hospital long term care, home health,
20 outpatient, et cetera, delivery system located in the
21 central part of the state and that's what she said to me.
22 So I'd like to reconcile that in my own head with what Chris

1 came up with.

2 DR. HAYES: We'll nail that down for you. I

3 believe he had access to some industry data on service areas

4 for hospices, self-declared service areas. But we'll

5 clarify that in the next draft.

6 DR. BRAUN: This is probably not the best time of

7 day, but I notice we often use efficient providers. I was

8 just curious as to how does one determine when a provider is

9 efficient?

10 DR. KAPLAN: Gee, I wish Julian were here. I

11 don't know how CMS would determine what an absolutely most

12 efficient provider would be, but I think they would very

13 much go by historical information as to how much cost and

14 whether the payments met the costs of providing care for

15 individuals with different characteristics.

16 DR. NEWHOUSE: Bea, that's what we do with our

17 update recommendation.

18 DR. BRAUN: I know.

19 MR. HACKBARTH: Okay, again, we don't need to

20 vote. I didn't hear any dissent about the two proposed

21 draft recommendations, Joe has offered a third in terms of

22 investigating an outlier independent of the other two

1 recommendations.

2 DR. NEWHOUSE: Let me note, I think that could
3 probably be put into place faster than a case-mix system
4 also.

5 MR. HACKBARTH: Any objection to that?

6 Thank you, Sally, Kevin.

7 We will have a brief public comment period. Same
8 ground rules; i.e., if one of the preceding commenters has
9 already made your point, please don't reiterate it; try to
10 make room for other folks. And if any given comment runs on
11 too long, due to the late hour, which I apologize for, but
12 in view of the late hour I'm going to urge the speaker
13 along.

14 MR. WEBB: Mr. Chairman, commissioners, you have
15 had a very long day and I will be as succinct as I possibly
16 can be. I am Ed Webb, director of professional and
17 government affairs for the American College of Clinical
18 Pharmacy. I want to express our appreciation for the
19 positive comments that arose during the discussion on the
20 issue of extending provider recognition to pharmacists in
21 the form of collaborative drug therapy management. I would
22 just like to make several brief comments.

1 First, to say that before my career epiphany 15
2 years ago to come to Washington and work on these issues I
3 was in fact a practicing clinical pharmacist in pediatrics
4 and neonatology in the state of North Carolina, so I do have
5 some personal experience in this regard from which I speak.
6 So I just wanted to share some thoughts with you.
7 With regard to the issue of prematurity of the
8 issue, and not just from the perspective of a neonatal
9 clinical pharmacist but the prematurity of the issue of
10 provider status, we would suggest to you that perhaps in the
11 context of the smart pharmacy benefit discussion that you
12 had earlier this morning that establishment of this kind of
13 a benefit prior to the time of the government beginning to
14 pay for the prescription drug product might in fact provide
15 a quality infrastructure support for the expansion of a drug
16 benefit at some later time.
17 As you mentioned, currently Medicare pays -- most
18 Medicare beneficiaries have some coverage for their product-
19 based services but not for the clinical care that they might
20 need to use those products more effectively. This is a
21 policy that can begin -- using this approach could begin to
22 address the issue of quality and integrated health care

1 delivery systems that have been reported in the Institute of
2 Medicine report.
3 There were questions about the models and how this
4 would be done. There's a rich set of models out there in
5 the 33 or 34 states. This is how clinical pharmacists
6 practice in the VA. This is how clinical pharmacists
7 practice in the Indian Health Service, and we think there
8 are a rich set of models for the Commission to look at and
9 we'll be happy to work with the Commission to look at those,
10 as well as cost estimates.
11 Our organization, collaboratively with two or
12 three other pharmacy organizations has commissioned a
13 private consultant to do an economic CBO-like analysis of
14 the provisions of one or more of these models. It should be
15 available toward the end of this month and we'd be more than
16 happy to share that with the Commission staff to deal with
17 that.
18 Finally, we'd just say that we are available to
19 work with the Commission staff on an ongoing basis and look
20 forward to the opportunity to do that, and appreciate all
21 the time that you spent on the issue today. Thank you very
22 much.

1 DR. LYNN: Hi, I'm Joanne Lynn. I'm the director
2 of the Rand Center to Improve Care of the Dying and of
3 Americans for Better Care of the Dying. But I'm speaking on
4 behalf of neither at this point, but more as a hospice and
5 long term care physician who's done an awful lot of research
6 in hospice care. Incidentally, I'm the PI on the project
7 that Chris Hogan was working on, and we could actually run
8 the data to answer the questions that were raised if you
9 want them done.
10 But the main thing I wanted to raise was whether
11 the Congress' question with regard to hospice had to do with
12 whether hospice as a program as it was established in 1983
13 was being run exactly correctly, and whether rural people
14 had the same access? Or is it at least possible that the
15 question was whether people coming to the end of life are
16 getting the benefits of hospice care in some reasonably fair
17 way?
18 The questions are quite different. It would be
19 like asking, do people have access to a transplant surgeon,
20 rather than, do people get the transplantations they need?
21 You may well have -- people have equitable access to a
22 transplant surgeon and yet have evidence that there would be

1 substantial gaps in the actual availability of
2 transplantation. I think if you used any similar analogy
3 with hospice care, there certainly has been pretty good
4 documentation that care of people coming to the end of life
5 with serious chronic illness are not getting very good care.
6 To the extent that the question about hospice has
7 to do with whether people are getting good care it seems
8 that it is not completely answered by the question of
9 whether hospice programs are growing and whether they can
10 manage to stay afloat with the current reimbursement. But
11 that the question would have to be something much more of
12 whether there is still an enormous gap in the needs of
13 Medicare beneficiaries.
14 I know that the Commission can hardly take that up
15 before an April deadline, but it seems that that really is
16 the question underlying this. To the extent that hospice
17 was meant to cover some of that need and some of that gap,
18 it will be part of the answer, but probably not all of the
19 answer.
20 I was especially perplexed by the presentation
21 saying that short hospice stays appear to arise from the
22 difficulty of making prognoses, beneficiaries unwillingness

1 to give up curative care, and the greater availability of
2 non-toxic therapies. And then to go on to say that Medicare
3 policy does not appear to be the cause, because all of those
4 and two or three more are rooted in the particular Medicare
5 policies that were put in place that started hospice.
6 There's nothing magic about hospice being turned
7 on prognosis or requiring that you walk out on curative
8 care. Hospice could have been more comprehensive. Hospice
9 could have turned on severity of illness rather than
10 prognosis. There are a number of ways in which the way that
11 hospice is now behaving in the care system is predictable
12 from Medicare policy. The fact that the average hospice
13 duration of stay now is less than 20 days and only 20
14 percent of Medicare beneficiaries get to use it would tend
15 to imply that in the two to three years people spend dying
16 of their fatal illnesses now, and that 83 percent of all
17 death in the U.S. is now in Medicare, would tend to imply
18 that there's a huge gap being left between hospice and all
19 of end-of-life care that is not yet being addressed.
20 Hospice it seems as a program could expand to
21 cover much of that, but can't because of the policies.
22 Hospice cannot -- it could expand a little bit but they

1 can't expand substantially to cover that population and by
2 constrained by the prognostication. The prognostication
3 data that was quoted is not the only prognostication data
4 available. There is pretty good evidence to show that
5 within a week of dying the average person still has a
6 prognosis too good to go into hospice. Yet they're terribly
7 sick and they're terribly disabled. You just don't know
8 exactly when they're going to die.
9 So if we mean to have end-of-life care be more
10 comprehensive and reasonable, then we're going to have to
11 figure out a way to evade the prognostication requirement
12 itself. The same issue arises with the others, but I won't
13 take the time at the moment.
14 I would call on you not to just take these
15 recommendations per se, but to call on yourselves or to call
16 on the Congress to ask you to look at the more substantial
17 problems of not just whether hospices can stay afloat and
18 continue to enroll patients, but whether Medicare
19 beneficiaries can ordinarily expect good comprehensive
20 services at the end of life, and what Medicare policies get
21 in the way of that. That I think would be a terribly
22 fertile inquiry.

1 MR. WOODRUFF: I'm Roy Woodruff, and I'm the
2 executive director of the American Association of pastoral
3 counselors, and a long time certified and practicing
4 pastoral counselor. I have been with you all afternoon and
5 understand you're tired, and also have a deeper
6 understanding of the difficulty and complexity of your task
7 and commend you for your effort.
8 In listening to your discussion of the non-
9 practicing practitioners and inclusion as providers in
10 Medicare it was apparent that there were a number of errors
11 of fact and of assumption in regard to pastoral counselors
12 that I wanted to very briefly speak to.
13 One of those that I need to clarify is in relation
14 to our name. What you have before you is called pastoral
15 care counselors. That is not the term we use and not how we
16 refer to ourselves. Somehow when the mandate from Congress
17 came to you to consider pastoral counselors along with our
18 collegial groups of other non-medical practitioners it came
19 in the form of pastoral care counselors. That's the first
20 time we've ever seen that. But the time we saw it, we were
21 told it was too late to change that in the process.
22 But it's a significant term because that can be

1 very confusing. Pastoral care is a general caring function
2 of clergy in general, of all faith groups. So that gives
3 rise to the question that was asked, if a priest is saying
4 mass or giving the sacraments or a rabbi is teaching, would
5 that be covered? That has nothing to do with what we're
6 talking about. That might be pastoral care, but it's not
7 pastoral counseling.
8 Pastoral counseling as we use it is a highly
9 disciplined, highly focused, therapeutic process with
10 persons seeking the assistance of pastoral counseling in
11 significant problems of mental health, a relationship, or
12 problems of living. So I don't want you to confuse that
13 with the general pastoral care work of pastors and clergy in
14 general.
15 Another misconception I think I need to clear up
16 is the distribution of pastoral counselors. It seemed to be
17 assumed that we, like some other health professionals, are
18 primarily in urban areas and not accessible in under-served
19 areas. That is absolutely not the case.
20 When we break down our certified pastoral
21 counselors into small town rural, mid-sized cities, and
22 large urban areas there are more practicing in small town

1 rural than either of the other two. So that is part of what
2 led the Office of Personnel Management in the management of
3 the Federal Employees Health Benefits Plans to, after about
4 a year-long, very careful study of pastoral counselors, to
5 mandate that certified pastoral counselors be included as
6 providers in the 12 medically under-served states. Because
7 they began to realize that our people are there and it would
8 help the mental health care service in those states if
9 pastoral counselors were recognized as providers.
10 So about a year and-a-half ago that happened and
11 now OPM recognizes and encourages all health care plan
12 providers in all states to include pastoral counselors as
13 providers.
14 Part of where they got their information was from
15 CHAMPUS TriCare where we have been providers for over 30
16 years and have a long and very positive history of
17 utilization and positive experience. That was reported out
18 to us by OPM so that when they looked at our history with
19 CHAMPUS it was clear that we were valued in that and that we
20 were seen as very qualified providers for mental health
21 care.
22 Let me make another comment about qualifications.

1 It also seemed to be assumed that somehow our members were
2 not as qualified as some of the other similar professional
3 groups and licensed groups. Again, that is not the case.
4 Most of our members are in fact licensed, but our standards
5 are very carefully and documentably equal or higher to
6 counselor licensing standards and some other kinds of
7 certifications.
8 I'll just use myself as an example. I have a
9 Ph.D. in pastoral counseling. Most of our certified members
10 do have doctoral level degrees in addition to a master's
11 degree. I completed my Ph.D. in the minimal amount of time
12 that's allowed for it, in six years after college. That's
13 because it's built on a lot of other -- a broad basis of
14 education.
15 MR. HACKBARTH: Mr. Woodruff, you're going to have
16 to bring your comment to a close.
17 MR. WOODRUFF: I understand. I just wanted to
18 correct these assumptions, and there are a few others that
19 we would place in writing, and we do appreciate your
20 consideration.
21 MS. McEWAN: Good afternoon, I'm Erin McEwan from
22 the American Nurses Association. I first wanted to address

1 the comment about nurses provide nursing care versus
2 medicine. I can't speak to what the position of the
3 association 10 years ago was, but I would suggest that today
4 perhaps it is a bit more nuanced.
5 With that said, to dive right into something with
6 full awareness of how unpopular it is going to be, I would
7 suggest that the nurses' association believes that nurse
8 practitioner care services often are directly substitutable
9 for specifically GP care. There's very good research done
10 on this recently printed in the January issue of Health
11 Affairs on physician substitutability for nurse
12 practitioners and how outcome studies have shown that there
13 is really no difference.
14 With that said, moving on to the first assist
15 issue, given the tenor of the conversation today I really
16 don't believe what I'm about to say makes that much of a
17 difference but I feel the urge to say it regardless.
18 One of the differences that I think should be
19 mentioned between nurse first assists and surgical techs is
20 the perioperative. As registered nurses, nurse first
21 assists do often provide all of the perioperative services,
22 be that the pre-op education to the pre-op workup, to the

1 actual services provided within the four walls of the OR, to
2 the recovery room care, to post-op education. I am
3 certainly not an expert on surgical techs, but I do not
4 believe that that is something that they do as well.
5 Thank you.
6 MS. POWERS: Good afternoon. My name is Diane
7 Powers. I've written to all of you last year about
8 inclusion of master's level therapists as providers for
9 Medicare. I have a LPC, licensed professional counselor.
10 I'm also a licensed marriage and family therapist, and I'm
11 also a certified rehabilitation therapist.
12 I have specialized skills in working with patients
13 with Lou Gehrig's Disease and am the mental health expert on
14 the website that represents them.
15 Prior to being a therapist, for 25 years I ran
16 physician's group practices and a department at a major
17 university. My undergraduate degree is in health care
18 administration.
19 So I have approached mental health as I approached
20 physical health, from an effective cost-containment,
21 continuity of care approach. It is from that perspective
22 that I would like to encourage you to take a second look at

1 inclusion of LPCs, marriage and family therapists and
2 pastoral counselors as mental health providers.
3 Today I have just gone to a seminar on depression.
4 It was out in Virginia. The statistics are saying the
5 incidence of depression in the elderly is as high as 60
6 percent. The attempted and completed suicides are equally
7 high. The botched suicides are of every attempted suicide,
8 maybe 10 percent are botched, or do not accomplish what the
9 person intended. That results, many times, in being
10 hospitalized for many years because of gunshot wounds that
11 were less than terminal.
12 The statistics also said that most elderly who
13 attempted suicide had seen their family physicians within a
14 week of attempting suicide, but they had not focused on the
15 mental health issue but actually the blood pressure and
16 things of that sort.
17 Additionally, last year this board or Medicare
18 powers that be included patients with Lou Gehrig's Disease
19 as recipients of Medicare. A little bit of background, Lou
20 Gehrig's Disease is a progressive neuromuscular breakdown in
21 the movement area, not the sensing area in the movement
22 area. Many people with Lou Gehrig's Disease would prefer to

1 stay at home with their caretakers.

2 One of the issues that was raised a few moments

3 ago was about hospice care. Why is the length of time that

4 hospice care is shorter than anticipated when the parameters

5 say six months until death. And yet, many people with ALS

6 will stay at home and only in the final week or month have

7 hospice care come into their home.

8 I put before you the fact that good mental health

9 counseling helps ALS people deal with their grief,

10 recognizes depression in the elderly, also recognizes

11 alcohol and substance abuse, medication, self-medication in

12 the elderly.

13 MR. HACKBARTH: Excuse me, the points you're

14 making are really critical ones. The reason you see people

15 starting to get up and leave is we actually have another

16 thing to do to at 6:30, so we are just about out of time

17 her.

18 MS. POWERS: I will talk very quickly.

19 MR. HACKBARTH: 15 seconds worth. We have two

20 other people.

21 MS. POWERS: In the area of mental health there is

22 cross-referral. I refer to social workers, they refer to

1 me. I have expertise in ALS, as well as other colleagues
2 have expertise in geriatrics.
3 I believe that this is a necessary thing for
4 Medicare clients to be able to receive. In the field right
5 now, many psychiatrists and psychologists and social workers
6 are withdrawing from participation in insurance. I believe
7 this will have a tremendous impact on Medicare within the
8 next six years when the baby boomers enter into coverage.
9 And so I ask you to be farsighted, rather than
10 shortsighted, and include social workers, LPCs, marriage and
11 family therapists, and family counselors in your Medicare
12 mental health program.
13 Thank you.
14 MR. HACKBARTH: Thank you. You, regrettably, are
15 at the end of the line but it is the end of the line.
16 AUDIENCE SPEAKER: I'll be very brief. I just
17 specifically wanted to address the issue of access with
18 respect to mental health services that was spoken about
19 earlier.
20 One of the things I think is important to
21 understand is that 57 percent of the U.S. population live in
22 areas that the federal government has designated as mental

1 health professional shortage areas. That is a practitioner
2 to population ratio that the federal government has used.
3 There are five core mental health professionals
4 that are used who are given equal weight within that
5 designation: psychiatrists, psychologists, clinical social
6 workers, psychiatric nurse specialists, and marriage and
7 family therapists. So when the federal government seeks to
8 determine whether or not we have an access problem, they
9 calculate the availability of marriage and family
10 therapists.
11 That creates a problem for the Medicare population
12 in that it creates a false sense of access, because in those
13 areas we believe we don't have an access problem, marriage
14 and family therapists are not covered by the Medicare. But
15 the government says we don't need to put any more mental
16 health professionals there because we have an adequate
17 supply.
18 There are access issues out there and I think
19 there's significant data to substantiate that a lot of
20 people in this country have difficulty access mental health
21 services.
22 MR. MEYERS: Good evening, I'm Nick Meyers, Deputy

1 Director for Federal Relations of the American Psychiatric
2 Association. I'll be extremely brief.
3 We believe that there is an access problem in the
4 Medicare program. There's an equity problem in the Medicare
5 program. Unfortunately, our view is that the addition of
6 additional non-physician and mental health practitioners
7 will do nothing to address it.
8 The real access issue, the real equity issue, is
9 Medicare's statutory discrimination against patients who
10 seek treatment from mental disorders by requiring them to
11 pay half the cost of their care out-of-pocket. We would
12 urge this commission to make a strong recommendation to
13 Congress that before it considers any other provider related
14 issues under the Medicare program with respect to mental
15 health services, it ought to address the existing structural
16 discrimination against patients who seek treatment for
17 mental disorders.
18 If you want to do one thing for patients, it is to
19 say to those patients that all they have to pay for a trip
20 to a psychiatrist, a psychologist, a social worker, or a
21 family practitioner for a mental health visit is the same 20
22 percent copay that they would pay if they saw an

1 endocrinologist for treatment of diabetes. Until that issue
2 is addressed, access issues will continue. That is the real
3 equity argument with respect to mental health services.
4 Thank you.
5 MR. HACKBARTH: We're adjourned until 9:00 o'clock
6 tomorrow morning.
7 [Whereupon, at 6:14 p.m., the meeting was
8 adjourned, to reconvene at 9:00 a.m. on Friday, March 22,
9 2002.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, March 22, 2002
9:01 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

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1 P R O C E E D I N G S

2 MR. HACKBARTH: We're going to go ahead and get

3 started. Before we proceed let me do a quick introduction.

