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**Medicare Advantage: Whose Cost, Whose Benefit?
Kaiser Family Foundation and Alliance for Health Reform
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ED HOWARD, J.D.: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform. I want to welcome you on behalf of the Alliance. Our chairman, Jay Rockefeller, Susan Collins our cochairman, to a program on the part of medicare that has been growing faster than all the rest called Medicare Advantage. It has made our audience grow faster than almost any topic that we have covered and I want to thank you for your patience, those of you whom we have had to accommodate at the last minute. We did have an overwhelming response to this program. This is a room that doesn't really accommodate as many people as some of the others we use so we are doing the best we can. We appreciate your being as compact in your use of space as possible so that others can enjoy the program as well.

You know, we used to think of Medicare Advantage as kind of a minor part of the story of medicare but one in five beneficiaries is now enrolled through these private plans that make up Medicare Advantage compared to the other 80% whose bills get paid through the traditional medicare fee for service system. At the same time more and more beneficiaries are signing up for a medicare advantage plan, there has been more and more controversy over the size of the payments in the plan, the added benefits that get financed with those payments. There is the question of whether enrolling so many in medicare

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advantage plans is leading to the privatization of medicare and if it is whether that is a good thing or a bad thing, so this promises to be both a timely and a lively discussion today.

Our partner and cosponsor of this briefing, the Kaiser Family Foundation, is one of the countries leading voices in health care and communications. You are going to hear from Diane Rowland, the executive vice president of the Foundation in just a moment. I do want to just touch on a couple of logistic items before we get into the program. A lot of background information as usual in your packets including speaker bios. If we had the power points in time for them to be put into the kits, you got those as well. By the way there is a tool kit that is not in your kits. It is electronic in nature. We put it together at the Alliance. Bill Irwin, with some excellent help from our interns this summer, put together a tool kit of resources on one aspect of medicare advantage that is private fee for service plans. If you haven't seen it, you might want to take a look at it on our website at allhealth.org. As of tomorrow, you will be able to view a webcast of this event on Kaisernetwork.org along with all of the materials that you have before you in hard copy and a transcript will be there within a few days. You have green question cards as usual. You can fill those out at the appropriate time and someone will bring them up to try to get them answered for you. There are also, if you are brave and

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can fight your way through the crowd, microphones that you can use to ask questions in your real voice so we hope to hear from you at that part of the program.

We really do have a terrific group of experts today. Now, one of our speakers, Peter Orszag, will be arriving late so we are going to start with presentations from our other panelists, move to Q&A if Peter is not here, and then hear from him when he arrives and then resume the Q&A until our closing time which, let me remind you, is 2:15 today. I want to thank all of our speakers in advance for their clarity of content as well as their brevity because we have so many folks we need to hear from, we are going to try to be as disciplined as we can in keeping to a relatively brief schedule.

Now, we are going to hear first, as I indicated, from Diane Rowland. She is both the host of this program as the executive vice president of the Kaiser Family Foundation and our first presenter in her capacity as one of the country's most knowledgeable people on both medicare and medicaid. She has been a senior professional staff member on the hill. She has been in key positions in the executive branch and her task today is to give us a brief overview of medicare advantage. Great to have you here on the panel, Diane.

DIANE ROWLAND, SC.D.: Thank you Ed and since I've done this [inaudible] so I will try to keep my opening remarks to

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just a few basic facts so that we can really get into the discussion. It's on.

Well, also turning the mics on is an important part of being part of the panel, too, so I will keep my remarks very brief to live within Ed's time frame. As he said, the medicare advantage plan now covers some 8.5 million medicare beneficiaries out of the total medicare population of 44 million so there are still 35.5 million in the traditional medicare program but this is a major segment now of how medicare beneficiaries get their care through the medicare program.

What is medicare advantage? They are basically health plans offered by private insurers that receive payments from medicare to provide medicare covered benefits to enrollees. As you see from the slide, medicare pays plans a per capita payment for each enrollee. The plans contract with the government a year at a time and beneficiaries sign up during annual enrollment period. These plans have really been an evolving part of the medicare program. In 1982, medicare HMO's were introduced as an option to the program and originally envisioned to save the program money as well as to improve the management of care, their original payment levels were actually pegged at 95% of traditional medicare costs to reflect the fact that they were to coordinate care and achieve savings. In the BBA of 1997, the medicare option to have managed care was

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created as a medicare plus choice program which allowed for some new types of plans to qualify as medicare managed care plans including private fee for service plans and local PPO plans. Finally, in 2003 the MMA renamed the medicare plus choice program to medicare advantage, giving us the name we use today and authorized some additional types of new plans, special needs plans, regional PPO's, and medicare medical savings accounts. To the medicare advantage enrollees, they pay the Part B premium generally but in some cases that has been reduced by the plans. They sometimes pay a supplemental premium for additional benefits and they typically now receive their Part D direct coverage through the plans. What we have seen over time is that with the legislative changes, there has been both a growth and the number of contracts in many of these contracts operate multiple plans under the contracts. In 2007 there were some 602 contracts outstanding. This has doubled since 2004 and you see there has been kind of a little bit of a U-shaped curve here on a number of plans and the participation would reflect some of the issues about whether plans want to participate in the medicare program, their payment levels, and other incentives that are addressed in some of the legislation.

Enrollment, however, while there are a number of plans, is highly concentrated, this slide really shows you that roughly half of all the enrollees in the program are enrolled in four major plans, that is 4.6 million beneficiaries in

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United Health Care, Blue Cross/Blue Shield affiliates, Humana, and Kaiser Permanente, but what we also see is that the majority of the types of plans that people are in today are local HMO's and PPO's accounting for 71% of where the enrollees are but one of the fastest growing components as Ed mentioned is the private fee for service option which accounts for a small share of total medicare advantage enrollment in 2007, only 18%, but the rate of growth far exceeds the rate of growth for HMO's and PPO's from 2006 to 2007. During this period, the private fee for service enrollment more than doubled to 1.6 million enrollees. These plans differ from medicare HMO's and PPO's in that they are not required to establish provider networks, report quality measures, or have CMS review and negotiate bids, so this is a somewhat different animal within the medicare advantage set.

When we look, however, at who uses the medicare advantage plans vs. who remains in traditional medicare, I think it is important to keep in mind the characteristics of the beneficiaries. There is relatively little difference between medicare advantage and traditional medicare in terms of the share of people with income below \$20,000, the lower income population so enrolled. Traditional medicare has a somewhat higher percentage of people in fair or poor health, has a substantially higher share of people who qualify for medicare as a result of their permanent disability so the traditional

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program is serving a larger share of the people with permanent disabilities and the traditional plan continues to serve a larger share of those in rural areas. So, these are some of the issues and complexity of trying to deal with the medicare advantage plans and where they are going and what they should be paid when you need to merge that against the characteristics of beneficiaries being served and the needs of those in both the traditional medicare program as well as medicare advantage, so with that we will open up our discussion to our discussants who each have different perspectives and options to offer you. Thank you.

ED HOWARD, J.D.: Thanks, Diane. We now have four very well informed and savvy panelists to start us off. First, Jeanne Lambrew, who is an associate professor at George Washington University and a senior fellow at the Center for American Progress. She has been senior staff at HHS and at the White House, both OMB and the President's Council of Economic Advisors. She is heading for Austin, Texas this fall and the faculty of University of Texas' OBJ School and I hope we can continue to say that she graces a number of alliances for health reform panels. We would love to have a Texan come back and we are grateful that you could join us on this discussion. Jeanne?

JEANNE LAMBREW, PH.D.: I will have to learn to talk a lot slower to be categorized as a Texan but Ed has told me to

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be fast so I have to talk fast to get through my remarks so you will have to forgive me for that.

