

---

vimeo

**Two Mayo Clinic Workshops  
Deficit Healthcare  
October 31, 2011 at 12:02 PM**

Paul:

Hi. I'm Paul [unintelligible]. You all know me by now. I want to thank you all for coming up. As I mentioned earlier, we are videotaping this tonight because many of our clients cannot come to these workshops. Many of them live out-of-state. So they had asked us last year when we did a client satisfaction survey if we could start videotaping these workshops. So tonight that's what we have going on right now and that's why the lights and camera are here.

I want to get into our featured presentation with Bob Smoldt. As I mentioned to some of you who were here earlier tonight, two years ago Bob Smoldt spoke to our clients at the [Monument] Resort in Paradise Valley four days after the Healthcare Reform Act was passed. For us, this was a very, very exclusive opportunity. Bob, who has 37 years with Mayo before he retired as the Chief Administrative Officer in Mayo, just for Mayo Clinic, was the Head of the National Healthcare Policy for Mayo. So he was out there on Capitol Hill, dealing with all the debate that was going on, and to have him come speak to our clients four days after the whole thing was a big deal.

Since he left Mayo in 2008, he now works for ASU, and he's part of the think tank there. So a lot of the things that you will hear tonight are the ideas that Bob has, and they're great ideas. Perhaps you have some ideas of your own. He's going to be asking for your opinion.

He's originally from Iowa. He grew up there and married his high school sweetheart. He went to USC and got his MBA. He came to Arizona. He spent three years in the Air Force, and then moved to Rochester, Minnesota where he spent 34 of 37 years with Mayo Clinic. Today, he lives part time in [Farm] Hills in Breckenridge, and for us, we have him for the next six weeks to do a series of workshops.

So with that, I'm going to turn it over to Bob.

Bob Smoldt:

Thanks a lot, Paul. I appreciate it. I appreciate your coming up tonight too. We'll make this informal with questions and comments, and I am going to get your opinions on this, so I hope you listen up to what's going on here. Now I'm going to tell you exactly what I think we should do, but I'm interested in your views on what we should do. I'm going to try and go over some of the [unintelligible].

Wow. What a topic, huh? Have you picked up a newspaper in the last month without seeing an article on the budget deficit or the debt of the United States or the debt in Europe and all around us it's causing. I mean, it's a big deal.

I'm going to start out with a small poll. So I'm going to ask you some questions that were asked earlier this year and reported in an article on Medicare and the budget deficit. So I'm going to get your views. This is one. Do you believe the federal budget deficit is a very serious problem? If everybody thinks it is, raise your hand. Okay. So we got 100% here. So you're not a typical group from the United States because only two out of three in the country thought it was a serious problem.

Question two - do you believe it is possible to balance the budget without cutting Medicare spending in one way or another? How many of you think we can balance the budget without doing something on Medicare? Okay. So it's a minority. Let's hear it. [unintelligible]. Yes, that's a good [unintelligible]. Did you hear that? You probably can [unintelligible]. Those were the other options.

Now, I know you're [unintelligible], but I'm not sure what each of you think when you see this question - what do you think the US response would be? Do you agree with the following methods of reducing the deficit? Number one, reducing military [equipment]. So we reduce the defense department. About half and half [in the country]. Raise taxes on people with over \$250,000.00. About two-thirds agree with that. Limit tax [unintelligible] for corporations.

---

Again, a pretty good size or the majority agree with that. Reduce Medicare spending in some way. What do you think the public would respond to this?

Female: Most.

Bob Smoldt: Only 22%. It's really kind of interesting to me, and you'll see why when we go through some of these numbers. The people who did this polling have done a lot of polls, and they said on this issue about Medicare, if they asked the question, like they did here, with a number of other options for reducing the deficit, they get [unintelligible] of respondents. If they do it just do we need to do something about Medicare, then that's about 50/50. So that kind of alters their opinions.

So tonight, what I want to do is analyze the Medicare issue in particular. But to do that, I think we have to have an understanding of the broader US deficit and debt issue. So we'll do that first, and then we'll get down to the Medicare program.

Okay. Let's go back a long time. Growth of the government spending as a percent of the economy. This goes back to the 1800s. Two percent is what it was. You remember the 1800s? [unintelligible] That's when Napoleon invaded [unintelligible]. It is when Thomas Jefferson was elected President. Do you remember this? What your history was? It was a tie in the electoral [unintelligible], and that's the only time the House of Representatives actually had to resolve the tie.

The interesting to me in relationship to that, only 2%. We didn't have a lot of spending then. Two years after that, 1802, is when the Louisiana purchase happened. All the land from Montana to the Mississippi River all the way down to New Orleans, in today's dollars, do you know how much that was? \$214 million. You could probably buy 500 acres of good farmland in Illinois for that today. So that was quite a bargain. So we were able to do some things even though we didn't spend a lot.

---

So we go to today. Federal spending of 24% of the GDP of the total economy of the United States by 2040 is expected to go - unless we do some changes - 39%. Well, this looks at that a little bit differently. These are the federal government outlays as a percent of GDP from 1791 right to the present. You can see these spikes, and if you look at the years, you'll know what those are, of course. It's World War I and World War II. But then in more recent years, if you take those spikes off, we're still really trending up quite a bit. This is a percent of the economy, is the scale we're using. It gives you a reflection of how much the federal government is part of all this.

What are we spending our money on, 1970 to 2000? So let's look at this. This was the biggest chunk back in 1970, and that was for defense. What was going on in 1970? Most of you know. The Vietnam War. The Vietnam War was going on. Now, we've got a war going on, but it's down to 20%. Now, granted, the growth in dollars - in constant dollars - has gone up 300% so it makes it easier for the percentage to go down. But at any rate, defense wasn't nearly as big as it was then. This blue part is other [discretions there]. So you take all of the branches of the government. The judiciary department that has discretionary spending. The education department, the agriculture department. So that has stayed fairly constant - 20%, 19%.

Look at the change in the red. Medicare/Medicaid and [health spend]. Four percent in 1970, all the way up to 23%, and this was 2010. The baby boomers have not started on Medicare yet. They just started on Medicare this year. Okay. Fifteen percent in social security has grown, but nowhere near like the health spending has. Then we have 12% on other mandatory. That is things like you're a federal employee and you retire. We've found certain retirement benefits to people. It's those sorts of mandatory things - food stamps, unemployment - that's in the other mandatory. That's a pretty constant as a percentage.

---

Then we have interest on the debt. Now, this is a fascinating one to me because it actual went - as a percent of the economy - it actually went down even though our debt has grown. So why is that? Here's why. This is the interest rate - effective interest rate. It's very low. Much lower than most people think really is realistic over the longer term.

