

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
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International Trade Center
1300 Pennsylvania Avenue, N.W.
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Friday, October 10, 2003
9:02 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA D. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Access to care: the beneficiary perspective
 -- Karen Milgate

P R O C E E D I N G S

MR. HACKBARTH: Good morning, Karen.
 Our first item for today is access to care.

Karen?

MS. MILGATE: This session is a session on talking about what we see about the beneficiary perspective on their ability to obtain care in the Medicare program.

Last year, the Commission developed a framework for monitoring access to care and there were three dimensions of that. One is to look at the capacity of the system to deliver care. The second was to look at the ability for beneficiaries to obtain care. And the third was to look at the ability for beneficiaries to obtain the appropriate care. So this provides us some information on the second one, which is the overall ability for beneficiaries to obtain care in the Medicare program.

The information presented here is at a very general and high level because it's intended to be included in the context chapter that Anne Mutti described at last month's session that will go in front of the March report, giving a context for the update recommendations.

There will also be other information on access that will be included in the specific setting chapter, so this is not all you will see on access to different types of care. But today what I'm going to do is present data from the beneficiary perspective, and essentially that's going to mean presenting data from three specific surveys of beneficiaries.

The first slide here is a bit busy but fairly straightforward. This is data presented from the Medicare Current Beneficiary Survey. You see here three types of questions that are asked on that survey. One is whether beneficiaries delayed health care due to costs. Secondly, whether they did not see a doctor if they needed one. And thirdly, if they had trouble getting health care.

You can see from 1991 to 2001, on the top two measures of delayed health care due to cost and did not see a doctor when they needed one, the trends have been good since 1991. And then trouble getting health care has been fairly stable over that period. However, you can see that 8 percent really is -- that in 2001 less than 8 percent of beneficiaries reported any problems, for example.

In 2001, the largest problem reported was in the delay due to cost, and that was 7.9 percent of beneficiaries. Those that said they did not see a doctor when they thought they needed one, 5.5 percent of

beneficiaries. And those that reported trouble getting care in 2001 was 4.3.

The only thing I'd like to point out other than that is that there did seem to be kind of a bottoming out on the top indicator of delayed health care due to cost in 1998 of 7.0 percent. It's inched up slightly since then. None of those differences in each of those years are statistically significant. However, the difference between 7.0 and 7.9 is. So it looks like something we might want to watch over the next coming years.

MS. DePARLE: Karen, did the word health care include pharmaceuticals?

MS. MILGATE: It isn't clear from the question, I mean that's all the question asked. But there are other questions actually on the MCBS that do look at that. I didn't look at those at this point in time in detail, but that's something that could be reported.

MS. DePARLE: I was just wondering if that significantly significant increase could be what we're observing also in the pharmaceutical area?

MS. MILGATE: Yes, it could include that. It certainly is not clear that it excludes that.

MS. BURKE: Although, there is actually a statistic that suggests that there was little difficulty getting prescription medicine which I found odd.

MS. MILGATE: We'll certainly have that discussion at the last slide.

MS. BURKE: I thought it was bizarre.

MS. MILGATE: I can say a few things about that because yes, that was an interesting finding in the CAHPS survey.

This next slide is data from the National Health Interview Survey which is actually not a survey specific to Medicare beneficiaries but it's asked of all persons. So here we're really talking about a subgroup of Medicare beneficiaries, those that are over age 65 and are on Medicare. So this does not include the disabled, for example, and the 65-plus.

Here, the question was whether the person failed to obtain care due to financial barriers in 2002. I only have one year shown here because the last couple of years were fairly stable so there was no real change to report. But it may be interesting to note that there was some stability in the last couple of years.

Again, what you see here is the Medicare beneficiaries, or at least those over 65, seem very satisfied with their ability to get care and report few financial barriers. The national average is 4.7 percent suggest that they have failed to obtain care due to financial barriers. Those 18 to 64, the number is higher at 6.2 percent. But then those over 65 report only 2.5 percent.

DR. REISCHAUER: You don't have the answers for these questions for those who have insurance who are under 65, do you?

MS. MILGATE: Those who have insurance under 65 versus others.

DR. REISCHAUER: You know, to compare two populations that are in a sense similar because they have insurance. Do people with Medicare have greater problems than others or less problems.