Thank you all very much for coming and really spending time at this critical moment to focus on this issue of medicare advantage. I think probably the way to consider this debate is to talk about what I call the givens and the questions. There are certain givens, meaning facts that are hard to refute. MedPack, the medicare payment advisory commission, CVO, the Office of the Actuary, all have concluded that we are paying medicare advantage plans about \$54 billion dollars more than baseline over the next five years. This is taking about two years off of the medicare trust fund in terms of the solvency and all seniors are paying more because of these overpayments to the tune of \$24 per beneficiary per year. It is also a fact that here is a significant variation in these overpayments based on geography. We know that in some areas these overpayments which average about 12% are about 50% more than the cost of providing health care to medicare beneficiaries through traditional medicare. We also know that the benefits they offer vary by plan. These are given facts about the program. We also know that the growth of enrollment in medicare advantage has been increasing rapidly. Since 2003 alone, the growth has gone up by about two-thirds which is a huge rate of growth in the past few years. Should these projections continue, that growth rate is going to triple the

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growth rate in the general part of the program and by the years 2020, 2030, you are going to see about a third of all beneficiaries in medicare advantage should trends continue. So rather than debating some of these facts, I think the questions that we should be discussing today are twofold. First, are these overpayments worth it? Are we getting from medicare's perspective the types of access, cost containment, and quality that the program deserves? Are the program goals, are we getting what we expect through the program and second, is there an alternative? As the old Harry and Louise ads used to say, there must be a better way. Well, we need to ask that question here today. Is there a better way to be spending \$54 billion dollars to achieve both medicare goals and health system goals?

So turning first to this question of is it worth it? One goal of medicare is to ensure that its beneficiaries get quality of care and there is some theory that managed care plans could improve quality. They do have an incentive to try to manage care and keep people healthy because to the extent that they are paid a fixed amount, sick people are more costly so they have an incentive to try to keep those people healthy. They have traditionally, especially in the staff model HMO's, had teams of providers which can help coordinate care which, for people with chronic illness, is quite important. They also have the flexibility to adopt innovative payment systems and benefits without an act of congress, without a regulation,

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which some have argued are advantages to managed care plans, but in practice I am not sure that this potential has been fulfilled. What we know is there is a fair amount of churning which leads HMO's across the board let alone medicare HMO's from really making the kind of critical investments in seniors' health that we would expect. We also know that today we still have healthier enrollees in medicare advantage than in the traditional program so the ability to try to figure out how the quality mechanisms are working in medicare advantage is lower because again we still have kind of a healthier population going into the program, and we also know from broad based studies of HMO's generally in managed care generally that there is really no evidence of improved quality under managed care. A review in *Health Affairs* of 79 different studies has found that quality is roughly comparable in the author's words in kind of traditional plans versus managed care plans. Now this is all about managed care plans I should note, as Diane said in her overview this is not about private fee for service plans, the fastest growing component of medicare advantage in which there is no effort to really improve quality. They are just basically fee for service plans. So, it is not clear to think it is the answer on the "is it worth it on quality?" What about on costs? This program was created about 20-30 years ago under the kind of expectation that they could provide health care to seniors, to people with disabilities, more efficiently

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than the traditional program. The theory is that they can create provider networks and in so doing negotiate lower provider payment rates by saying if you come in, you get this rate; if not, you are excluded from this set of [inaudible]. There also is this theory that the competition between plans and between private plans and medicare will force down prices. It is a competitive theory behind medicare advantage but in practice there are a few realities that have made the promise again less than proceeds, the first is that networks are unpopular. In the early 90's there was a real aggressive attempt to kind of use closed HMO's so people could only see the providers in their network to get care. That proved to be in the late 90's very unpopular so we have seen kind of diminution of these networks which make it harder for them to exact lower prices. Wherever price discounts are obtained are often offset by higher administrative costs, higher marketing costs, kind of all the intermediary costs that are associated with using private plans versus traditional medicare. It may be easier at some level to try to constrain use than price. If the plan has a choice of raising a copay or trying to negotiate a lower price for the hospital, in the absence of any other consumer protections, that may be where they go and most importantly for this debate, right now there is still much overpayment in the system that there is really no pressure for them to compete by lowering prices when they compete by

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offering extra benefits. I think these are important caveats about will these plans offer cost efficient care because I think at the end of the day when we are overpaying them, the answer has to be no.

The third area that people really look to, and this is the area that we know that there are some extra benefits being offered through Medicare Advantage plans that are not being offered in traditional medicare, again it is because there is more money there and it's possible to do it. The theory is why do this through Medicare Advantage through the traditional program? Some would argue that you could use it actual overpayments to align your benefits with quality provisions, coordinated care, certain extra benefits for people with diabetes, etc. In addition, there is this issue of choice. Are you actually giving beneficiaries what they want by having these private plans use competition to set benefits? The truth is I think we know that it is insurers, not beneficiaries, who are really designing these plans, these extra benefits, and those benefits vary based on where these overpayments are. We know that some plans are offering vision and hearing benefits to attract healthier benefits and we know that some plans including some of our HMO's that are high quality are having \$275 dollar co-pays for hospital care per day which at the end of the day is more than what you would pay for in traditional medicare. The ones who do use networks to reduce prices are

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accused of limiting access to providers because people are concerned about going out of network to get the extra care they need and again we are paying a cost for these private plans to be determining what benefits medicare should be covering. Up to 50% of the overpayments of private fee for service according to MedPack may be going to administrative costs. Again, questions about the promise are counterbalanced by also some concerns that we have seen in the past year. We have seen truth in advertising problems where some seniors have been told that medicare is going out of business so you should join these private plans. There has been a crackdown on these practices but they persist. We also know that some sick people have gone into these plans and found that they are actually paying more rather than less, despite the fact that we have overpayments. In your packets, there is testimony that describes how a woman with a hip replacement or a broken hip can find herself paying more in most of the plan choices in her area than she would under traditional medicare and I think this is a concern for some. Lastly, there is this issue that here today, gone tomorrow. Those of us who have lived through medicare advantage have known that they have come and they have gone and for seniors who are leaving retiree health plans, leaving Metagap to join Medicare Advantage is a concern that they won't be there tomorrow.

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Going on to the last slide then, the question becomes given the fact that there are questions about whether or not these medicare advantage plans are fulfilling the goals of the medicare program, the question is can we find other ways to spend \$54 billion dollars? Because these are choices that congress is facing. You can spend it on improving traditional medicare. We know that we need to do more primary care improvements, more care and coordination, more investment in research to figure out what works and what doesn't work. We also know that we could use \$54 billion dollars to provide extra benefits for seniors. We could do this across the board by improving prevention for all seniors, and improving other mental health benefits for all seniors, or target those extra dollars towards low income seniors because we do know that low income seniors need extra protection. We could do this across the board to the policies I think that John Rother will talk about later. We also could as fiscal conservatives say we are overpaying your medicare advantage and we should just stop it. Two years off the trust fund's life is a big deal for all of you have in the past tried to do medicare cost containment and this is something that is an option for congress to be considering, but I also think we need to be thinking outside of medicare because the truth is this is a lot of money. To put this into perspective, just this year the UN/AIDS report argued that we need about \$11 billion dollars a year to prevent AIDS

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globally, no matter who pays. That is a little bit more than what we are paying for these overpayments for medicare advantage today. An electronic medical record could be funded according to most experts with an investment of \$7 to \$10 billion dollars a year, again about the same amount that we are talking about here. Most pointedly, this week in the senate we will be looking at the SCHIP reauthorization bill. We know that we are overpaying these private plans by \$1,000 per beneficiary and the cost per child in medicaid and CHIP is just a little bit less than that. We could be covering about half of all uninsured children with the types of overpayments we are talking about today or the money redirected. The last point I will make is that this is not just necessarily an affirmative set of choices that congress is considering. The failure to act on medicare overpayments, given the trends, is an affirmation this is the way we want to spend our money, because next year there will be more people, five years from now there will be many more people, and the challenges that you all are facing today will only be exacerbated. So, I hope that as we have this debate going forward we do try to separate the facts from the debate and think carefully about the choices before us. Thank you.

ED HOWARD, J.D.: Thank you, Jeanne. Joe Antos is next. Joe is the Wilson Taylor scholar in health care and retirement policy at the American Enterprise Institute. Before

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he came to AEI, he served in a number of top executive branch positions, assistant director at the congressional budget office. He recently coedited a book with Alice Rivlan called *Restoring Fiscal Sanity*. I guess I would describe it, this sounds like a blurb come to think of it, a sobering and provocative look at the fiscal challenges facing America from health care and elsewhere and what to do about it. But you don't get to talk about your book except as you talk about the medicare advantage program.

