THE BROOKINGS INSTITUTION

A Brookings Briefing

"THE CAUSES AND POLICY IMPLICATIONS OF RISING HEALTH CARE SPENDING"

Friday, February 24,, 2006

1:30 p.m. to 3:30 p.m.

Falk Auditorium
The Brooking Institution
1775 Massachusetts Avenue, NW
Washington, DC 20036

[TRANSCRIPT PREPARED FROM A TAPE RECORDING]

MILLER REPORTING CO., INC.
735 8th STREET, S.E.
WASHINGTON, D.C. 20003-2802
(202) 546-6666

P R O C E E D I N G S

MS. SAWHILL: There's a very bright light out there that's right in—a very bright light in the—for those of us up here. But I guess we'll survive.

Good afternoon. I'm Belle Sawhill. I am Vice President, Director of Economic Studies here at Brookings.

I want to welcome all of you to this forum. It's the fourth in a series of forums we've had at Brookings on health care policy, and it's part of our effort to expand and deepen our involvement in this particular area.

I suspect most of you are fully aware that the health care costs in the United States are staggering. We spend nearly twice as much as most of other advanced nations, and we don't seem to get much better results for all that spending; and in addition, we still have 46 million uninsured.

In addition, and perhaps even more important, health care spending is rising faster than inflation and faster than GDP per capita, and it has been doing so for many decades now.

And that's a trend that's not unique to the United States. The acceleration, or the increase rather, in costs is something that seems to be going on in all advanced countries.

This year's economic report of the President addresses this problem and suggests at least a partial solution, in the form of health savings accounts.

We are very pleased and honored to have with us today to present the Administration's proposals Katherine Baicker, and I think they—we call you Kate. Welcome, Kate.

Kate is currently a member of the CEA. She also has a very distinguished academic background. She has a Ph.D. in Economics from Harvard. She taught most recently at UCLA, and I think that you're in for a treat to hear her presentation.

After we hear from Kate, we will get reactions from two people; first, from Stuart Butler, who's a Vice President at the Heritage Foundation and has been my partner in crime most recently in what we call a fiscal wake up tour of the country. We've been going around telling everyone that we can find that the budget deficits out into the future are unsustainable; that they need to be addressed; and we're hoping that in the process we will raise public consciousness and bring that public to bear on the need for those in elected positions to take some action.

I should point out, as Alice Rivlin always reminds us, that health care is the driver, the major driver, of the long-term budget deficit, so this issue is important not only because it's extremely critical to our wellbeing as individual citizens, to employers, but it's also critical to getting both federal and state budgets under control as well.

Marilyn Moon, a former colleague of mine from the Urban Institute, now a Vice President at the American Institutes of Research, and an old friend

who's here to also discuss the Administration's plan, and so I'm very pleased to welcome her as well. I haven't seen you for a while, Marilyn.

I think whatever one thinks of HSAs, the important point here is that the Administration is trying to address a critical problem, and we here at Brookings are delighted to have the opportunity to provide a fuller airing of their ideas.

So please join me now in welcoming, Dr. Baicker.

[Applause.]

MS. BAICKER: Thank you very much for that introduction, and now if I accidentally tumble off the stage, I can blame it on the bright lights. So that's good.

I absolutely agree with all of the points that you made in your introduction about the challenges facing the economy and the particular important role of increasing health care costs.

So the good news, which you can read about in the Economic Report of the President, along with many other important topics, is that the economy is strong and growing. We've seen strong GDP growth—3.1 percent last year; 3.5 percent forecast for the years to come. We've seen low unemployment rates—4.7 percent, and we've seen really high productivity increases. And in the long run, productivity increases are the drivers of increased wellbeing for people across the country in different areas of manufacturing, services, et cetera. That productivity is the main driver.

But that doesn't mean that we don't face challenges. And those challenges come from many different sources. It's important to increase future economic wellbeing through maintaining competitiveness—both competitiveness with other countries and competitiveness within the U.S. through innovation, education, and immigration. All of those will contribute to a vibrant workforce.

It's also important to keep energy costs under control. We know that real wage growth has been limited in past years by increases in energy prices that make it harder for families to afford a wide variety of products.

But the challenge that I'm going to focus on today is, of course, health care spending. We've seen growing pressure on both public and private budgets from increases in health expenditures, both through insurance and outside the insurance system.

So I will go pretty quickly through my introductory material, because I know this is a very knowledgeable audience, and get right to the Administration proposals as quickly as I can.

Just some background facts: As you know, health insurance expenditures overall, or health expenditures, as a fraction of GDP are projected to rise dramatically, from 16 percent of GDP now to more than 20 percent of GDP in 2015. And we might all have the number 20 percent in 2020 in mind. That was recently revised earlier. We're going to reach 20 percent in 2015, and it will be 25 percent in 2025. So that's an increasing share of the pie.

And that's a pressure both on public budgets, through Medicare and Medicaid, and on private budgets for people purchasing health insurance on

their own, for people getting health insurance from their employers and at the same time seeing limited wage growth.