MS. MILGATE: Does NHIS have that, Jill? I don't have them here but that is something we can look at, yes.

MS. BURKE: The disabled are included in the 18 to 64s?

MS. MILGATE: Yes, I believe they are. That would be right, the disabled under 65? Yes, because this is just an age break down, so this would include all persons.

MS. BURKE: So the Medicare disabled would be covered in the under-65s?

MS. MILGATE: Yes, so it would include all kinds of coverage under 65.

Interesting enough, I don't have this on here, those under 18 also have a lower level of reporting failure to obtain care. So it seems like for children and for folks over 65 that's the best category. And then in between I think you're seeing all the mix of different types of insurance and lack thereof.

Another question that's asked on the National Health Interview Survey that we reported on last year and wanted to update was whether people have a usual place to go for care in 2002. The difference isn't quite as stark here as the previous question, but you see once again that those over 65 report a higher level of having a usual place to go for care than the national average and than those who are of a closer age. Here I chose the 45-to-64 population to compare to rather than the whole 18-to-64.

MS. BURKE: The usual place to go could be an emergency room.

MS. MILGATE: It could be.

MS. BURKE: So it doesn't qualitatively give us an indication of where they think the usual is.

MS. MILGATE: That's true. The CAHPS data that going to now says a little more about whether they see a doctor or a nurse routinely. But this is general in saying a place to go.

The MCBS also asks it generally and then breaks it down. And you'll see that the rates that are in CAHPS on going to doctors and nurses actually are very similar to the rates of those on the MCBS that say they have a regular doctor. And then there's a difference on top of it that people go to EDs or just don't have one.

DR. REISCHAUER: Not to be jumping all over this about the limitations of this kind of information, but

there's also the problem that something like 12 to 15 percent of Medicare participants don't go to a doctor during a year. And something like a third of the rest of the population doesn't go. It would be hard to have a problem accessing care if you were healthy and never wanted to go.

MS. MILGATE: If you didn't try to go.

DR. REISCHAUER: And so if you were really doing these you would want to do the subset of people who wanted to see a doctor who then had a problem.

MS. MILGATE: Actually, the CAHPS data in some way does that because it asks if you needed to did you on most of the different questions.

DR. REISCHAUER: So is this a subset of that?

MS. MILGATE: No, I'm just getting to that.

DR. REISCHAUER: No, but you could do it.

MS. MILGATE: The next few slides are going to be from that, so that will give us a little more information. But you're right, that's true.

And I think it's important to note that these are questions that individual people are answering. So there is a lot of subjectivity. It's designed into the survey process. It's important information but it's unclear how much to act upon just this information.

The next three slides are data from the CAHPS survey and I want to just stop for a minute to say a couple of words about the CAHPS survey. This is a new tool in our tool kit of access and quality information. It's a survey that was originally designed for commercial health plans and then was altered a bit for Medicare+Choice. And then, in an attempt to make sure that they had information on fee-for-service beneficiaries as well, was again modified somewhat for fee-for-service.

This is one of the first times that I know of that these data that been reported publicly, so I just wanted to say that this is kind of new and interesting information. It provides some of the same types of general information you see on the other surveys but digs in just a tad deeper. So it's kind of an interesting one to take a look at.

CMS is clearly continuing to change and modify. We found some questions we couldn't compare over years and that kind of thing, just to try to get a better handle on what beneficiaries were perceiving when they were answering these questions.

It's a large sample as well. There's 100,000 to 120,000 beneficiaries are surveyed every year. So it's a nice large sample.

What the beneficiaries said in answer to the question that was presented on necessary care, and here's the question just so we understand what they are thinking when they answered it, if you or your doctor believed you needed care, how much of a problem was it to get this care? So it's a little bit better than do you think you got care

and whether you tried or not. We're going to presume they tried, because the doctor or them thought they needed it.

You can see here that for all three years 97 percent or more of beneficiaries reported it was a small or no problem getting their necessary care. And then a very small percentage reported it was a big problem.

That's sort of an overall question, and then they broke it down by urgent care and routine care. So here you see the data for routine care. And again, here's the question. The question is if you needed care right away for illness or injury, how often did you get it as soon as you wanted? So it puts a bit of a timing issue in there. It's not did you get it, it's how often you got as soon as you wanted. So again, a little bit of subjectivity there.