JOSEPH ANTOS, PH.D.: Where were you when we needed you? That would have been a great quote for the back cover. Thanks, Ed. I am, as most of you know, the medicare advantage payment system is awfully complicated to actually describe that in detail is very similar to reading 50 or 60 pages of medicare modernization act and you know how much fun that is. So, I am going to try to stick with principles if at all possible and there are three important principles that work behind the medicare advantage payment system. Capitation, as opposed to the way traditional medicare operates which provides payments on individual fee for service basis, the idea behind capitation is to provide a bundle payment and have the health plan responsible for all the health care, all the medicare covered health care for their beneficiaries for a period of time. That promotes efficiency but that can also promote other kinds of cost cutting that doesn't necessarily represent efficiency but

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that is an important principle with some refinement. One of those refinements is risk adjustment. You don't want to set it up so that everybody has the same dollar amount subsidy on the top of their heads. Healthier people would be very attractive to health plans under that situation. Sick people would be shunned by health plans so risk adjustment which is intended to take account of the expected use of health services and expect and adjust the payment accordingly so that people who are likely to use more health services get more of a subsidy associated with their enrollment. That kind of a system tied with capitation will do a reasonably good job of allowing people to enter these programs, enter these individual plans without prejudice and then finally just because you have a capitation rate, a capitation system with risk adjustment doesn't necessarily mean that you set the level of payment. You have got to set the level of the payment some way. In the past, the payment level was set very clearly according to the costs, the local costs of traditional fee for service. Now, with the new system, we have the kind of competitive bidding and the system, the idea behind competitive bidding, again the principle seems to me to be a sound one. Rather than setting an arbitrary payment level that may not really reflect the costs, the demands, the supply considerations in each local area, if you let the competing plans bid against each other, then depending on how you put that together you could at least

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in principle see them competing the price down without necessarily competing their quality or access down. Anyway, those are the principles. Now, why is there a problem? There are lots of issues here, certainly one of the first things that people point to is the Balanced Budget Act of 1997. We had a fiscal conservatism back then. Republicans were responsible for that one, and at a time when private health plans and medicare were doing extremely well, congress said well, why don't we capitalize on this by expanding the availability of these plans but of course we need some money so let's cut the payment severely. Well, you can add flexibility through regulation but when you cut payments, businessmen listen and the people who are running the plans, looking at the prospect of the two percentage point, the 2% update every year for the foreseeable future when health costs were rising probably on the order of 8 or 10%, that doesn't sound like a very good business if you are trying to run a health plan so from '99 to 2002 the number of plans fell from 412 to 204 and then with the medicare modernization act, the payment levels changed and from 2004 to 2007 we had exactly the reverse. We went from 234 plans to 424, so money obviously matters but so do the rules of the program and I think an important thing is back in 2003 I think the republicans were concerned that if they didn't provide additional payments that plans wouldn't show up, even with the additional flexibility. After all, they had been

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burnt once. Regional politics, senators from certain rural states wanted to have the benefits of plan choice and they saw to it by installing rural payment floors and later on there were all sorts of payment floors put in the program. That tended to raise the level of payments, flawed bidding system, a real problem there. This is a system that has not really gotten very far away from tying itself to arbitrary benchmarks. There are benchmarks in this program that are set according to the payment floors and other complicated factors but by and large the plans are bidding against an artificially high benchmark and they don't have a great deal of incentive to bid substantially below that and in fact there is a real reason why they don't have that incentive because when they do bid below the benchmark they essentially lose 25% of that reduction below the benchmark. Supposing the benchmark is, I'm going to make up numbers, \$100 a month and suppose somebody bids \$80 dollars a month, they lose \$5 dollars in the sense that \$5 dollars goes back to the treasury. The other \$15 dollars they can use in various ways that are attractive to beneficiaries. They can lower premiums. They can reduce coinsurance or they can increase benefits but the \$5 dollars goes so that tends to push up the bids and then finally incomplete competition, they are bidding against to the extent that they are bidding at all, they are bidding within a very closed system, only among the plans, not with the whole program. Okay, well most of the

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current rhetoric has been focusing on pay force for other important initiatives focusing on money and Willie Sutton was absolutely right, okay you should go where the money is, and so where is the money? Well, it is true that medicare advantage accounts for about 20% of spending but fee for service for the other 80% and the fact is that we should be concerned about both fee for service and medicare advantage when we are talking about spending money and ways to net efficiency. Indeed, it is not necessarily about the money. It probably isn't mostly about the money. It is mostly about are we going to get a medicare program that really works well? And I think we have got a ways to go there. We need better value from the program and that means not just for medicare advantage. We need better value from fee for service. Anybody who argues that fee for service is some kind of an ideal or some kind of a model to hold up against the other plans I think is sadly mistaken. We have seen lots of evidence that fee for service needs a lot of work, as Jeanne said, so all parts of the medicare program need some work, need some help on efficiency and improve the delivery of care. We want innovation and health care delivery. We don't know everything and so if we have experiments out there, real experiments, not demonstration projects that are here today and literally gone tomorrow, but programs that are meant to go on, then we are likely to learn something about how to deliver health care efficiently. We need more sensible

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benefit structures. In that case, I am really talking mostly about traditional medicare. I don't have to remind you just how complicated the program is and just how wrong it is to be subject to limits on the number of days that you might be in the hospital if you were extremely ill. We also need fiscal restraints. We also need options for consumers. If we are going to have fiscal restraint, then we ought to let beneficiaries choose their own poison. If it is going to be tough in the future and it will be, give them some choice.

So, what should we do here? I would argue that the focus on taking money out of the medicare advantage program is really missing the boat. That is a symptom of the problem. It is not the cause. The cause is, at least one of the key causes, is the bidding system and here I think we need to take a lesson from Part D. In Part D, because there was no medicare drug benefit prior to recently, the bidding is set up so that the plans bid against each other rather than against an artificial benchmark. That makes sense. Now, we can get from here to there. The question is how of course, and we need a transition to full competition. I mentioned comparative cost adjustment only because I figure half of you never heard of it. This was Congressman Bill Thomas' attempt to build a bridge to a sustainable competitive medicare program. He knew and a lot of people knew that setting up payments that were too high wasn't sustainable politically or financially and we had to get

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to a situation where there was more serious cost containment and real bidding and real competition. Fee for service and medicare advantage should be on equal footing at all dimensions, not only payment. We need to look carefully at how the regulations work. As you may, as you probably know, the default enrollment is traditional medicare. That is not necessarily the way you have to do it. There are lots of other situations with fee for service having an edge in a regulatory sense that medicare advantage plans don't have. If we are going to talk about equalizing payments we ought to think about equalizing the regulatory burden as well. Both fee for service and medicare advantage ought to be held accountable for improving health care quality, essentially that is a new frontier, and finally and I would emphasize most of all, all of this presupposes that we reform the fee for service program. If we don't do that, we haven't done much.

ED HOWARD, J.D.: Thank you, Joe. You have heard our analysts. Now you are going to hear our stakeholders. I am going to start with John Rother. John, most of you know and probably not primarily from the fact that he graces our panels from time to time, that he is one of the most respected health policy observers in town. He is the policy and strategy director at AARP where he has been since 1984. Before that, he spent some time on the hill running the staff of the Senate

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Aging Committee working for Senator Jacob Javitz and we are pleased to have him on our panel today. John?

JOHN ROTHER: Thank you, Ed. I do not have power points. What I brought instead was a speech by AARP CEO Bill Lovelli, that he delivered last week, and so what I am going to do in the next seven minutes is give you a verbal summary of this in what I would call verbal power point. I am going to make five points so it is easy to keep track and I am going to try to speak to the beneficiary interest in this debate and how I see it as part of a larger context of health reform. I am going to pick up on some of the themes that both Jeanne and Joe spoke to. So, the first point is that the medicare advantage offers in theory some important capabilities of care, coordination, patient counseling, more flexible benefits, and particularly more flexibility in care delivery and these are important things to consider because we are in a dynamic environment in health care and the pace of change is sometimes beyond the capability of the traditional program to stay up with and so I think it is important to start with the recognition that in theory there are some potential positives to medicare advantage but as I think Jeanne outlined very thoroughly, paying a bonus to medicare advantage is really unfair to current beneficiaries, the tax payers, and it does disadvantage the program unless we are getting something important back and I think that the evidence to date does not