So this is what's happening to the debt outstanding. It's gone up. You'd think the interest rate would go up, but it hasn't. Not yet, anyway. Not yet. This is why - because I've read more about all this debt of the United States issue. If you interview an economist - are there any economists in here, by the way? Okay. As you would expect, the economists argue about this a lot. When you find the people that - the economists that say they're not so worried about the debt of the United States, the argument they make is if this interest rate was going up, that's when we should be concerned. So they aren't quite so concerned. The other side says - what the people here said - Wait. That it probably will happen.

Well, as federal spending goes up, so has the deficit as a percent of GDP. Are there any guidelines about what that should be? The annual deficit as a percent of your economy, and what the European Monetary Union - so those are the countries that have the Euro. Since they're independent countries, they got together [unintelligible] 30 of the world's leading economies. [unintelligible] from the United States have joined the world, sat them down and said, "Give us some guidelines." So there are three main ones that they use - I'm going to talk about two of them with you tonight - that they have adopted.

One of them is on the annual deficit. It should not be more than 3% of your gross domestic product. If it's higher than that, they recognize you got to have some flexibility. When you're in a recession you may be higher than that, but you should be bringing it down. We hear about all the Europe problem, and there are some countries - I'll show you some data here in a minute - that really have some huge issues. But this was fascinating to me that EU 27, the 27

---

countries that are part of this union, their average roughly in 2009 in deficit of percent of GDP was 2.3. It was actually within that.

Now, you don't [unintelligible] right now. You think we're within that in the United States. We'll see. This, what are you thinking about that? Because here is us. There is the 3%. This goes back from 1950. Here is the 3%. We went a long time when we were below that. Then we've gone up, but we've gone back down. Now, we of course have jumped way above that particular marker. The issue will be we were at a bad recession. We probably still need to do some things, but as we move beyond that, are we going to put things in place to bring it down, or are we not going to do that?

With sustained deficits every year, what happens to the debt? Your total net grows. Wouldn't you think that just asking the question "how much debt do we have" would be a simple question? It's not. There are basically three answers. The first one is the debt held by the public. Then the second one - because it's easier for me to explain that if I go on to the second one. The debt held by the public plus debt held by other government agencies. So the government has trust funds. Social Security, Medicare. Does anybody here think that there are stocks and bonds and other security devices that are in those trust funds? There's nothing in those trust funds. Their money has been spent. There are IOUs. So there is debt that the government has to itself. It's basically through those trust funds.

So if you don't bring any more money during the year from the people who are paying Medicare taxes and the people who pay Social Security, as it goes out, the government has to then fund that. How do they fund it? Since we're running deficits, you issue the debt to the public. That's why many economists - but not all - think this is actually a better measure of debt. I personally agree with that. But often what you find is the first one. So when you see graphs, be sure to look at it because they don't usually tell you if it's debt held by the public or total debt. If it's debt held by the public, there's a lot of debt out there that we have in the United States that is not being shown in that pretty

---

good graph. Then you've got total liabilities. So that takes this total debt here, and it adds in future pension, social security payments and healthcare payments that are promised under current legislation. The projections of what that's going to be, and then they discount that down to present value.

It's no different than if you're an employer and you have a pension plan for your employees. You have to go through the same calculation of what's your liability, and then you have to have that funded through a certain way, or guess what? You'll get in big trouble. But the government doesn't apply those same rules to itself. Anyhow, that's the future. That's the total.

Well, let's go back to the debt now. The other guideline of the three main guidelines of the European Union under the stability and growth [thing], is that your total debt should not be more than 60% of your gross domestic product. So that's one guideline. Then there's another one that's a little bit higher, but it's actually more controversial, I think. [I've got two main studies]. One is from Harvard and another one is with one of the agencies in Washington D.C. They have 90%, and the reason they have 90% - this is fascinating, the study they did. They looked at 44 countries - so these are developed countries - for 200 years. They had 3,700 observations, and what they're looking at is debt as a percent of your GDP and what's happening to the growth of your economy. Their conclusion is when you get debt burdens above 90%, it basically reduces the growth of your GDP by 1% per year.

Why is that? I mean, to me it kind of makes sense. If you're spending a lot of money paying interest on all these debt, you don't have that money available to do things that will generate [unintelligible] the economy [unintelligible]. You're just paying off debt. This again, this is pretty controversial - and I'll tell you right now why it's controversial because we're [unintelligible] right through that in the United States.

So some people were saying, "Well, that's not a really good study." So these authors just recently published a response to their critics. I want you to know

---

that I think it makes some sense that there are people who disagree that it's a big deal, but what they said was this threshold is based on earlier periods of time before old age pensions, healthcare costs - which are getting big now with all the developed countries are just starting to get. So they think that, if anything, makes it even more important.

So those are the following guidelines - 60%, 90%. What's happened? So now we're looking at national [unintelligible]. This is the one you'll usually see. Here's the 60%, here's the 90%. The only time we ever went through the 90 and past was World War II. Right now, we're breaking through the 60% on that.

Here is the total debt if you include the amount for the trust funds. We went over 100% in World War II. We're blown by that. This shows it through 2010 with 90%. But to show you how fast this is growing, this year we will top 100%. Again, the way the government counts money, you'd think we'd know when it's 100%. There's an argument over whether we're already over 100% or if it's going to happen in October. At any rate, no one disagrees that I have seen that the total debt is going to go over 100% in this calendar year. So it's growing pretty rapidly.

Where are we then in terms of comparisons with some of the other countries? So we had Greece, Italy, Portugal, Ireland, Spain, United Kingdom, United States. This looks at our debt compared to theirs. Now the country that's in the most trouble is Greece. Right here. Italy is kind of [unintelligible]. The first bar for each country is 2011. Then the second, the red bar, is the estimate for 2016. Greece has taken some steps, and the European Union has kind of forced them to, but they haven't been as big as they hoped. I think [unintelligible] is part of this most recent ballyhoo about whether Europe would be getting there off Greece because Greece hadn't lived up to everything that they had promised to do the first time. But there still is some direction.

---

The point is here we're kind of right now in the same category. Then you'll see if you look at these pages we'll [unintelligible]. I like to read Sports Illustrated. It's [unintelligible] every other week. Every week, they have this one thing called "The Sign of the Apocalypse." This was one. Spanish bankers trying to get a loan and what's their collateral? Two Spanish soccer players. Now, that, to me, is a sign of kind of the apocalypse, if we're down to that bad a shape that our collateral is going to be soccer players.