Most beneficiaries in all three years, 92 to 93 percent, said they usually or always got the urgent care that they perceived they wanted or perceived they needed as soon as they wanted.

However, you'll see that is a slight increase in those that said they never got urgent care and also sometimes did not get urgent care as soon as they wanted between 2000 and 2002. So it's a very small increase but it might be something to watch as well, as they keep using the survey.

For routine care, the question here was if you made an appointment for regular or routine care, how often did you get an appointment as soon as you wanted? So again, it has that timing aspect in there. Here we see that between 2000 and 2002, 90 to 92 percent of beneficiaries reported they always or usually got an appointment as soon as they wanted.

Again, you see a slight but statistically significant increase in those that reported never or sometimes. So again, it might be something to watch. This is a larger increase than you see in urgent care, so there may be some beginning of an issue here in the obtaining of routine care.

Another aspect of access the CAHPS survey gives us some information on is continuity of care. It's asked on other surveys as well. Here the data show that 89 percent of beneficiaries have a regular doctor or nurse. So here they don't ask usual place. They say specifically do you have regular doctor or nurse. Almost 80 percent -- and I found the second bullet particular interesting -- of beneficiaries said they have seen their regular doctor for two or more years. And in 2002, 60 percent actually reported seeing the same doctor for over five years. So for a significant portion of beneficiaries, they have a regular doctor or a nurse and they actually have known them for some period of time.

50 percent of beneficiaries have actually been seeing the same provider since before they entered the

Medicare program.

In addition to asking some general questions about access to physicians, they asked about specialists and other types of health services. The services they asked about were specialists, prescription drugs, home health, durable medical equipment, and PT/OT/ST or physical therapy, occupational therapy, and speech therapy.

Clearly the numbers of beneficiaries seeing these different services varies. That doesn't necessarily mean it's unimportant if a small percentage need one service or the other, but I wanted to just put those numbers out there. Those reporting that they sought prescription drugs were 90 percent of beneficiaries. Those reporting they sought care from a specialist were 48 percent. And then durable medical equipment was 16 percent. PT/OT/ST, 13 percent. And those reporting they needed home health in 2002 were 7.9 percent. So there's a difference of how many beneficiaries actually needed the different services.

What you see from the charts that were included in your background materials is that access to all types of these services appear as good. Almost 90 percent report no or a small problem for any service. However, there are some differences and I wanted to highlight a couple of them.

First of all, as Sheila noted before for prescription drugs, 96 percent of beneficiaries reported that they had a small or no problem obtaining prescription drugs. This number is similar to other surveys and also -- is similar to other surveys that asks question in this way. And it's always been hard to interpret is what I've been told in talking to several folks about what does this mean.

You'll see this number when it's asked generally whether beneficiaries have access to prescription drugs. However, other data show a higher level of beneficiaries are actually skipping doses, splitting pills, replacing drugs for other goods that they might otherwise have bought.

The other thing to note is this number is different for different types of beneficiaries. A recent Health Systems Change Survey found actually higher levels for both whites and African-Americans when the question was asked in the last year how often did you delay getting a prescription because of cost. So that's a little different than this question. That survey found that whites were 6.8 percent more likely to say that and 16.4 percent of African-Americans said they were likely to delay at least one prescription due the cost.

So we have some conflicting data here on prescription drugs and it's important to understand this number in the context of those different surveys.

Specialist, 94 percent of beneficiaries said that it was a small or no problem to obtain a specialist. And then the other, I think, interesting number and particularly interesting to the Commission because of update

recommendations was the home health number. And that number was relatively good -- I don't know relatively, it was a fairly high level, 88 to 89 percent of beneficiaries said it was a small or no problem obtaining home health services.

But again we wanted to dig into this number little bit, to say of those who said they had a big problem, did they actually get it eventually? How big was the problem, of course, becomes the question.

So we looked at 2000 data, which was the most recent we had, of how many beneficiaries actually obtained home health services. We looked basically was there a claim for that beneficiary for home health. And found in 2000, 7.5 percent of beneficiaries had a claim for home health.