4 Yesterday I forgot to introduce Jill Bernstein to the

5 commissioners. Jill is the one that doesn't have the goatee

6 and mustache.

7 We're very fortunate to have Jill who brings lots

8 of relevant past experience to the Commission and our work.

9 She has worked with a long list of other familiar

10 organizations including PPRC and AARP and all of the

11 relevant initials, including a doctorate, a Ph.D. from

12 Columbia as I understand it. Jill is an important part of

13 the staff work for the June report so her arrival is very

14 timely and welcome.

15 Okay, Julian, you've got the floor.

16 MR. PETTENGILL: Thank you. At the January

17 meeting and yesterday, staff and a variety of visiting

18 lecturers presented you with a variety of information that

19 might be used to indicate directly or indirectly how well

20 Medicare's benefit package is doing in meeting beneficiaries

21 needs. Later this morning you will hear staff present

22 information about options for changing the benefit package

1 and the criteria that might be used to evaluate them.

2 Our goal in this session is to pin you down. You

3 heard a lot of information and now we'd like to know what

4 you think about it. What findings do you want to include in

5 the June report? Does the Medicare benefit package need

6 improvement? If so, what are the major problems? Given

7 constrained budgets, what improvement strategies might be

8 considered? What are the pros and cons of each strategy?

9 Your discussion yesterday morning was helpful in

10 identifying some themes: your desire to identify key policy

11 choices, and the difficulties of disentangling causes and

12 effects because of the complex relationship between Medicare

13 and other actors including private employers, private

14 supplemental insurance providers, and state governments.

15 But we also need to know what you take away from

16 the information you've been given, and what relative

17 emphasis to place in the report between identifying the

18 problem and the nature of the problem, if any, and focusing

19 on the options and the implications of those options.

20 To stimulate your thinking we sent you a short

21 list of tentative findings and little bit about ways of

22 thinking about them. In a moment Jill will talk about the

1 findings from the evidence, why policymakers might want to
2 respond to the findings, and frameworks for thinking about
3 the policy options. I want to focus briefly on the
4 motivation for the report and the broad policy questions.
5 Arguably, Medicare has been a highly successful
6 program. It has great popular support, so you might well
7 ask, why do this report at all? Based on the evidence many
8 might argue that for most beneficiaries the glass is
9 something like four-fifths full. So why do anything?
10 One reason is that the world has changed -- and
11 Jill will talk more about that in a minute -- and the
12 benefit package has not kept up. Consequently, Medicare no
13 longer provides the needed protection for many
14 beneficiaries. Many beneficiaries appear to be able to
15 manage on their own resources but quite a few have
16 difficulty obtaining a reasonable level of protection.
17 To give us guidance for writing the report you
18 could answer questions such as those on the overhead: does
19 the benefit design limit beneficiaries' access to
20 appropriate care? The second question really relates to the
21 idea that we're probably spending enough money overall to
22 furnish beneficiaries with the care they need if you

1 consider both Medicare and all the various private sources.
2 Is it possible to recast the way the money is managed to
3 better ensure beneficiaries' access to care and improve
4 their financial protection?
5 Alternatively, you could take Bob's questions from
6 yesterday morning. He identified three separable questions.
7 First, how comprehensive does the benefit package need to
8 be? Second, how do we deliver that benefit package to
9 beneficiaries? I take that to mean, does Medicare do it all
10 or do we split the responsibilities somehow between Medicare
11 and private entities as we do now? And third, how long
12 should the public subsidy be? You can get various estimates
13 of what the current public subsidy is depending on how you
14 count it, to what extent you take into account
15 beneficiaries' past contributions during their working lives
16 and that sort of thing.
17 Now I'll turn it over to Jill to talk about the
18 evidence.
19 DR. BERNSTEIN: I want to go through the evidence
20 fairly quickly. You heard a review yesterday morning and
21 then you heard evidence all morning and I'm pretty sure you
22 don't need me to tell you what you heard. But what I do

1 want to do is talk to you a little bit about how we want to
2 characterize the evidence and how we want to make a case for
3 whatever it is we decide we're going to make a case for.
4 This first slide refers to three different kinds
5 of evidence. One having to do with the fact that people
6 supplement Medicare as an indicators. Secondly, we talked
7 about a lot of problems with access to specific kinds of
8 care yesterday, and also about financial barriers. And
9 thirdly, about the financial burden for some beneficiaries
10 and for their families. I'm going to go through these in
11 three separate slides, not in the order that are on this
12 slide. It's not because I don't think you're paying
13 attention but because I want to deal with the supplemental
14 issue third.
15 The next slide has to do with access. Although
16 most beneficiaries have access to care that they need, there
17 is evidence that some people can't get the sorts of care
18 they should have in the most appropriate setting.
19 It's really hard to separate access from the
20 ability to pay, but as we already just talked about the
21 basic design of Medicare, which is a fee-for-service program
22 and the acute care model it was designed to accommodate,

1 present barriers to the coordination and management of care,
2 particularly for people with complex care needs. That's not
3 a problem created by Medicare's benefits package but rather
4 a reflection of how fee-for-service health care works.
5 But we also heard evidence yesterday that some
6 beneficiaries don't get care they need or that they
7 experience avoidable problems such as decline in functional
8 status related to problems with mobility or vision or
9 hearing because of gaps in the Medicare benefit package.
10 The most obvious problem is access to prescription drugs,
11 but we also heard about problems associated with coverage of
12 some preventive services, some medical therapies, devices,
13 et cetera, which would include things like glasses and
14 hearing aids which are expensive and are not covered by
15 Medicare and not by some forms of supplemental insurance.
16 There are also areas where specific or peculiar
17 details of Medicare's coverage appear to create some
18 difficulties. Some of these are closely related to payment
19 policy. We heard yesterday about the problem with mental
20 health benefits. There's also an issue that the Commission
21 has dealt with before about the coinsurance rate for
22 outpatient services; 50 percent copay could be perceived as

1 an access barrier for some people.

2 But it's also clear that access problems are more
3 prevalent among the most vulnerable populations, including
4 those with low incomes, people in poor health, and the
5 oldest-old beneficiaries. The factors that contribute to
6 access problems are also related to the ability to obtain
7 supplemental coverage.

8 The next slide deals with financial liability. I
9 think some of what we heard yesterday was very helpful in
10 sorting some of these issues out. Beneficiaries use more
11 health care and spend more on health care and have lower
12 incomes than non-Medicare adults in their fifties and mid-
13 sixties. Beneficiaries' cost for Medicare cost sharing,
14 non-covered services, and premiums for supplemental coverage
15 are all increasing.

16 For people with relatively low incomes, the cost
17 of health care can create financial hardship. The data
18 presented yesterday showed that about one in 10
19 beneficiaries' income minus their out-of-pocket spending for
20 health care equals poverty.

21 Dan's analysis also showed that beneficiaries'
22 out-of-pocket health care costs rose at about the same rate

1 as their incomes for much of the 1990s, leaving out-of-
2 pocket spending for health care costs at about 18 percent,
3 which is about what it was right at the time that Medicare
4 was passed, on average. Beneficiaries' incomes are now much
5 higher than they were then and they're better protected for
6 other reasons, but health care costs are now taking up a
7 larger part of their household budgets than they have in a
8 long time because throughout the '70s and '80s the number
9 was more like 11 or 12 percent of income compared to the 18
10 percent that it crept back up to in the 1990s.
11 For about half of all beneficiaries the budgets
12 that they're working with are very low. That is, within 125
13 percent of poverty.
14 Now let's turn to the issue of Medicare
15 supplementation which was a little trickier and we're still
16 trying to get this right. This slide reflects that we were
17 thinking a couple days ago, but let's work with it here.
18 Pretty much everybody who can supplement Medicare does, with
19 the important exception of people who are eligible for
20 assistance through the QMB, SLIMB Medicaid provisions where
21 we discovered that there are a lot of people who might be
22 able to get some help who aren't.

1 There is evidence that not having supplemental
2 insurance or coverage of any kind is associated with
3 underuse of some services, including prescription drugs, but
4 possibly some other services as well. We're looking at some
5 additional data that we'll bring back to you in April that
6 will look at that even more closely. There are some studies
7 that we've heard about that we need to track down that
8 looked at differences in surgical access for people without
9 supplemental care as well.
10 We also heard that the evidence shows that there
11 are higher rates of use for some health services by people
12 who have different kinds of supplemental coverage. It may
13 be that first-dollar coverage creates incentive to use some
14 services when it's not clear whether the services are
15 actually necessary or valuable.
16 More important probably is a finding that we don't
17 have, that Jeanne Lambrew couldn't give us and no one else
18 can either. That is we can't say with any certainty what's
19 going to happen to the different forms of supplemental
20 insurance over time. The evidence suggests, however, that
21 the availability and affordability of coverage may become
22 more problematic.

1 Now let's turn to the even harder part. I'd like
2 to move from how we characterize the evidence to what we do
3 with it. What we need from you is a discussion that will
4 let us know whether you're comfortable with the
5 characterization of the issues, and whether this or some
6 other way of presenting these issues defines a reasonable or
7 workable basis for the further discussion of policy options.
8 The evidence that we've reviewed suggests that
9 some of the gaps in Medicare's benefits may in fact directly
10 or indirectly divert beneficiaries and/or practitioners from
11 choosing the most effective or cost effective treatment
12 options. This could be related to cost-sharing
13 requirements, or failing to pay for preventive services, or
14 some of the other things we heard about.
15 The basic goal of Medicare as we understand it was
16 to ensure that retired older Americans who couldn't work or
17 weren't working any more had access to mainstream medical
18 care, and that they didn't have to impoverish themselves or
19 their families when they became ill. The evidence indicates
20 some beneficiaries have to spend a lot of money out-of-
21 pocket for uncovered services and for premiums for insurance
22 that they feel is necessary just because they have to fill

1 in gaps in Medicare.
2 We also found that the way that many beneficiaries
3 deal with the perceived problems of Medicare benefits, which
4 is having multiple forms of insurance, leads to high
5 administrative costs. To the extent that supplementation
6 contributes to the use of services that are of little or no
7 value, this additional insurance may also increase the cost
8 for Medicare and ultimately to beneficiaries through higher
9 premiums.
10 The bottom line is that our current solutions to
11 the perceived problems with Medicare benefits do not appear
12 to be very efficient. We might prefer them for a lot of
13 other reasons, but there are problems with the way we're
14 currently spending money.
15 Now moving to the next slide. Why are we doing
16 this now? Even if we agreed that there are problems and we
17 need to talk about them, does it make sense to do this in
18 the current policy environment? The basic reason that we
19 can offer for doing this now is that a huge public program
20 should not preserve structures, in this case Medicare's
21 benefit design, that undermines its ability to meet its own
22 goals effectively. The benefit structure is and should be

1 an issue whether or not there's any major reform legislation
2 passed now or in the next couple years.
3 Most of the major reform proposals under
4 discussion involves the addition of benefits, mostly drugs,
5 or rationalization of cost sharing, or both. Some reform
6 options would employ market forces; that is, competition
7 based on cost and quality, as a means of increasing
8 efficiency in Medicare.
9 Based on the experiences of large systems like
10 FEHBP, many analysts believe that competition can work only
11 if the core benefits package is comprehensive. Otherwise,
12 people with greater care needs would select the plans with
13 richer benefits leading to spiraling premiums in some plans
14 and favorable selection for others with healthier enrollees.
15 That would leave lower income beneficiaries with greater
16 health care needs at risk of being unable to afford a plan
17 that meets their needs.
18 In short, the benefits design is crucial to any
19 restructuring options.
20 But our review also suggests, at least to us, that
21 focusing on benefits is worthwhile even if reforms are
22 designed to be incremental and essentially budget neutral.

1 If there are ways to improve the efficiency and
2 effectiveness of the health care Medicare pace it would seem
3 reasonable to implement reforms sooner rather than later.
4 Now I want to talk briefly about how we can -- one
5 way that we might want to frame some of these options that
6 we're going to talk about later this morning. I'll just
7 divide them into two piles for the time being. One is
8 improvements that we can make without increasing any
9 Medicare program spending. The other are improvements that
10 would probably increase Medicare spending but not might
11 spend total spending for beneficiaries' health care.
12 There are actually two kinds of changes there.
13 One is expanding Medicare benefits directly. The other is
14 dealing with the structure and relationships between
15 Medicare and other payers.
16 What we need is your input on how we should frame
17 this discussion of policy options, and on the emphasis you
18 want to attach to this part of the report.
19 The first category of options includes changes
20 that would be designed to be budget neutral; would not
21 increase Medicare spending relative to what we expect it to
22 be under current law, at least now. For the most part, this

1 would be reworking deductibles and cost sharing. There are
2 also some possibilities for introducing some supplementals
3 or special programs within Medicare that deal with patients
4 with heavy care needs or whatever, under the condition that
5 those programs are expected to be, or are more or less
6 demonstrated to be cost efficient.

7 The second broad category reflects discussions we
8 heard yesterday about total spending for health care for
9 Medicare beneficiaries. What we heard basically was that
10 there's a lot of money out there. Ideally, it would be
11 possible to design a way to provide more comprehensive
12 coverage for beneficiaries without increasing total
13 spending, just moving the money around. This category could
14 include two sorts of options. We could add benefits to
15 Medicare's package or change the roles and responsibilities
16 of Medicare and other payers, including supplemental payers,
17 or Medicaid, or VA or whatever.

18 In the presentations you'll hear later these
19 options are sorted a little bit differently into cost-
20 sharing changes, specifically changes that would add
21 benefits to Medicare, and reallocating resources among
22 payers. But the cost implications, that is whether they're

1 budget neutral with respect to Medicare or to the system as
2 a whole will also be discussed. Most of the options that
3 we're going to present involve very difficult decisions
4 based on a variety of considerations and assorted tradeoffs,
5 and sometimes conflicting goals and values.
6 In the next session staff are going to present
7 specific criteria for describing and comparing policy
8 options that we think capture the major dimensions of the
9 values and goals that need to be considered and traded off
10 when considering these options. Before we get there,
11 however, we need your input on how to frame this discussion
12 on policy options for the June report.
13 MR. HACKBARTH: Before we proceed with the
14 discussion, it would be helpful to me if we could just try
15 to envision what the report looks like, not in detail but
16 more broadly. At the beginning yesterday we talked a little
17 bit about it being a report without specific boldface
18 recommendations such as the ones we usually have in our
19 March report. We talked about it being more educational in
20 nature in helping people structure choices, and a look at
21 different possible policy directions.
22 Here you've laid out one of the big policy

1 crossroads, if you will, that we alluded to yesterday. Are
2 we trying to resolve that and say, on balance the
3 commissioners think that this path is better than that path?
4 Or are we simply trying to say, as you work through these
5 issues you come to this crossroad and the arguments on this
6 path are these, and the arguments on that path are those?
7 I'd welcome your thoughts about that, Murray, but
8 I think all of the commissioners ought to weigh in on that.
9 It's a critical issue.
10 DR. REISCHAUER: I guess I would at this stage be
11 in favor of us taking the broader approach and saying, if
12 you want incremental reform or rationalizing the existing
13 system here's a set of actions that one can take, if one
14 wants to try and strengthen the system in a more fundamental
15 way, this is the way to go. Because I don't think the
16 debate in Congress has reached an overwhelming consensus
17 that one is preferable to the other.
18 DR. ROWE: Just on this issue before we get to
19 some of the others. What horizon were you thinking of,
20 Glenn, for this? Is this the recommendations that we think
21 should be put in place now to prepare the system more
22 effectively to deal with the beneficiaries' needs over the

1 next decade, or is this the beginning of a discussion of
2 more fundamental changes to deal with the dramatic increase
3 in numbers of beneficiaries that might occur at such and
4 such a time or whatever?
5 Whenever you're doing a strategic planning
6 exercise you're trying to think, is this a three-year or a
7 five-year or --
8 MR. HACKBARTH: Good question.
9 DR. ROWE: I think that would be helpful to me in
10 terms of responding to your question.
11 MR. HACKBARTH: Because we haven't focused on the
12 really fundamental imbalances due to demographic changes and
13 all of the financing issues and the like, I think implicitly
14 we are talking about a shorter time horizon. Whether it's
15 the next decade or next five years or something, I'm not
16 sure. But I don't think we're talking about the next 20 or
17 30 years based on the discussion we've had thus far.
18 MS. ROSENBLATT: I don't think we can do that. I
19 think we have to look at the long term. I served on a
20 technical advisory panel, looked at the trustee's report.
21 Ariel was involved in that. There's as huge baby boom bulge
22 coming up. I think we have to look at -- they usually run

1 75 years, and I consider anything in health care projections
2 over three years to be way out there. But I think we've got
3 to think in terms of maybe 25 years or we're not really
4 facing reality.
5 DR. NEWHOUSE: My question is whether the Congress
6 really is expecting to hear about the 2020, 2030 issues from
7 us or not. There's no question that they're there. My
8 personal view is actually the trustees are too optimistic.
9 But again, the Congress may not be looking to us for advice
10 on this set of issues. There was the bipartisan commission,
11 there is the trustees' annual report to them.
12 MS. ROSENBLATT: Can I just respond to that?
13 There's us as a commission and then us as individuals. As
14 the actuary on the panel there's no way I could say, don't
15 look at the 25-year picture. My profession would force me
16 to go in that direction.
17 DR. REISCHAUER: I'm having a hard time following
18 this conversation. We're talking about adequate benefit
19 packages, not necessarily the financing. The financing is a
20 totally different issue, which gets to my third question
21 which is, how deep should the public subsidy be? You can
22 have a narrow benefit package or big benefit package,

1 subsidize either a small or a large portion of either of
2 them. I think we're focusing on benefits that are cost
3 effective in some sense, so we're being responsible in that
4 way. But I'm not sure what the 2025 problem is in this
5 context as opposed to current policy.
6 MS. ROSENBLATT: The minute you touch the benefits
7 that are publicly funded you impact the balance of the trust
8 funds.
9 DR. REISCHAUER: If we say how we touch them is
10 going to be paid for publicly as opposed to through high
11 cost-sharing and higher premiums. But we haven't said
12 anything about that at this point.
13 MS. ROSENBLATT: That's true.
14 DR. REISCHAUER: As I said, these things are being
15 paid for now somehow, by employers, by individuals,
16 whatever. If you could capture all that money somehow,
17 which I know is politically infeasible and technically
18 difficult to do, but step back and imagine you could, you
19 could have a much-expanded benefit package without putting
20 any more burden on the government than now exists.
21 MR. FEEZOR: Just a little bit of departure from
22 the preceding comments. I would hope that the report early

1 on would send the signal to Congress that Medicare as
2 probably the single largest payment in the health care
3 industry forms a foundation by which health care is paid or
4 the incentives in which the operates, so at least frame it
5 in that regard so that maybe it does provide Congress an
6 opportunity to think a little more broadly then just
7 tailoring some benefits, whatever the horizon we decide to
8 pick on.