Now, this is a fascinating one to me as well. There's an individual, David Walker, who's the former Comptroller General of the United States. He did that from 1988 through 2008. Twenty years under Republicans and Democrats. He is very concerned about the fiscal situation of the United States and many of the industrialized countries. He thinks we need to make corrections. So he came up with an index. There's an index number for each country. I think 34 countries. It's based on what your debt is right now, what's the projection of your future debt, and are your fiscal rules and enforceability for making corrections going to allow you to make corrections. So he puts out through these countries - as I said, I think there's 34 of them. I want you to think where the United States would be on that. He's a pretty sharp guy. I'm going to give you these. Not every country. You think we're number one? Anybody? Give me a country in your mind. Who do you think would be the best? Their country's fiscal policies and position is the best in the world?

Male: Sweden.

Bob Smoldt: No. Sweden's is pretty good.

Male: Australia.

Bob Smoldt: Australia and New Zealand are fantastic. In fact, I saw somewhere - well, you could probably check this, but I think the Australian federal bonds are something like 5% over a ten year period. That's pretty good for the country that's got the best fiscal order in the world. You think we're number five?

---

Male: No.

Bob Smoldt: No. China leads us there. Twelve, India. We can't beat India either. France? Is anybody worse? Greece is 34. I'm going to give you Italy and the United States. We didn't quite beat Italy on this either. Now, why is that? Our present - if you look at these nations - our present debt is a little bit better than Italy's.

Male: It's the projection.

Bob Smoldt: It's the projection. If we'd all change in this - this is debt held by the public. Even that is - this is probably more realistic for the 60%. By the time we head out 20%, we're 145% [unintelligible] what it does from there if we don't make changes. In fact, David Walker has calculated - this black line is the revenue. This is the federal expense as a percent of GDP for interest. Social security, health outlays and everything else. So if we get out by 2055 and we don't change a thing, we have enough revenue coming in to take the interest cost. So if we bought an expensive house and we got your revenue coming in and you can pay the interest cost, you can go ahead and buy for anything else. That's not good [unintelligible] or fiscal [unintelligible].

So we're borrowing more now. We're [unintelligible] owing money to foreign countries who are buying our debt. It's not - I mean, sometimes you hear this and you think China owns 80% of our debt. They don't. Our total foreign holdings are 47%, but that's 5% in 1970. China does have the most debt. They have 16%. Our total debt to the public is owned by China, but that's up from 6% ten years ago. So it's gone up dramatically. Who do you think the second country is? Japan. Between Japan and China, they basically own a third of the United State's debt.

So more of it is going out there. Is it an issue? Would these countries ever get so mad at us they'd stop buying us debt? The reason I think it hasn't happened is we're still more stable than other economies that they invest in. Well, to

---

me one of the wishful thinking things if we can just do one thing and it will correct this deficit and debt problem. One is to increase taxes on the well-to-do Americans. One calculation on this when the bipartisan policy center - so it wasn't put up by one party or the other - is that you have to take the top two brackets, the 86% and 91% to 33 and 35. I personally don't think that's going to happen. I don't think it would be good for it to happen. Well, then let's just raise taxes on everybody. Then we do it. We double the marginal tax rates. We basically would have some middle income people behind 66%, and I don't think that's going to happen.

Grow the economy, and we definitely want to grow the economy. That's probably why you don't want your debt to get above 90%, because if your [unintelligible] is going to be reduced by 1% because of that. But if that's all we did to correct this - and mostly when you say [unintelligible], most people are trying to bring our debt back down that European Union 60% measure. So that's what they're saying - what do we have to do to get down to 60%? Debt at 60% GDP.

If it was just going to be from economic growth, the economy for a ten year period would have to average every year a 6% growth. We've never done that since World War II. The highest for any decade is 4.4%. I can tell you if you look at the graph on the growth of the economy, we aren't heading this way, and the growth is going up but the rate of growth is going down.

We'll look at some solutions, especially for Medicare. But before we go there, I think it's wise to look at underlying factors causing the increased debt. So this is the percent change from 1965. So it's kind of accumulative. The dot here is the GDP. So that's the way the economy is growing. You kind of want - your federal expenditures probably grow fairly much in line with that, and it isn't too bad. We had some surpluses, but now we've got - some debts have [unintelligible] in.

Well, let's look at some other components. Right down there at the bottom, here's defense. So it's growing, but it's growing less than the economy. So

---

what's growing faster if we've got things growing less? There's the [unintelligible]. It's huge. Now, in addition to the debt, we have these unfunded liabilities - that third measure. The total there is \$61.9 trillion. The debt is about \$14 trillion, and then there's some other liabilities. But the unfunded part of the social insurance programs, that's a huge part of the issue that we're trying to deal with. I saw this picture about a year ago [unintelligible]. "All I own is a dollhouse and I already owe \$38,000.00." Except that was about a year-and-a-half ago. It's now \$46,300.00. The total debt divided by the individuals in the United States, that's what it is. But that's [unintelligible] with the total. If you take the total federal debt and instead of dividing it by individuals, you divide it by households, which is kind of who pays tax, it's \$125,000.00. If you take that federal financial hole of the unfunded liabilities, per household in the United States, a half million dollars.

Now, do you want to really get depressed? Think right now. You've finally seen the statistics. What percent of households in the United States pay income tax? About 50%. If that's right, every [unintelligible] paying tax of at least a million bucks. So we've got an issue here for our kids and grandkids. Anyway, I think they're going to have to do.

Here's a couple of [unintelligible]. I won't read these to you, but basically what they're saying is we've got to put our house in order. We have to deal with the entitlement programs. That's where things are driving us. Now, the entitlement programs, Social Security and Medicare, which one has a big [unintelligible] liability? No. It's not even close. Medicare is by far the biggest financial issue. Why? Two basic reasons. Health costs are growing faster than GDP and we've got the baby boomers coming on. We've got this aging population. This is health cost. This is the percent change every year in healthcare expenditures and GDP. Generally, the healthcare expenditures grow more than the gross domestic product.

Now, this is an interesting period right here. So '94 to 2000. Basically, health expenditure did not grow any more than the GDP. Why? Does anybody

---

remember what has happened during that time? It was terribly unpopular with both physicians, hospitals and the public. HMOs. [unintelligible] managed care. So there wasn't a lot of people [unintelligible]. It was not popular, but guess what it did. It did keep health expenditures right in line with GDP. So there was a tiny period when we did. If it's really important to us, we probably could get back there again.

Now, I got to show you this though because you get the impression almost that we're the only country where healthcare plans are [up] with the GDP. That's not true. It's going up more rapidly in all the industrialized countries. Here's the US, Canada, France, UK. You look at the percentage change of the economy here to the left. The right is the change in the healthcare expenditures for almost a twenty year period, average. Those percentages are awfully close. Except for the UK that's even higher. Why is the UK higher? Because their healthcare expenditures are so low, their people were basically revolting. So they've had to provide more extra specialized services to surgery and those sorts of things. So we're not the only ones. So a growth in healthcare and the growth of the number of people who get each programs.