And concluded from that that most of these beneficiaries are seeming to get home health because those in 2000 on this survey who said they sought home health care were 7.7 percent. So there's a .2, 7.7 minus 7.5, difference between those who actually entered a claim and those who said they sought home health care. It appears, at least from those data, that there may be a reported big problem but they do eventually get home health care.

So it doesn't mean there's not necessarily an access problem, but they are actually obtaining home health care. The barriers aren't so high that they aren't actually getting the care.

In summary, I think what we see from these data, at least, that beneficiaries perceive they have good access to care. Clearly, these are national data so they can obscure important differences for certain types of beneficiaries and perhaps differences across geographic areas. But this gives us a good general overall picture.

DR. WAKEFIELD: Karen, I know these data are the aggregate data and you are providing them, they be included to provide context it sounds like. Because you mentioned that there will be some more precision around breaking these data down when that's relevant in subsequent chapters. So this is sort of a front-end piece?

MS. MILGATE: Exactly. Yes. It's intended to be, as you saw all the different charts that Anne Mutti showed last time of looking at the economy generally, Medicare trust fund, that sort of thing. And in that broad chapter, we say here is broadly what access to care looks like for beneficiaries.

DR. WAKEFIELD: I'm a little bit concerned about what this might wash out in these averages, but I also understand what you're saying, you're trying to do the big picture view. Will there be any place where you might be breaking this down by, for example, difficulty obtaining care, didn't see the doctor, cost a factor? Are you going to try and break that down at all by minority status, income, age, region? Is any of that kind of cut on this data going to be included to give us a little bit more

precision, in terms of what we're looking at?

MS. MILGATE: We hadn't planned on doing it broadly, but there might be particular places like what I just described for explaining prescription drugs, that it might be useful. So I guess that's the eye I would use is where it seems like it would be really useful, if it seems like the averages are not necessarily giving a good enough picture, that we might include some information like that.

DR. WAKEFIELD: There's a level of specificity that a person will never get to because the data won't support it I'm sure, and the sampling is not going to support it, in some ways. So I think the case that I'm thinking about, but we'll never see it here, is I was just doing some visits to travel reservations talking with people about their care for elders among American Indians in my region of the country. And gosh, access is just a huge issue for them and they are Medicare-covered. This is the program that pays for their care.

Now you're not going to get to that level of detail. You're not sampling at the level, and so on. But I'm wondering, somewhere between this, the big picture, and that, which you're not going to get to, can there be any slightly finer cut?

If this goes as it is, it suggests to me that by and large things are good in Medicare-land from a beneficiary perspective. And that may well be true. But I'm concerned about pockets. Again, minority pockets, age, income in particular, especially as we start to see changes in copays and so on, which maybe we're not picking up yet. But if the data will support that, it seems to me that would be a useful thing to do.

MS. MILGATE: Okay.

DR. REISCHAUER: What kind of identifiers are on these people? Is there a rural identifier?

MS. MILGATE: The CAHPS survey, which is really -- well, you could do it --

DR. REISCHAUER: Because 100,000 is certainly big enough to do some cuts like that.

MS. MILGATE: Yes, and we are actually -- let's see, how should I say this?

The CAHPS data, and the analysis they have, are somewhat new. And so I am now talking to both CMS and the contractors they have worked with on the various things that we might be able to do with the data. They are identified at the county level, which means there are a variety of different ways we could cut it, urban/rural. And we're discussing with them the possibility of doing that.

I hate to promise it by the time of the next meeting or the next report, but we are talking to them about being able to look at urban/rural breakdowns and some racial breakdowns.

I would just say that CAHPS, in the future,

provides us a lot of different possibilities that we could build on.

DR. REISCHAUER: I think what Mary's suggesting is just even a paragraph that said preliminary analysis suggests that in rural areas the number might be higher and over time we'll be able to hone in on this.

MS. MILGATE: The other thing that Sarah said that we should point out is that we do have some information by supplemental insurance status. So that's one thing we could include in there.

DR. ROWE: This is the CAHPS fee-for-service survey, right?

MS. MILGATE: Right.

DR. ROWE: Is the a CAHPS M+C survey?

MS. MILGATE: Yes, there is. This was modified from that, essentially.

DR. ROWE: Are those data available now, also?

