MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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8:33 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
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ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA item:
Assessing the Medicare benefit package
Mae Thamer

MS. THAMER: Good morning. For the rest of the Commission meeting this morning we'd like to give you some background and perspectives on the Medicare benefit package.

To put the benefit package in context let me just very quickly review the original goals of the Medicare program. The first one being to limit the financial liability of older Americans. The second one being to provide health insurance coverage that's similar to that purchased by the working population, thereby removing barriers to obtaining health care.

So why examine the Medicare benefit package? First of all, the needs of the elderly may be very different today than they were in 1965. For instance, there have been changes in life expectancy --

MS. BURKE: I'm sorry, can we go back to the previous slide for just one second? This is, I'm sure, semantics, but the point is to the original goals behind the Medicare program. Even I wasn't there when they did it but --

[Laughter.]

MS. BURKE: Just let me underscore that at the outset. I was in about the fifth grade. But having said that, in fact point three, I think -- I should ask Dr. Newhouse; he'll know. I think that it was less a question of literally just removing the barriers. It was really mainstreaming in terms then. It was really to not only remove barriers, but essentially to place them on the same playing as essentially everybody else.

MS. THAMER: Yes.

MS. BURKE: I think there's a difference -- a subtle one, but an important one, because there is a critical difference between that and what we did with Medicaid, in terms of making sure that they essentially were going into the same systems of care as the rest of the general population. So we may want to note that.

MS. THAMER: Yes, you're absolutely right. That's an excellent point.

So why examine the Medicare benefit package today? First of all, the needs of the elderly may be different today than they were in '65. For instance, among other changes there's been changes in life expectancy, there's been major technological innovations, and there's been a major increase in chronic diseases among the elderly.

Secondly, the clinical care and outcomes may be adversely influenced by the current benefit design. For example, the lack of outpatient prescription drug benefit may affect both clinical decisionmaking and/or beneficiary behavior.

Finally, beneficiaries are at risk for high out-of-pocket cost which may not necessarily be borne equally by all beneficiaries.

DR. ROWE: Did you say that there was an increase in chronic diseases in the elderly?

MS. THAMER: Yes.

DR. ROWE: But I understanding is that disability rates amongst the elderly are actually declining substantially.

MS. THAMER: Yes, they are. They have declined.

DR. ROWE: I also believe that the incidence and the prevalence of a variety of important chronic diseases in older people is declining. So I'm surprised by the statement that it's increasing.

MS. THAMER: First, we're going to have a whole session today a little bit later on on chronic conditions and I'll go into that in a little bit more detail. What I've seen the decline has been really -- there has been a decline in disability, definitely, which may not necessarily be the case though that chronic conditions. There may be more chronic conditions but a decline in the disability associated with the chronic conditions.

DR. ROWE: What I'm saying is -- and you may know more about this than I do because I'm just an insurance guy.

[Laughter.]

DR. ROWE: But when I last tuned into this, which was about a year ago, the data indicated that the actual incidence and prevalence of chronic conditions was declining, in addition to the severity, which would be reflected in the functional impairment. So we can take a look at this, but that is just --

MS. THAMER: We can look at that.

DR. ROWE: But let's just not accept that everything is always getting worse because in fact it may be getting better. It does, of course, suggest that they may be different than they were in 1965, which is the point of looking again.

MS. THAMER: And life expectancy has gone up, so one would expect that there might be more chronic conditions as a result of people living longer.

DR. ROWE: You don't want to debate this with me. You just want to go to the next slide.

DR. REISCHAUER: Certain people who have chronic conditions would have died earlier, and so it goes both ways.

DR. ROWE: Believe it or not, I actually understood what she meant by that. But why don't we move on?

DR. REISCHAUER: I thought you were just an insurance guy.

[Laughter.]

DR. ROWE: It's an age-specific thing we have to talk about, but the fact is -- I think the real key is here, if you want to get to this, that the dynamics of the elderly population. The old-old is growing larger, and that subpopulation has different clinical characteristics and needs than the young-old. I think that would be a way to discuss it.

MS. THAMER: Today we would like to present you with two panels. One panel will give you perspectives to think about, and the second panel will actually look at some of the perceived inadequacies of the benefit package. The goal today is simply to provide the Commission with background information and to begin the process of examining the Medicare benefit package for the June 2002 report.

The first panel, which is sitting here, will present you

with a brief history of the original design of the benefit package in '65. Secondly, the Medicare beneficiary profile, past and future trends. And third, the health expenditures for the elderly overall by payer and by type of service.

Then the second panel is going to present, as I said, the perceived inadequacies of the benefit package; financial liability and risk of Medicare beneficiaries; the care of beneficiaries with chronic conditions; and finally, primary and preventive care in the Medicare program.

Future presentations that we hope to be bringing for you in March and in April we'll be looking at changes in medical practice in the delivery of care since '65; changes in private sector benefit packages since '65; the supplemental health insurance market and Medicaid that many beneficiaries avail themselves of; and the possible criteria for changing the Medicare benefit package and what various options might be.

To start the first presentation in this series, a brief history of the Medicare program and the original design of the benefit package. Medicare was created in 1965, as everyone knows, when President Johnson signed into law the Medicare and Medicaid programs. It was comprised of three parts: coverage for hospital services which was Part A, which is paid by payroll contributions of employers and employees; coverage for physician services, Part B, which is financed by general revenues and beneficiary premiums; and finally the third unexpected part, which was coverage of low income Americans under Medicaid.

There were several salient founding principles of the Medicare program. The first one, as we mentioned, was to limit the financial liability of the elderly and their children. Each one of these I'm going talk about in a little bit more depth in a minute.

The second principle was that it was intended to be a federal social insurance program versus a social welfare program, for instance. Another major principle was the non-interference in medicine. And finally, it was a creation of an intergenerational trust fund, or social contract. So now I'll discuss each one in a little bit more detail.

The financial liability of the elderly. Private health insurance for the elderly in 1965 was prohibitively expensive. Only about half of all elderly had any health insurance at all, and most policies were either not comprehensive, or very expensive, or both.

Access to medical care, especially inpatient services, was impaired at the time. That's suggested by the fact that there was a dramatic increase in hospital use after Medicare was enacted, and that there was concern at the time that once Medicare was enacted that there would be an insufficient number of hospital beds to accommodate the elderly because of so much pent-up demand.

Third, it was often the children of the elderly who had to assume the burden of paying their parents' medical bills. Just to give you an example, in '64, two-thirds of the elderly had annual incomes that were less than $1,500, and the average hospital stay cost $700. So you could see how very easy it would

be to run up very catastrophic costs.