So here are the number of medical beneficiaries. It was 66 when Medicare started. Then you go from 2000 to 2030 with double the number of people who are on Medicare because of the baby boomers who started on Medicare with the first contingent in 2011. It's going to continue for another twenty years. So what happens because there aren't as many people replacing the baby boomer generation as they retire? You've got the workforce left. They're the ones who are paying this bill. When Medicare started you had about five workers for every Medicare beneficiary. By 2030 we're going to be down to about half of that. Probably even less than half of that. So for our kids and our grandkids, in the past five of them would have that as support - the people on Medicare. Now, two-and-a-half are going to have to do that, or we're going to have to change how we do this program.

---

Now, you often hear, “But we’ve paid Medicare taxes [unintelligible] this benefit.” This is an interesting statistic. I won’t read it, but basically what it says, if you had two 66 year old people who had average US earnings their whole lives, and then they retire, they and their employer would have paid \$110,000.00 in Medicare payable taxes. If they’re average, by the time they die, Medicare, they’ll receive \$340,000.00 [unintelligible]. If you’re 56, you end up paying more at \$140,000.00, but you get back \$430,000.00. So again, we have that three-in-one thing. We paid in, but the benefits we receive end up being more than what we’ve paid in.

Will the congressional debt appeal solve this problem? Probably not. I like to read The Economist. It gives a view of what’s going on in the United States and the world from a UK perspective, but they’re really quite interesting, I think. When we did our initial debt deal on August 6<sup>th</sup>, this was their editorial - the thoughtlessness. Their exact word. The thoughtlessness of the debt deal. What are they talking about? The failure to tackle the real source of our fiscal problems - the entitlement programs. It is a big word.

The other interesting thing, the government appointed Simpson-Bowles, a bipartisan group, to come up with savings. They came up with a plan, and it was going to be \$4 trillion of savings. So [unintelligible] spending reduction, etcetera for over ten years. There’s a similar group who didn’t receive as much attention, but it was a similar - really high caliber people that were on it - that did a similar thing. They came up with \$5.8 trillion. Why are they in that \$4 trillion to \$5.8 trillion? Because that’s what is calculated is going to take to get us down to 60% debt to GDP.

What’s the supercommittee’s target? \$1.5 trillion. About a third of what most people think we need. How many of you have a lot of confidence the supercommittee will actually come up with \$1.5 trillion that they agreed upon that Congress will pass? I don’t have a lot of confidence that they will.

Paul:

It would come closer to \$0.39.

Bob Smoldt:

[Laughter] In that sense, that could be. Will the Health Reform Bill of 2010 help? I don't think so. Half of the health - because not only will it get more people insured, which I agree with. I like that part. But half of the bill for that is coming from reduction - across the board reductions in what Medicare is going to pay. Provided, hospitals, physicians, home health agencies, nursing homes, half of the bill is paid by them. The Medicare actuary has done an analysis and it has sat down and [unintelligible] that will mean providers will be getting 50% less than they get right now. Fifty percent less. You've got to remember because I didn't know this. I worked in medicine for 37 years and it wasn't this way always, but it is now. Providers right now, on average - not in every patient - on average lose money in Medicare.

So we're going to take the group that loses money on average right now and we're going to down half of what they get. As the Medicare actuary said, and as the Congressional Budget Office implies, if you look at the Congressional Budget Office report of that Health Reform Bill near the end, they basically say we're not sure we can do this. The reductions in what Medicare is going to pay. Possibly less access to providers. Providers will limit the number of Medicare patients they see - it's prevalent throughout the United States right now - or there will be reduced quality, or there will be both if we do this type of reduction.

My own personal feeling, we should have heeded the advice of Democratic economist, Dr. Henry Aaron. This was his view early on in the health reform. He had an article that if you're going to extend coverage and you do one, the costs are going to be [unintelligible]. Even on old people they're going to spend money. They're going to get healthcare and you're going to have to pay for them. The same debt that you say you're going to pay for, there's a way you reduce what you pay. Everybody [unintelligible] come from efficiencies. Okay?

The savings from the delivery system before were speculative. So his conclusion was the worthy goal of health reform would be justified increasing

---

the budget deficit. In other words, if you say you're going to reduce Medicare by that much and you really can't, you probably won't. Then guess what? This program really doesn't pay for itself. What does that do? The budget deficit goes up. So he said reform must be paid for. He gave a [unintelligible]. If you're interested, I'll give it to you. He came up with a very great paperwork.

Another concern in the Health Reform Bill. The government asked us what the future costs are that always aren't so good. When Medicare came in place, what they estimated would be spent in 1990, when it was actually spent they were off by a factor of about ten.

Now, the Health Reform Bill has something that potentially could've been helpful, but not the way they made it. It's called the Independent Payment Advisory Board. The way it works is if Medicare spending goes up more rapidly than we want them to - the target - this board then has to come up with a plan for how to get it down to the target. You don't just submit to Congress, and then Congress has to vote and say, "Yes, we want to do that." It actually becomes law, unless Congress does the opposite and says, "We're going to veto this." So it has a lot more power than just an old group that says they're supposed to advise what to do.

Here's the problem, and this came from the Congressional Budget Office report. When they wrote the legislation, in order not to tick anybody off because they were trying to get the Reform Bill passed, the board did not ration care, it did not raise premiums, it did not increase [unintelligible], it did not restrict benefits, it did not modify eligibility, and as the Congressional Budget Office says, the only thing they're left with, further reductions will all be paid by providers. We're only reducing the 50% of what we're getting right now, and the only thing left for them that they can do is reduce them further. It's not surprising to me that President Obama renounced that we need to give more power to this group. He's actually right. If we want them to do it, they have to be able to deal with some of these things.

---

Now, to solve this, perhaps we learned something from Ronald Reagan [unintelligible]. You recognize these guys, right? Very conservative Republican and very little Democrat, but they actually worked together and social security was in deep trouble. What happened? The annual income had, for everyone's social security, had been greater than expense until '75. Then we had this period with nobody getting anything done from '75 to '81. Then we got this through. What did they do? It wasn't just one part of the [unintelligible]. It was [unintelligible]. It cut the benefits by 5%, it raised the tax rates. Not six times, but by 2.3%. It increased the for retirement age 3% to 67. What did it do? It restored the stability for 25 years. So we probably should [unintelligible] a bit more.

What it did was it basically just took us to where the baby boomers started. But still, that's better than if we had done nothing and will have to do something again now. But as you saw from the unfunded liabilities, social security is not even close to the unfunded liability for Medicare.