9 MR. SMITH: I think Allen is right, but let me try
10 to pick up on Bob's point. Julian, actually it's a question
11 for you. We've said several times this morning and we said
12 several times yesterday that we think there's enough money
13 in the game. I think that's right, but I think we ought to
14 have a little bit of skepticism about that. If everybody
15 got all of the drugs that are necessary, if drug costs keep
16 expanding, if everybody who needs an extra pair of glasses
17 had them; I just think we ought to be a little cautious
18 about whether or not there's enough money in the game.

19 We know and it's implicit in Alice's comment that
20 even if there's enough money per capita, the share of GDP
21 that's going to be devoted to health care and the subset of
22 that that's going to be devoted to Medicare is going to

1 grow. That is going to raise questions of where does it
2 come from, how do we subsidize it, what's the appropriate
3 level of subsidy?
4 I think we can't avoid thinking about those
5 questions, at least in the medium term, Bob. I don't know
6 if we have to go out -- we certainly don't have to go out
7 the trustees 75 years. They don't do it very well and we
8 are unlikely to do it any better.
9 But it would be crazy to think about a benefit
10 package as disconnected from beneficiaries and the growing
11 population of beneficiaries, which are also going to place a
12 new set of burdens on the delivery systems, and the
13 appropriateness and the adequacy of the delivery structures
14 both in geographic and simple size terms. So it seems to me
15 we need to think about that, and that raises another set of
16 financial questions that are appropriate.
17 But my guess is that the best thing that the June
18 report can do is be a conversation guide for a conversation
19 that's going to go on over the next four or five years.
20 Congress isn't going to do anything decisive between now and
21 the presidential election, but the conversation is going to
22 continue, and it will happen episodically and in fits and

1 starts.

2 It seems to me what we ought to be trying to do
3 here is to provide two lists that help shape that
4 conversation. One is a list of what's an appropriate
5 benefit package, and what have changes in technology and
6 treatment modality, what have they meant and what do they
7 require in terms of a simple update?

8 But the second is, what have we learned about the
9 health care system that ought to affect system design? What
10 are we trying to get out of this? We heard yesterday, and
11 we all know that issues of coordination of care, and issues
12 of the odd intersections between payment systems and
13 delivery systems create both inefficiency and inadequacy.
14 We ought to speak to that, because part of a good benefit
15 package is ensuring that appropriate coordination happens
16 and that both the frictional losses and the gaps are filled
17 in as much as possible.

18 What we ought to be trying to say in this report,
19 here's an adequate benefit package, or an appropriate
20 benefit package, and here are the systemic issues that occur
21 when you try to deliver that package. And here's how
22 Medicare, both on its own but its role as bellwether for the

1 health care system, here's how Medicare can structure itself
2 to deliver that package most efficiently.
3 It seems to me we want to try to do both. Maybe
4 it's A and B, but I would hope that the report informed the
5 country's conversation, which will happen whether or not we
6 do anything, and it will happen better if the June report
7 provides that kind of guide.
8 DR. NELSON: I'm coming down the same place that
9 Dave does but I articulate it a little bit differently. The
10 most valuable thing that I heard Jill say to me was that the
11 program is not structured and operating now to meet the
12 program goals and fulfill the statutory promise. I think
13 our report, that ought to be the basic message; say it's not
14 meeting program goals, operating to meet program goals in
15 the following ways, and identify possible solutions.
16 I think we have to ask ourselves whether our
17 report can contribute something different from the steady
18 stream of broad policy analysis that's going on with respect
19 to the Medicare program and the benefit package in
20 particular. We ought to try and identify a way that we can
21 make a contribution that's different from all of the rest of
22 this work that's going on.

1 MR. HACKBARTH: Alan, do you have any thoughts on
2 what our distinctive contribution might be?
3 DR. NELSON: Yes, the third point that I'll make.
4 I think that if we are to -- it's hard for me to see how we
5 can make a contribution if we just lay out all the options.
6 I think that there's some risk in it, but I think that we
7 ought to identify what the best benefit package would be to
8 meet program goals in the statutory promise, and identify
9 ways to get there. I think just saying, here are all the
10 options, that's being done by everybody.
11 Now whether we have credibility to identify the
12 best way to go about it is another issue I guess we could
13 discuss. But I think we ought to at least try.
14 DR. ROSS: A couple thoughts. One, to pick up on
15 Alan's, that is the issue here, is what's the comparative
16 advantage of MedPAC as a commission versus many of these
17 other reports that are out there? I guess my read of it is,
18 so many of them have focused purely on the financing side of
19 things, and I've read 1001 discussions of the baby boomers
20 are coming and I think that's now an established fact.
21 You can't fully separate benefits, payments, and
22 financing. We keep trying to. We do payments in March, and

1 now we're trying to do benefits in June. But I also think
2 you can say enough about them as somewhat stand-alone items.
3 Under any reform proposal I've read about recently,
4 traditional Medicare is going to be around for a long time,
5 however it's financed, with some combination of Part B
6 premiums or additional premiums or anything else. That
7 program will exist. It has to have some specified benefit
8 package in it. That's something to think about.
9 Where should the Commission go on recommendations?
10 I think there's value added if you do lay out options that
11 have not been discussed fully and thought through, and the
12 tradeoffs you make in going one direction or another. This
13 is the Commission's first crack at this. I think there's
14 ample room for further discussions as you go down the road,
15 but I think there's a value added just in the discussion.
16 Of course, if you're comfortable going beyond
17 that, that's your decision to make. But I think even
18 getting the different forks in the road laid out on one
19 table by an organization that doesn't have an ax to grind is
20 a useful contribution.
21 MR. HACKBARTH: Before I go through the list can I
22 just pick up on that list point? The amount of time that we

1 have spent on this, the amount of time that we have to spend
2 on it before the June report is really quite limited in
3 comparison to the scale and complexity of the issues. So I
4 like the way Murray thinks about it. I don't think this is
5 necessarily our last crack at these issues, and I do think
6 we would be making a contribution to simply frame choices
7 and some of their risks and benefits at this step, allowing
8 us to come back at a subsequent point and delve further and
9 make more specific recommendations. The time constraint is
10 very real.

11 MR. DeBUSK: Some of the things that Murray said
12 there encompassed some of the feelings I have in relation to
13 this. Of course, the financing piece is a major, major
14 piece of it. I understand about the statutory promise -- I
15 don't know as I totally understand; I'm aware of it and the
16 program goals. But we're in a situation where there's no
17 end to the utilization of services. There's got to be some
18 deterrent, some kind of cost-sharing program. The many
19 forms that it's taken in the present system, although not
20 perfect, seems to be a partial answer or addressing the
21 problem.

22 But going back to the utilization of services and

1 there's no end to it. Ralph, I think there was a model in
2 Great Britain a few years ago for some of the fund-holding
3 entities over there where they opened one region up and
4 said, okay, we're just going to treat everybody open. And
5 of course, it's totally paid for, totally socialized. It
6 was unbelievable the utilization within that region.
7 So it's no different here. We can never get the
8 perfect system. There's going to have to be some kind of
9 deterrent in whatever we put together or whatever we
10 recommend because there's no way we can ever afford it all
11 and address it. Well, you all are aware of all this, but I
12 think behind all this you've got to keep that in mind in
13 trying to model something going forward. But all the
14 entities that are in it now, looks to me will have to
15 continue to be players, where the employer is involved,
16 where the family is involved in coming up with copays and
17 what have you.
18 MR. HACKBARTH: Let me just think aloud here about
19 how we manage our time. We do have seven or eight people
20 that want to comment. What we started to do when we opened
21 up this dialogue was try to -- the question I asked was,
22 what exactly are we trying to produce in our June report?

1 Is it a map with options as opposed to distinct
2 recommendations on which path to choose? I think that's the
3 threshold issue that we need to get across and then turn to
4 some of the more substantive issues that Jill and Julian
5 have tried to frame for us.
6 So I don't want the conversation just to wander
7 off and us to use all of our time making general statements.
8 So could I ask people in the queue here, do you have a
9 comment on the specific question of what we're trying to
10 accomplish with the report? Let's keep our comments focused
11 there.
12 MS. NEWPORT: I guess the fundamental question is,
13 how do we best serve what constituency? Is it to provide a
14 nexus of data that is useful and that will inform that
15 political debate with our expertise in terms of all the
16 complexity that comes together with moving the boxes around
17 or creating opportunities to seek efficiencies, if there is
18 truly enough money in the system that could fulfill the
19 promise? I liked very much the way David put it, but I
20 think we do need to get to what is the most useful product
21 that we can come out with that may be just the first chapter
22 of a much longer exposition on this.

1 But I think that what I found very useful
2 yesterday and today is the melding together or amalgamation
3 of a lot of information and then being able to start, at
4 least in a formative state, explain what we've learned in
5 the past in terms of the interactions of these things, the
6 challenges that we might have in terms of access.
7 But I do think that the question I would like
8 answered at this point is, is the constituency the House and
9 the Senate, and what would they need? If that's a longer
10 term, 20-year piece, that's fine. But right now what we
11 have, and given the time constraints, is that we can
12 probably take hopefully a balanced view in pulling together
13 some information and identifying some further work or some
14 further focus. So I have a question that's buried in there,
15 but I have to say I felt very comfortable with what David
16 was saying as well.
17 MR. HACKBARTH: As always, our principal audience
18 is the Congress, but it's not our only audience, would be my
19 initial response. Here we are answering a question that was
20 no specifically asked, unlike our March report or the
21 various mandated studies. So I don't think we can
22 crystallize with precision what our customer is looking for

1 or providing something that they didn't ask for. So I think
2 it's not productive to try to answer that question in great
3 detail.
4 MS. NEWPORT: I know and I wasn't trying to be
5 more disingenuous than I normally am. I really do think
6 that every once in a while let's focus on what we're trying
7 to do and what we can accomplish in the reasonable term. So
8 I think that it is important for us, maybe every once in a
9 while to remind ourselves that there's a limited amount that
10 we can accomplish, what would be of quick utility, short
11 term utility. But also take the opportunity to maybe lay
12 some groundwork for future work on this.
13 DR. ROSS: Just a quick reply to Janet. I think
14 given the diversity of approaches that you see coming out of
15 the House and the Senate and the two parties, you can't
16 address every one of them. But that does suggest what there
17 is need for is, again, some reasonably objective and
18 analytic thinking of laying out the groundwork. Here are
19 the issues, here are the resources available, here are the
20 constraints you face. Because no matter what approach they
21 take they'll have to confront the same reality, and trying
22 to give them a reasoned description of that reality and the

1 tradeoffs they're facing, I think that helps all of the
2 parties involved.
3 DR. NEWHOUSE: I'm a little unclear about where we
4 are in this discussion. That is, are we still talking about
5 the macro level issues of the June report or are we trying
6 to get down to the material that Julian and Jill presented?
7 MR. HACKBARTH: The macro issue. Again, I'd ask
8 all the people in the queue to try to focus on that. I
9 think we're using up a lot of time here.
10 DR. NEWHOUSE: I had a specific comment on the
11 material presented.
12 MR. HACKBARTH: Hold it then for just a minute and
13 I'll get back to you.
14 DR. NEWHOUSE: I should say, the macro points I
15 agreed with Bob Reischauer and Murray on how to structure
16 the general report in light of the time we have.
17 DR. LOOP: I think it's important that we try to
18 force Congress to think long term, at least up to 2030. I
19 think it's impractical to think about increasing spending
20 within the current program because the demographics are such
21 that the spending will increase anyway as the baby boomers
22 start in 2010.

1 Another variable in this that we have to consider
2 is that employer funding of the retirees is probably going
3 to disappear over time.
4 The third point I want to make is that the young-
5 old are a lot healthier today than their counterparts. I
6 think if you reach 65 you have a 70 percent chance of living
7 another 20 years, and that's probably going to stretch out
8 further. So there's going to be a lot of diagnosis and a
9 lot of treatment, and as we already know from yesterday, a
10 lot of chronic disease that needs attending. So I like the
11 idea of staged benefits, the younger people have more
12 deductibles and more copayment, and then the older-old start
13 getting cared for with a full subsidy.
14 But one thing that I would really like to have us
15 address in this report is protection against catastrophic
16 illness for all seniors.
17 DR. BRAUN: Actually I agree with a lot of what
18 has been said. I do think though that it's important for us
19 to consider a comprehensive benefit package and then
20 consider the ways of financing it. I think what we're
21 saying is that there is money in the system and the question
22 is just how to move it around in order to finance it. But I

1 think the basic thing is to try to see what is a
2 comprehensive benefit package.
3 The other thing I wanted to ask also was access.
4 When we're talking about access in the present time, are we
5 talking about access to presently covered services, or are
6 we talking about access to clinically appropriate care? I
7 think it's very important for us to define what we're
8 talking about because we frequently say access is okay.
9 Access is really not okay to a lot of things. A lot of
10 people are not getting medication because they can't afford
11 it. So I think we need to make that definition when we talk
12 about the present situation, what are we talking about when
13 we talk about access.
14 MR. MULLER: I find the framework that was posed
15 helpful. I wouldn't see this an either/or framework but
16 together, because I think a lot of what was discussed
17 yesterday showed that interrelationship between the various
18 supplementary packages and basic Medicare. For example,
19 even the conversation that has been going forth and will go
20 forth on prescription drugs could be informed by pointing
21 out that a lot of these drugs are being paid for right now
22 out-of-pocket. We may consider that portion of out-of-

1 pocket to be unfair by some policy standards, but between
2 the retirees and Medigap and Medicaid this is being paid
3 for. There's a lot of unevenness in it.
4 So from my point of view, looking at this
5 framework of what perhaps -- from a point of view of system
6 effectiveness and efficacy, might be better made in a more
7 coordinated way, if perhaps it were done inside Medicare.
8 Obviously that has consequences in terms of what one puts
9 into the federal government versus in private and other
10 kinds of budgets.
11 But this kind of framework that points out where
12 Medicare benefits fit in with other sources of health
13 benefits and allows for the understanding to go forth as to
14 how choices that are made are not necessarily just choices
15 of putting more things into the Medicare package at taxpayer
16 cost at a time that everybody is worried about that, but
17 also if that choice is made there may be some ways of
18 relieving other budgets and even thinking of ways of -- I
19 don't quite know how to bring that money back into Medicare
20 if one relieves the Medicaid budget and so forth.
21 So I would vote for staying with -- this framework
22 I think is helpful. I would make it not an either/or but

1 these two frameworks in some kind of continuum. Then I
2 would use it -- I would take some illustrations. Obviously
3 the drug one is the important one, but perhaps also the
4 issue of the comprehensiveness of care. That's an issue
5 that I think most people are very much concerned about
6 around this table and elsewhere -- and point out how
7 comprehensiveness or lack of comprehensiveness there is
8 inside the system right now.
9 I think we got a very good start on that
10 yesterday. So that would help us to point out where there's
11 some gaps in the comprehensiveness, if that's a word, of the
12 care package inside this framework. That then ties benefits
13 and financing together. Because I see the way this
14 framework is posed as having a very central financial
15 framework.
16 DR. LOOP: I wanted to react to what Bea and Ralph
17 both said about a comprehensive benefit package. In theory,
18 I agree with you, but I think that it's like the definition
19 of the efficient provider, whatever that is. The
20 comprehensive benefit package is a floating concept. It's
21 driven by all these changes in science and technology that
22 will occur and never end. Once you give somebody a so-

1 called comprehensive benefit package and define it, you can
2 never take it away. So I think that's the problem with
3 defining a strict comprehensive benefit package because it
4 can only enlarge.