To talk a little bit about the theory of social insurance, which is the bedrock of the Medicare program, social insurance evolved historically as a response to inevitable wage interruptions, and a major component is the pooling of risks across the sick and the healthy by a mandatory transfer payment system. The government usually plays an important role in most social insurance programs, and administers the program with no profit and very low administrative costs.

It's an entitlement program where only those who make contributions have a right to receive benefits. And it spreads the risk of health care costs across generations, ensuring that the very old and the very sick receive the same benefits as younger, healthier Medicare beneficiaries. Which is another way of saying that benefits are not directly tied to one's contribution.

Non-interference in medicine was the first clause in Medicare law. It allows beneficiaries to choose almost any provider. Likewise, it allows for almost any provider to participate in the program.

The original design of the Medicare benefit package was to emulate the existing private benefit packages. Like private insurance at the time, it covered only medically necessary care for the treatment of an injury or illness. There was also limitations on coverage to primary acute care and physician services, and there was also significant beneficiary cost-sharing.

Second, there was a focus, as there was at the time, on acute medical services. There were two parts: Part A, compulsory, and Part B, which was voluntary, and they were financed separately. I think the important to note about the Medicare benefit package is that it has remained largely unchanged since '65 with the exception of selected preventive services that have been added.

I thought we would have the panel discuss -- each person would do the presentation and then we'd have questions for that panel, if that's okay.

MS. LOWE: Jack has done a great job introducing my topic here. Older Americans today are living longer and healthier lives than their peers in earlier generations. Advanced medical technology and behavioral changes have led to decline in disability among the elderly and are likely to continue. However, there are challenges ahead of us as far as demographics and economics of this population.

This picture pretty much says it all. What you see up there is the projections of the elderly population from 2000 out through 2070 as done by the Social Security Administration. At Medicare's inception, the Medicare program served about 19 million beneficiaries. Today that number is about 40 million and expected to double again in the next years by the time we hit 2030. Today, one in every eight Americans is over the age of 65, and by 2030 that number will be closer to one in five. We can anticipate some challenges to our health care system as we look at the individuals it serves.

The fastest growing segment of the population, as Jack mentioned, is the over-85 group. Right now that number is about 4.2 million. In 30 years that should be about nine million. Interestingly, when we look at the over-85 population now, the people in that group, women outnumber men by a ratio of two to one.

Financially, older Americans are still somewhat unprepared to absorb the rising costs of health care. Gender disparities certainly persist with women lagging significantly behind men as far as their annual incomes. As you can see, that distribution of income is heavily weighted towards the low end of the spectrum compared to the general population.

Certainly, income is also influenced significantly by the age of the beneficiary. Where we see the 65 to 69 population on a family basis, their income is about $30,000. Whereas, if you look at the over-85 population that drops down to about $17,000. As a result, when you look at both the demographics of the population and income disparities, elderly women who are living longer are also far more likely to live alone on minimal income and in poverty, about 12.5 percent of that population.

MS. NEWPORT: Marian, I'm having trouble distinguishing between black and black on the bar there.

MS. LOWE: I'm sorry, those did not photocopy well. The bars to the right are the over-65 population. There was a technical photocopying challenge there.

When we look at the ability of older Americans to provide for their health care needs it depends not only on their income but also on their informal network of caregivers; primarily their spouse. In 2000, nearly half of all women over 65 are widows. Not surprisingly, more than 40 percent of non-institutionalized women live alone, compared to only about 17 percent of men.

Secondarily, the divorce and separated population, although still a small part of the Medicare population, is growing significantly. They represent now about 8 percent of the total Medicare beneficiaries. The reason I add this up here is that for those people who were not married for at least seven years or worked 10 years of their lives, they do bear the cost of participating in the Part A program, which is about $319 a month. That is consistent with the eligibility requirements for Social Security.

Next, obviously the proportion, as I mentioned earlier, living alone, increases with age. Half of the women over age 75 live alone, and about 18 percent of the over-85 population is living in nursing homes. When we look forward at the projections, the size of the over-85 population expected to double in the next 30 years, we do see the number of Americans over 85 living in nursing homes could actually outnumber the total number of Americans over 65 living in those facilities now.

Very briefly, when we look at the disabled population that came into the Medicare population in 1973 and were about 1.7 million beneficiaries. It's just over a percentage point of the U.S. population. Today, that number has grown to 5.2 million and is nearly 2 percent of the population. As they project into the future, we anticipate that that will be about 2.25 percent of the

population by 2030. Still a very significant part, and certainly from a cost basis also something we need to look at in the future.

MR. HACKBARTH: Marian, could you help me reconcile this with the point that Jack was making a little while ago. I too have read about declining disability. Is this because --

DR. ROWE: This is non-elderly.

MS. LOWE: This is disability of the general population when we look at the non-elderly.

MR. HACKBARTH: Of course. Thank you.

MS. LOWE: Then just very briefly I want to throw up some statistics just to put all of this in perspective. Back in 1965, actually on this first data point, the number of uninsured over 65 was about 50 percent. Today that number is down to 3 percent. Medicare enrollment, obviously, has grown substantially with the size of the growing elderly population. It's still a very -- 5 million is part of that 40, for the total, so still the elderly are contributing primarily to that growth.

Life expectancy, as we look at declining disability, has gone up significantly. There's still some gender disparity in those numbers.

One of the things we looked at as far as Medicare's ability to help us rationalize the financial liability for older Americans, looking at the percent of the population below the poverty level, as you see today, the disparity between the over-65 and the under-65 population is very minimal, as opposed to where it was in 1966. However, it is interesting to note that in 1959 the percent below the poverty level was about 35 percent. So that number was coming down already at that point.

Finally, when we look at the income spent on health care I think this says a lot. For the over-65 population we're still looking at 20 percent. Between 1966 and 2000 that number has changed very little.

With that, I'll turn to Ariel.

MR. WINTER: Thank you. We're going to be looking at health care spending on beneficiaries in a couple of different ways. One we're going to be looking at is total spending on health care services received by beneficiaries, both by type of service and by source of payment. We will also be looking at Medicare spending alone.

This slide and the next three slides include spending on both Medicare-covered and non-Medicare-covered services by all payers, which includes Medicare, Medicaid, supplemental coverage, and out-of-pocket spending. These data do not include Part B and supplemental insurance premiums.

This particular slide shows health care spending for all beneficiaries, including both the institutionalized and community beneficiaries. Just as an aside, about 6 percent of beneficiaries are in nursing homes or institutionalized.