The first step of solving the Medicare issue, from my standpoint, is to recognize this - denial is not a policy. To deny that this is not a big issue is not going to help us. The longer we wait to do something, the more they're going to have to get involved. So I'm going to give you what I think are some options that would help with Medicare, and you could use a portion of these. Then at the end I want to come back and see if you think any of these are worth considering. You can vote for more than one because I don't think anyone is going to do, as you'll see.

One is to raise the eligibility age. Well, what has happened? When Medicare came into being, if you reached the age 65, the average person lived fourteen years basically. About fourteen years. Now, they live about nineteen years. So they increased here about 4.3%. So now what happens? When we started Medicare, now we've got to pay for an additional four years than we did initially. Guess what happens to average cost per person as you get older.

---

Female: It increases.

Bob Smoldt: It increases. Why? Because we have more medical problems. I mean, it's common sense. So that makes the problem a big issue. If we were going to correct it on the basis of this, you'll hear a lot about when we get to 67, we should be [unintelligible] 69 or 70, and we pay for the same number of years, but even the 67 would help.

Another problem, when you hear the projections of how long the Medicare trust - the so-called trust fund. As if we actually had some investments in that trust fund that's going to last. They based that on expectations for what's going to happen with life expectancy. So in 2005, the trust fund projection was that in 2025, twenty years down the road, at age 65 males would live 17 to 25 and females would live on average twenty years. What had happened by two years after they issued that report? We were basically there. They were saying that was going to happen twenty years down the road? So it depends partly on what occurs, and some people think that with all our current diseases, we may stop having life expectancy grow. I don't know. But it is funny, isn't it? Because if our life expectancy gets shorter, it actually would help us out financially. So maybe we should all do really dangerous stuff.

Have any of you seen what - there's an Internet deal. Have any of you had that sent to you? If you've got a sense of humor, you're willing. I'm over 65 too. I'm a Medicare person. But it really is kind of funny. It says to solve this problem, here's all these things we should do. We should try and fly motorcycles over the Grand Canyon and all those kind of stuff.

This is the perfect question. Do you want to raise your life or not? I find this fascinating. Is medicine allowing us to live too long? Are we retiring too early? If you go to 50 to 2005, the gain in life expectancy was 9.6 years. We were retiring 5.7 years earlier. So when you retire and then your sons were in social network and has a healthy [unintelligible], probably, that's a fifteen year

---

spread. Think about that. That's huge. It's huge. It's already started. People are really working longer.

McKenzie did an interesting study looking at boomers back in 2008. What they realized, boomers aren't ready for retirement. They didn't put enough money aside. So they said they had two options. They could either retire when they were thinking about and just spend less in retirement, or they could work longer, and then they [might even up]. They said there's a huge economic interest to the GDP of the country. If we reduce spending, what happens? The GDP goes down. It would reduce it over this - what? Thirty year period by \$5.4 trillion. That's huge. If boomers worked two years longer over that time period, because then you're spending money, you're going to [unintelligible] other people for what you're spending money on. It actually grew by 13%. So not only do the boomers get out, because the other thing, if boomers work two more years, it reduced by half the number who weren't ready financially to retire. Are they retiring really young? This would take them out to 64. Not really young from my standpoint, and like I say, I'm 67. So anyway, I kind of realize my biases and all that.

The second one, increase beneficiary ratio over cost. If you're on Medicare right now and you pay a premium for Part B - that's the physician and outpatient department - the size of your premium depends on what your income is. I don't think people realize how much this is already geared to income because I've heard people say [unintelligible] we need to increase beneficiary cost for the more well-to-do Americans. I've talked to some people who were actually CEOs of hospitals who didn't even know what was graduated right now. At any rate, so if you're in this up to \$85,000.00, your premium is 25% of the cost and then the government accepts 75%. If you're over \$214,000.00, for premium for physicians and outpatient services is already covering 80% of the cost.

Now in our proposals now that what we should do then is take this up to 100%. That could have - because that's one of the things that's being considered. Oh,

---

let me go back. There's two ways that you can increase this beneficiary [unintelligible]. You could increase these percentages, or a slower way to do it that people don't recognize quite as much is you don't index these out with inflation. So then more people end up just over time falling into the higher categories, or you can just [unintelligible]. They could both be considered.

You can limit the benefits or move coverage to more of the catastrophic. Kind of what insurance you think of when you don't insure your car or replace your oil. Change your oil. You replace it. You had insurance in your car so if you get in major accidents. So you do the same thing on healthcare, and if you did catastrophic. But you can also limit the benefits. To get the Medicare cost down to where it's sustainable, a study that was done and reported in Forbes, that you have to reduce benefits by 53%. So that's a pretty big reduction in benefits. Again, you don't have to get it all from this category, and there are more limited adjustments that are possible. Deductibles, co-pays. Those sorts of things. You can either change it from the program overall or from components.

What do I mean by components? Nursing homes, laboratory tests. Those sorts of things. In the supercommittee, I'm betting every one of these will be - if they did an agreement, every one of these will be there, and they are doing this, this component. They prohibit Medigap policies from paying the first \$550.00. A Medigap policy is covering what Medicare doesn't. If they would limit that coverage, then Medicare itself would save \$53 billion over a ten year period because of the higher co-pay we all use for your services. Then lab tests, home healthcare, skilled nursing, increase in the [unintelligible]. So those are the sorts of things where you change the benefits of.

Increase Medicare taxes. To correct the underfunding of Medicare - it's 2.9% of your earnings right now - you'd have to up that by 3.9% to 6.8%. So if you took a self-employed person - so that person is his own employer, he has both the employee and employer share - who made \$100,000.00, his Medicare tax would go from \$2,900.00 to \$6,900.00. Then of course all that is in addition to his

---

income taxes. So it'd be a huge jump. Again, you don't have to do the whole thing from that.

Change in Medicare policies and payment approaches to get more efficiency rather than the across the board reductions that the government does right now. You try and financially incent people to become more efficient. Now, what do I mean? This is a look at hospital referral regions. Every hospital referral region in the United States have been studied and there's a huge variation in how much it costs to take care of Medicare patients by hospital region. Some places are just more efficient than others. When they first put this data out - then you can map it out. When they first put it out, New York City cried like crazy because they were one of the higher ones, and Miami and LA. But you know what? It costs more to live here, it costs more to buy space here, it costs more to hire our staff. We have more people who are uninsured, and that increases our costs as well, and those sorts of things. They're legitimate points.

So what do these [unintelligible] do? They did a huge - what's called risk standardization in adjusting the cost. They tried to - and it was in 30 things they were adjusting for to make this as apples to apples as they could. When they did it, there wasn't as much variation, but there's still a huge variation in cost. So this means the top 10% of hospital referral regions actually spend 17% less than the national average. The percent they spend less than the highest spending, a huge difference there. So if we could get everybody into this or get all of these people into these categories, you really could save 12% to 18%.