5 I like your idea but I don't know how to do it is
6 what I'm trying to say.

7 MS. ROSENBLATT: I think MedPAC has a lot of
8 credibility and I don't want us to lose that credibility. I
9 like the idea of putting out choices, but I think it would
10 be irresponsible of putting out choices on benefits without
11 considering all the different funding issues connected with
12 that. One thing that I didn't see in our background
13 information is the difference in funding between Part A and
14 Part B. I don't think we can ignore that as we talk about
15 how to redesign the benefit. Because moving benefits from
16 Part A to Part B changes things from general revenue versus
17 payroll tax.

18 So I think our contribution could be, if we do it
19 right, how do we lay out an analytic framework for
20 policymakers to use in considering the choices? I would say
21 the concept of budget neutrality for one year is absolutely
22 not enough. The trend rates of these different benefits --

1 prescription drugs have a very different trend rate, given
2 the way the science base is changing, than the trend rates
3 for hospital, the trend rates for outpatient care.
4 So you've got to look at -- if you want to
5 consider budget neutrality, you have to consider budget
6 neutrality over some suitable length of time. If we could
7 lay out somehow what are the costs of doing that, what's the
8 impact on payroll tax, what's the impact on cost sharing?
9 How do all the pieces fit together? How do we lay out an
10 analytic framework for doing that?
11 That is not a simple task. I'm not sure we've got
12 enough time to do it. But if we could even make a start in
13 doing that, that's where I think we could add value.
14 Now yesterday or this morning somebody mentioned
15 actuarial studies. I would certainly hope that those
16 actuarial studies that we're going to start on in terms of
17 laying it out are not looking at budget neutrality for one
18 year. I think that would be totally inappropriate.
19 DR. ROWE: I think the report should have four
20 parts and I would propose that this work that is being done
21 now handle the first three, and that the fourth perhaps be
22 discussed at the retreat. I think the first part should be

1 an explication of what is referred to in one of the early
2 slides as aging of the population. It's not just simply
3 more old people.
4 There is the myth of the elderly. When Medicare
5 started there was an elderly. That doesn't exist any more.
6 We have at least two major elderly populations: a rapidly
7 growing old-old, increasingly frail, multiply impaired,
8 often irreversibly ill population with a 40 percent
9 demential rate. And we have a young-old population with
10 rapidly decreasing disability rates, increasing activity,
11 functional capacity, and different needs. In addition, we
12 have subsets of the elderly population that we've
13 increasingly spoken of in the last year or two here and that
14 deserve attention.
15 So I think that there is the myth of the elderly,
16 of the beneficiary population. It's not just the aging of
17 America. That would be one section. There's a lot of
18 interesting material that we can put in that.
19 The second set I would say has to do not with just
20 changes in technology, which is on one of the slides. I
21 would say the second set are the changes in production,
22 distribution, and financing of health care services for

1 these elderly populations. The changes that have occurred
2 and what their implications are.
3 Production: we have different providers. We
4 talked about that yesterday, different kinds of providers.
5 We have different sites of care: ambulatory surgery centers,
6 more home care, rehab hospitals, more outpatient, less
7 inpatient, et cetera. And financing: less employer-based
8 benefits for retirees, the Medicare+Choice program, all kind
9 of different financing things. So we have changes in the
10 production, distribution, and financing in addition to
11 technology in production of the services for these elderly
12 populations.
13 The third section might be the implications of the
14 intersection of these two sets of changes for the Medicare
15 program. Do we have two different programs like Floyd
16 suggested? Maybe not everybody should be dealt with equally
17 financially because there are two different populations, et
18 cetera. Try to lay out some of the questions and the
19 framework. If we do a good job in that, that will be a
20 contribution I think.
21 I don't think we can go further than that at this
22 point without much more discussion and analysis, and I can't

1 imagine us as a group getting it done by June, even though I
2 can imagine Julian and Jill getting it done by June maybe.
3 Maybe the retreat would be a great place if we could get
4 those three pieces written and everybody read them and
5 understood them, we could have a robust discussion about
6 whether we want to make some proposals going forward.
7 That's how I see it.
8 MR. HACKBARTH: Jack, in that framework where does
9 the discussion of supplemental insurance and the issues that
10 Alice and Bob helped framed yesterday fall? Is that future
11 --
12 DR. ROWE: I would include that in changes in the
13 financing. That the employer benefits are going down,
14 Medigap may increase as M+C decreases, et cetera, the
15 pharmacy benefit if it's not handled, there might need to be
16 two new Medigaps proposed. I would include that in that
17 last part.
18 DR. REISCHAUER: But you aren't really suggesting
19 that we talk at all about revisions to the benefit package
20 then. This is all the build-up to that.
21 DR. ROWE: I was going to say that we would talk
22 about them but we would not make specific proposals. We

1 would say that a recognition of these kinds of changes in
2 the population and their needs urges the availability of
3 certain kinds of benefits that may not currently be
4 available. I don't know what those would be. I would have
5 no hesitation to do that; not at all.

6 The hospice benefit is an obvious benefit that if
7 we had looked back 20 years ago somebody would have said,
8 look, there needs to be a hospice benefit for this
9 population. There isn't one; let's invent one. If there
10 are other things like that, I would embrace that. I'm just
11 trying to take what I'm hearing here and organize it in a
12 way that's iterative.

13 MR. HACKBARTH: I welcome your comment, Jack,
14 because we do need to get down to the concrete and try to
15 frame this report. What I hear you describe overlaps
16 substantially with the framework that I think the staff has
17 been presenting.

18 DR. NEWHOUSE: I like this, I think, on first
19 hearing it. But in any framework we're going to have some
20 discussion about financial liability. Indeed, that surfaced
21 here. So I wanted to talk about how to frame that. I would
22 have started with the notion that the issues are really

1 protecting against large losses and paying for low income or
2 poor populations or what special protections there are for
3 them.
4 Then I think I would go to our data, which to me
5 show that the major issues creating financial risk are the
6 omission of drug benefits and the omission of long term
7 care. I would include the portion of the Med supp premiums
8 that go to cover drugs, insofar as we could estimate that.
9 I think long term care is somewhat a little different
10 footing because the risk is more to the estate typically
11 than to current standard of living, but it overlaps.
12 Then secondarily, there's an issue about the lack
13 of stop-loss provisions in Medicare A and B that's mostly
14 handled by supplementary insurance. We have that now, but
15 not fully so because everybody doesn't have it and that
16 leads us on to the point, this is a very expensive way to
17 provide catastrophic coverage.
18 What I would not do in terms of narrower points, I
19 would not talk about the incomes of the elderly being a
20 third lower because it's not clear that consumption needs of
21 the elderly are similar. All the retirement advice columns
22 say you need 80 percent of your income or some such and so

1 far. I would not talk about the out-of-pocket share on
2 medical care of income being doubled because it all has to
3 add up to 100 percent and as Bob said a time or two ago,
4 what do we want them to spend it on.
5 I think I would not, if we talk about -- I would
6 not talk about adequate supplementary insurance unless we're
7 -- in the context of what we really want the supplementary
8 insurance to do is protect, if there is supplementary
9 insurance is to protect against financial risk. And if
10 there were a stop-loss provision and a comprehensive benefit
11 package or a coverage of drugs, as Bea said, we wouldn't
12 necessarily need this extra administrative expense; the
13 points that are here now.
14 DR. REISCHAUER: I like Jack's approach but it
15 strikes me it got us up to the bar but we didn't order the
16 drink. Building on something Alice said, I think there's a
17 very simple exercise that all of could go through without
18 worrying about 2025 or financial burdens or anything like
19 that. That is, if we had no Medicare system at this point
20 and were given a budget equal to $248 billion, how would we
21 design a benefit package. We certainly wouldn't have a one-
22 day hospital deduction of $812. We wouldn't have no

1 prescription drug coverage. We wouldn't have lots of things
2 that are in there, and we would shift things around.
3 That, it strikes me, is a contribution that we can
4 make without getting nervous about the future. We'd
5 probably have much higher premiums, because we know people
6 are paying premiums outside for these things. We'd probably
7 have copays in laboratory and home health and smaller copays
8 elsewhere. I think saying something about what an
9 appropriate benefit package, given the technology, the
10 population, the delivery system that we have now would be an
11 appropriate last chapter to Jack's report.
12 MR. HACKBARTH: So here's what I hear as the
13 framework of the report and what we're trying to accomplish.
14 Again I'd emphasize that I think it really does overlap very
15 substantially with what the staff initially brought us. We
16 need to lead with this explanation of the context, the
17 discussion that Jack referred to of the population being
18 served and how it may be different and more diverse than
19 some people think, and the corresponding changes in the care
20 delivery system that have been occurring. So that's the
21 contextual foundation for what we're doing.
22 Second, this is a report about benefits, as we

1 initially stated, but an important theme throughout needs to
2 be that benefits cannot be totally disconnected from changes
3 in the care delivery system that have happened and may be
4 needed in the future, as David was saying, or for that
5 matter with payment and other issues. This is not easily
6 abstracted from all of those other points.

7 Third, we can clearly, I think, structure some
8 choices, some alternative paths that we might take. Bob has
9 presented one way to think about how you might frame one of
10 those paths. I'm not sure we're ready to say that that is
11 the one necessarily to take, but I think we can provide a
12 lot of structure for future thinking by this Commission and
13 others.

14 Fourth point is that as we look at those
15 alternative paths we would be remiss if we didn't make early
16 and frequent reference to the long term fiscal challenges
17 facing the program, and the country for that matter. It is
18 an important consideration in ultimately choosing among the
19 alternative paths we may lay out. So those are four pieces
20 of common ground that I heard in the comments.

21 I think we would really now need to move forward
22 with what would be item three on my list. Yesterday we

1 spent a lot of time talking about the context, the
2 population, the delivery system, changes and what may need
3 to change in the future. I don't think we need to go back
4 there. We also talked a bit about the interconnection, and
5 that will be an ongoing theme.
6 What we really haven't done is say, concretely
7 here are the paths that we want to present, here are the
8 crossroads that we want to really focus on in the June
9 report, and here's what we want to begin to say about the
10 merits and demerits of different alternatives. So I think
11 that's where we are in the conversation. I'll put a
12 question mark at the end of that. That's the critical issue
13 for me, leading us to a point where it fits with what we
14 have prepared for the rest of the day.
15 DR. NELSON: I agree with that. I would like to
16 see explicitly someplace in the report the fact that when
17 Medicare was passed it promised to Social Security
18 beneficiaries health insurance coverage with benefits that
19 were comparable to those that workers and other Americans
20 received.
21 Over the course of the last 40 years insurance
22 coverage under Medicare has not kept pace with the changes

1 that have occurred among other insured Americans; the most
2 visible example being drug coverage. That's what I meant
3 about not meeting the promise, because it hasn't evolved as
4 the private marketplace has. And I don't think you can say
5 its inertia has resulted in a superior product.
6 MR. HACKBARTH: Looking at our planned agenda here
7 we are -- I'd welcome, Murray, your guidance on this. The
8 next item that we had scheduled on the agenda was the
9 criteria for evaluating the potential directions we might
10 take, which seems to fit well for me. I'd suggest that we
11 move to that. We're running a little bit behind schedule
12 here.
13 Before Julian and Jill depart, any thoughts,
14 guidance in particular that you need before you lose us,
15 other than the right answers?
16 MR. PETTENGILL: That's just what I was going to
17 ask for. We sent you a short list of findings, and we put
18 those together fairly cautiously. We were not being
19 aggressive in the way we stated the findings. Since no one
20 has, I don't think mentioned any of them --
21 MR. HACKBARTH: Could I ask that rather using the
22 time right now that we send those or phone Julian and Jill

1 with them?

2 Thank you.

3 Whenever you're ready, Mae.

4 DR. THAMER: I'm here to discuss the criteria to
5 evaluate the Medicare benefit package. To start, the way in
6 which the benefit package is design obviously has a
7 significant impact on the health care received by Medicare
8 beneficiaries as well as the cost and sustainability of the
9 program. So devising a systemic approach to evaluate the
10 current benefit package as well as any proposed reforms is
11 critical so that the values that are being considered can be
12 more easily identified, and the tradeoffs inherent in
13 different policy options can be more clearly understood.

14 We are proposing six criteria to evaluate any
15 proposed changes to the Medicare benefit package. These
16 criteria are financial protection, access to care,
17 efficiency, financial sustainability over time, operational
18 feasibility, and freedom of choice. Before I get into each
19 one I want to say that there are many tradeoffs associated
20 with using these criteria.

21 For example, some criteria can overlap or
22 contradict one another, depending on the specific proposal.

1 But the utility of applying the criteria lies in making the
2 process of evaluating proposed changes systematic and
3 explicit.
4 We would like the Commission to provide guidance
5 on the six selected criteria and their definitions. For the
6 remainder of my presentation I'm going to attempt to define
7 and briefly describe each criterion.
8 The first one, financial protection. Does the
9 Medicare benefit package protect the financial security of
10 enrollees and their families? In other words, does the
11 benefit package provide sufficient coverage to all
12 beneficiaries to ensure that beneficiaries are adequately
13 insured and are not exposed to prohibitively high out-of-
14 pocket costs?
15 MR. HACKBARTH: Mae, could I just interrupt you
16 for just one second. I've got us in a bit of a time crunch.
17 We're scheduled to run a little bit later today than usual
18 and I know because of plane schedules people will be pinched
19 at the end. Will you help make up for my getting us behind
20 schedule and try to get through this material as quickly as
21 possible? Because I think what you've sent us in advance
22 pretty well frames what we've got to cover here. Thanks.

1 DR. THAMER: Why don't I then just go through the
2 criteria and just give you, for some of them, examples of
3 how they wouldn't be met, for instance. For example, with
4 financial protection, this criterion wouldn't be met if the
5 benefit package was modified in such a way so that the
6 beneficiaries would have to forgo or delay care, or not
7 fully comply with recommended care because they couldn't
8 afford it.
9 Next criterion is access to care. Does the
10 benefit package ensure access to medically necessary care in
11 the most appropriate setting? An example here, there's a
12 proposed option to modify the benefit package, would it
13 increase out-of-pocket expenses for the sickest
14 beneficiaries in a way that would make it more difficult for
15 them to afford needed care? In other words, for this
16 criterion, the potential distributional effects of any
17 proposed reforms, it would be very important.
18 Efficiency. Does the benefit package encourage
19 the purchase of appropriate care at the lowest possible
20 price and minimize administrative costs? In other words, is
21 the care delivered of high quality, consistent with
22 preferences of patients, and minimizing the use of

1 ineffective or unnecessary services? This would be measured
2 by a proposed reform in terms of the incentives that would
3 be created for beneficiaries to use health services when
4 they're necessary and they're worth their cost.
5 Financial sustainability over time. This was one
6 that was referred to a lot this morning and yesterday, can
7 the Medicare benefit package be provided without imposing
8 undue burdens on beneficiaries or taxpayers? If the program
9 is so expensive or reforms proposed are so expensive as to
10 place an undue burden on taxpayers or beneficiaries it might
11 be financially and politically unsustainable for the long
12 term. So issues of how much of the national budget to
13 allocate to health care versus other national priorities
14 have to be considered.
15 Operational feasibility. Can the benefit package
16 be implemented without causing major disruptions to
17 beneficiaries or to providers? It addresses the ease with
18 which any proposed changes could be implemented. Just for
19 an example, if there's a proposed reform, could it make use
20 of the current administrative systems that operate the
21 Medicare program or would it require new mechanisms?
22 The last criterion is freedom of choice. Does the

1 Medicare benefit package allow beneficiaries to make choices
2 about their health care, and would any changes affect
3 provider participation? This refers to the Medicare statute
4 that explicitly prohibits the government from exercising any
5 supervision or control over the practice of medicine as well
6 as the original legislation which guaranteed all
7 beneficiaries the freedom to use any qualified provider who
8 participated in Medicare.
9 This really goes to the heart that there are
10 differences among individuals regarding their choice of
11 providers, health care settings, or treatments, and that
12 given resource constraints these choices have varying
13 implications in terms of costs and outcomes. That's it.
14 MR. HACKBARTH: Thanks, Mae.
15 DR. ROWE: Mae, just a couple quick points here.
16 I know we want to move along. One is I think we should
17 recognize that if you asked the question, is the Medicare
18 program meeting its needs or how effective is it, that some
19 people might see that in the context of the kinds of
20 questions people say, how's the American health care system
21 versus that of Europe and the measures they use are not the
22 measures you used. They use life expectancy, mortality

1 rates, things like this. You have none of those here.

2 There have been dramatic reductions in disability
3 in the elderly since Medicare started. Life expectancy at
4 age 65 and 85 have increased dramatically. I don't believe
5 that's because of the Medicare program particularly, but you
6 might at least address some of those issues up front one way
7 or the other and say, we can't do anything about them, or
8 they're secular effects, they're coincident with Medicare.

9 But one issue I think should be here, the word
10 should appear and it doesn't, is prevention. Because under
11 access to care you specifically say medically necessary
12 care. That sounds like it's treatment for a specific
13 disease. I think that one measure of whether the Medicare
14 program is meeting the needs of the beneficiary population
15 is whether or not they get access to appropriate preventive
16 services. So I would add preventive as well as -- I would
17 at least somehow make it clear you care about that.