Per capita spending on all beneficiaries was, as you can see, over $9,000 in 1998. As we show later, these average spending numbers mask significant variation in spending levels across beneficiaries. Acute and post-acute care account for about 80 percent of total spending, and nursing home care

accounts for about 20 percent. The largest acute care components, as you can see, are inpatient hospital, about 28 percent, and physicians, lab, and durable medical equipment, 22 percent.

DR. ROWE: This is not what's paid by the Medicare program.

MR. WINTER: This includes both what's paid by Medicare and by all other payers, Medicaid, supplemental coverage, and out-of-pocket spending.

DR. ROWE: Drugs are only 9 percent of the spending?

MR. WINTER: That's right, by beneficiaries.

DR. NELSON: But growing fast.

MR. SMITH: This includes out-of-pocket?

MR. WINTER: This includes out-of-pocket, yes. We have data going back just to '92 by all payers and drugs, as I recall, has increased a couple of percentage points as a share of the total. I think it was about 6 or 7 percent in '92.

DR. NEWHOUSE: How do we calculate drug spending for beneficiaries in HMOs?

MR. WINTER: All the drug spending -- let me just point out that the source of this data is the Medicare current beneficiary survey. They go and survey beneficiaries about their expenditures, both made by them and by other payers on their behalf for all health care services. For non-Medicare-covered services there's a lot of filling in the gaps because beneficiaries are obviously going to be under-reporting their expenses just by not recalling all of them. So they do do some imputations.

DR. NEWHOUSE: They're not going to have a clue what Jack pays for his beneficiaries.

MS. RAPHAEL: How do you differentiate nursing home and SNF?

MR. WINTER: A nursing home facility would not be covered under the SNF benefit. So custodial care as opposed to skilled nursing care. This obviously includes both the institutionalized and non-institutionalized beneficiaries.

Joe, I can get you more data on how they estimate drug spending on beneficiaries.

DR. NEWHOUSE: I'm not sure I need data so much as words.

MR. WINTER: We can get you those.

This chart is just the community beneficiaries, so it excludes the institutionalized. Average spending on community beneficiaries is lower, under $7,000, than for all beneficiaries, which was over $9,000. Average spending on institutionalized beneficiaries alone, which is not shown here, was over $41,000 in 1998. There's a big disparity because nursing home care is very expensive, and nursing home residents are sicker than average beneficiaries, so they use more acute care services as well. Because there is no nursing home spending on community beneficiaries, inpatient, hospital, physician, and other acute care spending is a larger share of the total than on the previous chart.

This slide and the next slide show total spending on Medicare and non-Medicare-covered services by source of payment. Like the previous slides, these also do not include spending on Part B or supplemental insurance premiums. This slide includes

both the institutionalized and non-institutionalized beneficiaries.

As you can see, Medicare, which includes both fee-for-service and Medicare+Choice, accounts for about half of spending. Out-of-pocket spending is about one-fifth of the total, which translates to average estimated out-of-pocket spending of $1,850. This figure would be higher if we added in the Part B and supplemental insurance premiums.

Dan will be talking more in detail about out-of-pocket spending in his presentation in a couple of minutes on financial liability, so if you have questions you can save those for him.

The next slide includes only community residents, so it's sources of payments for community beneficiaries. Medicare represents a larger share of spending on community beneficiaries than on all beneficiaries; 62 percent versus 51 percent. This is because we've subtracted nursing home spending, which is financed mostly by Medicaid and out-of-pocket spending. Thus, Medicaid's and out-of-pocket's share of the total dropped from the last slide to this slide. Medicaid drops from 13 percent to 3 percent, and out-of-pocket drops from 20 percent to 16 percent. Average out-of-pocket spending for community residents was about $1,100 in '98. Again, not including the premiums.

MR. SMITH: That 20 percent figure for percent of income spent on --

DR. ROSS: Use your mike.

MR. SMITH: I'm sorry. In the previous presentation, Marian's presentation she said that the share of income devoted to health care expenditures had changed very little; '65 to 2000 had stayed around 20 percent. That 20 percent does include the premiums that are excluded from this data; is that --

MS. LOWE: I believe that does reflect this.

MR. WINTER: This slide takes a closer look at how Medicare spending alone is apportioned. The largest shares of Medicare spending go towards inpatient hospital at 48 percent, and physician, lab and DME at 27 percent. Average spending per beneficiary was $5,340 in 1998. This was based on CMS and Medicare trustees' data.

However, a small proportion of beneficiaries accounts for most Medicare spending, as we'll see on the next slide. So this chart gives you an idea of how skewed Medicare spending is. This shows that just 6 percent of beneficiaries account for half of total fee-for-service spending. That's the top of the left bar and connected to the top of the right bar. Then 35 percent of beneficiaries account for just 1 percent of total fee-for-service spending. They spent less than $500 per person.

DR. ROWE: I'm assuming you're aware that the point here is that this is in fact less concentrated than the entire population. In the entire population of my 20 million customers, 6 percent account for 66 percent, I think, of the expenditures; not 50 percent. So in fact, in the elderly population there's less of a concentration, not more of a concentration. That's the point.

DR. NEWHOUSE: The decedents are in here; is that right?

MR. WINTER: I would assume so. I will check on that. I

would assume so.

DR. ROWE: But some of these things you might want to compare it to the overall population.

MR. WINTER: That's a good point. We'll work on that.

DR. ROSS: Jack, it also reiterates why risk adjustment is so necessary in this population as opposed to the commercial population. It's more predictable here. Jack's got his small group of random spenders.

MR. WINTER: That's my last slide so I'll it back over to Mae for any questions.

DR. ROWE: I have a couple points that I'd like to offer. I think that there are two general points about the changes, trying to focus on the changes that have occurred over the last decades. One is the point that Bob was referring to when he was talking about, there are more of them -- there are more of these people and they're living longer, so there are more cases of these diseases. I think that what I would offer you is a couple things.

I think you should make a clear distinction between the disability rates, which are going down, and the number of disabled elders, which is going up. Because the number of old people has doubled and the disability rate has gone down 25 percent. So that there are more disabled elderly people in the community than there were. So you have to try to clarify the difference between the changes in the size of the population, particularly in the old-old, and the rates, et cetera. I think it would be helpful.

The other is to give a couple specific examples of diseases. For instance, I believe -- I'm going to make these numbers up -- that the prevalence of Alzheimer's disease at age 65 is in the 5 percent range, maybe 5 to 7 percent. At age 80 it's in the 40 to 45 percent range. So obviously, as you get more people who are in the old-old group, you get many more people with Alzheimer's disease.