We also, as taxpayers, pay for a big chunk of that private health spending through the preferential tax treatment of employer-provided health insurance, and I'll talk more about that in a minute or two.

We also pay for people who don't have health insurance to get care that they need in emergency rooms or in clinics.

So as taxpayers, both private and public spending strain our budgets, and then as individuals going out to purchase insurance, as insurance gets more and more expensive, fewer and fewer people can afford it.

So this is obviously a big problem across all sectors of the economy. This is a familiar graph to many I'm sure.

Now, as was mentioned in the introduction, public spending on health insurance through Medicare, through Medicaid in particular, and through those other channels that I've talked about, composes an increasing fraction of public budgets, so we've seen relatively stable federal spending over the last, you know, 60 years, since post World War II, relatively stable federal spending, relatively stable federal revenues.

But that stability of the past, as Alice Rivlin has pointed out on many occasions, masks an explosion in public spending that we'll see if there's nothing changed in entitlement programs—Social Security, Medicare, and Medicaid. You can see on this graph—it's a little compressed—but the green

bars are rising much more rapidly than, say, the orange bars, which are discretionary spending.

In fact, if you look forward, if we didn't make any changes to Medicaid or Medicare spending, it would soon crowd out all other spending that the federal government does. We either have to raise a lot more money to pay for it through higher taxes, completely cut other spending, or find some way to bring health care costs back under control. That's the Medicare spending projection.

This is a graph showing the composition of private health insurance rates, the employees' share and the employers' share. You can see that there was some leveling off in the '90s that could be attributed to the HMO increased managed care penetration that for a while brought the reimbursement rates that providers got down a bit and flattened out growth, but there was a limited amount of that that could happen.

So we've seen private health insurance premiums rising and rising and rising. Interestingly, the employer and employee shares have stayed relatively stable, so that total burden is probably borne by employees in the form of lower wages. But who's actually writing the check hasn't changed all that much.

So all of that you know. Health care spending has been going up, up, up. We can't afford it. It's terrible. It's terrible.

Really, I'm not so worried about the amount of money that we spend on health care. I'm worried that we're not getting our money's worth out of that

spending. We don't sit around bemoaning the fact that we're spending much, much more on consumer electronics than we did in the 1800s or we're spending much more on DVDs than even 10 years ago, because we assume that people are making rational decisions about what consumer goods they want to purchase and that more things are available now and people spend differently.

We feel differently about health care, because there are lots of things that interfere with the efficient allocation of resources so that you can argue we're spending too much money on health care overall, and we're spending it on the wrong people or the wrong procedures. So the total amount of health care spending may be inefficient relative to other things and within health care spending, we may not be getting as much value for that spending as we should.

So there is some evidence of that, both across countries and within the U.S. As Belle mentioned, we spend a lot more than other developed countries, other OECD countries, on health care, certainly in dollar figures, but even as a percent of GDP. We spend much more.

But that higher spending does not seem to buy us better outcomes. There are a number of different indicators that suggest that our health outcomes in infant mortality, in post-heart attack mortality, in utilization of best practices, across a wide spectrum of things, we don't seem to be getting our money's worth on that measure.

We also see that within the U.S., there is wide disparity in how much we spend that doesn't seem to be evidenced in better outcomes in the

places where we spend more. And millions of people don't have health insurance.

So we spend a lot more. There isn't all that much evidence that we get a lot more.

So the goals of policy should be to create a system where spending decisions are made rationally evaluating costs versus benefits and only doing those procedures where the benefits are greater than the costs, and, in turn, where the health care is then made available and affordable to a wider segment of the population.

Now, those two goals sometimes seem to be intentioned, and so what I'm going to argue over the next 15, 10 minutes is that, in fact, there are a number of policies that could further both goals, and those are the places where we should concentrate our effort.

So just to give you a little bit of evidence of those points I just made, you can see that U.S. spending is substantially higher as a share of GDP than a lot of our major trading partners, and, in fact, is not growing any more slowly. It's not that we just started spending more earlier. They are all trending up.

And, in fact, if you look at infant mortality rates, while our infant mortality rates have been falling over time, they have not been falling any more rapidly than our trading partners, and, in fact, are still higher than lot of our trading partners. Now, a lot of different things go into infant mortality. We know that there are a lot of socio-economic factors that aren't a direct result of

health policy, so this is not evidence alone that our dollars aren't going as far as they can, certainly not evidence that we're getting as much as we possibly could.

Now, this may be a little hard for you to read. The point of this graph is that if you look at Medicare spending, so within a unified system where people are supposed to be eligible for the same benefits, if you look at the dollar amounts spent on any Medicare beneficiary by state and you compare that to the quality of care that that person receives, using some very standard quality measures, in fact, there is a negative relationship.

In states where Medicare spends more money on a beneficiary, that beneficiary is a less likely to get high quality care.