I'll tell you, I was a Health Administrator for 37 years. I firmly believe that if we could get the places that do not practice medicine very efficiently to practice the way they do in these regions, we could get these savings, but then we have to change how we pay for care to do them.

Yes?

Male:

Just a quick question. This is just Medicare that you have?

---

Bob Smoldt: Yes.

Male: You don't have Medicaid access or any of that [unintelligible] to you?

Bob Smoldt: Not in this one. Not in this one.

Male: Because the providers - I mean, in their world, that's something else that they only [unintelligible] with.

Bob Smoldt: Absolutely.

Male: Because there's an onslaught that's been thrown to the [unintelligible]. Now they're taking on more insured than you do look at.

Bob Smoldt: Yes. Medicaid is going to be a big issue because under the Health Reform Bill, of the people who we're adding, half of the people who are going to have insurance that didn't have insurance will be on a Medicaid program. So they're going to have a 50% increase, if it really holds out and we can do it. I'm not sure we can. By 2020, I think there's a 50% increase in the number of people who are on Medicaid.

Male: Well, that [unintelligible] exacerbate your insurance.

Bob Smoldt: Oh yes. Yes, it will. That's exactly right. The way they would do this, if you are with Medicare, they take our most expensive patients. Twenty percent of the patients account for 80% of the cost. So we can do a lot of work on 80% of the people with over 20% in cost, and guess what? They're not going to pay for all the [unintelligible] on cost. You've got to deal with the expensive patients. Those [unintelligible] ones who are hospitalized, you can reduce. The ICU days, you can reduce. The readmissions, you can reduce. If you do that, you reduce imaging tests, lab tests. That's how you get this down. But you've got to financially reward the providers who used your resources right now. So you

---

want to identify, and we can do this. I'm making a case now for some of my - the next two programs. I'll tell you how I think we can do this, and I'll show you [unintelligible] that will show you.

You've got to do this. Find out who has good patient outcomes and the cost per patient over time and you financially reward them. Then you financially penalize those who don't do it. Guess what those who aren't doing it going to do? They're going to be knocking on the door of the ones who are being able to do it and they'll say, "How the heck do you do that?" Then they're going to figure out how to do it too. What happens today? The more readmissions you have, the more [unintelligible] we have. We've got to change that [unintelligible].

Male: Well, it was not mentioned at all up to this point, but it was certainly implied in the stuff, is total reform. Because an awful lot of what's done in medicine today is to prevent lawsuits.

Bob Smoldt: Yes. Total reform, absolutely.

Male: That's a big piece of this alligator that [unintelligible] doesn't talk about.

Bob Smoldt: Right. You won't see it here today, but it is a big issue. We will be talking about it in some of the others. I just try to take from the [unintelligible] program itself right here. So we've got to change these incentives. If we do that, providers will self organize to do it. Like I said, they'll be knocking on the doors of the people who are getting it done. But here's a frustrating thing. In that reform bill, there's some really good things in there too. One was it instructed Medicare to start paying for value and good outcomes. To me, value and good outcomes over cost. They have issued the initial guidelines on this. They are going to be paying for good outcomes or reduced cost. They aren't even looking at cost. If they're just looking at, gee, this is the process I can do. If you did this as a hospital, you get a 5% reward. It's not really paying for value. This is a frustrating thing. That's what they call it. They say we'll

---

happily pay for a value program, or we're going to have one in a couple of years. But what it really is, it's not actually going to pay for value.

So move [unintelligible] to a premium support model with prior insurance. Do any of you remember seeing this recently? Because it's kind of what Ryan suggested, but he isn't the first one. What would happen is there'd be a Medicare program, but Medicare would not be a government-run insurance company. Instead, it would function the way federal employees get their health benefits. There's a coordinating group, and they have to meet certain standards, they have to take all [comers], and you enroll each - a federal employee picks the insurance company they want to go into, and the government provides the said amount of money to each beneficiary for them to help them pay for that.

So that's what a premium support is. So that's what it means. Rather than you being an insurance company, you provide dollars to help support the premium that you're going to pay as an individual. Now this is not very [unintelligible]. As I said, Representative Ryan recommended it, but it's been around awhile. President Clinton appointed a bipartisan commission to look at Medicare. When his health reform bill failed, he appointed a commission to look at it. That's what they recommended. The majority of the members of that group recommended they go to premium support. The [unintelligible] didn't take it up and neither did the House or the Senate. It didn't even get a hearing. The bipartisan commission, a policy committee taskforce, in 2010 recommended it as well.

When Representative Ryan came out with his proposal - and I like premium support, but I don't like the way Ryan did it, actually. I would do it differently than he did. It's interesting because here's an editorial that was written by the Washington Post editorial writers. Not somebody who somebody sent in. The Washington Post is not Fox News. It's a fairly modern to liberal paper. Here's what they said. Democrats have scared seniors [unintelligible] for years. The next thing, Republicans switched tables on them the last time.

---

Because of paying for the health reform [unintelligible], the Republicans switched tables. They said, “You know what? This health reform bill is going to take [unintelligible] Medicare people.” So they switched the package and it worked. Now Ryan is giving President Obama and his party the chance to reclaim - not the high ground, the low ground - and they jumped.

They said there won’t be Medicare anymore with this, but Ryan’s proposal - in other words, premium support - is honest enough to acknowledge that simply preserving Medicare as we know it is not an option. I hope you agree that we can’t just keep doing things the way we have. I don’t think we can for my kids and my grandkids.

Then they point out what I mentioned. This concept is not beyond [unintelligible]. It’s had support from Democrats. President Clinton’s Budget Chief, Alice Rivlin, has recommended it. Senator John Brown has. It actually undergirds how the Obama reform plans would pay for health coverage for people who weren’t on Medicaid. Basically, what they’re saying is the premium support is something we should consider. Maybe we don’t do it, but we’ve got to consider it.

Male: Is that the program our senators and house representatives are under?

Bob Smoldt: Yes. They’re under the federal employees health benefit plan. You basically would be giving them the type of - if you implement that - I mean, it all is in the details, but that, in essence, is what it would be. It’s always been interesting to me. The members of Congress have not wanted to give that up. It should tell us something. Or there can be some combination of these. I mean, those are some of the basic options.

Now, I do want to just take a vote of hands on what would you do. Not that this is the only thing, but would you? If you were [unintelligible] and you could do this, would you consider to solve this Medicare problem with raising the eligibility age? With this one, let’s see what we have. Okay. Probably 75% to

---

80%. How many would consider increasing beneficiary share of the cost? Probably 40%. Limit the benefits? Okay. Fewer. Thirty percent? Increase Medicare taxes? Okay. About 20%. Change the Medicare policies to get to more cost efficiency? Anybody would do that? Okay. About 80% to 90%. Again, consider moving to a premium support model like the federal employees have. Okay. Some combination. Yes, [not everybody] because I think [unintelligible] it's going to take.