The same thing with hip fracture; a dramatic, dramatic increase. The answer to hip fracture is, if you could delay the onset of hip fracture by five years you'd prevent half the hip fractures, because people would be dead before they had their hip fracture.

So I think that a couple of these dynamics, of showing the different age-specific incidences of diseases, so that people just don't think there are young people and then there are old people and all the old people are the same. So I think that that's one thing that you might put in.

A second thing that you might consider putting in is that not only have old people changes, but health care has changed. For instance, in 1965, my guess is that not too many old people had cardiac surgery. It just wasn't -- you know, why would you operate? Why would you operate on
-- you know, people had this idea, the average life expectancy was 70. Why operate on a 75-year-old?

As the technology advanced, and the safety improved, and the mortality rates in the elderly with good anesthesia reduced, the permeation of many of these technologies into the elderly

population was dramatic. I think that's one of the major factors that's driven up cost. Health care for older people in America, even if the elderly were the same and hadn't changed, is different than it was in 1965. So it's not only about the elderly changing. I think it's about our health care system changing, and technology. I think that might just be helpful to think about considering.

DR. REISCHAUER: I agree with what you said but I want to correct your misinterpretation of what I had said earlier, which is in 1950 people with heart problems had a heart attack and died at age 55. Now we operate on them, we give them drugs, and they have a chronic condition. So the fraction of people with certain conditions can go up. I was talking about the rate, not the absolute numbers. Although in general in other areas they go down.

MR. FEEZOR: David had highlighted, bracketed, I think the fact that was presented in Marian's that just struck me. That was actually the two bottom lines on that last slide, sort of then and now, in '65 or '66. Even though we had basically the number of people over 65 in poverty drop by about two-thirds, the fact that the average spending, out-of-pocket spending still actually remained about the same or went up.

That probably tells me, not only I think in Jack's point in terms of how much more health care that we are consuming, but in fact that despite some of the original intent they probably have more people getting more access; that's better care. But the reality is that the financial burden on our senior citizens, even though they are hopefully, would appear more or better off at least by definitions of federal poverty, that in fact there still is that almost same financial burden. It says something about maybe our design, maybe our coverage, maybe how care has shifted. But I just felt that those two last lines were terribly, terribly powerful in terms of the need to revisit some things.

MR. HACKBARTH: So a big part of Social Security is a transfer to health care providers, in effect. So it's increased their incomes but a big hunk of it is going to higher health care costs.

MR. SMITH: But it is important to remember here that that 20 percent is buying a lot more health care.

MR. FEEZOR: Absolutely.

MR. SMITH: I agree with Allen's point, but I want to make sure we get the other point. It might be useful to have a then and now consumption pie chart, as you have for current consumption, because we don't want to suggest that people are paying 20 percent and getting the same health care they were in 1965.

DR. REISCHAUER: But also there's the issue, if not health, what? Skiing vacations, hang-gliding? Think of this, the fraction spent on food, on clothing, on housing has declined in America. You've got to spend it somewhere. The rest of us are doing it on compact disks and skydiving lessons. I don't want the 65-year-olds out there doing that.

[Laughter.]

DR. NEWHOUSE: Not to mention child care.

MR. MULLER: But in terms of the predictors of what it will cost is Jack's point about the old-old going up much more disproportionately than the young-old, is that going to be the -- it strikes me that's a big driver in terms of what happens than perhaps the shifting -- the other point that there's more medical interventions available right now.

DR. NEWHOUSE: There's a difference between Medicare and non-Medicare. Medicare by age is actually much flatter than total by age because of the greater incidence of nursing home at old age which isn't covered. Correspondingly, the less tendency to do aggressive intervention among the very old in the covered services.

DR. ROWE: Right. With each additional year the actual per-year expenses fall with advancing age, right? Isn't that what the HCFA studies have shown?

DR. NEWHOUSE: The last I saw, which was now quite a while ago, it was a very shallow inverted U starting at age 65 with a peak around the mid 70s to early 70s.

DR. ROWE: I guess what I was saying is that the projected increases in Medicare expenditures were, over the next decades were dramatically driven by the number of elderly, not the increase in life expectancy. Because the actual increase in life expectancy had a very modest effect on increasing overall expenses.

DR. NEWHOUSE: Right, and also the increase in just cost; the amount of services that we expect we will have to deliver and how expensive they will be per elderly is also a big driver.

DR. ROWE: Is it Lubitch who did this work when he was at HCFA?

DR. NEWHOUSE: He certainly did the work on cost of care at the end of life.

DR. NELSON: I think in a discussion about the benefit design, not only the reality of these changes but the changing expectations of the beneficiary population are important to consider in any kind of future planning. There is a greater unwillingness to pay for predictable expense, which was part of the original concept of insurance: things that you could predict were going to happen, you accepted the burden of paying that yourself, much more it seems than the current Medicare population is willing to do. At least from the changes in legislation that have provided predictable preventive services that certainly is a reality.

There's also, I believe, not the acceptance of care being provided by the family, particularly home care to the degree that there was. My expectation is that the rejection of the notion that it's the obligation of the family to provide the kind of domiciliary care that was part and parcel of the culture a couple of decades ago is probably going away.

Finally, I think that as the boomers age there will be a rejection of the notion of limitation being a part of life to the degree it has been in the past. That is, if they can have cosmetic surgery, they're going to want cosmetic surgery. If they can walk without a limp, it's no longer part and parcel of being elderly to have a limp and they want to get rid of the

limp.

So I think the expectations are changing, will continue to change, will continue to be an important part of increasing utilization and this needs to be taken into account as we look at the benefit.

DR. ROWE: I think that one other change that has occurred -- I agree with Alan's point of adding expectations in addition to changes in the practice of medicine, in addition to the changes in the nature of the population. I think a final one that I could think of at this point was that in 1965 there was basically nothing known or written about health promotion and disease prevention late in life. Health promotion was a pediatric initiative. It was about vaccinations. Then there was cholesterol in middle age and things like that. But the concept of health promotion late in life really was not a part of medical knowledge or training. When people started talking about it there was a lot of resistance to it.

Now I think there have been, as Mae pointed out, a number of preventive things added. But that was not the initial intent of Medicare. One of the problems on getting more prevention stuff in is people always point to the founding legislative language and they say it's about the treatment of disease, not about the prevention of disease, et cetera. It's always an uphill fight. And there are lifestyle issues about smoking cessation, and exercise, and weight maintenance and other things that are just not benefits, if you will, and maybe they shouldn't be benefits. It's a different discussion.