Now, I am certainly not meaning to suggest that spending more money causes people to get low quality care. Rather, I think this suggests that it is not at all sufficient to spend a lot of money to get bang for the buck out of what you're spending. And, in fact, there is some evidence that higher use of intensive specialists treatments crowds out the use of high-value effective care that people might otherwise get.

So you see a lot of specialists, and none of them thinks to give you a flu shot, and you end up spending a lot of money through specialist visits without enough money spent towards things that are very high value and very cost effective.

So this is all evidence from within the U.S. and from across international borders that our dollars should be going further.

Once we set up a system where our dollars are getting us our money's worth, by the way, I'm going to be much less concerned about how much money we spend on health care, because I'll assume that it's more valuable to us than the alternative uses of the funds. Right now, there's no way you can say that.

So why has health care spending been going up so much? I think therein lie the seeds to the solution, thinking about what the underlying causes of the increase in health expenditures are.

Surprisingly, or surprising to me, you probably already knew it, it's not the number of doctor visits that you have. It's not the number of times you're admitted to the hospital or the number of days that you spend in the hospital. What it is the intensity of treatment that people get once they go to the doctor or once they go to the hospital.

Now, part of that is a good sign. We didn't use to have all that fancy technology. There's only so much you can spend when the best medicine at your disposal is leeches. But now, we have lots of fancy procedures that are life-saving, wonderful technologies that we're very glad were developed, and that we want to continue to incentivize the development of in the future.

That said, those life-saving technologies may be developed in the absence of the development of technologies that would be cost saving, and that's because nobody has an incentive to develop a procedure that does the same thing only cheaper. And I'll get to why that is.

The underlying fact is that no consumer or actor in the system has an incentive to really evaluate costs versus benefits.

So when you are faced with a reimbursement system that incentivizes more spending, there's no development of more efficient technology to do the same thing, and there's no reason for anybody to evaluate whether a procedure is really worthwhile or not.

What are the institutional barriers that make that not happen in health care relative to other areas of consumer spending, where we don't seem to have this problem?

Well, on the public side, programs like Medicare reimburse for more care, not for higher quality care. So a Medicare patient goes to see a doctor, the doctor gets a much higher reimbursement for doing an intensive procedure than for treating with a more cost effective, low-tech, less invasive procedure, and that may be part of the explanation for why you saw that downward sloping relationship between spending and quality. So that's one issue. And you may also be familiar with the failed experiment within Medicare to reimburse physicians based on what condition the patient has when the patient walks through the door, not on what the physician or hospital does to the patient. That diagnostic related group, DRG, based treatment was supposed to give providers a chunk of money to care for patients, and then let them do it in the most effective way possible. In fact, very soon, DRG pricing devolved into pricing that was based on what you did to the patient, not based on the patient's condition.

So, for example, treatment of a heart attack got divided into treatment of a heart attack with catheterization and treatment of a heart attack without catheterization. And those were two different diagnoses.

You can imagine what happened to catheterization rates, because catheterization—heart attack with catheterization was considered a more serious condition and was more highly reimbursed.

So the administrative pricing within Medicare, even when attempts were made to make it more closely tied to what a patient needed rather than what a patient got. That administrative pricing did not seem to work, and continues to promote more intensive invasive care today. That's the public side.

What about the private side? And the area where I'll focus more now.

The premiums for employer-provided insurance are tax preferred; whereas, what you pay in out of pocket spending for health care that you consume is not tax preferred, so there's a discount on any dollars you pay to an insurance company through your employer relative to everything else.

So what this means is that it is cheaper to consume care that you have pre-paid for with premiums than it is to go make an individual decisions about some particular procedure. So insurance is very good. We—you know we all benefit from the financial protection that we get through insurance, but that always comes at the cost of dulling the incentives to make decisions about individual consumption.

And that's a fundamental tension in all social insurance programs and in all individual insurance choices.

That said, if auto insurance or home insurance were structured in this way, imagine if your employer could purchase your home insurance and anything that came through that you got at a 30, 40, 50 percent discount included in your home insurance would be things like mowing the lawn, repainting the living room—basic maintenance of your house, because it would be cheaper if you got it through your insurance program than if you decided to do it on your own.

And it's because of this tax preference that health insurance looks so different from other insurance products that we all buy, like auto insurance and home insurance. Health care is mostly purchased as pre-paid care through insurance; whereas, those other products aren't.

So that promotion of first dollar coverage means that none of us has an incentive to then choose the most cost effective procedure. This is not news to anyone here.

Even if we did, however, want to go out and choose the most cost effective procedure, we do not have the information available to us to do so. Even in the absence of incentives, there is no way to know if I go to the doctor how much it actually costs.