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really substantiate that we are getting much back that benefits those that are not enrolled in the plans. So, AARP certainly supports as a general principle, leveling the playing field in terms of reimbursement. I think this is the third bullet then is that this is especially problematic when it comes to private fee for service which doesn't even in theory offer the advantages of other more coordinated types of plans within medicare and I think private fee for service is a prime candidate for more aggressive action in terms of efforts to save money and to keep the program balanced and sustainable so how would I resolve all this? I think the fourth point I want to make is that bringing medicare advantage payments down to the level of traditional medicare could ignore the need to address the health delivery challenges that are in the traditional program and here I will pick up from what Joe just said, we do need to pay more attention to care coordination. We do need to pay more attention to measuring outcomes and holding providers and plans accountable for those and the traditional program reimburses procedures more than it reimburses anything else and that is a shortcoming, so I do think this presents us with an opportunity and here is my big finish. Point #5, how do we reconcile all this? I think we should start with the principle that medicare payments should be neutral as regard to what form of health delivery the beneficiary chooses but I think we could think about ways to

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improve the traditional fee for service program to mimic parts of what medicare advantage offers by including the medical home concept in fee for service and paying physicians or other providers for the care, coordination and counseling part of health care that is becoming increasingly important and the plans at least say they are doing. And, so they are going to be paying both sides of the equation to do that because it is critical to good health outcomes and secondly, and I know this is a longer term goal, I think we ought to be paying not by procedure, not by plan type, but we ought to be paying for who provides good outcomes of care? We can do this in the traditional part of the program by moving over time to paying for episodes of care and then paying a premium for good outcomes and we should pay the plans on the same basis. We should ask them to be accountable for the outcomes of care and that we should reward good outcomes where possible where we can measure it so we are treating both sides evenly and in that spirit we are also promoting very important goals in health reform. So, this is all laid out in the text that you have. I think that it is a road map for how we can get to a place where we retain what is valuable about the medicare advantage program but we add those elements to medicare fee for service so that both sides have the advantages and then we can see who does the job best at promoting health in the older population. Thank you.

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ED HOWARD, J.D.: Thank you John. Our, I guess we can now say, pen ultimate speaker will be Karen Ignagni, who is the president and CEO of America's Health Insurance Plans, AHIP. She, too, has served in a number of senior hill positions in previous incarnations. She was also director of the AFL CIO's Department of Employee Benefits in the early 90's and I want to acknowledge, Karen and I have been talking about this that Karen doesn't always work on medicare advantage. She has actually led AHIP into a position of active advocacy in favor of broadening health insurance coverage generally for all Americans, a subject near and dear to the heart of the alliance for health reform. I want to acknowledge that and we will hear from you about that on another occasion. Today, Karen is going to give us the plan's viewpoint about medicare advantage and we are pleased that you are willing to do that.

KAREN IGNAGNI: Thank you, Ed. Good afternoon, everyone. It is a pleasure to be part of this very well qualified panel. I have given you too much information so I am not necessarily going to talk about every slide but I wanted to give you something that was comprehensive. Also included in the materials that we have supplied is our testimony that we submitted for the house budget committee and on page 3 you can see very specifically for the members of the budget committee, we ran out what the numbers looked like in their areas with respect to enrollment and through the prism did congress get

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what it wanted to achieve after 2003, so I am going to begin with some power point here and I think there are, let's see, I did press, okay thank you very much. I am sorry to be such a ditz about this. Okay so the choices before you are very simple. Are we going to maintain choices in all markets or reduce or eliminate and the particular thing I would like to leave you with, I will be talking about the history in a moment. I think Diane and Jeanne did a very good job of that so I will just say one other thing about it on the value. I am going to let physicians in California who came and spoke to a number of you last week speak for themselves about the value of medicare advantage. The physicians in California representing 59,000 physicians, 150 physician groups came here last week, they had a press briefing, they have a report, and they made a very compelling case about how through medicare advantage they are able to provide better care for their patients. They talked very specifically about the services that they are able to provide, the importance of this way of delivering health care for people with chronic illnesses and they said that this type of care coordination is only possible in medicare advantage. It does not work the same way in the traditional program. We have had a lot of experience with that in the commercial area, trying to create care coordination in a non organized setting and it is very, very challenging to say the least so I will let the docs speak for themselves about that.

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In terms of constituent impact, I know that many of you are hearing from your constituents. We have done a great deal of polling, some of which we have used and some of which we haven't yet, but I think that you will see as you talk to your constituents, hearing from them very specifically about what is at stake as you make these decisions with respect to how you go forward.

Here is a slide that CMS has used and what we did was simply put a couple of markers here. Joe talked about what happened in '97 which was balanced budget act, roughly \$100 billion dollar cut over ten years, and we saw enrollment definitely decline but at that time there was a decision made to adopt a rural floor. This is the first floor decision that was made, legislatively decided, because of the special challenges of bringing medicare advantage into rural areas where providers were highly consolidated and they basically didn't have an interest in doing HMO's or PPO's. The second floor was adopted back in 2000 in the BIPPA legislation, some of you were here, some of you weren't, again it was bipartisanly adopted. MSA, urban floor, this is how it was developed and I will show you a picture so you can see exactly where it was. In MMA, there is a lot of discussion about whether how much was put in to the MMA to help the private plans. We provided the numbers here as most of you know, virtually all the stabilization fund has been already drawn

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down so this is the number that actually went in and there was a tremendous response to that and then of course we saw the development afterwards in terms of enrollment and the chart here on page 3 looks at just these areas but it is replicated across the country so what you see in the next slide, the fact that we did floors prior to MMA and that is an important part of the discussion because it is a prism through which you are going to have to make decisions. Here is a very good chart about what the landscape looked like prior to or beginning in '03 and what we see now in '06 and I think that for the purposes of this discussion for all of you, if you are wondering are you in a rural floor area, an MSA floor, the red is the rural, the MSA floor is the blue, and the other is the white. And, the floor discussions and whether or not we should bring medicare advantage funding down to 100% of fee for service means very specifically each and every one of you who are in districts who are in floor counties, that is a significant cut for your constituents and I want to come back and talk about why that is the case.

In terms of congressional intent, you can look at the benefits, rural to urban. You can look at what the seniors say about the program. I think this is well understood. I would like to spend just a moment here just quickly talking about the vulnerable population. We have now done two studies on the population under 20,000. We have specifically focused on the

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cohort of 10 to 20, because those are the active choosers. Under 10, as most of you know, covered by medicaid in most cases and in some cases that is not the case. We provide all the numbers here. Between 10 and 20, those are the individuals who are active choosers not likely to be covered by medicaid and not likely to have employer coverage. We see a very significant concentration here of African Americans in medicare advantage, 70% have incomes under \$20,000, Hispanics 70% also have incomes under \$20,000, to give you a marker in terms of white Americans it is 45%. So it gives you some benchmarks with respect to the populations being served. I am going to skip over this because you can read it but I do think that this is a cautionary tale about what reducing this program would mean to people who are particularly vulnerable. We are often asked questions about extra benefits and services, who is using them, this is a CMS slide that we noted that they used recently in congressional testimony, 93% of beneficiaries nationwide have access to medicare advantage plans that provide protection against out of pocket costs, \$2,500 dollars or less. The last chart I think brings together quite a lot of information about, and I apologize for the smallness of the type, but I think all of you have it before you, the trustees were very specific about what is driving the problems in the medicare arena. The growth in spending on the physicians' side particularly, the increased utilization, we haven't had a conversation about

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this. Medicare advantage essentially provides a medical home, the care/coordination, that is available and we can do a great deal in terms of addressing disease management. We are doing, we have materially made a difference in terms of the Part D cost reductions. The actuaries over at CMS have stated that the cost of Part D are 25% less because of the ability of medicare advantage to be in the system and drive down the costs. Finally, on the aging of the population, managing disease is going to be the key for handling the baby boomers as they get older and go into public programs and I think the data are very compelling about the efficacy here.

So, in sum, we understand you have to make some very difficult decisions. I hope that as we engage in questions and answers, we will have an opportunity to talk more about why the floors, the two floors, were developed well prior to 2003, why democrats and republicans supported the development of those floors, what we are actually having to pay providers as a percent of fee for service, and what benefits would be at risk if reductions were made. Thanks very much.

ED HOWARD, J.D.: We are going to transition the pointer and the timer from one end of the dais to the other so bear with us while we do that. It is a primitive system but it does have its merits. And I am very happy to have to be able, or I guess to be able to have to do it because we are very pleased to have as our final speaker Peter Orszag who is head,

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since January, of the Congressional Budget Office. If we were to get him to roll up his sleeves, he could show you the scars on both forearms from fending off slings and arrows from both left and right. It goes with the territory. He has been a senior economic advisor to the President. He came to CBO from the Brookings Institution where among other duties he directed the Hamilton Project that aims to promote America's long term prosperity and my economist wife is a great fan of the Hamilton Project. We are very pleased, Peter, that you were able to juggle your schedule to be with us for a significant part of this discussion and we are looking forward to hearing from you.