I didn't want to completely impress everybody here, so I am with this slide. It's from the state of [unintelligible], but I think it's so much less. Yes, we can. It seems like [unintelligible] are huge problems, but there is a way out if we're willing to try working at it. To do it, say we do it, if we do our part, but we need to start now because the longer we wait, then the more severe the correction has to be.

Now, with that I'm going to quit. I want to get some questions and some comments here in the room. Nobody can leave. You can't get up and go to the bathroom or anything else until we have some questions. So let's see what you have there, what you have to say to me. Yes?

Female: A comment. I was going through some papers and my husband's birth cost about \$15.00 in 1931. That was baby care and everything.

Bob Smoldt: Yes. Did you catch that? What was it? Fifteen?

Female: Fifteen.

Bob Smoldt: Fifteen dollars. Like [unintelligible].

Male: The cost was two for a nickel too.

Bob Smoldt: Yes. The cost of medicine has gone up more. But I'll tell you what, there's an economist at the University of Pennsylvania that put this in a very interesting way that caught my attention. I thought it kind of put it in perspective. He

---

said, “If I was running an insurance company, I could offer you an insurance policy that would say I am going to cover everything that’s available for medicine to do for patients that exist today, and I’ll do it for the next five years, but I’m not going to cover any new advances that come along to treat.” He had gone back to some calculations. He said if I do that - I can’t remember who it was - I can sell insurance for like 20% less. But he said I bet nobody would take it.

This is the thing. We’re hurt by our own advances from a financial standpoint. I mean, we’re gaining, but there’s all these new discoveries. You think that they’re going to reduce cost, but they don’t because what happens is, as a group, there are some things that we do trust. But the more things you can do for patients and patients want them, doctors and providers want to do that because they want to help patients. So there’s more things you can do. What happens? When [use] goes up, the cost goes up. So that’s a huge part of this, and that’s why every country, everybody said, are your health costs going up faster than GDP? It’s because there are new things that medicine can do.

The UK has tried their hardest to keep them out. Like there’s a new discovery for breast cancer that they weren’t going to allow there, and the outcry was horrendous. Then they finally gave in.

Yes?

Male: Could you flip back to the previous slide?

Bob Smoldt: Yes, sir.

Male: Thank you. All of those things could be done. All those things could be managed. All those things could be real, except E.

Bob Smoldt: Except for E? Change the policy? Oh, I disagree with you. Because you think Medicare won’t do it, or you don’t think it can be done?

---

Male: I don't think Medicare will do it.

Bob Smoldt: Oh. Yes. I think you're probably right about that. I think it can be done. That's why I actually think going to premium support would be better, because guess who is doing this already. Some employers are already starting to put [unintelligible] and place their own employees. But for Medicare, it's such a political nightmare. Like I say, I've had 37 years of doing it, dealing with it. So it's a [unintelligible] to get done. So I think there are ways to do it. I'm not sure Medicare could get it done.

Yes?

Male: What's a shame is everyone is wanting healthcare at all cost, at any expense. There's a lot of people who do not take into consideration lifestyle. Smoking, obesity, health aspects of your life. Then the next thing you know, generations of bad lifestyles are now causing these major, major expenditures. We just got it done with my wife's mom over at the [unintelligible] hospital in emergency. Three days. They did more testing than I ever believe in, like the gentleman in front of me, and they probably did it to cover their backside. Three days in there. It was over \$30,000.00. A few weeks later, we have her back in. \$18,000.00. I'm shaking my head, going, "We know what the problem is, but here we go." We have got to go to emergency. Medicare is picking all of that, but I look at the bill when I go in. This is a 96 year old woman we're talking about.

Bob Smoldt: Yes. Well, you're onto just about [unintelligible]. Another interesting issue that came up at the other session we did, and that is care at the end of life. Again, if you look at care at the end of life, a lot of these hospital referrals [unintelligible]. The variability is huge. It's probably four to one. Does anybody here have a guess at which hospital referral region, which geographic place, has the lowest cost in the last six months of life under the Medicare program for a person that dies? So its cost in the last six months of life for the

---

Medicare beneficiary who dies. Does anybody have an idea where that would be? Anybody from Wisconsin? La Crosse, Wisconsin.

What happened? Now La Crosse, Wisconsin is very close to [unintelligible] in Rochester, Minnesota. I know that already. I did not know if they did this. I know there are two providers there who have integrated systems. They do an excellent job. In one of them, I think fifteen years ago or so, they brought in an [unintelligible]. The [unintelligible] was making rounds around the hospital. He came back with the physicians and the administration and said, "You know what I've done? There is an ethical problem that's here. We have patients in here [unintelligible]. Nobody knows what they want to do. You can't talk to the patients, they're too bad. The family doesn't know. The physicians and the people dealing with them don't. So nobody's willing to make a decision, and so we just keep doing stuff." Then the [unintelligible] said, "I'm convinced we're doing a lot of stuff that these patients really would not want done to them."

They got a huge community effort by both of those provider communities. Frankly, everybody in the La Crosse, Wisconsin area has a living will. It's in those two medical centers. They know what it is and they try to abide by it. Guess what? They have the lowest cost at the end of life. Basically, what it tells me is the people didn't want a lot of that stuff that was being done to them. They really didn't want it. They put it in their living will and then their [unintelligible] could do it. The family felt more comfortable with it. But that's a whole other issue of this very thing that you bring up.

Female: Let me die.

Bob Smoldt: Yes. Yes, sir?

Male: On your C there, I think it's confusing the way you've combined it. [unintelligible] or move coverage to a more catastrophic insurance model. Twenty-five to thirty years ago, I ran a company and our healthcare costs were going up. So we went to self-insurance with coverage for catastrophic that we

---

sold out to the insurance companies, and we had a huge savings than we had in the other scenario.

Bob Smoldt: Yes. You really are right. I felt bad about putting that. It's interesting to me you picked [unintelligible]. I felt bad about putting it there, but I didn't want to pick too many issues here. But you're right, and right now, there is for employed populations, it's called a high deductible health plan or a health savings account. So you have this big deductible, and then you have the catastrophic. Then what they do, everybody - the way it gets criticized is it gets criticized, you don't cover anything preventive, I think. You won't get preventive care. But the places that had it had first dollar coverage for preventive services. For flu shots in that. Other than that, you pay this big deductible.

Just the experience of the employers that had put it in is exactly what you said your experience was. When you have to pay for it yourself, you try to think about, do I want to do this or not? Will I go to the emergency room? Will I contact the doctor or somebody else to [unintelligible]?

Yes, sir?

Male: Yes. This is my concept of free, okay?