Now, you think that sounds easy. You just ask. Well, apparently, it's not that easy. There was an audit study that came out of California a couple of months ago showing that people who went—people who called hospitals to

find out the cost of a specific procedure had a very hard time getting information about how much that procedure would cost them, because, of course, for the hospital's perspective, it depends on what kind of insurance you have, on who's doing it, on who's covered by which insurance policy, and no one is in a position to really know ahead of time. So this audit study found that some people, in fact, had to make 17 separate phone calls and visits to find out how much a particular procedure costs. And even then, the information was not comparable across hospitals. In some places, it was all inclusive. In some places, it wasn't. In some places, it was an estimate. In some places, it was a hard quote. It is very difficult to get information about how much your health care costs. You get a bill afterwards, and again there's no other consumer good where you say, yes, I'll take three, and then six months later, somebody gets a bill.

Even more difficult to obtain is information on quality. So, yes, I'd like to know how much something costs, but I'd like to know how much I'm getting for the price. I don't necessarily want the cheapest doctor. I want the best doctor considering how much resources it costs. There's very little information on that as well.

Now, I've already hit on most of the consequences of inefficient spending. Our health care dollars aren't allocated efficiently within the health care system. Things that are more highly reimbursed may not be the most effective, so dollars aren't going to the places where they're going to do the most good. Given that we're spending upwards of 16 percent of our GDP on

health care, I'd like to think that we're spending it on the best stuff, and we're not.

Then we're also not allocating resources efficiently across health care versus food or housing or any other things that we'd like to consume, because we are not able to evaluate the value of the things that we're getting.

So consumers have less money to spend on other things, and, in fact, a good chunk of the stagnation of wage growth that we've seen can be attributed to the fact that employees are getting a higher and higher fraction of their compensation through health care benefits, rather than through wages.

So I think most people have in mind that those things are totally separate. Most employees don't realize when they get their paycheck, how much their employer is actually spending to provide them with health care. If you ask people what their premiums are, a lot of the times they'll tell you how much they are paying out of pocket. Now, that's partly because we're not asking the question specifically enough, but it's also partially because people just don't know how much their employer is contributing to their health insurance premiums. So that's an important distortion in consumer and employee incentives.

And as the price of health care rises and rises, there are more uninsured people, and that's very bad for them, and it's also bad for the rest of us who finance their care through uncompensated care at hospitals, through public health insurance programs if they become eligible, et cetera.

So with that backdrop, that's all well and good. I can stand up here and say that things are bad. We need to fix them.

What are we going to do?

So I hope convinced you that this underlying disconnect between the incentives to evaluate the costs versus benefits is the source of a lot of the misallocation of resources.

So how do we make it better?

Well, if we were to level the playing field between out of pocket expenditures versus things that you buy through your employer's health insurance plan, you would no longer have an incentive to pre-pay for every health care item you consume through higher premiums. You could evaluate basic, routine care, things that you can afford by deciding how much it's worth to you and then couple that with catastrophic coverage to give you financial protection from any large expenditures.

So, again, insurance is good, and I want everyone to have that financial protection for anything above a routine, affordable expenditure.

This would let patients and their doctors decide together what care is best for them rather than forcing them to pre-pay for everything with these really high premiums that fewer and fewer people can afford.

I think people hear about consumer-directed health care plans and they have in mind that people are out on their own, having to decide through a maze of options that seem, you know, beyond their knowledge and ability to choose. People should not, by any means, be out on their own. They should be

working with their doctors to make the best decisions possible. Their doctors need more information, so they can advocate for their patients, and their patients need more information, so they can convey to their doctors what their preferences are. And I'll give you some evidence on how powerful that information can be in a couple of slides.

So there are many ways that you could try to achieve this vision of how we could make things better, and one very promising approach is to build on health savings accounts.

I think everyone knows what health savings accounts are in the room, although, as it turns out, people outside the room not as much as we might have thought. There's been a lot of debate lately in the papers about health savings accounts. Could they work? Who would they benefit? Healthy? Wealthy? You know, would they bring costs down?

And I think Kaiser recently did a survey asking people what's a health savings—have you ever heard of a health savings account? And most people had not. So we have a long way to go in thinking through whether this is going to be a broadly appealing item, because broadly speaking, people don't know what it is. So that's the first problem.

Health savings accts are accounts that let you pay for your out-of-pocket expenditures, tax free, as long as you have a high deductible health policy to go along with it. They were first—they were enabled in the legislation in 2003; first offered in 2004. We now have up to three million people covered by these policies, up from a million just 10 months ago. So they are

increasingly rising in popularity despite their somewhat limited appeal right now.

So under current HSA rules, you have to have a high deductible policy, where, again, I think there's some misperception about what a high deductible means. It doesn't mean a $10,000 deductible or a $20,000 deductible. It means a thousand dollars for a single person—a $1,050 for single person; $2,100 for a family.

There's also a misperception that preventive care isn't covered by these policies. Because of some evidence that we have that preventive care is very cost effective in the long run, these high deductible policies can cover preventive care first dollar. So your preventive care, if you go to the dentist, if you go to a—take your child to the pediatrician, routine preventive services are covered first dollar. They're not subject to your deductible.

Then above your deductible, you may be required to make some co-payment, as with most traditional PPOs or fee-for-service plans, but up to an out-of-pocket maximum of at most $5,000 for individuals; $10,000—$10,500 for families. It could be lower, but that's the worst financial exposure that a person could be subject to while in one of these plans.