PETER ORSZAG: Alright well thank you for having me. I am particularly pleased that in the way over here I looked in my packet and I now have a pink shield to defend myself against all those attacks because my testimony is in pink, which I think is a first. In any case, I really like the pink testimony. CBO is increasingly focusing on health, as you all may know we are gradually out of necessity becoming the congressional health office and that is in large part because of this first chart which shows you what will happen over the next 40 years if health care costs for beneficiary continue to grow as rapidly as they did over the past 40 years. Medicare and medicaid will rise from 4-1/2% of the economy today to 20% of the economy by 2050. This is the central long term fiscal challenge facing the United States, period. So, out of

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necessarily, CBO and other analytical bodies are turning increasing attention to what might help bend that curve. I know that today's topic is a modest component of that but nonetheless is a component of it and that has to do with medicare advantage plans which are growing very rapidly. In 2006 alone, 1.5 million beneficiaries were added to medicare advantage plans. Since the beginning of 2007, there have been an additional almost a million beneficiaries added to medicare advantage plans and I note in yellow that private fee for service plans which I will return to in a moment are growing particularly rapidly with more than 700,000 beneficiaries added this year alone which is quite striking. So we are now up to about 8-1/2 million beneficiaries or almost 20% of medicare beneficiaries in this type of plan.

In CBO's baseline, we project continued growth in medicare advantage plans under current policy with particularly marked growth in private fee for service plans. I think you can see from this graph that almost all of the growth is projected in that component. Private fee for service plans, unlike HMO's and PPO's under medicare advantage, tend to have less utilization management and don't have their own network of providers so they are of a different nature than the rest of medicare advantage. We typically think of medicare advantage as a managed care kind of situation. Private fee for service has much less of that sense to it. Because of that growth in

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private fee for service, we estimate that enrollment in medicare advantage plans would rise from current levels to more than 25% of beneficiaries or thereabouts by the end of our ten year budget window and again most of that growth is occurring in private fee for service plans. I would note that if anything, our review is that this projection may underestimate projected growth in private fee for service plans under current law and that in the absence of policy interventions the growth may turn out to be even more significant which is one reason why I have stated that if growth continues at roughly the same rates as we have experienced say this year and last year, the result will be whether it is good or bad, the result will be a fundamental change in the nature of the medicare program because such a large share of beneficiaries will be in privately run plans of one type or another.

Another feature of the medicare advantage system is that as I'm sure has already been covered, the government pays the plans a certain amount. Both CBO and MedPack estimate that those payments from the government are roughly 12% more than the cost of enrolling a beneficiary in the fee for service program on a local basis. That additional 12% is actuarially returned, well to a rougher approximation is returned to beneficiaries in the form of additional benefits or lower premiums which is one of the main motivations for joining the plan in the first place. We have also provided estimates of

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what would happen if you reduced payments to different thresholds relative to local fee for service costs so for example reducing payments to plans to 100% of local fee for service would reduce spending over the next five years by about \$50 billion dollars and over the next ten years by about \$150 billion dollars. Another notable part of this chart is that even if you limited benchmarks to say 150% of local fee for service costs, there is still some cost saving that we estimate and what that tells you is that there are some parts of the country, in particular at that upper threshold in Puerto Rico where the differential between the benchmark and local fee for service cost is more than 50%. There have been other options that have been put forward. For example, limiting benchmarks or payments basically to 100% of local fee for service costs only for private fee for service plans but not for other types of plans, we estimate would reduce spending by about \$15 billion dollars over five years and eliminating the ability of medicare private fee for service plans to have access to medicare providers on the same terms that medicare does, this so called deeming provision, would result in roughly the same amount of savings. All of these options by making the system somewhat less attractive to beneficiaries to enroll in medicare advantage would reduce enrollment in medicare advantage plans, in particular moving towards 100% of local fee for service costs for all plans, all medicare advantage plans, we estimate

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would reduce enrollment in medicare advantage plans by about 50% in 2012. That is about 6 million beneficiaries, so there clearly would be an impact on enrollment in part because you are making the terms of the deal less attractive to potential beneficiaries.

As Karen already mentioned, one of the aspects of, one of the other aspects of moving towards 100% of local fee for service costs is that it would have significant regional variation, roughly speaking the lighter areas of this map would be the ones that would have the most significant reductions embodied in moving to 100% of local fee for service and the darker regions would have smaller reductions that were entailed so there is clearly a regional pattern and I think I will wrap up just by saying that there seems to be several key policy issues to evaluate in the policy choices surrounding medicare advantage. One is whether the additional payments that we are making are worth it in some sense. You can think about medicare advantage as additional benefits and lower premiums being provided to a particular set of beneficiaries and being financed by the rest of the beneficiaries and by workers through the payroll tax and sort of is that a good deal or not and partially that will depend on what sorts of quality outcomes we are getting both under medicare advantage and under local fee for service, under the fee for service program, and I would say we have too little reporting on both fronts and

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especially if we are going to be viewing this, medicare advantage as a sort of an experiment in which we are providing public money to try different things on care coordination, disease management, etc, there is a lot more quality reporting and outcome reporting that could be done in order to see whether the federal government is getting a return on its dollars. Another aspect of that is the distributional one that I believe Karen brought up and there clearly is some distributional pattern to the beneficiaries under the medicare advantage plans. The natural question to ask is whether this is the most efficient or the best way of providing additional benefits and premium support to, premium assistance to that particular class of beneficiaries. There are other ways also, and then I think finally there is a broader set of questions around moving towards a new medicare program or a fee for value or medicare program that has more of an emphasis on value rather than just a fee for service one. You could view part of what is happening with medicare advantage as part of that broader movement but you could also view it from the opposite perspective. I think regardless of what happens to medicare advantage, even if our projections turn out to be underestimates of enrollment, the majority of beneficiaries for the foreseeable future are going to remain in the traditional fee for service program and there is substantial amounts that can be done to improve that system towards moving it towards a

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higher value system which again coming back to my first point is perhaps the central long term fiscal challenge facing the United States. Thank you.

ED HOWARD, J.D.: Thank you very much, Peter. We have a little over a half hour now of time for us to hear from you and give you the chance to question I think a wide variety of very well informed and knowledgeable people. We have some question cards, let me remind you, which you can write on. We have microphones here that you can use. At the microphones we would ask you to identify yourself and be as brief as you can to allow us to cover as many questions as possible. We have our first question.

STU GUTTERMAN: Hi, I am Stu Gutterman of the Commonwealth Fund and I sort of have a two part question. One is Joe, when you talked about reforming the fee for service system, I wanted to refer the panel to a proposal that was made by several of my colleagues that they called Medicare Extra that would sort of put together a more comprehensive version of the medicare fee for service program that seems to me would be a better sort of counterpoint, better competitor, to the private plans in medicare advantage and I wanted to get your reactions to that to the extent you know about it and the second part of the question was as a transition to a better way, what does the panel think of taking some of the money that is currently paid to private plans and restricting the rewards

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to the most efficient private plans, that is rewarding plans that actually bid below the fee for service rates which most HMO's appear to still do in medicare advantage program and also to reward plans with the highest quality, there are HEDIS measures that can be used and I think countless other measures that can be used to do a pay for performance kind of system with medicare advantage that currently doesn't appear to be on the table.

ED HOWARD, J.D.: Okay, do you want to do the Medicare Extra part of that first? Joe and then John?

JOSEPH ANTOS, PH.D.: I think the general idea without getting into specifics of that proposal, the general idea of making traditional medicare a system of greater coordinated care and more sensible benefits and better structure of copayments and financial barriers and lowering the financial barriers where that is appropriate makes an awful lot of sense and would certainly be an important part of trying to make the whole program work, along with a lot of other ideas that people have already said. I wouldn't dismiss however the idea that we still have to have head to head competition, you know, between the sections. They shouldn't be separate sectors. It ought to be one big, probably complicated, program. I like the idea if we can figure out a way to do it of rewarding plans for let's call it appropriate behavior. One concern that I would have is that some plans might bid below fee for service but not

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necessarily meet other performance standards that we might want so I think that would be something to worry about.