But I think that the management by the average physician of the average elderly individual in America, say a 67-year-old individual, includes an awful lot more prevention-oriented activities now than it did in 1965. I think that should be included in this chapter as one of the secular changes, if you will, in this population that might urge some consideration about what a future benefit package should look like for this population.

DR. WAKEFIELD: This is really a nice opportunity I think for us to step back and maybe infuse a little bit of new and creative thinking when we think about Medicare. So we're talking about financing and the benefit package, but I'd also like you to think for at least two minutes in your spare time, of which I know you have none, to think a little bit about what, if anything, that might be some lessons that we could incorporate in our thinking in terms of structuring the care for Medicare beneficiaries that ultimately finds its way into that benefit package.

And a place I'd go to look for some of that thinking would be in the Institute of Medicine's Crossing the Quality Chasm report. There's a lot of discussion there, for example, about meeting chronic health care needs, and ways of doing that. At least some fairly new ideas I think in terms of prioritizing and reconstructing health care delivery for individuals with chronic care; a big part of what we're talking about today.

Also there's a lot of discussion about the use of information technology and communication vehicles. I think Alan

maybe yesterday had made some passing comment about physicians communicating with e-mail, and nurse practitioners, and psychologists and others, I would add, perhaps communicating by e-mail with their patient population. So there is a discussion of information technology there that may have some relevance to our thinking about this huge program, Medicare, that can help set the stage for how health care is delivered.

Just the last example I'd say is, there are discussions there about putting into place systems that facilitate or that provide clinicians with tools to operate from an evidence-based practice. That too is an important to a Medicare beneficiary that enters a health care delivery system.

So given that this is an opportunity to step back and do an assessment, I'd like, to the extent you can, recognizing what the real focus might be here, issues around financing and the actual specific benefits, if there's a way of stepping back a little more broadly, that I think would be an excellent source of some ideas that might be relevant to Medicare beneficiaries. So I'd encourage you to look at that if you haven't yet.

DR. STOWERS: Just building on what Mary is saying and being in practice taking care of a lot of geriatric patients, as they switch over, and looking at the demographics, there's a huge percentage that end up depending on Medicaid. There's a lot of federal dollars that flow through to create that Medicaid benefit. But having been on the border of two states, there was tremendous inconsistency between the way that Medicaid took care of that age group and their chronic care needs.

I'm wondering if we relook at this package, is that the best way to pass out these federal dollars through individual programs with all the state variability and regional variability and what care they receive? So I think one other thing, building on what Mary says is, we need to look at that variability in that stage and see where we're headed with it.

MR. HACKBARTH: Okay, should we move to the next part?

MS. THAMER: Our second panel will be discussing the perceived inadequacies in the Medicare program. One of them that we touched on quite a bit already has been the needs of beneficiaries with chronic conditions.

Looking at the prevalence of chronic conditions, according to one study, as many as 90 percent of Medicare beneficiaries have at least one chronic condition, and 70 percent have more than one. Now this is using a very broad definition of chronic condition. The definition that's usually used in these types of studies are that it's a condition that has lasted 12 months or is expected to last at least 12 months, and that it either requires ongoing medical care or it results in functional limitation. So as a result of a relatively broad definition you have statistics such as these.

What's more important is that chronic conditions vary in severity, as we'll discuss a little bit later, and that they have the potential to curtail functional status and the ability to live independently.

This chart shows the most common chronic conditions among those over 70. As you can see, the prevalence of each of these

conditions, with the exception of hypertension, has increased from '84 to '95. To give you a sense of how severity can vary, however, bear in mind that while 58 percent of beneficiaries over 70 report having arthritis, only about 11 percent report arthritis of a cause of a limitation in their daily living. Likewise, while 21 percent report having heart disease, 4 percent report heart disease as a cause of a limitation in daily living.

Now having seen -- next chart, please. This overall shows you the percentage of Medicare beneficiaries 65 and older who are chronically disabled. Overall in 1994, 21 percent of beneficiaries who were 65 and older reported some level of chronic disability. That is, they're having difficulty with at least one instrumental activity of daily living, or activity of daily living, or they were institutionalized.

To remind the Commission quickly, IADLs include trouble with housework, laundry, preparing meals, shopping for groceries, et cetera. ADLs include eating, getting in and out of bed, getting around inside, dressing, bathing, et cetera.

This chart also shows a decline in the level of disability from 24 percent in '84 to 21 percent in '94. The source of this chart is the national long term care survey, which has been done several times in the '80s and in the '90s. Several other surveys have also shown a decline in rates of disability, including the share of elderly living in nursing homes which has fallen.

It's been speculated that the decline may be due to medical care improvements, for instance, joint replacement, cataract surgery, introduction of new drugs. It might also be due to changes in health behavior, the most salient one being a decline in smoking, or increased use of assistive devices like walkers, canes, handrails, et cetera.

Now the recommended care for chronic conditions has many aspects to it. One of it would be -- the first one is an interdisciplinary team assessment. This allows for flexible and individual patient needs. A second major component is the early detection of functional impairment. There are many simple interventions that can slow or prevent functional loss. These can be detected using routine physical exams or preventing vision and hearing loss.

The third one that's been mentioned is the use of proven, evidence-based treatments. Another crucial aspect is the support for patient self-management. Additionally, the appropriate use of medication. Then finally, assistive devices for mobility, hearing, and vision.

With regard to mobility and rehab in general, it must not be contingent on only showing improvements, but it should also be appropriate for maintenance, to prevent further decline, which is something that there's an issue in Medicare reimbursement. Hearing loss affects 40 percent of the elderly. That can lead to isolation and withdrawal from the workplace and decreased productivity. Vision loss can lead to near total dependence, without treatment. And both vision loss and hearing loss are major risk factors for depression among the elderly.

The recommended care, however, for chronic care is not always delivered. This applies to the health care system as a

whole and is not just an indictment of the Medicare program. Care if often fragmented, with little communication across settings and providers, both between medical providers and between medical and non-medical providers. Treatment regimens often do not conform to evidence-based guidelines. In a recent study it showed that fewer than half of U.S. patients who have hypertension, depression, diabetes and asthma receive appropriate treatment.

Finally, providers typically devote insufficient time to assessing function, to providing instruction on behavior change or self-care, and to addressing the emotional and social distress of patients who have a chronic condition.

Medicare's ability to promote quality chronic care is limited. The basic benefit package under Medicare Part A is still organized around a spell of illness which by definition is time limited. High quality chronic care, on the other hand, requires continuity and stability over time. Also, Medicare is an individual entitlement. While it is increasingly understood that serious chronic illness is something that happens to families and that effective patterns of care address both the patient and the families and the caregivers.