Now, along with the high-deductible plan comes the account that lets you pay for things with pre-tax dollars. You can contribute up to your deductible or $5,450 for a family depending on which is lower, and the balance is rolled over indefinitely tax free, so that's different from what people used to have through flexible spending arrangements through their employers, where it

was use it or lose it. And you see all those ads up at the end of the year in the eyeglasses store—get three pairs today, because people are trying to use up their use it or loose it dollars. HSAs are not like that.

Another important feature that is sometimes overlooked is that you can contribute after you realize that you're going to have an expenditure. So as long as you do it within the tax year, you can say, gee, I just went to the doctor and got a thousand dollar test. I'll put a thousand dollars in my HSA that will then pay for the test.

So it's not that you have to know ahead of time how much you're going to spend.

That said, there are things that we could do to make HSAs more widely available and more broadly attractive.

People have higher out-of-pocket exposure than just their deductible, because of that co-pay. People should be able to contribute to their HSA up to their full out-of-pocket exposure, not just their deductible.

People should be able to purchase HSAs through their employer or on their own or rather the high-deductible health policies that go along with the HSA—I'll call them HSA policies—with tax free dollars, whether it's, you know, whether they're offered employer insurance or not.

Low-income people who can't afford the premium of the policy should be given a credit towards the policy, and employers should be allowed to contribute more to the HSAs of chronically ill people. So one complaint that you hear from employers is I'd like to get more of my employees into this, but

some of the sick people don't want to move over into this policy. They should be able to contribute more to those policies if they want to.

Now, all of that is predicated on the idea that once people are in higher deductible policies, they're going to make different decisions about their health care, decisions that are better for them.

Well, they need information to do that. They need information about prices. They need information about quality, and they need information about the cost effectiveness of different treatments. And hand in hand with that goes better health information available system wide. Doctors should be able to figure out what tests you had from another provider. Patients should be able to move from hospital to hospital and not have to duplicate their records.

There's some evidence that a number of diagnostic—a large fraction of diagnostic tests done are duplicated because physicians simply can't find access to a test that was done just a week earlier. So it's much easier to just order a new test than to find the results of the old one in the system. So that's clearly inefficient for everybody.

Now, here's the real heart of the presentation, and I think the thing that we have the most to discuss about as a group and that is what are the potential issues with HSAs? This all sounds great to me—consumer choice, people getting to decide how to use their resources, with financial protection for high expenditures, giving people, you know, who don't currently have access to employer insurance new insurance possibilities.

But there are issues that we want to think through in designing these policies. First, is something like this likely to reduce overall health spending? That's the goal really, although my goal is more precisely to make our health spending dollars go further. Surely, that's going to involve lower growth of health care over the long run.

Second, is health care going to be affordable not just for the healthy and wealthy, but for the poor and sick? That's certainly a distributional implication we want to be careful to consider.

Third, what's the effect on the net insurance rate? So some people are going to move from employer markets to individual markets. Some people are going to move from uninsured to individual markets. Some employers are going to start offering insurance where they didn't before. What's the net effect on the total number of people who are insured?

What's the effect on risk pooling? One important function of insurance is to provide you money when you're in a bad state of health relative to a good state of health. What does this do to the ability of individuals and employers to pool risk in larger groups?

And last, do patients actually have the capacity and the ability to make informed decisions, such that, no matter what happens to our health care spending, we're getting more bang for the buck. We're getting higher value health care, because that again is the ultimate goal.

So I argue first that health savings accounts can indeed reign in overall health spending. One of the arguments you hear is well, 80 percent of

the people—80 percent of the health care dollars are spent by the top 20 percent of spenders. That's true. Most of our health care spending is done by people with high expenditures in that year. It's very heavily right skewed.

So does that mean that everybody is going to be beyond the part of their policy where they actually face any cost sharing, and HSAs aren't going to work? It turns out, no. If you look at what fraction of health spending is done by people within the range of spending where they still have some cost sharing in the typical policy, the answer is about 50 percent. About 50 percent of health care dollars are spent by people with less than $12,000 of total spending.

Keep in mind that's not $12,000 out of pocket. That's less out of pocket because they have a deductible and then sharing up to a lower, at most $5,400 per person out-of-pocket expenditures, but that translates up to $12,000 of total spending, because of the partial cost-sharing above the deductible.

So if you can make half of our dollars spent better, that's great. That goes a long way. So I think this makes it very promising. Also, there is some evidence that even when people are above their cost-sharing threshold, the habits of investigating prices and quality that they learn while they're in the cost-sharing part of their spending spill over to higher spending.

So I think this is a floor as to how much spending would be affected by a policy like this.

Second, people say what about disease management? A lot of the spending is done by people with chronic conditions, and we don't want to take away the incentives for people to do better disease management that health

policies currently try to implement in their populations. HSAs and the incentives that those create work in conjunction with disease management. Most HSA policies that people buy come along with rewards for doing better disease management. The insurer has just as much of an interest in you using your dollars effectively as you do, because above that threshold, it's all the insurers' dime. So they have implemented consistently disease management provisions as well.