JOHN ROTHER: One of the things that I think most people don't realize is just how substandard medicare's benefit is in the traditional program and today on average a medicare beneficiary will spend about a quarter of her total income for out of pocket costs of health care which is extraordinary. So, I certainly would favor anything that would make the medicare program a more adequate, more efficient provider. In terms of the reward for coverage, that is what I spoke to, reward for quality, I don't see the need to reward efficiency since presumably plans already capture some of that but I do think we ought to be paying for a bonus for plans that can demonstrate higher outcomes of care, not just conforming to procedural standards but better results.

KAREN IGNAGNI: Stuart, I am really glad you asked that question. Two responses quickly, one, according to MedPack, 95% in 2006, 95% of plans bid below the benchmark. I wasn't sure, I thought it was 90 but I called back to the office just to make sure we got the right number and I think that Peter has been very thoughtful about this, 25% goes into, back to the treasury as you know and 75% then is available for those additional benefits. In terms of the pay for performance idea, I think that we think, we have been working very, very actively with virtually every physician speciality group in the context

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of an organization called the AQA. It is on the web, AQA Alliance.org, to lay down what should be the measures that physicians feel are fair and transparent for judging quality and that work is proceeding very, very well and the specialty societies have been very focused on making sure it is fair and transparent and there is a lot now that will be laid down as a potential benchmark for pay for performance. Having said that, we would very much like to talk about the context of pay for performance but you asked the question at a time when each and every one of you sitting here will have to make some very, very tough trades in terms of are you going to be using medicare advantage for example to fund the SGR? So, if you want to talk about pay for performance, let's do it across the board. We are having an SGR discussion and I have been really disappointed that some leading medical organizations have been so aggressive about talking about MA cuts because we have an SGR discussion because and for those of you who weren't here, there was a physician cap developed a number of years ago and the cap is a function of price times utilization. We are having the SGR discussion because utilization on the physician side has been soaring so let's have a broad debate about pay for performance, about utilization, about quality. I think you are absolutely right, we would love to sit at the table and work with democrats and republicans to that end.

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STU GUTTERMAN: If I can clarify my question a bit, I wasn't referring to the benchmarks as the benchmark. For efficiency, I was referring to say some other level like 100% of fee for service because clearly there is a lot of money on the table now and as congress decides how to perhaps reallocate that money, if they are reluctant to get rid of it all at once, they could at least target some of those extra payments to the plans that appear to be performing best and most efficiently.

PETER ORSZAG: If I could just add two thoughts, one is the quality measures that we do have for medicare advantage plans suggest very substantial variation in the reported measure so as MedPack and others have reported, very significant variation across the plans. It at least raises the possibility as you highlighted of trying to pay for better performance rather than just paying for whatever performance turns out. The other thing I would suggest or that I would highlight is that in evaluating quality and outcomes, I do think and this came up a little bit in the discussion before, moving towards outcomes and not just process measures is a very important direction for these sorts of things. I would note for example, that there are lots of people who believe that coordinated care will improve outcomes and reduce costs. The evidence that we are getting from the coordinated care demonstration project within medicare is not very promising, especially with regard to costs, so there are lots of things

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that from a process perspective we believe that may not actually turn out to be true.

ED HOWARD, J.D.: Yes, Diane, you have been sorting through the many questions that people have brought up and maybe we can start with that and let me just say while you are getting set that I neglected to ask you as we are moving through this period to pull out those blue evaluation forms and try to fill them out so that we can get your feedback on how well we have been meeting the benchmarks of expectations to make these programs more useful to you. So, go ahead.

DIANE ROWLAND, SC.D.: Oh we have a number of questions here that relate to the private fee for service plans that are part of the MA system and specifically one requesting that we speak to how the increased care coordination many associate with MA applies to private fee for service, another about the rationale for payment to these plans being overpayment when they may not be providing that kind of coordination of care and finally, one about having problems if, in our state, more and more providers are deciding not to accept MA private fee for service plans, in some cases deciding not to accept any MA plans. There is a growing trend and why is this occurring? Start with Karen.

KAREN IGNAGNI: In terms of the private fee for service, we have been talking to a number of you about what can happen in the context of private fee for service and what can't

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with respect to care coordination. On the private fee for service side, you can coordinate care with respect to how you relate to the beneficiaries so what the plans do in private fee for service context is that they do all of the work that we do both in the commercial world as well as the managed care world with respect to using predicted modeling to determine who is most likely to be suffering from asthma, diabetes, congestive heart, etc, contacting those individuals, getting them into a disease management program. What we cannot do is deal with the physician or the hospital, the provider, because we are not allowed to do that in the context of private fee for service but you can do a significant amount on the beneficiary side. We have taken that further and we have made recommendations to the committees that are working on this that they could very specifically and I think this goes to some of what Peter said earlier about care coordination that they could specifically require the kinds of services that we are providing so that people would feel that it is transparent, it is clear, etc. In terms of docs and hospitals not wanting to take the plan, this is the reason that in 1997 a rural floor was developed and private fee for service was authorized. Private fee for service was part of the balanced budget act and the rural floor was part of the balanced budget as well. In that context, it was very, very clear that from the standpoint of the floor that members of congress understood that special provisions are

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routinely made for rural hospitals, in particular under the traditional program, and they were attempting to get some parody with respect to the special challenges of rural areas and rural hospitals in particular. In terms of the private fee for service, that was set up because many of those rural facilities, because they were in monopoly positions had no interest in joining HMO's or participating with HMO's or PPO's so we couldn't negotiate a managed care type arrangement. That is how the private fee for service came about. If you were to require these facilities, these individual providers who have monopoly positions in many of your areas to participate, then that is a whole other story. Members of congress weren't willing to do that, so Diane, that is how it got developed in 1997.

JEANNE LAMBREW, PH.D.: I'll just say that this area is I think the hardest to defend because if you look at it, we know first of all on average we are paying 12% more for medicare advantage, 19% more is the average overpayment for private fee for service. What are they delivering? By definition, not really care coordination because they are private fee for service, not private managed care. By definition, not really lower discounts. They are using medicare payment rates. They are doing this deeming that, Dr. Orszag talked about earlier. They may be providing lower cost sharing for some seniors and people who are beneficiaries.

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There are people with disabilities who get in to them but we are paying them a huge overhead to do so, so the idea that this type of product is offering little value to medicare I think is widely questioned and criticized and I think if you are looking for an answer to the problem of how do you get people in rural areas or underserved areas extra benefits, this is where the ideas like medicare Part D make a lot of sense because you are not sort of basically overpaying by 19% to get these private organizations to just be replacement plans for medicare.

ED HOWARD, J.D.: I'll just add to that, by the way, as I mentioned we do have a tool kit available specifically on private fee for service plans which collects a number of useful pieces including a very good one by Tricia Newman from Kaiser on private fee for service plans and the arguments for and against both the current system and some proposed reforms. Yes, Tony?

TONY HOUSENER: Tony Housener. First I'll make a brief comment. One of the things when I was at CMS that we talked about was trying to compare the HMO's and other plans with the fee for service system on quality of care measures and I certainly would encourage more of that, either on HEDIS measures or some other set of measures. I think it is important to make those comparisons thoroughly. The question I would like to ask, one of the things we have talked about in

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terms of medicare advantage is that a number of them offer extra benefits. I wonder if any attempt has been made to quantify how much those extra benefits are in terms of dollar impact and what are the implications particularly in terms of quality of care of those extra benefits are. If we get those extra benefits, does that have implications for quality of care for instance?

ED HOWARD, J.D.: We will address that to several of the panel, particularly Karen and Joe.

KAREN IGNAGNI: [Inaudible] politically I think that [inaudible], sorry evaluation of extra benefits which I think we don't have good data on at CMS, I'm pretty sure in terms of what is the amount of extra benefits and the nature of that, that are coming in, so we do need to I think have better reporting on that but I would argue that the question is what are you comparing it to, right, because you would have to compare apples to apples a plan with the same level of benefits to figure out if there is actually better quality being offered and I think that is sort of the challenge that we face, which is we are paying and we are not exactly sure what we are paying for, and we are not able to [inaudible] or easily compare the value being offered for these extra subsidies to the traditional program.