Specifically, Medicare doesn't cover, but provides only limited coverage for certain important care for the treatment of chronic conditions; for example, prescription drugs, case management. And that fee-for-service Medicare doesn't promote coordination and continuity of care.

To give you an example of how important coordination of care might be, an analysis of Medicare claims data suggested that the average beneficiary who has one or more chronic conditions sees eight different physicians in one year. So coordination of care is really quite vital. Current Medicare policies do not reimburse for telephone or other provider-patient interactions that aren't face to fact. It doesn't reimburse for care of patients in group settings, or many patient education activities, despite the demonstrated efficacy of such interventions.

Finally, there's higher out-of-pocket spending among the chronically ill. Beneficiaries with three or more chronic conditions spend nearly three times more than what's spent out-of-pocket by those who have no chronic conditions. In general, there's roughly a linear relationship between the number of chronic conditions that you have and your out-of-pocket spending, in a recent study. The largest expenses are for prescription drugs, dental services, and office physician visits.

To put it in perspective a little bit, almost one-fourth of all single elderly living alone that have one or more chronic conditions, they have spent more than 10 percent of their income on out-of-pocket health expenditures. For senior couples, that's about 18 percent of them spend 10 percent or more.

I think that's a nice segue into Dan's presentation.

DR. ROWE: May I make one point with respect to this, if I may? First of all, I think this is really excellent. I would only want to add one consideration. That is, I think that many people misunderstand the nature of health care utilization by chronically ill elderly. The point to be made is that most of

the expenditures are for acute care.

You look at these diseases, heart disease, chronic disease, most of the expenditures are an acute hospitalization for congestive heart failure, or worsening angina, or an arrhythmia. People with hypertension who have a chronic disease, most of the expenditure is they get admitted to the hospital because something happens. Osteoporosis is a chronic disease, but hip fracture is an acute complication of it, if you will. Cancer, people get admitted to the hospital with cancer when they have an acute problem. Diabetes, people get diabetes out of control and they admitted.

So it's the acute complication of an underlying chronic illness. When you look at the utilization of the health care resources and Medicare spending and you categorize it as acute or chronic, most of the people or many of the people who use the acute resources are people who are chronically ill. So it's really not a different category of utilization.

It tells you something about pathways to reduce acute utilization, and that's why disease management, patient management programs are something that perhaps Medicare should consider because it's by managing the chronic illness, not only do you improve functional status, which you said, but you reduce acute care utilization. It's not all just about function. I think that idea might be something you might consider including.

But this is really very nice.

DR. ZABINSKI: Today I'm going to discuss positive aspects and perceived problems of the Medicare benefit in terms of beneficiaries' financial liability on medical care. Now the Medicare program has had some positive effects in reducing beneficiaries' liability. Prior to the Medicare program many elderly had no health care coverage, or poor coverage. Now the elderly have nearly universal coverage under Medicare.

Moreover, the program pays most of the cost of Medicare-covered services, paying about 80 percent of those costs in 1998 for example. In dollar terms, this translates to the program spending about $4,200 per beneficiary among those who participated in fee-for-service Medicare for all of 1998. This coverage improves beneficiaries' access to care by making care less costly.

Now despite these positive effects, many are concerned that beneficiaries face substantial financial liability problems. Sources of these perceived problems include first of all, cost sharing for Medicare-covered services in the form of deductibles and coinsurance. Furthermore, Medicare does not have a catastrophic which is an attribute of most private health insurance plans.

Second, many believe that Medicare does not cover some important services, including outpatient prescription drugs and long term care in facilities, particularly nursing homes.

Now earlier I mentioned that Medicare pays 80 percent of the cost of Medicare-covered services. However, when we also considered services not covered by Medicare we found that the program pays only 50 percent of the cost of all services, including long term care again. Beneficiaries are liable for the

main share. Moreover, the combined effect of cost sharing and uncovered services on beneficiaries out-of-pocket spending can be substantial.

On this diagram here we show average out-of-pocket spending in 1998 by beneficiaries living in the community, those living in facilities such as nursing homes, and the two groups combined. The first two columns of numbers indicate that for both the community and the nursing home populations, out-of-pocket spending on uncovered services is larger than out-of-pocket spending due to cost sharing on covered services.

Average out-of-pocket uncovered services is especially large for the nursing home population, about $12,500 per year, and about $300 of that amount is long term care in facilities. In the community average out-of-pocket on uncovered services is much smaller than what it is for the nursing home; it's only $940 on average. But it's still much larger than the average out-of-pocket due to cost sharing, which is only about $210. Amongst the community population, the largest components of uncovered care are on prescription medicines and services provided by providers and their supplies.

Finally, in the third column we have displayed out-of-pocket costs of premiums which combines the Medicare Part B premium with premiums for supplemental coverage such as Medigap. This column indicates that the premiums contribute heavily to out-of-pocket burden in the community, averaging nearly $1,200 per year. I think it's important to note that supplemental coverage substantially reduces beneficiaries' out-of-pocket spending, paying for about 61 percent of the cost that beneficiaries are liable for.

Now a significant effect of the supplemental coverage on beneficiaries' out-of-pocket spending on services is due at least in part to most beneficiaries having supplemental coverage. In 1998, 89 percent of beneficiaries in fee-for-service Medicare had some sort of supplemental coverage, and that includes Medicaid.

One of the benefits of supplemental coverage is it reduces beneficiaries' risk of catastrophic loss. For example, 19 percent of beneficiaries were liable in 1998 for health care service costs, including long term care, in excess of $5,000, but only 7 percent had out-of-pocket spending greater than $5,000.

Despite this benefit, supplemental insurance does have some disadvantages. First, it can be fairly costly for beneficiaries to obtain. Average out-of-pocket spending on supplemental premiums was about $700 in 1998. Second, this is often an inefficient way to supplement Medicare coverage because administrative costs and Medicare premiums are typically quite high. Finally, supplemental insurance often pays deductibles and coinsurance for Medicare-covered services, making beneficiaries less sensitive to the marginal cost of care which conceivably could cause them to overuse care.

Now Tim's going to talk about primary and preventive care services.

DR. BRAUN: I've been concerned about the premiums on Medigap. Does that average employer-retiree premiums or just Medigap premiums? Because it seems to me they're much too low.