MS. MILGATE: They are available in a different way and I should have said that. I am planning for us to include some comparison because we do have some comparisons. What they've done with the M+C is create composite rates from a variety of different questions. So we could certainly compare the scores on the composite rates. I found the level of detail included in individual questions in some ways more useful and interesting for fee-for-service, but there is a higher level comparison that could be done.

DR. ROWE: Also, it would be interesting with respect to the race and ethnicity information whether or not there have been any improvement over time, rather than just the differences these disparities seem rather intractable. None of us are going to be surprised by finding another disparity, there's one under every rock and behind every tree. But it would be nice to see if we're making progress, since you now have longitudinal data here.

And I think it would be interesting to compare those changes over time in the M+C versus the other, the fee-for-service.

MS. MILGATE: I don't know if they've broken the M+C by race, but I suppose you could.

DR. ROWE: Yes, they have.

MS. MILGATE: Okay.

DR. ROWE: The data that we get from the CAHPS survey for our beneficiaries includes race and ethnicity.

MS. MILGATE: We will also be able to compare -- I should say this, there is another set of indicators we're running for quality purposes that we will use also probably for some access information, and that's the ACE-PROs that we've talked about before that looked at the provision of clinically necessary services in the ambulatory setting.

And there we are looking at a racial analysis, as well as urban/rural breakdown, that will give us some

information both for quality and access purposes.

DR. ROWE: The interesting question here that everybody is familiar with, but when these disparities were found in the fee-for-service population and people looked at the M+C population, it helped in answering the question of whether or not it was the lack of a primary care physician that was part of the limitation in access. Because in the M+C program, by definition everybody has a primary care physician. In fact, it made no difference. People still had the access problem.

So here they were. They were insured and they had access to primary care physician and still report -- I think the Commonwealth Fund supported some work that was published that show these rather significant reductions in Medicare beneficiaries, in getting beta blockers after a heart attack, getting follow-up after mental health admissions, et cetera.

So I think that one of the values of comparing the datasets is that in one dataset we know there's a primary care physician, and certain other services are provided. In another dataset it isn't. And we can start to answer some questions.

MR. HACKBARTH: Karen, my recollection from my previous life at Harbor Community Health Plan was that we tended to get different results based on the type of survey. For example, an annual member satisfaction survey versus a visit-based survey. So if you asked people to reflect back over the course of the past year consistently we tended to get higher satisfaction levels than if you asked them right after a visit.

I don't know what explains that. It could have to do with at the time of the visit maybe they have a health problem and there's a higher level of anxiety, whereas if you asked them to reflect back over longer periods. But there is some -- biases isn't the right word, but there are some real tendencies depending on the type of measure you're using. It was our experience that you tended to get the most favorable results when you asked these sorts of questions.

The other thing that was striking to me in that experience was how different the response of different population groups would be. Seniors tended to have the highest levels of satisfaction. So even if you asked a senior and a younger population using the exact same facility, controlled as closely as possible, they had the same access, the same physical facilities, that the seniors will always give higher scores to everything.

MS. MILGATE: Just a couple of comments on your second one. The older you get, the better it seems actually, also. On some of the surveys that break down Medicare beneficiaries by age you'll often see high rates of satisfaction for those over 80 than those 65-to-74. And

that's kind of interesting.

MR. HACKBARTH: So in the chapter, when we talk about comparisons across groups, we may want to have something that reflects the fact that there are some.

MS. MILGATE: I would just say one thing though, about the CAHPS survey. It's sort of in between what you describe because they do at least six months. They don't ask the whole year. I don't know if that was by design or it made it more convenient for their administration. So they do do it by six months, but I don't know that that means that there's any difference really.

And then the other thing is that in the future, when they get the hospital CAHPS, because they're also working on a CAHPS that will be okay now you were just in the hospital, tell us about your experience. That might give us some other really interesting information, because it is right after the event occurred.

MR. SMITH: (off microphone) On the visit-based stuff they pick up the Newhouse computation.

MS. MILGATE: The Newhouse computation. I don't know about that phenomenon....

MR. HACKBARTH: I don't think Joe was ever a member.

MS. BURKE: Karen, a terrific job, it's fascinating stuff.