DIANE ROWLAND, SC.D.: Ed, can I say something? I think Tony when you were there the very good study that was

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published in JAMA which is the latest data that are available in I think it was 2003 showed just remarkable accomplishment on the private sector side relative to the public program in terms of specific kinds of chronic care and performance and addressing chronic care. I didn't bring those slides but Ed, I would be happy if we just took them down from the JAMA article, I would be happy to do that. I think if you look on the slides that I provided on eight, no cost sharing for cervical cancer, breast cancer, prostate cancer screening, you can see that the orientation of the plans both in rural areas and in urban areas is to get people in early so we can detect disease. It is the most straightforward approach. It works in the commercial arena. It works in the medicare advantage arena and it particularly works for people who have a number of comorbidities and the data shows that. We have been urging CMS to do the comparisons, to take now a new look, a fresh look at '06 or '07 data to compare it to the traditional program, I think will show even better results but the data from 2003 were very, very significant.

PETER ORSZAG: Could I just add two things quickly, one is as you undoubtedly know, private fee for service plans are exempt from many reporting requirements including all the HEDIS measures so that makes comparisons difficult and I would just add that while we continue to monitor the situation, we are not aware of any evidence suggesting any significant quality

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differences between medicare advantage plans and traditional fee for service at this point.

KAREN IGNAGNI: Ed, could I just say that we have suggested that there be specific monitoring. You can't have HEDIS measures that involve physicians in terms of private fee for service because we don't have the ability to relate to physicians and manage the care but there are a number of measures that could be used on the private fee for service coupled with specific requirements on the beneficiary care coordination side that we have proposed that I think would make people feel that they can now have the beginning body of data to assess the claims that have been made and I think we are looking and we are seeing plan data but we clearly need to see more organized studies so we are very much supportive of moving in those directions.

DIANE ROWLAND, SC.D.: This question kind of follows up on the private fee for service issue. It says if the medicare traditional program is a fee for service program, why should there be a private fee for service option? What is the advantage of it?

JOHN ROTHER: For those of you who haven't been around as long as I have, which is probably most of you, the genesis for medicare private fee for service went back to health reform and there was a concern by many right to life groups that there be plan choices available in medicare and actually for everyone

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that did not involve termination of pregnancies and when they proposed this, this was thought to be a very minor idea that would be of appeal to a very small part of the population and no one thought that it should be a major option in medicare as this has come to be. That was purely an accident.

KAREN IGNAGNI: All of the women here want you to clarify the pregnancy with respect to medicare and [inaudible].

JOHN ROTHER: Health reform, we were thinking big.

JEANNE LAMBREW, PH.D.: I think it actually was the end of life sort of issues, not the beginning of life issues that were at stake, but I want to say this goes back to this question of you know when it was created we were back in a period where we were not overpaying plans, sort of roughly close to, probably a little less than what we call level playing field. I think a lot of the questions that we have on the table today wouldn't matter so much if you were paying on an equal basis. You are saying okay if they can compete, great, if they can offer extra quality, maybe or maybe doesn't matter if there is no proof one way or the other that they are offering something extra but we are [inaudible], just like a farm bill, we are over subsidizing these plans. We made a decision that this is the way to go and when you look at those lines without any changes now we will continue in that direction so I think that this is not a question of kind of an equal situation in what is better. There is an overpayment to

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these plans that is causing more of them to come in, more people to enroll in them, and that will happen every year on out to the point where it will be very hard to change the program if we indeed have a significant enrollment in it so I think that the questions about the proof matter more now because of the situation we are in.

KAREN IGNAGNI: But if you have the goal of maintaining choices in all the areas and if you have monopoly systems that refuse to contract with the health plans, if you are going to achieve that goal of maintaining choices in all areas, you have very few choices and that is also why private fee for service was developed because we couldn't negotiate contracts with those hospital systems and physician groups who didn't have an economic incentive to negotiate, so if you want to have all the choices available, which I know a number of you do in your areas, then you really get to a couple of different options, maintain the current system or require participation and you know, we can talk about both.

DIANE ROWLAND, SC.D.: We have some really quick questions here. Jeanne, someone has asked you to define churning leads to little health investments.

JEANNE LAMBREW, PH.D.: Sure. We have a challenge which is if you want to try to really make sure that somebody is healthy over a long period of time, you need to kind of think early on in the disease directory about how do you make

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sure people get the flu vaccines or the right cancer screenings, etc, and to the extent that those sorts of investments in an individual don't have their benefits accruing for another 5, 10, 15, 20 years which can happen in medicare. The plan who gets that senior today may not have the incentive to invest in them now because they won't necessarily have that senior tomorrow. It is the challenge that we have in kind of any sort of insurance system, probably more exaggerated when we talk about the non-elderly folks.

DIANE ROWLAND, SC.D.: Karen, really quickly, are the views of the California physician different from the views of the AMA? That is the questioner's understanding.

KAREN IGNAGNI: Right, first a postscript on Jeanne's point about churning just some data, 90% of individuals did not change plans last year in open enrollment. Second, I think the CMS data about what is being offered and what people are using indicates very clearly that the plans are making a significant investment in the early intervention because it is not only the right thing to do but it is the most efficient and effective thing to do. In terms of the California physicians versus other organizations in the physician community, I do think that there are different physicians, Diane. The California physicians were very, very clear about the value of this program to their patients and spoke very eloquently about that. It is I think disappointing to see that others are not

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reflecting that experience which is the case across the country and particularly in the context of an SGR discussion where we haven't begun as a society to talk about the fact that the physician cap, the budget has been destroyed because of the soaring utilization so as we talk about medicare advantage and the issue of how medicare advantage relates to the medicare program, I think it is very important as we talk about pay for performance and looking across the sectors that we have a debate which there is some parody to it.

DIANE ROWLAND, SC.D.: Okay. This one comes from a hill staffer, having worked on the hill for more than a decade, I remember when health plans would come saying they could provide better care for less money than traditional medicare. Now plans come in and say they provide more services, some say they do it better, although that is certainly not the case with all plans but there is no talk of savings or efficiency like there was a decade ago. What happened to the savings and efficiencies plans said they would bring to medicare? Why should we pay extra money so plans can provide extra benefits to coerce seniors into them which is the real reason that plans have grown. [Laughter] That goes to you, Karen.

KAREN IGNAGNI: I assume.

ED HOWARD, J.D.: Don't you agree? [Laughter]

KAREN IGNAGNI: No exactly. I think that the answer to this question really one needs to look very closely at the

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data. We have begun to look very clearly at data from around the country about how much health plans are paying doctors and hospitals as a percent of fee for service. In many parts of the country as will not surprise anyone sitting here, we are forced to pay in some cases 150%, 175%, 200% in some academic health centers, etc, so you have that issue with respect to the cost of the care, number one. Number two, when the floors were put into place and by the way the MedPack analysis of 112, if you take out the legislative floors you get to 105 and the floors were put in place both in '97 to reflect the challenges that were unique to rural areas, very similar to the sort of packages that get developed every year roughly for rural markets to deal with their special needs. This year isn't any different. There will be a package before all of you for the special needs in rural areas. It was an attempt to address those specific challenges. Back in 2000, in BIPA, when the second floor went into place, people, legislators from Oregon, from Washington State, from New Mexico, from Upstate New York, from lots of parts of Pennsylvania and Ohio, were concerned about the payment levels and the need for more and that is how those payment levels developed so I think that one of the things that we are seeing is that we are doing a very good job of getting people into care coordination and disease management and we, too, want to have a discussion with each and every one of you about a set of data that would give you more assurances

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for all of that. I think that makes sense. It would be even more transparent. We need to move to pay for performance and we would like to participate in those kinds of discussions, so I think Diane there has been a lot of positive development. We think we can do even more and we think the point about developing a data system is a very sensible one, a very thoughtful one, so we can really look very carefully at performance.

JEANNE LAMBREW, PH.D.: Just a quick response which is I think there are some and the question, and obviously the person who asks it, raises two very, there are two different answers to that question. One is if you believe that indeed there is no value offered for these products, some people would argue get rid of them. Why have a medicare advantage program at all if they are not offering anything? I think there are a lot of other people who would argue why not try to save that they can participate on equal playing field and if indeed they can, if the dispute is can they offer better quality, better access, lower costs, let them try, and I think that, when I was in the Clinton administration, we supported having medicare advantage plans in a competitive defined benefit proposal. I think a lot of the ideas that Joe talked about, I think they are something I agree with, but there is not a level playing field right now. It is kind of like the debate is over. We decided we think they are doing a good job so we are paying

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them more and I think that some of us think we ought to revisit that but I think we ought to separate out the two questions. There would still be a vibrant role for medicare advantage in a level playing field if indeed they are delivering the types of quality and benefits that Karen was talking about and I hope that we have a chance to test that.