Bob Smoldt: Yes.

Male: I get free things in my window of my car, and every time I go to the carwash they want to replace the window. They'd say it won't cost me anything. Well, it won't cost me anything, but it sure as heck isn't free.

Bob Smoldt: Yes.

Male: So there's a lot of stuff that's done, I think, with Medicare that you wouldn't do if it wasn't free, and we all know it's not free.

---

Bob Smoldt: Yes. That's true. Yes, exactly. Ron, did you have a question?

Ron: Yes. In one respect, when you compare the cost at the hospital level, is there any indication when you separate the Medicare patients' cost versus those that are in the hospital that have no insurance or aren't even citizens of the country? Those burdens fall directly on the hospital and the emergency rooms and the costs are astronomical.

Male: Exactly.

Bob Smoldt: Yes.

Ron: Are we saying that because of the way the system is, that Medicare just kind of absorbs part of that, and therefore...

Bob Smoldt: Medicare doesn't absorb any of them. I'll tell you this, the average hospital in the United States in group practice loses money on - not on every Medicare patient. We lose money. Stanford & Middleman, which is an actuary firm, did a big study on this. I think six years ago, 15% of the cost that people under age 65 were paying for their insurance was simply to make up for the amount that Medicare and Medicaid pays less than cost. The point they made, then they showed how much of that gets transferred. What was the percentage for the uninsured? I think it was 2% or 3%. You bet, the cost for the uninsured, the people who can't pay, and for Medicare and Medicaid [unintelligible] cost, our kids and grandkids are picking that cost up. I'm betting right now 20% of their cost is going for that.

There was a big article in the Boston newspaper on this because Mass General released its - and they [unintelligible] their margin by the payer. They lose big on Medicare, they lose bigger on Medicaid, they lose bigger on the uninsured, but there are a lot more people in Medicare and Medicaid. So their total loss was there, and what was their profit margin? If they only made 3% margin

---

overall, what was their profit margin on one of your kids if you lived in Boston? We're seeing the same thing here. For the people who have private insurance, 40%. You need a 40% margin to have a 3% margin overall. Our kids and grandkids are paying huge for that. Maybe it's fine. It's a tax, and people don't know about it. It's a hidden tax. Maybe that's the way we want to do it. I don't know. That's the way it's being done right now, but it's [unintelligible]. No doubt.

Yes?

Male: I'm trying to analyze what you presented here and see if I've got this right. It seems to me that you're talking about two different kinds of things when you talk about cost. One has to do with controlling cost within the medical delivery community, and the cost involved in providing the services, irrespective of who's paying for it.

Bob Smoldt: Yes.

Male: Then the other part of that, which is [unintelligible] different, but yet related, is who ends up paying for how we - as a society, how do we organize ourselves in such a way as to pay for the health facilities. One challenge is reducing the costs as part of the medical delivery system, as through doctors, nurses, hospitals and medicine. All that stuff. Then the other has to do with reducing cost as relating to how we go about paying this through insurance companies and all those things.

Bob Smoldt: Yes.

Male: So there are two different things.

Bob Smoldt: Absolutely. Bingo.

Male: They only get confused in the conversation.

---

Bob Smoldt: Yes. Yes, they do.

Male: It seems to me.

Bob Smoldt: Yes. They absolutely do.

Male: So there's a real challenge as to doing this, and there's also another challenge to doing that, but they are different challenges.

Bob Smoldt: They are different challenges. Here's another key thing. What you really want is to get the cost of delivery and care to be more reasonable. Here's something to remember. We're coming back in two months. I'm sure I'll do this in one of them. Total cost of delivering care is a very simple formula. I come from a foreign family, but I can understand this. It's the price per unit of service times the number of units of service that you'll use. How many doctor visits do you have? How many hospital visits? How many hospital days? How many ICU days? How many imaging tests? If you look at low spending, low cost here in the United States, high cost here in the United States, what makes a difference? Price per unit or number of units used?

Male: Price per unit.

Bob Smoldt: No.

Female: The number of units.

Bob Smoldt: The number of units used is 80% of the difference. How are we trying to control cost in the United States? Reducing the price per unit. We've been doing this for 25 years. It hasn't worked yet, and guess what, we need to follow the cowboy kind of life. If you find yourself in a hole, the first thing to do is stop digging. We're in a hole here in this healthcare field, and if we just keep digging, we're going to reduce the price we pay per unit. You know what happens when you reduce it? I'm sure you [unintelligible]. I'm sorry, you

---

really hit on a hot button right here. I can show you this data. What happens when you reduce the price per unit?

Now let's say you're a physician's office. So you're getting 30% less than you did for the office visit. You end up seeing more patients. Why do you think you're spending so little time with physicians? Medicare keeps reducing it. I can tell you this. Ten years ago, I showed this to our board of trustees with Mayo Clinic. A mechanic working on my car made 30% more per hour than Medicare pays for an internist to see you and try and work out your problem. So you see more patients per day, and then what do you do? You order more lab tests, partly because you aren't spending as much time with them. If you can't figure it out yourself, order a blood test, order a [unintelligible].

I've got a great slide on this that shows that reducing the amount you pay in a three year period of Medicare [unintelligible], the cost per beneficiary went up exactly the same as in years when they increased it. Utilization is the key. Don't remember anything else. You got a key thing here. We want to actually lower the cost. Price per unit times [usage]. [Usage] is the key. I'm sorry, but you really hit one of the hot buttons. You're absolutely correct and on target with your comment. Absolutely.

Male: Hey, Bob, could you set the stage for your upcoming workshops? You're going to be speaking again in two weeks here, and then again in November. Can you give an idea [unintelligible]?

Bob Smoldt: Well, the next one would be on general fallacies about improving US healthcare. You hear these things all the time. Maybe I'm wrong, but you'll get to hear my opinion. If you disagree, be able to tell me how you disagree, and maybe you have something else. I'll give you one example. I'll give you one [unintelligible]. You hear a lot of this in the press all the time, we don't have enough physicians. I think that's fallacious. I think that's not the issue. So come in two weeks and I'll tell you why that's one of the fallacies that [unintelligible]. At any rate, in my view.

---

Then the next one is what do we need to do to improve healthcare? This, people would mention this, but it isn't - again, it's just like we can't solve this problem just by making one of these [letters]. I think to improve healthcare, there's all kinds of letters as well. There's all sorts of things that providers - the physicians, hospitals, nurses - need to do differently. There are all sorts of things that employers and insurance companies need to do differently. There are things the government needs to do differently. Then there are things that we as individuals need to do differently. I'll talk to you about it. So that's what the next two of them are.

You guys have been a great audience. These have been fantastic questions, and you even got my hot button going.

[Applause]

- End of Workshop Proper -