You also see these working in conjunction with insurers negotiating with providers. Insurers again have an incentive to get the best rates that they can, both because they can offer lower premiums to the people enrolling who will then choose their insurer over somebody else, but also because again, they're responsible for paying the costs above your cost-sharing threshold.

So all insurers who offer HSAs still negotiate with providers. So this is another tool in our toolkit. It does not replace the tools that we already have.

Slowing spending by even a small percent would, in fact, bring health insurance expenditures as a share of GDP way down, and as a share of individual compensation. And we have some evidence that, in fact, these effects are in place; that HSA premiums have gone up at roughly a third the rate in the last year or so as non-HSA traditional policies, roughly 2.3 percent versus 7.4 percent. So that's a big difference in the increase that we've seen.

Now, you might think well, great. People may be saving money in the short run only to spend more in the long run. We know prevention is important.

Well, prevention is covered by these policies with first dollar coverage, so people should not be dissuaded from getting preventive care. We don't have all that much evidence on individual behavior within HSAs versus within other policies mostly because they're very new and because it's difficult to get experimental design or kind of like experimental design results out of this, but the preliminary evidence that we have suggests first of all that HSAs are not only permitted to offer preventive care first dollar, they do offer preventive care first dollar. A study of the Federal Employee Health Benefit Program showed that HSA policies were just as likely to offer preventive care and were, in fact, likely to offer it at lower co-payment rates, with no co-payment required relative to traditional plans.

So people are offered these services, and again we're going to have to wait a little bit to get evidence of the long-run health consequences of the decisions that people made. They're just too new to have good micro-level data.

The second point I'd like to make is that HSAs, in fact, can make overall health insurance more affordable to a wider segment of the population. A lot of employers don't offer health insurance because it's expensive. A lot of individuals don't purchase health insurance if they don't get it through their employers because it's expensive. Health savings accounts policies are substantially cheaper than traditional policies, partly because people make

better decisions about how to spend their money, so they lower utilization overall. That makes the plans cheaper—also because people pay for routine care, non-catastrophic care, with dollars that they could use for other resources.

Now, when thinking about whether low-income people are going to be able to afford these, people focus on the deductible and they say a thousand dollar deductible or a three thousand dollar deductible. A poor family can't afford that.

In fact, the typical premium for one of these policies is 1,000 to $3,000 less than the premium for a traditional policy, and the deductible is about $1,500 to $4,000 and I've give a wide range, because I looked across a wide sample of policies. The deductible is $1,500 to $4,000 more. So yeah, the deductible goes up, but the premium goes down by a substantial fraction of that deductible. So unless you're hitting your deductible year after year after year, you're financially better off in the HSA plan. And, in fact, most employers contribute to the HSAs of people who sign up for them. I think the average employer contribution is $550 for singles; $1,200 for families.

So the employer contribution can cover a big chunk of the deductible, and then when you consider how much lower the premium is, total expenditures are much, much lower.

So that makes these policies much more affordable to people who might not otherwise be able to afford them.

Again, data on who's actually signing up for HSAs is quite limited, and we have a pretty wide spread of information on that based on whether you're

looking at individual policies versus employer-provided policies; whether you're looking at singles versus families; where you're looking in the country. So I think we all read a lot of conflicting statistics in the paper and part of that is just lack of data. But a good chunk of people signing up for individual HSA-type policies were previously uninsured. I've read estimates from between a third to 40 percent of the people signing up for policies who don't get it through their employer had no insurance before.

In fact, if you look at the Federal Employees Health Benefit pool of people signing up, the non-retirees signing up looks slightly younger by maybe a year than people signing up for traditional plans, but looks demographically very similar.

We also see that there are potential policies that might, in fact, make HSAs and all insurance more affordable to people who are really hard to insure, the chronically ill who don't have group insurance, who have not bought into any kind of group while they were healthy and then find their premiums so high that they can't afford them or perhaps aren't quoted insurance at all.

It's important that those people have access to some sort of supplementary protection, either through state high-risk pools, through vouchers given to them to help them buy private insurance, and the Administration's '07 budget includes a provision to seed innovative state programs to try to cover the chronically ill, who might not otherwise have an access to insurance. But it's also important for people who aren't chronically ill, who are just low-income who don't have the resource even to afford these cheaper policies. They should

get a tax credit that enables them to buy a policy and then put the balance into their HSA. And their premiums and payments should be exempt from payroll taxes no matter where they get their benefits, whether it's through their employer on the individual market. That disproportionately benefits low-income people who are in the part of the income distribution where they're still paying payroll taxes.

And, in fact, the tax preferences for individual purchases of health insurance relative to group purchases disproportionately help low-income people, because, in fact, they are much less likely to have access to insurance through their employer.

So there are a number of provisions that particularly target low-income people or the chronically ill.