I am, however, as concerned at the point that Mary has raised, and that is that we may leave a false impression of living -- if you'll forgive me -- in Lake Woebegone, that everybody's above average and all is well. When in fact, if you begin to differentiate among the populations, there are significant differences in how they experience treatment and how they access it. And so I think a paragraph that notes that is critical.

But I also wonder, particularly around the issues around income and around race. I mean, there are certainly geographic issues as well that we're well aware of, particularly around certain services. But the generic impact of income on access and the difficulty of gaining access and around race because of the disparities issues, I feel that to the extent that we can, we need to highlight that because a lot of the work that suggests that in fact the low income elderly are incurring greater and greater out-of-pocket costs, larger percentages of their income go towards the purchase and access to care, their difficulties in accessing.

And I would worry about appearing -- I mean, the drug number sort of underscored that sort of disconnect with at least the reality that some people face.

And to the extent that we can do that with a paragraph, suggesting that these are averages in a sense. But to the extent that we have any data that allows us to begin to separate out some of those groups, I think would be

a very important for the overall context of the debate.

MS. MILGATE: I think we can certainly add some more context to the context. But we also have already planned to do some on the cost-sharing levels for different types of beneficiaries. So we'll meld that together more directly with the access piece, as well.

MS. BURKE: Okay, great.

MR. MULLER: On the same theme that Mary and Sheila have raised, looking at the subsets, we probably don't have any language markers and so forth. But when you start looking at -- I think for L.A. County there's like 100 languages or more, something like that, some enormous number. I know that my experience has been that a lot of times people will travel a long way, three or four or five hours, to go to a physician, a nurse, et cetera, who can speak the same language because of the difficulty of communicating a lot of the technical aspects of medical care, having somebody that precisely knows the language as opposed to just generally is very helpful.

So I don't know whether we have any kind of indicators of that, but I think in certain pockets you would find that. That's one theme.

Another one is, to go back to some of the supply questions in some of these pockets, where there are indicators of physicians per thousand or beds per thousands and so forth have any kind of impact on access. Because I think that we're going to find the access problems -- again in these subsets -- that 4 or 5 percent can capture a lot of variety. And while it gets lost in the overall samples with people being okay at the 90 to 92 percent level, I think there's a lot of action in that 7 or 8 percent.

So the question is how to try to identify that how much of that is supply-based, how much is on the classic factors of disparity that Jack and Sheila have mentioned, and so on.

So since we have a large enough sample here to keep looking for what some of the indicators of the difference may be, it's helpful.

MS. MILGATE: Geographically, also.

MR. MULLER: I think there's a lot of suspicion that supply could have an effect, whether the supply numbers of CAHPS have a small enough granularity to -- if it's at a county level, then you really won't notice the difference. It really has to almost be below a county level, and so forth.

MS. BURKE: This goes back to Bob's earlier point. Do we have the capacity to test these questions against people who actually sought out and accessed care? Or does this number include those people who did not, for whom there's no problem because there was no problem.

MS. MILGATE: It depends on the survey. CAHPS I feel like did about as good a job as you can.

MS. BURKE: But just in the way the survey is structured, does it survey --

MS. MILGATE: Who does it survey? It surveys randomly. So it would be those who wouldn't have tried and those who would have. But what they do before every question is say did you seek. So if you didn't seek a doctor or a specialist or you didn't seek prescription drugs or you didn't seek home health, then you're not --

MS. BURKE: You wouldn't get picked up as someone who didn't have a problem?

MS. MILGATE: Right. Necessary care. Did you or your doctor think you needed necessary care and you tried to get it? If you did, then how much of a problem --

MS. BURKE: So hopefully, the way it's structured will sort out those.

MS. MILGATE: On CAHPS, yes.

MS. BURKE: Because I do worry, there are a huge number of people who have no problem.

MS. MILGATE: Right. Now some of the other surveys aren't as granular, but the CAHPS survey I think they did a pretty decent job at that, yes.

MR. FEEZOR: Just to pick up on a comment that Sheila made, that I think our readership interest would be significantly higher if we could have some sub-national numbers and geographic. Not just urban and rural. but if there are some significant regional variations, I think picking that up, if not this time at least subsequently I think would be very helpful to some of our decision makers.

MR. HACKBARTH: My understanding is, at least in the non-Medicare population surveys I've seen, there are significant regional differences in satisfaction.