MALE SPEAKER: Hi, my name is [inaudible], I am a joint degree student at [inaudible] med school, I just had a quick question in terms of my limited readings on sort of the whole disease management and care coordination. I understand that has been done in both private as well as in some medicaid programs, and I know for example in North Carolina medicaid, which serves a lot of rural patients, there has been a move towards using administrative service organizations and so whether using strictly private or public system to deliver such care, I was just wondering has such a system which seems to be cheaper than reimbursing anywhere from 12% higher to 50% higher than considering the medicare.

KAREN IGNAGNI: I just don't want to take too much time away from the rest but I'm happy to tell you what we know about the commercial [interposing].

DIANE ROWLAND, SC.D.: Karen, lots of these questions are directed towards you.

KAREN IGNAGNI: I know, I'm sorry. I thought I had a hunch. Okay, what we are seeing in the commercial arena is and

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certainly medicare advantage, generally if you look at the numbers that were put up in terms of most people being in local HMO's or PPO's, a number of our plans started out in disease management by contracting out to a number of specialty organizations, for diabetes, for congestive heart, for asthma, etc, increasingly they have been bringing those services back in and integrating them with the idea that there are so many individuals who have congestive heart and diabetes or congestive heart and asthma, etc, so there are a number of different models. I can't yet say one works better than the other but the focus of the plans has been to integrate more actively as opposed to necessarily looking at a particular condition. We realize the advantage of coordinating across the scope of different disease stages and disease states and so that, you will see more of that I think both in the medicare advantage as well as in the commercial sector.

PETER ORSZAG: I would just add that obviously this is something that CBO is very interested in to the extent that coordinated care and disease management and other programs could help to reduce costs. Perhaps the most compelling evidence to date is through this coordinated care demonstration program that has been conducted in medicare itself and the early results there I think should give significant applause to anyone suggesting that care coordination is going to significantly reduce costs. It may well improve quality but

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again the results from that demonstration project thus far are not at all consistent with the view that there would be a significant reduction in cost that results and that is fairly consistent with other evidence that CBO has reviewed more broadly about disease management while for particular conditions and in particular settings there may be net cost reductions that result on a broad basis, we unfortunately have not yet been able to find evidence of significant cost reductions as opposed to improvements in quality that results and we would welcome additional evidence of such cost reductions because I like to say as CBO director it is so rare that I am able to say that anything helps to save money that I am always desperate for anything that actually would so please provide the data to us.

ED HOWARD, J.D.: Okay we have about five minutes.

Trish?

TRISH NEMORE: Trish Nemore from the Center for Medicare Advocacy, I think it was Jeanne in her earlier comments setting out some of the things that we might be thinking about here who mentioned some more across the board protections for low income beneficiaries and Karen has talked about how plans disproportionately provide extra benefits to the low income population, but looking at her slide if you look at the entire population under 20,000, there are actually more who are getting extra benefits through medicaid than for

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medicare advantage plans, but I have a couple of questions and points. One is Karen, what can you tell, I mean we know that there are beneficiaries who are dually eligible who are enrolled in medicare advantage plans, how many of those plans have as a requirement for their provider networks that they are also medicaid providers so that people can get the wrap around services, and how many plans are coordinating with state agencies to actually get the copayments made that states are required to pay for low income beneficiaries? And my third I guess sort of point and maybe question is we would suggest that a better use of these dollars is to expand the medicare savings programs across the board so instead of to the extent that you are getting something better in a medicare advantage plan and we have heard that might be questionable to the extent that is even true, shouldn't it really be spread across for all low income medicare beneficiaries and improving those programs called the medicare savings programs?

KAREN IGNAGNI: I think that in terms of the slide, we are, to say it very, very directly, we have never endeavored to not be clear that we have been talking about the particularly the 10 to 20 cohort because that is the cohort that largely doesn't have medicaid and doesn't have employer coverage. That is why we provided all the data for our report. This is the second time we have done our report. The first report was done by Ken Thorpe for Blue Cross/Blue Shield several years ago,

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then we began to use the current population survey and do our own reports and have never endeavored to do anything but present all the data and all of our reports have been focused on in particular that cohort but we have provided it all so people could see the distribution. In terms of the wrap around and the reach back to state agencies, we clearly realized within the last two years that our plans had to do much more with respect to wrap around for the duals, post MMA, and we think that we have made great strides but there is more to do so as you talk with representatives from our different plans around the country, you will find that they are developing a whole range of best practices to reach out to make sure that they are looking at every and all possible way to make sure that people are getting what they should be getting and we think we still have more to do in that arena but we are working on it very, very actively. In fact, at AHIP we have spent a great deal of time focusing on this whole concept of best practices and how we can have learning among the plans to make sure that we are doing this as effectively as possible. In terms of taking the funds and trying to figure out are you getting the best bang for the buck if you will and I was really struck by what, Jeanne framed the question I think very, very well. I don't agree necessarily where here conclusion was going and I don't agree because if you were to think about reducing the plans to 100% of fee for service, not only would

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that mean I think some significant reductions in benefits from populations that you all care about but I think that you would have to rack that up with a discussion of requiring doctors and hospitals to give us 100% and that is a discussion that I think very, very congressional offices want to have but that is effectively what you would have to do and so then we are back to why do the floors come in to play? How are we using the funding? And what are we doing? And our message is we welcome more by way of data requirements. We have suggested some ourselves. We welcome requirements in terms of care coordination. We are doing that and we would be delighted to engage in more dialog about the best practices with respect to state agencies.

JEANNE LAMBREW, PH.D.: Just a quick comment. Back to the issue of the low income seniors which I think some of us have also been spending time focusing on SCHIP reauthorization and questions of targeting [inaudible] and use of resources is quite at the top of our minds and when you think about it indeed you can debate about how many of these low income medicare advantage people are in there or not but fully 50% of medicare advantage enrollees have income above \$20,000 dollars I think is in the charts. For all those seniors, they are getting on average \$1,000 more so it is not a very targeted policy. We are paying \$1,000 more in medicare advantage for half of all these enrollees, many of whom have this, are in

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these higher income brackets. If you were to take those same resources and target it, we could do things like eliminate or loosen the asset test for the low income drug subsidies, make the QI program permanent, try to simplify both the medicaid and the low income drug subsidy program so we could actually improve participation because sadly many of our low income seniors are eligible for these programs and people with disabilities are not enrolled and that I think is a clearly important policy priority that we could probably do better with, with more resources.

ED HOWARD, J.D.: We have come to the end of our time. There is one question we wanted to squeeze in and if you will bear with us, Diane will get it to you.

DIANE ROWLAND, SC.D.: This question is just that most of the discussion has focused on seniors. There are people with disabilities on the medicare program, they are not heavily enrolled in these plans and isn't it better to improve services for everyone that would bring them along? Aren't these plans cherry picking against the disabled?

The question was, are we seeing that people with disabilities are not getting an equal playing field in the medicare advantage [inaudible]?

KAREN IGNAGNI: Actually one of the things that I think you will see in the open enrollment season here is and I think we haven't talked about this Diane but it bears on this

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question, plans have already bid I think as you know to CMS for 2008 and open enrollment is scheduled in November in 2007 for the 2008 season. I think that as you think about this, more and more people I think are thinking about a four year rather than five year window here because unless you are going to be suspending open enrollment, so that is something we haven't really talked about but it is very, very important from an administrative perspective in terms of how the program works and there hasn't been much conversation devoted to it in the context of hearings, etc. In terms of the disabled, I think you will see an open enrollment, assuming that it goes forward, that plans are reaching out very specifically in special needs areas to the disabled population to demonstrate the services that they have for them to take a look at with respect to their particular conditions and I have been really excited about what I have seen in the development stage from the plans in terms of using the capacities that they have developed on the commercial side now to move them into the medicare area so I think you will hear a lot from our plans about the disabled population. I am really excited about what I think you are going to see in an open enrollment situation.

ED HOWARD, J.D.: Okay, I think that is the last word. I want to thank you all for being patient, adjusting to our slightly different time schedule. Thanks again to the Kaiser Family Foundation for its support and very active participation

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in the program and please join me in thanking our panel for I think a constructive, coherent, civil discussion of a very interesting and controversial topic. [Applause] Please, as you go out, show us you are a great juggler by filling this out as you walk.

[END RECORDING]