Now, you're thinking. Okay. So great individuals who didn't have access to employer insurance can get it—who weren't able to afford it before. But what about people who are getting insurance now through their employer? Are there employers going to be less likely to offer insurance? Is there going to be some breakdown in risk pooling?

Well, first, a lot of employers have found health insurance under the current regime to be unaffordable. Sixty-nine percent of employers offered insurance in 2000; 60 percent in 2005. The driver of that is rising premiums.

So anything that makes premiums more affordable will help stop that employer erosion and will, in fact, enable particularly small employers, who don't currently offer insurance to offer it to their workers.

Now, what about sick people who are in small firms who are currently being cross-subsidized by healthy people? Wouldn't they be hurt if the healthy people go buy individual insurance?

In fact, risk pooling within firms is substantially limited now by a couple of different factors. First of all, employers make different contributions to different plans. There's already breakdown of risk pooling within employers, where healthier people are signing up for the more bare bones plans.

Second, there's some evidence from the economics literature that people with high health expenditures, or high predicted health expenditures, see lower wage increases. So they're already paying more.

This doesn't say there's no cross-subsidization within employer pools. There certainly is, but it's unlikely to be significantly undermined by any of these policies that make it cheaper for people outside the employment system to get an HSA-type policy.

Furthermore, there are several other policies that make it easier for employers to offer insurance. Contributing more to the chronically ill I'll already mentioned and the seed money at the end if there's time, which I can see already that there is not.

I could discuss other alternate proposals like association health plans that would let small employers band together to offer insurance where they might not otherwise be able to.

Now, all of this, as I mentioned before, relies on people being able to make good decisions once they have resources available to them. So they

have a lot more money to play with once their employers have given them cheaper policies. With funding in their health savings account, they can then have higher wage growth that they can use for whatever they want. Well, that's great if they had the information available to make good decisions for themselves.

There's a fair amount of evidence from the clinical medical literature that with a what I would consider bare bones amount of information, people make health care dollars go much further. For example, there's a clinical trial looking at the effect of providing people with information before they get spine surgery. So there are two alternate treatments for specific back conditions, where you could have surgery or you could do bed rest. And the surgery has—you know, it's uncomfortable. It has some risks in terms of going under general anesthesia, and it has the same success rate as bed rest, but bed rest takes much more time, but it doesn't have those side effects. So these are two treatments that are about equally effective, but have very different monetary costs and very different side effects.

And if you look at the rates that people elect to have surgery, when they have these two choices, take that as a baseline, and then show them a half-hour video on what the different choices are, where the video is produced by the best experts in the field just outlining what the clinical ramifications are, the rates of surgery fall dramatically. With the information at hand, people say actually I would rather not, and they don't. And that's one example where they happen to choose the less costly thing. In some instances, they may choose the

more costly thing, and that' great. People should make the decision that's best for them, taking into account the costs and the benefits. And it doesn't take that much information to do that.

You might also think, well, people can only make choices like that about non-pressured, life-threatening situations. Like, oh, yeah, you've got a sore back. What if you're having a heart attack?

Well, certainly people who are in an emergency situation, who are disabled at the time, aren't in a position to make decisions on their own, but their physicians and their families still need the information to make decisions for them as their proxy.

And, in fact, information on quality does affect people's choices about where to get treated even in the case of severe cardiac events. So the study in New York, looking at cardiac care, that found that after the publication of information about which hospitals were higher quality, there was a significant shift in people towards the high-quality treatment centers. Even though a lot of the people going to them were in the throes of a severe incident, they still had enough resources available to their physicians and their family members to make a better decision.

Now, the federal government should lead the way in this effort, and there are a couple of different ways it can.

It can provide information about how much it reimburses through Medicare. Now, that doesn't necessarily directly affect individual payments, but

it's a great baseline for people to have in mind when they're looking at their own costs.

They can also require insurers through the Federal Employee Health Benefit Program to provide price and quality information to enrollees. I'm enrolled in FEHB, and I would love to have that information, and soon I will. So that's a good thing.

These other proposals that I don't have much time for we'll look at: making it easier for small groups to band together to get better underwriting rates and lower load costs when they go to buy insurance. People should be able to buy insurance across state lines, which would make it much easier for them to take their insurance with them when they go from one place to another. It would make insurance more portable, and it would also let people choose the mixture of benefits that was right for them.

The federal government also needs to lead the way in the use of health IT, which I mentioned before, and to promote preventive care and healthy lifestyles, and that's obviously one of the big underlying drivers of long-run health costs.

So with all of those policies together, hopefully we'll enable price sensitive consumers to make good decisions about the use of their health care resources, which will promote cost effective technology, which will make our dollars go further, and then however much we spend on health care is however much we spend.

Thank you very much.

[Applause.]

MS. SAWHILL: Thanks very much, Kate. That was very clear and convincing and thorough, and so we'll turn now to some reactions from Stuart and then from Marilyn.

MR. BUTLER: Stuart, who will not be convincing and thorough; right?