MS. MILGATE: Possibly.

MR. FEEZOR: If there are.

MS. MILGATE: It's possible to do. I haven't looked at it, so I don't know what it looks like for this.

DR. STOWERS: I was just going to make a comment, it sometimes brings it home, like Sheila was talking the variance in come, that Medicare is only picking up 55 percent of the total health care bill there. So there's a huge part that is out-of-pocket or coinsurance or whatever. So sometimes I think they need to be reminded of that, that Medicare is not picking up the majority of that.

MR. HACKBARTH: Karen, could you go back to the initial graph on difficulty in obtaining care?

MS. MILGATE: Yes. You want me to put it on the screen?

MR. HACKBARTH: To me the big news there is the long-term decline in the percentage saying that they delayed health care due to costs. I was sitting here trying to figure out why, what happened over this time period that resulted in this very significant improvement.

MS. BURKE: I'm still trying to figure out what's

going on in 1991.

DR. NEWHOUSE: A depression was going on, or a recession. The economy is getting better.

MR. HACKBARTH: Good for Medicare people.

DR. REISCHAUER: Another hypothesis, which is relative to private payers, Medicare becomes a better payer during this period.

DR. NEWHOUSE: This is delayed health care due to costs which sounds like it's a beneficiary.

MS. BURKE: But is this a Medicare population?

MS. MILGATE: Yes.

MR. HACKBARTH: So Medicare hospital payments went up but beneficiaries never see that anyhow.

MS. DePARLE: The only policy change was the physician fee schedule during that time really, wasn't it?

DR. NEWHOUSE: [off microphone]

MS. DePARLE: And you had the outpatient coinsurance going up, up, up. So I think beneficiary income went up.

DR. REISCHAUER: This is the period of the huge increase in HMO participation and the overpayments, and so people fall into a kind of insurance that they don't have copays or very low copays.

MS. DePARLE: Not really, though, Bob. That really didn't start occurring until like '95, '96, '97. The peak was 1998.

MS. BURKE: You may be looking at 3 percent in '91, maybe 3 or 4 percent.

MR. HACKBARTH: We could sit here for several hours generating notions. But to me, it sort of gives me pause when I look at these results when there are patterns like this that I can't readily explain, it just sort of puts my antenna up about everything else that comes afterwards.

MS. MILGATE: I can give you a couple of thoughts but this is not based on any serious analysis.

DR. REISCHAUER: [Off microphone.] As opposed to ours.

[Laughter.]

MS. MILGATE: Yes, I know. I thought they would be much more intelligent on this than I. But I'll jump in a bit.

M+C enrollment went up during that time. I don't know about income of the elderly, but that was a fairly significant increase in the -- the economy did pretty well during that time. So I'm wondering if the income of the elderly simply went up.

And then Sarah was saying that the QMB/SLIMB programs went in around that time, for more lower income. So there could have been more on the side of the beneficiaries' ability to cover these costs than having to do with payment. That's the lens that I would suggest might be more directly involved.

DR. NEWHOUSE: So did Medicaid expand in these years?

MS. MILGATE: Yes, not for the elderly, though.

MS. BURKE: [Off microphone.] That's a lot of the kids --

MR. FEEZOR: [Off microphone.] The private sector market at this time in the late '80s and early '90s was --

MS. DePARLE: That's what I was going to say. This is the Clinton health plan period when it was the response of all those health care plans and Congress was really looking at it. It makes you wonder if the beneficiaries were just reflecting some of that insecurity.

And then, as we all know, it disappeared in the early '90s. And maybe that's where Joe's explanation comes.

MS. BURKE: [Off microphone.] But just on the face of it, it seems counterintuitive to me that you delayed care due to cost but you didn't have trouble getting care.

MS. MILGATE: That's what I found interesting, too, Sheila. I said wouldn't it show up in your trouble getting health care. They delayed it but eventually got it, I guess.

MS. BURKE: [Off microphone.] It's a huge bell curve.

DR. REISCHAUER: [Off microphone.] But a delay isn't trouble.

MR. SMITH: [Off microphone.] A delay may mean you didn't seek it, so the answer to the second question is no.

MS. MILGATE: No, you needed it, but delayed it is...