DR. ZABINSKI: This includes any sort of -- it's an average, first of all, and it includes any out-of-pocket expenditure on supplemental coverage. That includes Medigap, that includes some contribution to an employer-sponsored plan. One thing I think maybe to add is that, I looked at the distribution in this out-of-pocket as well and up at the upper tail, for example at the 95th percentile, the out-of-pocket is about $2,300. So it gets to be pretty high in some cases.

DR. BRAUN: It goes way up. For instance, if you only do Plan A on Medigap, which is the cheapest one, at 65 I've got two of them, one is $768, the other one is $858. At age 75 they go to $1,380 and the other one says $1,098. So they're fairly high even for Plan A. So if you consider them all at 65 that would be a different thing. You get up to J and you're over $5,000 at age 75 or higher. So they're terribly high.

DR. REISCHAUER: This is all premiums paid divided by all people.

DR. ZABINSKI: Exactly.

DR. REISCHAUER: So it has people who are on Medicaid and aren't paying anything for premiums for supplemental. It has people who are employer-sponsored where the employer pays 100 percent of the premium, or some others that pay -- so this really isn't a number that --

DR. ROWE: It's not a meaningful number.

DR. REISCHAUER: I think you're right, it gives the wrong impression --

DR. ROWE: There's a lot of zeroes averaged in there.

DR. BRAUN: So you're dividing by the number of population?

DR. REISCHAUER: Of Medicare beneficiaries, yes.

DR. ROWE: It's the Medicaids and the QMBs and the SLIMBs.

MR. HACKBARTH: So Bob's agreeing that this number is not an accurate reflection of the typical burden felt.

DR. ZABINSKI: Just doing a back-of-the-envelope calculation, if you include only the people who have supplemental coverage I think you come out to about $1,000 on average.

DR. REISCHAUER: But half of those are employer-sponsored where the employer is subsidizing 60, 70 percent of it.

DR. ZABINSKI: Actually over half of them are -- about 60 percent of people who have supplemental, it's employer sponsored.

MS. NEWPORT: I'm going to the same point here, is I think it's important as you amplify on your work that we have that properly clarified in terms of what percentage is purchased individually, what percentage is covered by retiree plans, what percentage may be Medicaid, SLIMBs, QMBs, that sort of thing, because I think that's important.

The other issue here, because your focus is the right focus though, is that what we're missing is, in the market for Med supp products, not in every area, A through J is not available.

DR. BRAUN: That's right.

MS. NEWPORT: So within that is a prescription drug deductible or cost coverage included, and to what extent can you wrinkle out that issue? So I don't know if the data is available. I know that there's some market analysis out there.

But I think that, at least anecdotally I've been told that

over time there's been an erosion in availability in the breadth of these products. And the other part of this is guaranteed issue at certain points. In lieu of just straight fee-for-service, and some demographics we know you might not have employer coverage, you might not have A through J, you might not be able to afford it because of your age or whatever, and change in status.

So I think it's becoming increasingly complicated, just to make your lives full and everything. But I think that we don't want to miss a really important aspect of what really is covered in total and then what the out-of-pocket costs are. If you can tweak that out I think it would be very helpful.

DR. ZABINSKI: I've always thought it would be really useful to look at things by breaking out by what type of Medigap coverage they have, but in our database there's no indication of whether it's A, B, through J. We can separate by whether it's employer or individually purchased, but that's about as far as we can go.

MS. NEWPORT: Are there industry sources for that data?

MS. THAMER: Let me just say that we hope next time to come back with a much more detailed report on trends in Medigap coverage, trends in retiree, Medicaid, whether there is or isn't an erosion in what's being offered, and have the premiums gone up. So we should be able to get you a lot more detail then. Because we realize it's very important and we just touched on it superficially today.

MS. NEWPORT: As usual, you're ahead of us on most of these things.

DR. WAKEFIELD: Can I just say in terms of looking at out-of-pocket costs for beneficiaries I think we had some data, maybe from AARP, in the June report that looked at rural versus urban Medicare beneficiaries, if we could also incorporate that piece into it, please.

MR. GREENE: Good morning. I'll very briefly go over a summary of where we are as far as looking at preventive services, which as we've said is the major change in the benefit package in the last 30 years.

Initially Congress limited Medicare coverage to services that are reasonable and necessary for diagnosis and treatment of illness and injury. Beginning in 1980 with coverage of pneumococcal vaccine, Congress expanded coverage of preventive services. This overhead is a selected list of important services covered over time. It's not comprehensive. There's more information in your briefing material.

After coverage of pneumococcal vaccine in the 1984-'91 period we saw expansion to hepatitis B vaccine, flu vaccine, pap smear, and the first coverage of mammography for cancer screening. In 1997 the BBA provided the largest expansion of preventive services to date, including colorectal cancer screening and PSA for prostate cancer screening, and despite some controversy, osteoporosis screening provisions. Finally, BIPA the year before last added further expansion.

How do we assess both the historical and recent expansions? First, an independent body designated to review and recommend

preventive treatments is the U.S. Preventive Services Task Force of Department of Health and Human Services. The task force follows rigorous standards in determining which services have clinical benefit, although it explicitly doesn't look at cost effectiveness criteria, just clinical benefit as a standard.

We compared the services recommended by the task force for those 65 years of age and older with those covered by Medicare and we see a reasonable amount of consistency, though the program doesn't cover all recommended services for the elderly. For example, the task force recommends and Medicare covers flu and pneumococcal vaccine and pap smears. Similarly, the task force does not recommend coverage and Medicare does not cover screening for lung cancer and cholesterol.

On the other hand, we do see some inconsistency. As indicated, osteoporosis screening is not recommended but it is covered by Medicare. Congress found that desirable. On the other hand, the task force recommended but the program doesn't cover counseling for smoking cessation and diet or exercise improvement.

Now another basis for judging covered services is comparing Medicare with services offered by private plans. Here again we see a certain amount of consistency and a certain amount of difference. Once again, both private plans typically cover and Medicare also covers mammography and pap smears. Incidentally, when we said private plan covers we mean, in a survey approximately 90 percent of plans offered this services. When we said they don't cover it, 25 percent or fewer offer the service.

Again, we see common patterns for mammography and pap smear, and also common patterns with the counseling, behavioral change services, smoking cessation and so on. Both not covered by either the private sector or by Medicare. We see some difference in things like routine physical and gynecological exams which are typically covered in the private sector but not by Medicare.

Finally, we do see that despite coverage limitations many of the elderly receive some services that are maybe desirable in some ways, but are obtained regardless of coverage rules. Although routine physicals are not covered by Medicare, approximately 90 percent of the elderly, even relatively old, report having received physicals within the last two years. The same is true for other services.