18 MR. HACKBARTH: Jack, on that point, can those two
19 be tied together perhaps under the heading of access to
20 care? It's access to care that will help improve the
21 longevity and reduce the morbidity of this population.

22 DR. ROWE: That's right. When I saw access to

1 care that's where I expected to see it. But then you went
2 and said specifically, medically necessary. I was concerned
3 that by doing that you were excluding prevention.
4 DR. THAMER: If we change it to appropriate health
5 care services, getting away from medically necessary?
6 DR. ROWE: There's no penalty for using the word
7 prevention. It's in fact a good thing. Why not use it?
8 Just say appropriate preventive and diagnostic and treatment
9 services.
10 DR. THAMER: Right, then we'd have to specify the
11 others, but that's all right.
12 DR. ROWE: Same number of words.
13 [Laughter.]
14 DR. ROWE: I'll bet you a dollar prevention is not
15 in it the next time we see it, but we'll try.
16 The last thing I would say is, some people would
17 use patient satisfaction with the system as a measure of
18 whether or not it's serving its purpose. Satisfaction of
19 the consumer or the beneficiary is not here anywhere. You
20 may wish to exclude it, but if you do you have to, I think,
21 say why, because somebody will ask.
22 DR. THAMER: Freedom of choice is not a big enough

1 umbrella?

2 DR. ROWE: No penalty for using the word

3 satisfaction.

4 MS. ROSENBLATT: I actually think it's a good

5 list. I like Jack's comments. I have another criterion to

6 add. Jack, maybe you can help me with the words here, but

7 the issue that I think is not there is -- I think Jill

8 previously used mainstream medical care, you hint at it in

9 medically necessary care.

10 But with the science base changing I think there's

11 another criterion in terms of the benefit structure which

12 is, what should be covered by a social program and what

13 shouldn't. If we add prescription drug should Viagra be

14 covered, should cochlear implants be covered, should LASIK

15 eye surgery be covered? More and more of that kind of stuff

16 is going to confront us as we move through time.

17 So I think we might be getting into ethical issues

18 there but I think that's something we need to consider.

19 MR. SMITH: Three very quick comments. I think

20 this list is right. I have trouble with number four. We

21 really don't mean financial sustainability over time. We

22 really mean political sustainability over time. We can

1 spend the money if we choose to spend the money. It's a
2 political decision. There's not objective economic
3 constraint to going to a higher percentage of GDP for health
4 care or simply for Medicare. We need to be careful not to
5 establish some barrier or suggest a barrier which is
6 quantitative.

7 I do think, given the discussion of yesterday, we
8 need to make sure that when we talk about Medicare and we
9 talk about criteria we set our framework within the entire
10 system. That what we care about is that the system meet
11 these criteria. Medicare is only part of that system,
12 whether it's the supplemental part of it or the Medicaid
13 part of it or the employer paid part of it. But the
14 criteria, what we want out of the system, we want Medicare
15 to encourage the system or to provide that the system meet
16 those criteria.

17 Then thirdly, I think it's very important in the
18 financial protection to be specific in the two ways that Joe
19 described: that we have a stop-loss concern and that we have
20 a particular concern -- it relates to the access question --
21 for low income beneficiaries. That the system ensure that
22 financial protection simply doesn't mean you don't spend too

1 much money out-of-pocket, but it also means that low income
2 folks have got access to the services.
3 DR. BRAUN: I just realized the word quality isn't
4 in here anyway and I'm just wondering where we can put it.
5 Clearly I think we should have something in there on
6 quality, whether it comes under the access or --
7 DR. THAMER: Yes, I was going to say, it should
8 come under the access and possibly we could put it under the
9 high quality preventive, diagnostic, and treatment services.
10 But that's a good point.
11 DR. BRAUN: The point is high quality treatment.
12 MR. FEEZOR: I haven't quite gotten the wording on
13 this but it seems to me Medicare benefit design -- and I
14 think we probably need to use benefit design as opposed to
15 benefit package. It's a nuance, but if you think about it,
16 not a small one. Also needs to at least facilitate or at
17 least be facile in combining with supplemental efforts. I'm
18 not saying here supplemental insurance. Hear me clearly
19 before I set anybody off. But in fact is something that can
20 be easily attached, maybe by other social programs or that
21 can in fact be used as a base for other social programs.
22 It's a social insurance program and yet there are

1 many other social programs that probably will be building
2 around it for our aged. I'll come up with a better term but
3 generally that concept I think is a characteristic in terms
4 of any redesign of Medicare that ought to be kept in mind.
5 I'm sorry I don't have a better idea on that right now.
6 The other thing is just the issue of freedom of
7 choice. That's a loaded term. How about just choice and
8 how we deal with, whether it's choice of provider or choice
9 even of maybe even some benefits.
10 DR. WAKEFIELD: Mae, I just want you to draw your
11 attention to the Crossing the Quality Chasm report that
12 might inform your thinking. I'm not going to explicate the
13 bridges that I see. I worked on the committee that crafted
14 that report at the IOM, but I do see different places where
15 it could jump-start some of the thinking even here in terms
16 of the proposals there for redesigning the health care
17 system at large.
18 There actually are some pieces of that that I
19 think fit nicely with what was said yesterday morning by the
20 panel, the summary of that group that collectively came to
21 some recommendations about how to improve the benefit
22 package. That actually flowed in some interesting way in a

1 parallel fashion to some of the recommendations in the IOM
2 report.
3 You can target quality different places but where
4 I saw it when I read your text was, purchase of appropriate
5 care. It doesn't matter much to me where it goes, it's just
6 that we hit hard where we can and draw on maybe some of that
7 work where a tremendous amount of effort has already gone
8 before us and informing that more broadly thinking about
9 quality, reflecting that here. If I can help you in any way
10 with that I'd be happy to do it.
11 MR. HACKBARTH: Yesterday we spent time, aided by
12 Alice and Bob, talking about different views of the
13 supplemental market and whether it could be done
14 differently, more efficiently, more effectively by bringing
15 all the resources together and providing government coverage
16 in lieu of having it done through a patchwork of private.
17 As I listen to that discussion and think about how it might
18 be received on Capitol Hill, a lot of people would
19 characterize that as a discussion about the appropriate
20 roles of the government and the private sector in financing,
21 and in this case, providing coverage.
22 I'm not sure where that fits in this set of

1 criteria. I know for some people on the Hill that's a very
2 important criterion, is the respective roles of the private
3 sector and the government. Can we, should we somehow have
4 this on this list of criteria?

5 DR. THAMER: We had initially considered that
6 under efficiency. That is where, does the benefit package
7 encourage the purchase of appropriate care at the lowest
8 possible cost and minimize administrative costs. It's
9 buried within that verbiage. That was our intent, and
10 minimizing the administrative costs would address the larger
11 issue. But what you're bringing up is a different way to
12 look at it.

13 MR. HACKBARTH: I welcome thoughts from other
14 people about that. I'm not sure that characterizing it as a
15 matter of administrative efficiency really would capture the
16 concern that people would feel, or the passion they might
17 feel about the issue.

18 DR. REISCHAUER: I think Mae's description here
19 says there are trade-offs between these criteria. On the
20 one hand efficiency pushes you in one direction, and choice
21 and consumer satisfaction, and the desire to have innovation
22 pushes you in another. So I think it's really in several of

1 these.

2 DR. ROSS: There is probably a school of thought

3 up on the Hill who would distinguish between the economies

4 of scale in expanding the government role here and not

5 immediately assume that to be more efficient in the long run

6 if it doesn't respond to market changes.

7 MS. ROSENBLATT: I don't think administrative

8 efficiency really gets at it because you're talking about

9 the smaller piece of the health care dollar. You still have

10 the larger piece on claim cost, the smaller piece on admin,

11 so I think it's inappropriate to look at it that way. But I

12 do think the way you word it, financial sustainability over

13 time, in terms of payroll burden is probably the right way

14 to deal with the Med supp.

15 MR. HACKBARTH: Bob, as I think about what you

16 just said, let me tell you what I hear you saying, is that

17 actually we attach in the political debate these big labels

18 to these things, public versus private, and people become

19 impassioned about them. Maybe that's diffused somewhat if

20 you break it down below those big labels and look at it as

21 tradeoffs among various criteria as opposed to work with the

22 big labels. Is that what you're suggesting?

1 DR. REISCHAUER: I think so. But just to show you
2 where I am on this, which I think most of you know, I'm for
3 a significantly expanded benefit package delivered through a
4 premium support system. So it has a very significant role
5 for private sector entities, but at the same time it has a
6 mandated benefit package that is very different and much
7 more comprehensive than the one we have now. So I don't
8 think these things are as closely tied as your original
9 suggestion implied.
10 MR. HACKBARTH: One other thing I wanted to touch
11 on, going back to David's comment about financial
12 sustainability, and it's really not a matter of finances but
13 rather of will and political sustainability. I'd welcome
14 some discussion of that point.
15 MS. ROSENBLATT: I think you can deal with that
16 issue by showing what the choices lead to, but I think
17 that's going to be very difficult to do in the framework.
18 If we end up with payroll taxes doubling over the next 10
19 years, that's certainly a possibility, but people need to
20 see that's what's going to happen. So my concern with
21 lessening that is not making that point somehow.
22 MR. HACKBARTH: Murray, what was your take on that

1 or your concern about it?

2 DR. ROSS: I think it gets to a fundamental
3 question and it's ability to pay versus willingness to pay.
4 I guess one way to think about it, Alice, we're not going to
5 try to do 75-year cost-outs for different benefit packages.
6 This is something that's going to be handled in text as an
7 issue that is going to confront any set of choices you make.

8 I guess we can handle it by both talking about the
9 trustees' projections on, here's the general issue of what
10 this is going to cost and then recognize that there's a
11 political dimension to it and deciding about, at least cost
12 under current law assumptions. Then there's a political
13 question of what do you want to do about it and who do you
14 want to pay for that. I think we can handle it.

15 I accepted your distinction, David, between the
16 political decision versus these numbers aren't given by God.
17 So I think we can handle that but it does raise an issue
18 that I guess we had treated a little bit too simply in our
19 thinking.

20 DR. REISCHAUER: There's a question of what the
21 counterfactual is here. It's not the burden that we're
22 experiencing now. If government doesn't pay for it socially

1 through taxes, individuals are going to pay for it through
2 supplementary premiums or adequate benefits are not going to
3 be delivered. We can't pretend that the situation we're in
4 right now can persist because it can't. It's a question of
5 choosing among not wonderful alternatives.
6 DR. ROSS: It's not just appropriate benefits or
7 appropriate care being consumed but also a question of how
8 much additional, depending on how you finance it.
9 MR. HACKBARTH: The distributive implications are
10 greatly different.
11 DR. LOOP: I understand the components here and I
12 think the discussion is good. But assuming that we order
13 that drink, what are we going to do? Are you going to
14 redesign Medicare or are we going to stick to a more
15 comprehensive benefit package? I'm not quite sure what
16 direction we're going to do after we get to the point of
17 ordering the drink.
18 MR. HACKBARTH: I'm not sure that I can pursue the
19 bar analogy in those terms. What I envision, based on our
20 earlier discussion, is that actually Bob's suggestion about
21 thinking about this or framing it as if we were to start
22 over we would face some alternative paths that we might

1 choose among. So try to remove ourselves from the specifics
2 of the current Medicare benefit package and say, if we were
3 to start from scratch, where would we go in pursuit of
4 achieving these criteria?
5 There are I don't know how many alternative paths
6 and decision nodes that we would deal with, but we'd try to
7 lay those out, at least at a gross level and say, here are
8 the strengths and weaknesses of those different choices,
9 potential choices. So that's what we're trying to
10 accomplish at this step.
11 DR. REISCHAUER: But then the next tab has in it a
12 number of very specific suggestions about how the benefit
13 package might be changed. Most of them lead to increased
14 cost and I'm not sure we have to go much further than to
15 say, some combination of either increased premiums and
16 higher coinsurance elsewhere could be used to pay for this
17 if one wanted to keep this within a budget constraint.
18 MR. HACKBARTH: Did we even graze your question?
19 DR. LOOP: I was trying to get us to commit to
20 either thinking ideologically or politically here. I think
21 maybe the next tab will get us on one track or the other.
22 MR. HACKBARTH: Is there another choice? Can we

1 think analytically or philosophically?

2 DR. REISCHAUER: Spiritually?

3 [Laughter.]

4 DR. NEWHOUSE: At the risk of being the uninvited
5 guest, I am concerned about some of our language with we're
6 hiding some issues with using appropriate care and medically
7 necessary care. Alice touched on this with her comment
8 about technology, but it's really beyond that. There's lots
9 of care that provides positive benefits to people but isn't
10 necessarily worth its cost. What these words actually mean
11 is somewhat in the eye of the beholder, and we use them as
12 if they have a meaning.

13 I'd offer, for example, do you do a diagnostic
14 test such as a scan if the probability of finding something
15 is positive but very small? What's medically necessary in
16 that case? I admit that almost everybody uses these words,
17 but I think maybe we should point out there's at least some
18 ambiguity here.

19 MR. HACKBARTH: I absolutely agree with your
20 point. I'm not sure it's an issue that we will be able to
21 resolve here. In fact I know it's an issue we can't resolve
22 here but we ought to allude to it.

1 The issue that I heard Alice raising was about
2 things that have a clear benefit but the question is whether
3 it's a benefit we wish to buy. Viagra might be an example
4 that -- I know we wrestled with it at Harvard Community
5 Health Plan, and many others did. Big cost, certainly
6 initially, but is this an essential benefit. There are many
7 others like that.
8 MS. ROSENBLATT: The point I'm trying to make is
9 where is the cutoff between what is elective, so to speak,
10 and what is provided to everyone.
11 DR. NEWHOUSE: My point is actually that's a much
12 bigger question because there's many services, procedures,
13 devices and so forth where one would say, absolutely for
14 some people these should be part of the benefit package, but
15 for other people the very same service might have a very
16 modest benefit and should not be.
17 MR. HACKBARTH: Agreed.
18 MS. ROSENBLATT: I guess just the other part of
19 what I'm raising is, and I think cochlear implant is a great
20 example, is you can help someone here with a hearing aid or
21 you can help them here with a cochlear implant. Big
22 difference in cost and how do you make that distinction?

1 DR. LOOP: Before we move on, I think we have to
2 be very practical though about some of these criteria and
3 limit this to the program sustainability, access, and
4 choice, and financial protection at the limits. The other
5 criteria are sort of words, you know, efficiency, and
6 program feasibility. I think we ought to stick to a few
7 core criteria here no matter what direction we go later on.
8 MR. SMITH: Just back to Joe and Alice's comments
9 for a minute. I think the distinction, Joe, isn't between
10 whether or not it ought to be in the benefit package or not,
11 but whether or not it ought to be delivered. The word we
12 need to wrestle with here is appropriate.
13 DR. NEWHOUSE: And medically necessary.
14 MR. SMITH: And medically necessary. But it's not
15 a question of what ought to be in the benefit package.
16 Alice raises an appropriate --
17 DR. NEWHOUSE: Except insofar as we use that to
18 say medically necessary should be in the benefit package.
19 MR. SMITH: But medically necessary ought be in
20 the benefit package. There are some things -- Viagra is a
21 good example -- that maybe ought not to be in the benefit
22 package. That's exactly the appropriate market for consumer

1 choice and supplemental. Both those are two different -- we
2 talked about it as if they were the same distinction. I
3 don't think that's right.
4 What we want to make sure is that medically
5 appropriate care, medically necessary care is covered in the
6 benefit package and that some things don't fit into that
7 basket and they ought to be outside of the benefit package.
8 MR. HACKBARTH: We need to move on. I think we've
9 got a good start on the criteria list. I think one of the
10 problems you always have when you're dealing with criteria
11 like this is that in many cases they're subjective. There
12 aren't readily available metrics to measure how well you're
13 accomplishing one versus another and make tradeoffs, et
14 cetera.
15 I think at this point the best thing we can do is
16 take this list and flesh them out further, make them as
17 concrete as we can. Maybe as we go through that, Floyd, we
18 will see opportunity to condense or reduce. I don't want to
19 condense too quickly though because I think you run the risk
20 of losing credibility if you quickly become a lumper as
21 opposed to a splitter and your reading audience thinks that
22 things that are important to them just haven't been

1 considered at all. So there's a delicate balance that needs
2 to be struck.
3 MS. NEWPORT: Glenn, I'm sorry, I'll only take a
4 moment. In statute there are terms of art around medical
5 necessity benefit interpretation. I'm happy as a sidebar
6 with the staff to walk through. There's a tiered structure.
7 The way to look at it, which I think will create some safety
8 in terms of people's comfort in the discussion around these
9 things, they're actually legal terms and the structures and
10 implementation are pretty clear, which gets to how do you
11 include more efficient services and what are the options.
12 So I can walk through a structure for people and
13 then they may be able to come back and answer some questions
14 that have been raised here.
15 MR. HACKBARTH: Thank you, Mae. Now we're moving
16 on to the discussion of options for changing the package.
17 MS. MUTTI: In this presentation we discuss an
18 array of policy options that would address some of the
19 problems that we've identified in earlier presentations with
20 the current Medicare benefit package. As consistent with
21 your conversation just before this, we're not making draft
22 recommendations for you but instead laying out some of the

1 pros and cons of the different approaches and some of the
2 design questions that you might need to consider.
3 We have organized these policy options into three
4 categories that are progressively more fundamental in their
5 degree of reform. As you can see up on the screen, the
6 first is potential cost-sharing changes. These changes
7 preserve the basic structure of the program while addressing
8 problems such as the lack of protection from high out-of-
9 pocket costs and uneven cost-sharing requirements that can
10 result in inappropriate use of services.
11 We then consider additional benefits that could be
12 added to the Medicare benefit package. Specifically we
13 present options on prescription drug, case management,
14 preventive services, and long term care issues.
15 Finally, we address a notion that I think has
16 become familiar to you now. We call it fundamental
17 reallocation of resources among existing payers. Where
18 beneficiaries would be offered a single comprehensive
19 benefit package that would reduce their demand for
20 supplemental insurance, which as we have indicated has
21 introduced numerous inefficiencies in current total spending
22 for beneficiaries. So in theory, under this approach the

1 savings gained from eliminating the inefficiencies would
2 offset the costs associated with a comprehensive benefit
3 package.
4 Now for the remainder of the presentation we're
5 planning to go through each of these categories and give you
6 a sense of the array of options we have identified and the
7 types of issues we plan to discuss. We are looking for your
8 feedback on whether you are comfortable with the
9 categorization of our options, the range of options
10 themselves, whether we have identified the key design
11 considerations, and what level of detail you would like us
12 to go into, especially given our time constraints.
13 At this time then we'll begin with cost-sharing
14 changes and Ariel Winter will present.
15 MR. WINTER: Thank you. First I would like to
16 review the goals of cost-sharing in health insurance design.
17 Cost-sharing should be low enough to provide financial
18 protection against high medical costs and facilitate access
19 to care, but it should be high enough to discourage use of
20 services of marginal value. Cost-sharing should be lower
21 for less discretionary services such as inpatient
22 hospitalizations and most price sensitive discretionary

1 services such as physician visits.