MS. BURKE: [Off microphone.] Delay means you sought and delayed. It didn't mean you didn't ask.

MS. MILGATE: Yes.

DR. ROWE: [Off microphone.] It was delayed, it wasn't cancelled.

DR. REISCHAUER: Could we have a panel of respondents to this at the next meeting?

DR. MILLER: What I was going to suggest is I think it would make sense for us to look at the supplemental trends at the same time for Medigap, M+C, Medicaid coverage, as it relates to the Medicare population and see how those are tracking at the same time.

MS. MILGATE: And we can include some discussion to the extent we feel we learn something that we can conclude on this because it is an interesting question.

MR. HACKBARTH: Any other questions? Dave.

MR. DURENBERGER: All the good questions have been asked, but it may not be a question or thoughtful responses given, as an observation. That is when you read this, you say well everybody's really happy with the Medicare program. And whether it's Lake Woebegone or some other place, people ask can you see a doc? Do you regularly see the doctor?

Can you get to a hospital? Do you get whatever you need? People will say yes.

But if you ask people if they're happy with the system, if their doctor is pleased with the system, if they have to take a relative into the hospital with them, those kind of questions there's a lot of unhappiness in the system.

And if you push on it with the providers of care - - you don't even have to push on it. They will volunteer and they will say the problem is Medicare. And the private payers will say the problem is Medicare.

And I don't mean what they mean is -- they don't mean the adequacy of the benefit structure. They mean the adequacy of the financing. Or the way in which the financing is provided.

So if I have a question it's simply so what? What value does this particular piece of analysis add to our consideration of appropriate financing of the various parts of the health care delivery system? Do you understand my question?

MR. HACKBARTH: I think I do, yes and so much of what we do in Medicare payment policy is designed to insulate the beneficiaries from that. And so it either works to their advantage by reducing out-of-pocket payments, coinsurance, and the like, or they are not exposed to it at all, in the case of say hospital services. But these are clearly not measures of system satisfaction, system health. It's much more narrow than that.

I think one of the themes of all of the comments has been that we want to be careful in how these are presented. We don't want it come across as oh, everything is okay. And I know you appreciate that. And some of the questions and the sensitivities -- wait, wait.

We don't want it to be a simplistic statement that this shows that everything is just fine. There is a lot of good things happening but there are also real issues. So it's a careful balance that needs to be struck.

DR. REISCHAUER: And now the other side of the argument. This is a problem of is the glass half full or 90 percent full or 10 percent empty? The fact of the matter is I think most of us at this table were surprised by these numbers, the degree of satisfaction and the lack of -- well, you aren't because you saw them before.

MS. DePARLE: Beneficiaries like Medicare.

DR. REISCHAUER: But we're looking at this in general. There might be pockets of problems. In general, the thing is working pretty well from the standpoint of access. And we've gone through a decade of turmoil and it doesn't seem like the turmoil has upset the apple cart tremendously. And I don't think we should shy away from the fact that it's working pretty well on this dimension.

Can things be better? Yes, they can. Are there

specific problems we should focus on? Yes. But you don't want to look at something where 92 percent of people were satisfied or they're getting what they want and say oh, god, 7 percent, let's change the system.

DR. NEWHOUSE: I'm with Bob. If the numbers had come out triple in terms of problems we would have said it shows that what we thought was right. I agree with Bob, I think these are somewhat surprising and there's a sort of reluctance to accept that there might be some good news.

MR. DeBUSK: There's a regional issue here that could come into play.

DR. NEWHOUSE: We have to see those data.

MS. BURKE: [Off microphone.] I don't think there's a reluctance to agree --

DR. REISCHAUER: Turn on your microphone when you say that.

MS. BURKE: And I absolutely agree with Bob but I think -- I mean, we would all agree that Medicare has done an extraordinary job. Having said that, I think we do need to be cautious about not masking that there are these pockets.

So I would not suggest that we say oh, whoa, it's only 90-something. But I think we say great, it's 90-something but there are still pockets that we need to be concerned about. But I don't disagree with you at all. It's the little engine that could. The big engine that could.

MR. HACKBARTH: I think that's well put, Sheila? Any other comments? Okay, thank you.

Next up is outpatient PPS and specifically the outlier policy.