On the other hand, we can see that coverage is not the key for obtaining preventive services in a different sense. That a variety of factors, insurance coverage, education, age and other factors seem to have played an important role in whether individuals seek out and obtain services that may be of benefit.

In the first category, for example, we see that members of Medicare+Choice, who obviously have more complete coverage of many services, use the typical preventive services more consistently. We find beneficiaries with lower levels of education, though it's not as consistent, with higher age to be less likely to use a variety of services.

Finally, both in the under-65 and among the elderly we find that availability and use of information, exposure to education campaigns of the sort that CMS operates and so on, also increase

service use. It might be noted that the heavy use of services by members of HMOs, Medicare+Choice plans may be partly due to the promotion of these services and the information provided to beneficiaries in those plans, apart from the pure insurance coverage aspect.

Finally, that leads us to suggest that if we're serious about expanding use of preventive services that might be of benefit to the elderly we want to look beyond pure coverage policy to a variety of additional policies. Some such as reduced cost sharing have already been pursued by the Congress. Many of these services, the vaccines and so on, are provided with zero coinsurance now, but other efforts of outreach and beneficiary education might also be pursued.

DR. BRAUN: I just wondered where you got the information on the physical exams? The reason I'm asking is I'm just wondering how many of those people don't have anything else wrong with them and therefore there's no Medicare reimbursement for that physician visit. I would not think that's very high.

With the number of chronic illnesses and the fact that physicians usually go through the whole person, if they're an internist particularly, if the person comes in for a visit -- that the patients themselves might think they had a physical in the sense that you're asking. I just wonder how many people with no other illness over 65 are going in for physicals.

MR. GREENE: I don't know. That's based on survey data, health interview survey and other sources, not from CMS data that allows us to say very much about the nature of the individual. Those are very basic statistical profiles of the elderly, so we really can't say much about the characteristics of these people.

DR. BRAUN: So they're just asking the question, have you had a physical exam --

MR. GREENE: Yes, with some demographic detail but without diagnostic and medical detail.

DR. ROWE: Just a couple points. One is, I think you should include a general description of different kinds of preventive services, primary prevention, secondary prevention.

MR. GREENE: We have it in some of the text, yes.

DR. ROWE: I think that this is an opportunity to address the M+C programs a little bit, because one of the things that the M+C programs offered was the preventive orientation that the HMOs brought to the table, and that was one of the things that was presumably attractive to some of the beneficiaries. They liked that in addition to the other benefits like eyeglasses and pharmaceuticals, et cetera. So I think that you might see if you can get some history on that, or at least mention that some Medicare beneficiaries had access to more preventive services through that program than they may have through the other program.

The third thing I'd say is just as a general summary of this field I think this is really excellent.

DR. WAKEFIELD: Could I just tag on to his first point, Jack's first point? Just to the extent, I agree to provide that history would be appropriate in terms of coverage. But would you also then, if you do that, please incorporate what it is that

rural Medicare beneficiaries; i.e., all of North Dakota's elderly, for example, don't have access to, and that is they do not have access to M+C, using that as an example. So what implications that has for a proportion of our Medicare beneficiaries and their access to preventive benefits compared to their urban counterparts.

MS. NEWPORT: Tim, I don't know how readily available the data is but it sort of builds on the last two comments, is what I'm trying to do. For example, we might not cover smoking cessation directly in the plan because, let's say the rate. But we have been able in some areas to negotiate discounts with Smokenders, if I can use a proprietary name here. So that we've used a variety of explicit and implicit devices to offer a wellness benefit to the extent that we know that it accrues to the beneficiary.

So sometimes it will be directly in the benefit packages, but sometimes it will be as an option you can get a better rate on some of these programs. We have trouble explaining this to the regulators sometimes, including joining health clubs and things like that. But it all works together in the aggregate. You may just need to sit down and talk with the industry a little bit; amplifies that if we can't do it explicitly we have these other programs that we can funnel people into at less cost to them out-of-pocket.

smoking cessation

MR. HACKBARTH: Any other comments?

DR. ROWE: Just one general comment. In looking at these two panels, one area that I think might not be currently covered, although it may be and I missed it, that we might consider is the emergence since the program was developed of special populations within the elderly; the frail elderly, the PACE programs, et cetera. That the provision of health care services to these populations has changed over these 30 years. These new programs have been developed; the SHMOs and the PACEs. I think that that's a reflection in part of the growth of the over-85 population. But the care at the end of life, frail, et cetera, might be something that might deserve some attention.

MS. NEWPORT: The other issue and you talk about it earlier in your presentations has to do with management of depression. There are quality programs and disease management programs that some of the plans have that sort of envelop the chronic conditions with management of depression, which has better health outcomes. So I think that that needs to be more explicitly talked about at some point. It's of extreme value.

MS. THAMER: So as a comorbid condition, depression. Because we don't want to get into anything disease specific because then we'll be talking about totally unique conditions. But as a comorbid condition to chronic conditions in general.

MS. NEWPORT: That's right. But our identification within our program of that, incorporating it very affirmatively in our disease management programs has had a very, very positive outcome, recognizing that in terms of depression and its effect on people being able to get well, stay well, is very important.

MR. SMITH: Just one last set of questions, Tim. All of

you, like my colleagues I found this very, very useful. Tim, I wonder if there isn't -- and maybe it's just not useful, but we've got some information about determinants of use -- availability of insurance, education, which may be a proxy for income -- but I wonder whether or not income is not independently important.

The other question that I wondered as I looked at that was, are there distinctions between -- and Mary raises one of them -- geography. But are there age, gender distinctions between users that are independent of things like insurance and education? Does it matter where you live? Does it matter how old you are? Does it matter what your social circumstance is? Are you alone or --

MR. GREENE: Income doesn't appear to matter.

MR. SMITH: And certainly insurance and education are probably a reasonable proxy for income, but I would appreciate if we could take a look at to what extent income matters and how that shows up.

MR. HACKBARTH: Last one, Ray.

DR. STOWERS: I think too that reminds me of the fact that there's a lot of -- especially when it comes to rehab -- corrective shoes, all sorts of things that are left up to the discretion of the local carrier. How much does the benefit package really vary per the different regions?

Like I said, I was in two regions where our practice is and there was a lot of difference in some of those benefits and the packages. So somehow that may need to be looked at, or what that discretionary difference in the benefit package is.

MR. HACKBARTH: Thank you very much. Good start on this. It's now time for our brief public comment period.

[No response.]

MR. HACKBARTH: Okay, that was briefer than I had expected. Thank you very much.

[Whereupon, at 12:06 p.m., the meeting was adjourned.]