2 Using these principles as a guide, Medicare's
3 current cost-sharing structure is less than optimal. It
4 imposes high cost-sharing on inpatient hospital and
5 outpatient hospital services, for example. It requires
6 fairly low cost-sharing on many Part B services, and it does
7 not provide a catastrophic cap on beneficiaries' total
8 liability.

9 I'm going to discuss how this cost-sharing
10 structure could be changed to accomplish three objectives:
11 to improve beneficiaries' financial protection from high
12 medical costs, to reduce financial barriers that limit
13 access to care, and to provide better incentives to control
14 the use of price sensitive discretionary services.

15 First, changing Medicare's deductible requirements
16 could help accomplish these goals. Currently, the program
17 has an inpatient hospital deductible of $812 per spell of
18 illness and an annual Part B deductible of $100. This
19 structure imposes high costs on those with hospitalizations
20 and provides weak incentives to control the use of Part B
21 services. To address these concerns, policymakers could
22 consider raising the Part B deductible, lowering the Part A

1 deductible, or doing both in combination.

2 Second, policymakers could consider making changes
3 to Medicare's coinsurance rules to improve protection from
4 high out-of-pocket costs, especially for less discretionary
5 services, and increase cost-sharing on more discretionary
6 services. These options could include eliminating the
7 hospital coinsurance for days 61 to 150 of a hospital stay,
8 requiring cost-sharing for home health services and clinical
9 lab services, modifying the skilled nursing facility
10 coinsurance, reducing outpatient hospital coinsurance,
11 reducing mental health outpatient coinsurance, and
12 eliminating coinsurance on preventive services.

13 Third, policymakers could consider adding a cap on
14 out-of-pocket spending for covered services. This approach
15 would help protect beneficiaries against high medical costs,
16 and depending on the level of the cap, may encourage some
17 beneficiaries to forgo supplemental insurance.

18 That brings us to the last type of change that we
19 consider here, which is altering the type of coverage
20 offered by supplemental insurance. As we discussed
21 yesterday and today, supplemental insurance covers most
22 cost-sharing, which reduces financial barriers to care, but

1 also induces beneficiaries to use more services by making
2 them less sensitive to their cost.
3 One option to consider is encouraging supplemental
4 insurers to reduce coverage of first dollar costs, such as
5 the Part B deductible, and adding a cap on high out-of-
6 pocket costs. The Administration's proposed new Medigap
7 plans K and L would include these features.
8 To get a sense of how these cost-sharing options
9 could be combined to achieve different objectives we have
10 developed five packages that illustrative different
11 combinations of changes. I want to stress, these are just
12 illustrative changes. There are many other changes you
13 could consider as well.
14 At the far left of the table are the cost-sharing
15 features we've changed in some or all of the packages. The
16 first column shows current law. The next five columns show
17 the changes in each package. And the bottom row displays
18 approximate 2002 cost of each package to give you a sense of
19 what can be done at different spending levels. We've not
20 done five, 10, or 30-year estimates; just a one-year
21 estimate to give you a sense of the magnitude of the change.
22 Option A, as you can see, would be about budget

1 neutral. Options B and C would cost in the range of $4
2 billion to $5 billion. And Options D and E would cost about
3 $9 billion in 2002. These costs come from a model developed
4 for us by Actuarial Research Corporation which I can give
5 you further details about if you'd like.

6 Option A would replace the separate Part A and
7 Part B deductibles with a combined annual Part A and B
8 deductible of $400. It would also eliminate copayments on
9 inpatient days beyond 60, and eliminate limits on the number
10 of covered days per stay. This combination would provide
11 more complete inpatient hospital coverage. This improvement
12 in hospital coverage would be financed by higher deductible
13 on Part B services which improve incentives to use Part B
14 services prudently. If supplemental coverage were to
15 respond by covering the combined deductible then we would
16 expect smaller efficiency gains.

17 Relative to current law, the 20 percent of
18 beneficiaries with inpatient hospital use would have lower
19 cost-sharing while the 70 percent of beneficiaries who
20 currently spend over $100 on Part B services would face
21 higher liabilities. To the extent demand for supplemental
22 coverage is motivated by the currently high Part A

1 deductible, this change could reduce demand for supplemental
2 coverage. However, higher deductible on Part B services
3 could increase demand.
4 Option B would add a $5,000 cap on out-of-pocket
5 spending on Medicare covered services. About 3 percent of
6 beneficiaries would reach this cap. We estimate that this
7 option would increase costs by about $5 billion. If we
8 restricted Medigap from covering the combined deductible we
9 expect that use of services would decline due to greater
10 price sensitivity and the cost of this package would be cut
11 in half.
12 Option C would do two things. It would add a home
13 health copayment of $10 per visit capped at $200 in total
14 per episode, and it would replace the current skilled
15 nursing facility copayment on stays beyond 20 days with a
16 copayment of $25 per day for all days of the stay. Adding a
17 modest cost-sharing to home health services would improve
18 incentives for beneficiaries to use home health
19 appropriately. It would also save the program almost $2
20 billion in 2002 which would help offset the cost of other
21 changes. As an aside, the Commission recommended a modest
22 home health copayment in its 1998 report.

1 Imposing copayments on the entire SNF stay and
2 reducing the copayment per day would have three main
3 effects. It would improve equity, because all SNF residents
4 would share in the cost, not only long stay residents. It
5 would reduce the financial burden of longer stay SNF
6 residents. Under the current system, beneficiaries who
7 incur any copayments -- that is those with stays of over 20
8 days -- incur total average cost-sharing of about $3,000
9 which would fall to about $1,200 in this approach.
10 Finally, shifting cost-sharing from the last 80
11 days of a stay which are the most discretionary days, to the
12 first 20 days which are the least discretionary, would
13 reduce incentives to control the use of SNF services.
14 When considering a home health or a SNF copayment
15 it's important to keep in mind that these services are in
16 some cases substitutable. So you don't want to encourage
17 beneficiaries to choose SNF or home health on the basis of
18 which one has no cost-sharing. That's why we structured
19 both of them to have copays on the initial visits or days.
20 The SNF copayment change would increase cost by
21 about $1 billion. So the total cost for this option is
22 about $1 billion less than Option B.

1 Option D would make three changes. It would
2 reduce the out-of-pocket cap to $3,000; about 8 percent of
3 beneficiaries reach this cap versus 3 percent of
4 beneficiaries who would reach the higher out-of-pocket cap
5 of $5,000. It would eliminate cost-sharing on currently
6 covered preventive services that require coinsurance to
7 encourage greater use of preventive services. And it would
8 reduce coinsurance for outpatient mental health services
9 from 50 percent to 20 percent.
10 Currently, Medicare discriminates against
11 beneficiaries on the basis of their illness by charging
12 higher cost-sharing for outpatient mental health services
13 than other services. Equalizing the coinsurance rates would
14 ensure parity of coverage and improve access to mental
15 health care. Relative to Option C, , lowering the out-of-
16 pocket cap more than double the cost to $9 billion.
17 Option E is essentially the same as Option D but
18 we return to the $5,000 out-of-pocket cap and we add a
19 buydown of outpatient hospital coinsurance to 20 percent of
20 the total payment amount. Currently the coinsurance is
21 closer to 50 percent of the payment. The Commission has
22 previously recommended that the buydown be accelerated to

1 reach 20 percent by 2010.

2 This would reduce the financial burden on
3 beneficiaries who use outpatient services and it would
4 equalize coinsurance across different sites of outpatient
5 care, reducing financial incentives to choose one site over
6 another. This option would also cost about $9 billion
7 because the cost of the outpatient hospital buydown is about
8 the same as reducing the out-of-pocket cap from $5,000 to
9 $3,000.

10 The bottom line is that one could change the cost-
11 sharing structure to improve financial protection, reduce
12 financial barriers to care, and improve efficiency. Some
13 changes could be done in a budget neutral fashion but others
14 would require some additional spending, such as the out-of-
15 pocket cap and the buydown of outpatient hospital
16 coinsurance. In addition, restricting supplemental
17 insurance from providing full first dollar coverage would
18 reduce Medicare spending and produce savings that could be
19 used to help offset the cost of new benefits.

20 So that's what we have for the cost-sharing
21 changes.

22 MR. MULLER: I was wondering, what's $100 of

1 deductible worth in billions? So if it were $500, $600,
2 $700, what's that worth in billions?
3 MR. WINTER: I'm not sure. I can do a quick
4 calculation and get back to you on that.
5 DR. ROWE: What's the denominator? When we're
6 looking at $9 billion what's the denominator?
7 MR. WINTER: $9 billion would be about 4 percent
8 of total costs, 4 percent increase above current cost which
9 are about -- in this model they're about $268 billion. But
10 with the new estimates coming out they would lower it to
11 about $250 billion so the percentages would change.
12 DR. REISCHAUER: This is all quite interesting,
13 but I would love to see another line in here, and I don't
14 know if Jim can produce a line like this. That is, how much
15 of a reduction in a Medigap premium would this represent?
16 By doing that you would take the actuarial value, add the
17 loading factor, multiply by 100 percent of the beneficiaries
18 and come up with a billions of dollar number, because that's
19 really the comparison we should be making here. So that
20 would be one sort of, if we could do it, it would be nice.
21 The second question I'd ask is, why, or did you,
22 in addition, estimate what elimination of the three-pint

1 blood -- I don't know whether you call it the deductible
2 draw or what. It strikes me as one of the more bizarre
3 characteristics of the Medicare program. And why not
4 coinsurance on lab fees?
5 MR. WINTER: Let me first address the question
6 about the premium. We did convert the increase in Medicare
7 costs into what it would be for a per-beneficiary premium.
8 That would range from about, for the B and C about $120 per
9 year versus about $240 per year for Options D and E. But we
10 can look into how that would play out in terms of the
11 Medigap premium. We did not calculate eliminating the
12 deductible on blood. We can look into that.
13 We thought if we considered adding a coinsurance
14 or applying the Part B coinsurance to clinical lab services
15 we could go ahead and model that. We decided not to for
16 this round because the coinsurance amounts, because the cost
17 of the services are so low, the coinsurance would also be
18 very low, and the cost for the lab of billing that
19 beneficiary for that coinsurance might exceed the amount
20 they would be collecting.
21 DR. REISCHAUER: I must be going to the wrong
22 labs.

1 MR. WINTER: That's at the average. But there are
2 certainly services that would cost a lot where the
3 coinsurance would be more. The other factor we considered
4 was that beneficiaries have lower control over the labs that
5 are ordered on their behalf than on physician visits or
6 other services. But we could still go ahead and model that
7 for you.
8 MS. ROSENBLATT: I liked this chart, although I
9 think it would be much better if we added some of the other
10 metrics that have been suggested, like Jack's percent, and
11 Bob's premium impact. I guess I'm confused with the -- I
12 like the idea of the combined deductible, but how do you
13 deal with that in terms of the funding issue between Part A
14 and Part B? When you're saying it increased the premium,
15 how did you deal with that issue?
16 Then I've got another suggestion. Since you're
17 only dealing with a one-year view, my suggestion would be
18 that anywhere you've got dollar amounts like $400, $10 a
19 visit, $25 a day, index them, so that when you're describing
20 it you're describing this as indexed numbers. This is what
21 it would be in 2002 dollars. They would change. But I
22 would like that A versus B question answered.

1 MR. WINTER: Those are both good points and we'll
2 consider the indexing question.
3 We did think about how this would impact Part A
4 versus Part B because obviously doing combined deductible
5 would shift costs from Part B to Part A. Part A would
6 assume more because beneficiaries would pay less of a
7 deductible. We did not model how that would affect the
8 underlying financing because there are ways in which you
9 could conceivably keep Part A whole by having Part B pay
10 some money back into Part A to offset its reduced costs
11 under this combined deductible approach.
12 In terms of the premium amount that I was talking
13 about would reflect how much the beneficiary would have to
14 pay to absorb all of the costs of these changes, regardless
15 of whether the costs were -- they were compensating the Part
16 A trust fund or the Part B trust fund. So the premium
17 doesn't mean that that would be the additional Part B costs
18 alone. It would be absorbing both the Part A and the Part B
19 additional costs.
20 MS. ROSENBLATT: I just think when we lay this out
21 we've got to describe all that. You just reminded me
22 there's another issue connected to that which is the overall

1 out-of-pocket cap also is an A versus B issue. I may not
2 know it, had to deal with it, but it would seem to me that
3 that's a true operational feasibility issue. I think it
4 would be very, very difficult to administer.
5 MR. WINTER: Yes. That's a good point.
6 MR. HACKBARTH: The A versus B issue is clearly an
7 important one from a variety of different perspectives in
8 terms of the financing implications, in terms of committee
9 jurisdiction and a whole lot of different ways.
10 Having said that, one of the things that I liked
11 about Bob's suggestion that we think about this exercise in
12 terms of starting anew is that it allows us to remove
13 ourselves from those constraints. I think we need to
14 acknowledge that they are real world issues, but I would
15 prefer that we not say, this is an immutable constraint that
16 we've got to accept and can't look at options in this way.
17 I think we'd start to tie ourselves in knots.
18 DR. ROSS: Just to follow up on that point. That
19 split is no longer anywhere near as clear as it was even
20 four years ago because in BBA the law transferred a good
21 chunk if home health spending arbitrarily from A to B. We
22 throw around the term of 25 percent Part B spending. It's

1 actually not quite that, it's 25 percent of estimated
2 spending for the aged. It doesn't include the disabled.
3 So on these kinds of numbers I was encouraging
4 staff to sort of round to the nearest $10 billion, so don't
5 look for too much precision here. We're trying to give you
6 the flavor of what you can get, and what kinds of things
7 trade off at, if you will, hand-waving levels of equality.
8 If you want to buy down this, here's the right order of
9 magnitude to pay for it.
10 MR. HACKBARTH: Again, our mission in this report
11 is not to identify the right answer but rather to illustrate
12 possible directions.
13 DR. NEWHOUSE: I don't think what I'm about to say
14 would change the first significant digit on the cost number
15 but we can do this and I think it might be nice to do it,
16 which is to estimate the Medicaid cost, either up or down,
17 including the federal share here. So that implicitly when
18 we say cost I think we want to say cost to the federal
19 budget.
20 DR. REISCHAUER: But if we're saying that, the
21 costs are much lower because Medicaid saves a whole lot.
22 DR. NEWHOUSE: I understand. That was my point.

1 It's not totally clear because some of the cost-sharing
2 stuff will throw back onto Medicaid costs. But I think
3 that's how it will come out, and I think it probably won't
4 change anything or maybe just $1 billion. But somebody
5 could easily raise that issue.
6 DR. ROSS: If you knew how Medicaid offsets were
7 really estimated you wouldn't make that request.
8 DR. NEWHOUSE: Sounds like if anybody should do it
9 we're the people that should do it then.
10 MR. HACKBARTH: Any other questions or comments
11 about this table? If not, Anne?
12 MS. MUTTI: We'll just move on to talk about the
13 next two categories of options. The very next one is
14 expanding the array of services covered by the benefit
15 package. Each of these options has the potential to
16 increase access to care, although benefit design would
17 influence how actually benefitted. In most cases additional
18 benefits will add costs to the program, although the first
19 one we'll discuss, case and disease management, has the
20 potential to reduce program costs.
21 Both case and disease management seek to
22 coordinate care for those who are at risk of needing costly

1 medical services, many of whom are chronically ill. They
2 seek to improve quality and reduce costs by encouraging
3 adoption of evidence-based practices, educating patients on
4 managing their condition, and improving access to support
5 services.

6 They differ in their emphasis and their target
7 population. Case management programs tend to focus on fewer
8 but more diverse patients who are medically and/or socially
9 vulnerable while disease management tend to serve greater
10 patients with more similar clinical needs. Interventions,
11 therefore, tend to be highly structured and emphasize use of
12 standard protocols.

13 While these programs have been successful in the
14 private sector, it is not certain that they can be equally
15 effective as part of fee-for-service Medicare. There was a
16 recent Medicare demonstration on case management and the
17 results of that found that it neither improved quality or
18 reduced costs. CMS is required by law to implement two more
19 demonstrations in this area in fee-for-service Medicare, but
20 these results will not be available for several more years.

21 Among the issues that we identified that would
22 need to be resolved if integrating this benefit in Medicare

1 are how best to align payment incentives among providers so
2 that they have the incentive to select those who would most
3 benefit from this program and offer the most cost effective
4 services.
5 It would also need to be resolved whether it's
6 necessary to include additional benefits in the case
7 management program such as reduced cost-sharing or
8 prescription drug coverage. Although these additional
9 benefits may improve patient compliance with treatment
10 protocols, the cost of them may more than offset the savings
11 achieved from better management and may be replacing
12 existing private resources rather than filling a coverage
13 gap.
14 Another issue is how to overcome objections that
15 some beneficiaries who are not selected to participate in
16 this program may have on the grounds that they are unfairly
17 excluded from receiving additional services, be it
18 educational counseling on how to manage their condition or
19 prescription drug coverage. Another issue is how to manage
20 this type of benefit on a national basis, and as was
21 mentioned yesterday, how to link payment with patient
22 outcomes, if that's another desired goal.

1 The second type of option under this category is
2 preventive services. In the draft that we've given you so
3 far, rather than discussing the merits of covering each new
4 type of service or screening or program, we have focused on
5 improving the process for making these determinations.
6 There's widespread agreement that the current
7 process does not rationally direct limited resources, so the
8 alternatives that talked about are basing Medicare coverage
9 decisions on recommendations by the United States Preventive
10 Task Force, which takes a much more clinical approach to
11 assessing the evidence than is currently done, or changing
12 statute to eliminate the general exclusion on coverage of
13 preventive services not expressly covered by law, and
14 therefore allow consideration for coverage of preventive
15 services to be evaluated in the same manner as all other
16 medical procedures and services for coverage.
17 Next among the options is long term care. Long
18 term care is an obvious and intentional omission from the
19 current benefit package that could be reconsidered. At this
20 point, however, we are noting that there is a problem and
21 identifying a range of potential options. But given the
22 magnitude of resources required to address this problem and

1 the limited available resources we have not fully fleshed
2 out any of our options.
3 But we do recognize that there's a range, a
4 spectrum of options that could be pursued from incremental
5 to more fundamental, from those that rely on private sector
6 solutions to those that rely more on public insurance. An
7 example of incremental would be pursuing programs like the
8 PACE program where Medicare and Medicaid financing can be
9 joined and pooled in improving care management incentives.
10 Another option is to focus on encouraging middle
11 and upper income beneficiaries to purchase long term care
12 insurance. This could be pursued through tax incentives or
13 perhaps more creative measures. For example, you could
14 create a program where beneficiaries could opt to trade in
15 their Part B home health benefit for Medicare coverage of
16 catastrophic long term care costs and beneficiaries would
17 fill in their more immediate long term care needs through
18 private insurance. There's certainly a lot of tradeoffs
19 with any of these proposals and we would briefly mention
20 them.
21 Perhaps the most sweeping change would be to add a
22 long term care benefit to Medicare. As with any new

1 benefit, design would have a big impact on costs and who
2 benefits. And to contain costs, policymakers may opt for a
3 higher deductible design.
4 The last additional benefit we discuss is
5 prescription drugs, and that brings us to the next slide.
6 There are three main approaches that we identified to
7 addressing the most commonly cited limitation of the
8 Medicare benefit package. Policymakers can add a
9 prescription drug benefit to the benefit package, they could
10 pursue alternative policies to expand access to drug
11 coverage, or they could pursue approaches that reduce drug
12 prices faced by beneficiaries, particularly those without
13 insurance coverage.
14 We plan to discuss in somewhat of an abbreviated
15 format some of the design issues that need to be resolved in
16 adding a prescription drug benefit. In June of 2000, MedPAC
17 did a report that went into greater depth on some of the
18 design questions and we plan to refer readers to that rather
19 than reiterating some of those issues.
20 But at a minimum, we certainly hope to make it
21 clear that even if all parties could agree on the exact
22 number that they wanted to devote to prescription drug

1 spending that there are a lot of fundamental issues that
2 need to be resolved underneath that number, including
3 whether the benefit should be voluntary or mandatory,
4 whether the benefit should be subsidized. If so, how? Who
5 should administer the benefit, and how it should be
6 administered. Like what drugs should be covered, what tools
7 should be available to contain the costs. Those are all
8 important issues that would have to be addressed.
9 If for a moment we can flip to the next slide you
10 can get a sense of the rough cost of adding a drug benefit.
11 Again, some of the same caveats about the estimates apply
12 here as with Ariel's numbers. For the purposes of this
13 illustration we have made a number of simplifying
14 assumptions: enrollment is mandatory; management of the
15 benefit is not particularly aggressive; beneficiaries pay 50
16 percent of the premium; and all three options include
17 similar subsidies for low income beneficiaries.
18 The three options differ in the extent of coverage
19 and cost-sharing design and reflect some of the proposals
20 being considered by Congress. The light, sort of striped
21 section, is what Medicare covers, and then the darker is
22 what is left as the beneficiary liability. Package A

1 reflects a design that offers first dollar coverage and
2 would provide tangible benefits to nearly all beneficiaries.
3 Under this design Medicare covers 50 percent of the first
4 $3,000 of drug spending. While all of these estimates
5 assume that improved drug coverage will increase the use of
6 drugs, this design in particular is expected to induce
7 greater use of drugs.
8 Package B is more catastrophic in design with a
9 $500 deductible. Many beneficiaries will not have Medicare
10 pay for any of their drug costs. But for those who have
11 higher drug spending, they will have significant coverage,
12 particularly the more they spend. Between $6,000 and
13 $10,000 Medicare pays 75 percent of their costs, and over
14 $10,000 Medicare pays all of their drug costs.
15 Package C is a mix of the first two approaches.
16 It has a relatively small deductible of $250, covers 50
17 percent of costs between $250 and $3,000, and then leaves
18 beneficiaries bare until $7,500 is spent, after which it
19 covers all of their costs. In a sense, this option provides
20 a little bit for everyone.
21 As you can see from the line down toward the
22 bottom, none of these options come cheap. Monthly premium

1 estimates range from roughly $30 to $50, and the cost to the
2 program is between $15 billion to $24 billion in 2002. In
3 part this high cost is one reason that policymakers are
4 considering two other options or two other types of
5 approaches listed on the previous slide. They could be
6 pursued in tandem with an integrated Medicare benefit, as an
7 interim step, or as an alternative.

8 Just briefly on the other two approaches,
9 alternative policies to expand access to drug coverage
10 include expanding Medicaid eligibility for drug coverage to
11 more low income beneficiaries, federal grants to states to
12 expand their state drug programs, and restructuring the
13 Medigap market so that plans could offer better prescription
14 drug coverage while avoiding the adverse selection problems
15 they experience today.

16 Achieving this objective may be possible if all
17 plans are required to offer the same drug coverage,
18 offsetting the higher cost of this benefit by reducing other
19 coverage. For example, some of the first dollar coverage
20 that has led to some of the inefficiencies we've mentioned
21 earlier.

22 The third approach is to reduce drug prices faced

1 by beneficiaries. This approach is exemplified by drug
2 discount card proposals, policies to reduce the period of
3 exclusivity for brand name drugs, and allowing drugs
4 currently dispensed by prescriptions to be sold over-the-
5 counter.

6 We come to the third category of options by asking
7 the question, is there a better way to allocate current
8 total resources spent on beneficiaries' health care.

9 MR. HACKBARTH: Anne, before we go on to that,
10 would it make sense for us to stop and allow for questions
11 or comments about the preceding material?

12 DR. ROWE: I have a question on the prevention. I
13 think it's really a contribution to highlight this, as we
14 spoke yesterday a little bit, this difference between what
15 Medicare covers in prevention and what the U.S. Task Force
16 recommends.

17 In the material that you wrote though you pointed
18 out a couple areas in which these differences exist, and one
19 is in cholesterol measurements. I guess the U.S. Task Force
20 probably recommends that and Medicare doesn't pay for it.
21 But I'm not sure that the U.S. Task Force recommends it for
22 old people. They may just recommend it in general. I

1 personally don't believe that cholesterol is a very
2 effective predictor of cardiovascular disease in late life
3 so I'm not sure that --
4 I would just clarify somehow that we would look
5 for an objective group to provide recommendations relevant
6 to the Medicare population. Of course, there are 5 million
7 disabled Medicare beneficiaries that are not elderly, but I
8 think we want to make sure that if we're turning to an
9 objective group, that that group should be giving
10 recommendations relevant to our population.
11 The second thing is I'm a little concerned about
12 the medical specialty societies as the group that would be
13 recommending whether certain services would be covered. You
14 include that, and we are, of course, always interested in
15 their opinion, but I'm not sure that I would characterize
16 that necessarily as an objective professional group in all
17 instances. So I'd like to see us not include that group.
18 MS. MUTTI: In terms of that group, you're saying
19 the United States Preventive Task Force?
20 DR. ROWE: No, the specialty societies. I mean
21 the American College of Gynecology and Obstetrics, or the
22 American College of Ophthalmology for, you know, should

1 LASIK surgery be covered, for instance. I just think we
2 need not -- we'll no doubt receive their opinion and we'll
3 take it into consideration, but I'd like us to -- we have
4 this U.S. Task Force. It's very distinguished. It's been a
5 long time. It's got a great track record, why not use it?
6 MS. ROSENBLATT: A comment on the prescription
7 drugs. I thought it was very good that you mentioned
8 options to reduce prices. There have been some recent
9 example of moving stuff to over-the-counter, so that if we
10 could expand on that as an option that would be great.
11 MR. HACKBARTH: Any others?
12 MS. MUTTI: That brings us to the third category.
13 Perhaps the best way to open it up is by asking the
14 question, is there a better way to allocate current total
15 resources spent on beneficiaries' health care? In other
16 words, could some of the inefficiencies we have identified
17 in current spending be eliminated and that spending be
18 redirected in a way so that, on average, beneficiaries would
19 have improve coverage at about the same cost? Certainly,
20 hopefully that coverage would be more assuredly available in
21 the future than the current forms seem to be.
22 One approach to consider is offering a single

1 comprehensive benefit package that would reduce beneficiary
2 demand for supplemental coverage. If incentives worked as
3 planned, savings could be expected as beneficiaries no
4 longer paid for supplemental coverage that include high
5 administrative costs, they had reduced utilization as a
6 result of elimination of first dollar coverage, and some
7 savings may also result from less duplication in coverage.
8 This is a lot of theory here that we're playing
9 with. We're hoping to work with actuarial consultants to
10 model how total resources might be reallocated if a
11 comprehensive benefit package were offered by Medicare. We
12 plan to look at a comprehensive benefit package that would
13 include an out-of-pocket cap, a more rational deductible
14 structure, lower cost-sharing on hospitalization and
15 outpatient procedures, cost-sharing on home health services,
16 and a prescription drug benefit. This is illustrative.
17 We're happy to add a little or take away a little, depending
18 on what your reactions are.
19 Before we have done a thorough analysis it is
20 difficult to assess the outcome, but ARC's -- that's our
21 consultant -- current estimate of changing cost-sharing,
22 similar to what Ariel discussed under Option D, as well as

1 adding a drug benefit, Option B, the most expensive one that
2 I just discussed, would result in a total spending roughly
3 equal to current per capita spending of $11,000 per person.
4 I hesitate to make this comparison until we have fully
5 refined our behavioral effects and done an analysis on out-
6 of-pocket impacts by cohorts, but it does give you an idea
7 of whether the changes that we're talking about, is there
8 the money in the system now or not.

9 There are a multitude of issues to be resolved if
10 pursuing this type of fundamental reform and they are
11 largely interactive. Among them are how comprehensive
12 should the benefit package be. This was raised earlier. In
13 order to redirect money spent on supplemental coverage
14 toward the cost of a single benefit package it is important
15 that the benefit package be sufficient to encourage
16 beneficiaries to forgo their Medigap coverage and for
17 employers to redirect the money spent on retiree coverage to
18 offset the premiums for the comprehensive package.

19 It is unclear how comprehensive the benefit
20 package has to be to induce this response. If it has to be
21 very comprehensive with near first dollar coverage it would
22 likely increase costs systemwide. On the other hand, if it

1 can be somewhat more limited it could net out to be cost
2 neutral systemwide.
3 Then I just wanted to offer a couple of thoughts
4 on potential behavioral responses. It's unclear how
5 employers will respond under this, as I have mentioned.
6 Under the scenario, they may redirect their contribution to
7 offset an increased premium for this new comprehensive
8 benefit package. They would happy to be out of the business
9 of managing health benefits.
10 On the other hand, they could choose to continue
11 to offer additional wraparound because that basic benefit
12 package, even though more comprehensive, may still not be as
13 comprehensive as what they were offering before. Or they
14 may take the opportunity to reduce their role in retiree
15 health insurance, withdrawing a portion or all of their
16 previous commitment.
17 Then in terms of those who have Medigap, some may
18 choose to continue to supplement the comprehensive package.
19 They may value the predictability of their liability, even
20 though we have filled in a lot of the gaps. Then we also
21 need to take into account that if the comprehensive benefit
22 package were offered, Medigap premiums could be expected to

1 decrease, or at least not increase as fast as would have
2 been expected before, although these plans would be forced
3 to spread relatively fixed marketing and admin costs across
4 a smaller benefit which could decrease their value.
5 Another question is whether enrollment should be
6 voluntary or mandatory. Mandatory enrollment solves a lot
7 of problems but creates others. It would reduce the
8 problematic effects of adverse selection, but it would
9 potentially require that some beneficiaries pay more for
10 benefits they already receive through alternative sources.
11 MR. HACKBARTH: Anne, you say enrollment. What
12 are they enrolling in under the restructured package?
13 MS. MUTTI: I was allowing for a scenario where
14 you could have a comprehensive package stand side by side
15 with the current benefit package, or you'd have it totally
16 replace it and then it's therefore mandatory.
17 Voluntary enrollment invites adverse selection
18 problems, which in turn increases costs but avoids forcing
19 people into plans that are not to their individual
20 advantage.
21 Another question is who should administer the
22 benefit package. This comprehensive benefit package could

1 be administered by CMS just as the current fee-for-service
2 Medicare program is administered. On the other hand, it
3 could be offered by private plans which could, for example,
4 compete to attract beneficiaries or be designated regional
5 administrators of the plan.
6 How would the role of government supplemental
7 insurance be affected? Should Medicaid continue to pay for
8 cost-sharing for low income beneficiaries or are there
9 efficiencies to be gained by having Medicare cover these
10 costs? What happens to eligibility for VA benefits that
11 beneficiaries are increasingly relying upon?
12 And the final question that we offer up just in
13 this quick summary, but I think there are many more to
14 discuss in the paper, is how would the comprehensive plan by
15 financed? As we mentioned, ideally the higher costs
16 associated with this comprehensive plan would be offset by
17 savings achieved by eliminating inefficiencies, and as
18 resources are redirected from other premiums now to this
19 single big premium.
20 However, a big question is whether there's any way
21 to avoid creating winners and losers, and whether even
22 though there could be efficiencies to be gained, the winners

1 and losers issue could politically doom such a proposal.

2 MR. HACKBARTH: We know the answer to that

3 question already. We don't have to study that one.

4 MS. ROSENBLATT: First of all, congratulations to

5 staff on being real quick learners just from yesterday.

6 MS. MUTTI: We picked up a few things.

7 MS. ROSENBLATT: Absolutely, you picked up some

8 good points. I was going to mention, Jack, my first comment

9 is a tone issue. Once again, as I mentioned yesterday, the

10 Medicare supplement tone issue -- and I will give you guys a

11 copy of my underlined paragraphs where I found that tone to

12 not be something I liked seeing.

13 The other issue, I was pleased to see that Jim and

14 crew will be looking at the estimates, because there were

15 some statements in there that increasing the basic package,

16 and therefore decreasing the supplement, would actually save

17 overall, and I don't know that those statements are correct.

18 They really need to be checked out.

19 MR. HACKBARTH: Any other comments?

20 DR. NEWHOUSE: I thought we covered in the prior

21 discussion a lot of our answers to the issues on the final

22 slide. It may be better use of our time to ask Anne or

1 others on the staff to say what they wanted more on of these
2 issues.
3 MS. MUTTI: You feel that we actually have
4 concrete answers to each of these questions?
5 DR. NEWHOUSE: For example, I think we said, or at
6 least as I heard the Commission they wanted a comprehensive
7 benefit package. We didn't really talk about the stand-
8 alone versus replace, but I think the general assumption was
9 it would replace. Who administers, I think we kind of know
10 the answer to that one also.
11 MS. MUTTI: But are you comfortable with me
12 talking about pros and cons of different ways to go on each
13 of these questions?
14 DR. NEWHOUSE: Sure.
15 MS. MUTTI: That was what I was planning on doing.
16 Not presenting there's one right answer on each of these.
17 DR. NEWHOUSE: All right, fine.
18 DR. BRAUN: I think there's one group of needs
19 maybe for older folks that are not mentioned in this which
20 are low tech, and that's vision, hearing, and dental, all of
21 which I think grow more important as people get older.
22 MS. MUTTI: So then is everyone comfortable with

1 these three categories and us describing the options in sort
2 of a progressively fundamental reform approach? We'll
3 acknowledge under each of these sections that they could be
4 done cost neutrally, they could cost money, they could save
5 money depending on how design is done. That gets at some of
6 the other issues that we wanted to talk about too, I think.
7 MR. HACKBARTH: Good. Thank you. It's starting
8 to take shape.
9 We are now ahead of schedule; substantially ahead
10 of schedule due to expert leadership of your chairman. So
11 we're switching gears yet again, now taking up our statutory
12 responsibility to review and comment upon the CMS initial
13 projection of the SGR update for 2003.
14 I think last year when we did this we took two
15 bites at the apple. You did a preliminary review and then
16 came back again in April and we talked about. Again, I
17 don't think that's going to be necessary this year so listen
18 attentively. This is the one time we will talk about the
19 SGR update, or the projection of the SGR update.
20 Kevin?
21 DR. HAYES: Part of the reason for spending just
22 one meeting on this would be that the Commission, as you

1 know, has recommended that the Congress replace the SGR
2 system. In the interim here we are required, nonetheless,
3 to review this early estimate from CMS and put a review of
4 it in our June report. So that's what we're here to do.
5 So if we look at our next slide we will see some
6 of the details of CMS's preliminary estimate. I would draw
7 your attention to two numbers here. The first is the bottom
8 line, the update estimate, which is a reduction in payments
9 of 5.7 percent. That comes on the heels of a reduction that
10 occurred this year in 2002 or 5.4 percent.
11 The other important number on this slide has to do
12 with that update adjustment factor that you see there of
13 minus 7 percent. That is the maximum reduction that is
14 permitted under current law. That same thing happened this
15 year for 2002 where we had a maximum reduction of 7 percent.
16 So the question becomes, why is the system continuing to hit
17 these maximums?
18 The next slide tells the story. What you see here
19 is two lines. The orange line shows actual spending for
20 physician services over time and the black line shows the
21 target that is determined by the so-called sustainable
22 growth rate.

1 As you can see here, actual spending started to go
2 up faster than the target in 1999 and that continued through
3 2001. That difference doesn't necessarily mean that actual
4 spending was too high. It just means that actual spending
5 differed from the target. The Commission is on record
6 saying that the target as it is currently determined by the
7 growth in real GDP, gross domestic produce per capita, that
8 that kind of a target is too low. But nonetheless, because
9 there is this difference between actual and target spending
10 there is a requirement for a reduction in payments.
11 MR. HACKBARTH: Last year when we had this
12 conversation we thought the orange line was below the black
13 line for those years, '99, 2000, 2001. In fact for '99 and
14 2000 there were substantial updates in the conversion factor
15 based on the assumption that the orange line was below the
16 black line. So that's where the things -- the picture, the
17 drawing has changed a lot in the last 12 months.
18 DR. HAYES: That's right. Reasons for that are
19 first that the economy has slowed down. We now have a
20 report of a recession, in 2001 anyway, and the Department of
21 Commerce revised its estimates of historical real GDP. That
22 too resulted in lower estimates of growth in GDP. A third

1 factor has to do with a rise in actual spending. CMS failed
2 to consider some billing codes when totally up actual
3 spending in earlier years, '98 through 2000. When they
4 finally discovered the problem last year, put that actual
5 spending back into the calculations, we see the kind of a
6 rise that -- contributes to the rise that you see here.
7 A couple of things to point out about this which
8 shine a light on how the SGR system works. The first thing
9 is that you can see here, if we project out what will happen
10 under this system over time you can see that it's not enough
11 for actual spending to come back down to the target. Actual
12 spending must be driven below the target for a period of
13 time so that the overspending, so to speak, excess spending,
14 whatever you want to call it, that occurred from '99 through
15 2003, that spending needs to be recouped somehow. So the
16 way that this system does that is to drive actual spending
17 below the target for a period of time.
18 You see two areas here. You see one area that's
19 above the target bounded by actual spending above, and then
20 another area to the right which is spending below the
21 target. Eventually those two areas must be equal in order
22 for the system to achieve the balance that it's trying to

1 achieve.

2 MR. MULLER: How does that curve compare to the

3 $40 billion estimate of a freeze that either Glenn or Murray

4 referenced yesterday? Would the orange be tracking the

5 black? Is that a freeze or not?

6 DR. HAYES: No. We'll get in a second to another

7 slide which will show us what this implies in terms of the

8 updates. But the short answer to your question is that, no,

9 this is not a freeze situation.

10 DR. ROSS: Kevin, can I just interrupt for one

11 second? That $40 billion, Kevin just said that those two

12 areas above and below the curve need to be equal. The $40

13 billion would be the difference by which they were not

14 equal. You didn't recoup all of the spending above the

15 target in the earlier years.

16 MR. MULLER: That's what I was asking. So in

17 other words, that gap in some -- if the orange at '03 had

18 tracked the black until '09, that's $40 billion?

19 DR. ROSS: A part of that.

20 DR. HAYES: Let me just make one more point about

21 this slide and then we'll get on to what's going to happen

22 to the updates. What you can see here is a relatively

1 gradual process that's happening and that's because the
2 system is hitting those maximum reductions that I mentioned
3 earlier of minus 7 percent. So the effect of that process,
4 of those limits, is to spread this rebalancing of actual and
5 target payments out over a period of years. Of course, a
6 much sharper reduction occurring in any year would cause
7 this process to move much more rapidly, but then you'd have
8 a sharp, sharp dropoff in payment rates.
9 So what does this mean then? Let's go to the next
10 slide and get at Ralph's question about the $40 billion.
11 This shows what we can anticipate from the SGR system out
12 into the future. What you see here is a series of very
13 steep reductions through 2004, and then another smaller
14 reduction in 2005. If those reductions went away, of
15 course, that's what would cost $40 billion, if you were to
16 just flat-line the update and eliminate those reductions.
17 The total effect of those reductions would be
18 about 17 percent for the period 2002 through 2005. We can
19 contrast that with what MedPAC's proposal implies. Joe
20 correctly pointed out yesterday that we don't know exactly
21 what would happen under MedPAC's proposal because the
22 Congress could step in in any given year and change the

1 update. But what's shown here is an assumption that the
2 updates equal the change in input prices minus an adjustment
3 for productivity growth of 45 --
4 MR. HACKBARTH: In fact it goes beyond, Kevin,
5 doesn't it, the Congress stepping in? Under our proposal we
6 do our payment adequacy analysis, so without changing our
7 recommendation we could say at any given year, we have
8 evidence that the rates are too high or too low, so the
9 right answer for this year is not MEI minus one-half of 1
10 percent.
11 DR. REISCHAUER: Kevin, did we find out why the
12 actuaries thought that our recommendation, which would
13 increase physician payments, would stimulate volume and
14 intensity?
15 DR. HAYES: We asked them that question and the
16 thought is that the presence of a target mechanism has
17 served to dampen growth in the volume of services, and if we
18 were to remove that target mechanism that volume would
19 somehow rise.
20 MS. ROSENBLATT: I just wonder if we're putting a
21 different interpretation on what they're saying, because if
22 you look at the long term projections the SGR mechanism

1 right now has a certain effect on those long term
2 projections; that you don't need to worry about utilization
3 because you've got a mechanism that controls it.
4 DR. ROSS: Controls spending.
5 MS. ROSENBLATT: I'm using the wrong words.
6 You're right.
7 MR. HACKBARTH: What Kevin said is what they said.
8 He's repeating their explanation that they believe that the
9 existence of the mechanism has the effect of reducing
10 volume. Not just controlling spending but reducing volume.
11 DR. HAYES: That's right.
12 MR. HACKBARTH: Now by what logic they arrive at
13 that conclusion, I don't know, but that's what they --
14 DR. NEWHOUSE: That's only if you take it back to
15 the individual physician level and you think there's some
16 relationship between the fee and what the physician does.
17 Then it's whether the fee goes up or whether the fee goes
18 down, they increase volume, it sounds like is the answer.
19 MR. MULLER: Joe, I'd just say, we now know how to
20 define integrated delivery system.
21 MS. ROSENBLATT: I'm sorry, just one thing because
22 I think -- Ariel, maybe you can help me, but I think when

1 that panel actually looked at a study it did show that. I
2 think there was some data.
3 DR. NEWHOUSE: The data showed that when the fee
4 went down, the services went up, and when the fee went up,
5 the services went down, not up. Hence, Bob's question.
6 That was why we missed in the volume offset estimates when
7 we put in the RBRVS -- and Alan will probably remember --
8 and the miss was then in part because all the data we had
9 were pretty much for fee reduction. We didn't have the data
10 on what happened with fees increasing. But in fact several
11 of the fees did increase and that accounted for an error.
12 DR. HAYES: Just one more slide and a few more
13 points here. Returning now to CMS's estimate for 2003 we
14 see no reason to question its accuracy because the reduction
15 that we're looking at for 2003 is kind of sandwiched in
16 between two maximum reductions that would be required under
17 the SGR system. It seems likely that that would occur if
18 the system remains in place.
19 The more important point that we wanted to make in
20 the report was that the system is flawed and the Congress
21 needs to repeal it. Staff propose to include a few
22 paragraphs in the report to the effect and we sent you those

1 before the meeting. If there's any feedback on that
2 material we'd be happy to hear about it.
3 MR. HACKBARTH: Comments? Questions?
4 DR. ROWE: I had seen in the press a number of a
5 17 percent reduction over the next several years in
6 physician payments. I don't know if that was an accurate --
7 that is the sum of this area under --
8 DR. NEWHOUSE: It's the sum of the these --
9 MR. HACKBARTH: If you look at this graph.
10 DR. ROWE: That's 17 percent? Okay.
11 DR. REISCHAUER: Actually the graph, not to be
12 picky here, looks -- we have 5.4, 5.7, then something that
13 looks like 6 and something that looks like about 1.7, which
14 if I compounded it would get me close to 20 my guess is.
15 DR. NEWHOUSE: No, not 20. It goes the other
16 direction.
17 DR. REISCHAUER: Okay, so it's getting smaller.
18 MS. ROSENBLATT: Jack made a real good point
19 yesterday about the impact of this on commercial premiums.
20 I'm just wondering if it's worth making that point.
21 MR. HACKBARTH: Elaborate on that, the impact on
22 commercial premiums?

1 MS. ROSENBLATT: The providers who are going to be
2 seeing a 17 percent decrease over the next few years are
3 going to be looking for revenue elsewhere, which will drive
4 up other parts of the health insurance sector.
5 MR. HACKBARTH: That may or may not be correct.
6 I'd prefer not in this letter to broaden our issues, if you
7 will, on this subject.
8 DR. ROWE: It's not in our best interest to have
9 that included, Alice, because then Congress will say, good,
10 somebody else will pay.
11 DR. NELSON: As a matter of fact, private payers
12 often set their payment based on this, so actually it will
13 have the reverse effect.
14 DR. ROWE: I don't think so.
15 DR. NEWHOUSE: And it presumes that doctors
16 wouldn't start to treat Medicare patients like Medicaid
17 patients.
18 MR. HACKBARTH: Let's stick with what we've got
19 here.
20 We are to our last session. Congratulations,
21 Sally, although I think you've got an alert --
22 DR. KAPLAN: I won the prize this month, twice.

1 MR. HACKBARTH: You've got an alert group. We are
2 now taking up Medicare coverage of cardiac rehab programs
3 and pulmonary rehab services.
4 DR. KAPLAN: Let me start by saying, we're hoping
5 for one bite at this apple, too.
6 BIPA required MedPAC to study Medicare's coverage
7 of cardiac rehab and pulmonary rehab. The results of this
8 study are due to the Congress in June. At the end of my
9 presentation you will have to decide which of our two
10 suggestions you prefer to respond to this mandate or suggest
11 another alternative or other alternatives.
12 The BIPA language is included in your mailing
13 materials. The language asks us to focus mainly on clinical
14 issues, qualifying diagnoses, and level of physician
15 supervision. Medicare has covered cardiac rehab programs
16 for beneficiaries with one of three conditions since 1982.
17 In February 2001, using the process established to make
18 national coverage decisions, CMS began evaluating whether
19 coverage for cardiac rehabilitation should be extended to
20 other diagnoses. CMS planned to make the coverage decision
21 by the end of 2001. We planned to assess whether CMS used
22 due diligence in making that decision because we did not

1 feel that MedPAC was the right organization to make clinical
2 coverage decisions.
3 CMS did not plan on making a national coverage
4 decision about pulmonary rehabilitation. We planned to say
5 that we would review CMS's due diligence when its decision
6 about pulmonary rehabilitation was made.
7 CMS ran into a dilemma in the process of
8 evaluating the evidence that cardiac rehabilitation was
9 efficacious for other condition. Cardiac rehabilitation is
10 paid as incident to physician services. Direct physician
11 supervision is required for providers to be paid. The
12 evidence, however, suggests that a physician's presence may
13 not be necessary, but without physician supervision the
14 provider could not be paid. CMS requested that the Office
15 of Inspector General determine whether providers are in
16 compliance with the required level of supervision, and
17 recommend what CMS should do to solve their dilemma.
18 Now we have a dilemma. CMS will not make a
19 decision before our report is due in June. The two options
20 we came up with for solving our dilemma are on the screen.
21 We could send the Congress a letter delaying our response
22 until CMS makes the decision. As a practical matter, we're

1 not the best entity to make clinical coverage decisions. It
2 is not our area of expertise or comparative advantage.
3 Therefore, staff prefer the second option, that we send a
4 letter basically explaining that we are not the best entity
5 to make coverage decisions.
6 You may have another option. We plan to
7 distribute the letter to you by e-mail after this meeting,
8 so one bite at the apple.
9 MR. HACKBARTH: I think this makes sense but I
10 just want to pursue it a little bit further. We do a lot of
11 things. We've got a broad agenda and we touch on a lot of
12 things that have clinical implications certainly. Before we
13 give a response that might seem to the sponsors of this
14 particular provision, unresponsive, I'd like to clearly
15 understand why this is different than the other things we
16 do. Could you just elaborate on that for me, Sally?
17 DR. KAPLAN: I think a good example is the non-
18 physician providers and coverage, whether Medicare should be
19 paying for them. You're making decisions there basically
20 on, shall we say, education, consistency in the program,
21 that type of thing. Here we're being asked to decide what
22 diagnoses would benefit from cardiac rehabilitation, which

1 requires very extensive review of the clinical literature
2 for which CMS has a process on their national coverage
3 decisions.
4 We also are required to weigh in on the issue of
5 how much supervision physicians should give. That again is
6 another clinical decision. So I just feel that this is
7 different than deciding whether non-physician providers
8 should be covered because in some respects that's going to
9 be an issue of consistency in the program.
10 DR. ROWE: I support the staff's proposal but I
11 think that it should be stated in such a way as not to try
12 to indicate that MedPAC has no clinical expertise or
13 interest.
14 DR. KAPLAN: I wasn't suggesting that, Jack.
15 DR. ROWE: No, but I think that Dr. Loop, a
16 distinguished cardiac surgeon, might have an opinion with
17 respect to cardiac rehabilitation. There are some other
18 doctors or former doctors here as well.
19 So I think what we really have to say is that
20 while many of the issues that we deal with are clinical, and
21 in fact we talk all the time about the clinical needs of the
22 population and whether the benefit package meets those needs

1 -- I wouldn't go into it saying, we're not interested in
2 things clinical. I would just say that with respect to the
3 technical aspects of making this decision there is an
4 apparatus at CMS. We don't have such an apparatus, and it
5 would be duplicative for us to try to develop such an
6 apparatus, and we don't have the staff that are experts in
7 analyzing this kind of question.

8 I just want to make sure that we don't try to walk
9 away from all things clinical, because in fact I think many
10 of the things we talk about, including preventive services,
11 hospice care at the end of life, are very clinically-
12 imbedded discussions.

13 DR. REISCHAUER: Can't we phrase the response in
14 terms of, there's a continuum and this is way down at the
15 end; technical, clinical kind of decision?

16 DR. ROWE: Just like the U.S. Preventive Services
17 Task Force, this would be another example of whether this
18 preventive service should be included or not. I think we
19 would probably say, why don't we ask them, they're set up to
20 answer that question; not us. That would be another example
21 that we would punt.

22 DR. LOOP: If you don't want to say that we don't

1 want to make clinical coverage decisions and you choose the
2 former type letter, you could privately tell CMS there's two
3 publications that can answer their questions. One is
4 Clinical Practice Guidelines, and the other is Guidelines
5 for Cardiac Rehabilitation in Secondary Prevention Programs,
6 Third Edition. The answer is fairly clear in that and they
7 should be able to make a decision soon.
8 DR. KAPLAN: Let me speak in defense of CMS, which
9 isn't a normal role for me. I think they were ready to make
10 the clinical decision. The problem that they ran into was
11 the direct supervision issue. There's no benefit -- you
12 have to have a benefit category to pay for anything under
13 Medicare. There's a benefit category, for instance, for
14 home health care, for hospice care. There is no benefit
15 category for cardiac rehabilitation services. So the only
16 way you can pay for it is incident to physician services,
17 which requires the direct supervision of physicians.
18 So what do they do? Do they ask Congress to
19 create a benefit category, which in essence could mean that
20 everybody in the world could get cardiac rehabilitation
21 services without any restriction? Or I think another choice
22 that they presented to the OIG was, do they develop

1 conditions of participation for all cardiac rehab programs?
2 Then the third option was, do they continue to require the
3 direct physician supervision, although perhaps the clinical
4 evidence suggests that it might not be that necessary?
5 DR. ROWE: I think this is an excellent example of
6 the kind of thing Julian and Jill can include in their
7 chapter when we talk about the changes in the production and
8 the distribution of health care services that are needed by
9 Medicare beneficiaries over time and how that requires some
10 changes in the Medicare program. Here is a specific example
11 of a service that no doubt is very important for
12 beneficiaries but there is this conundrum or dilemma. So I
13 just point this out. I'm sure there are thousands of
14 examples but here's one.
15 MR. HACKBARTH: So I think where we are, Sally, is
16 with the second bullet with somewhat modified language so
17 that it's not overly broad and saying, we don't do things
18 clinical.
19 DR. KAPLAN: Okay, thank you.
20 MR. HACKBARTH: Thank you. Now we're to the
21 public comment period which will last 15 minutes.
22 DR. NEWHOUSE: Or less.

1 DR. ROWE: No more than 15 minutes.

2 MR. HACKBARTH: Hearing none, we are adjourned

3 until our April meeting.

4 [Whereupon, at 12:00 p.m., the meeting was

5 adjourned.]

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