But it certainly was, and I think paid very important attention to the microeconomics of health care, which I think has had short shrift unfortunately for so much of the debate and so critical to understanding it.

I must say in passing that, Kate, I think gap a bad rap to leeches, which I think you mentioned once. I actually saw a Headline News program just a few minutes ago before I came down showing the value of leeches and leech saliva to actually deal with many conditions dealing with the knee. And leeches don't bill you, although I gather their handlers do, so maybe it is cost effective. But anyway.

Certainly, the Administration I think needs to be praised for raising the issue of health care for the—for working people and for emphasizing that in this State of the Union and budget. And in doing so, I think has emphasized the need to address three particular areas, which Kate alluded to—well, alluded to—really focused on.

The issue of costs for individuals and how addressing the way individuals see costs and react to them will affect the long-run general costs of the health care system in this country, in other words, the focus on the micro

aspects of this in order to have an effect on the macro side of the equation; to also focus on the availability of affordable care. Many of the areas that she didn't emphasize quite so much in terms of association plans and other approaches are certainly attempts to try to make available to a broader set of the population affordable plans; and also to focus on the issue of continuity of coverage. I think when we look at portability often people think portability just means being able to go from one plan to another without any difficulty, but, of course, continuity really means being able to carry your preferred plan wherever you work under whatever condition. And I think that many of the elements of the Administration's approach seek to try to achieve that objective.

But, of course, this Administration, like all others, is constrained by public attitudes and the politics, the political economy, of the way people think about health care and react to proposals.

Certainly, when you look at ordinary Americans, their primary concern is their personal cost, their personal after tax costs, not the cost of the entire system. I have never seen a demonstration of people outside with banners saying keep health care costs below 17 percent of GDP. It just doesn't happen. People want to have their costs reduced, and they're interested in looking at it from that point of view, so it does make a lot of sense I think to approach the general macro problem of costs by focusing on people's perceived perceptions of the system itself.

They also tend not to see the link between employer costs, the costs directly paid by other people on their behalf, and their own income, as Kate

mentioned, over time, but we are seeing an erosion of the growth of cash income because of the growth of health care costs. People don't tend to see that. Maybe some who work for General Motors and Ford these days see it rather more, but generally speaking that is certainly the case.

So when you look at how people respond to any proposal, they tend to look it very much on their immediate health care costs.

I think it's also very important to note that people in terms of the political environment to any proposal, people are very resistant to very large changes. The Clinton Administration certainly discovered that; and, therefore, an approach that has a major effect by implication, by changing the dynamics of the way people make decisions on health care, in my view, holds a lot more promise for really having a large effect on the structure and costs of the health care system than trying to approach it in a large macro way in terms of holding costs down in a direct way.

And so I think it's not surprising that the Administration has moved towards trying to approach the individual cost as the major target and also the opportunity to address these broader issues in health care.

Well, the issue is, of course, will it work? And I just want to make some observations quickly with regard to that.

Kate and others in the Administration have emphasized for a long time that the current tax treatment of health care does have—does tend to lead to a pressure, an upward pressure, on health care costs by insulating people, particularly the upper incomes, from the actual costs of health care and certainly

the distinction between out-of-pocket costs and insurance; and, therefore is a major factor in the problem that we general face.

And in putting forward this proposal, in a sense, I think one could say that the Administration is undertaking a big gamble on different pressures on health care costs and making the argument of one will, in fact, achieve—will overwhelm the other. And these are that if you increase or extend the tax treatment of health care to new groups of people, particularly one modeled on the tax exclusion, which may be simplest to do, but certainly has other effects and consequences, if you do that, you will have an effect of causing people to be less concerned about their health costs, even if they have HSAs, and that will tend to be an upward pressure on costs.

On the other side of the equation, of course, by giving people greater control over their health care costs and decision making and by encouraging more competition and availability of different forms of health plans, the argument is that that competitive pressure, that individual attention to costs and benefits, will tend to counteract any upward pressure of extending the tax treatment; and on net, will reduce long-term costs.

Well, I'm open-minded, but I'm somewhat skeptical about whether the net effect will be, in fact, to reduce health care costs. I think it's an open question that should be discussed further.

But let me just look at two or three features of this in the general approach. One, this issue of the tax treatment.

Certainly, if one tries to provide tax benefits, tax advantages, for people to set up HSAs and pay directly and buy insurance outside the employment-based system, that certainly will address their individual costs to some degree and encourage greater competition.

But it is a very, from a public finance point of view, a very expensive and inefficient way to give people tax benefits in order to obtain health care for the very reasons we know about the tax exclusion. It's very badly targeted. It does tend to favor people who are upper income rather than lower income.

And that's one reason why the Tax Commission addressed this issue and argued for placing some cap at least on the total exclusion or the total tax benefits associated with health care. And I would certainly have liked to see the Administration moving more in that direction of looking at a tax benefit to enable people to obtain HSAs or to obtain health insurance directly modeled much more on a limited, more targeted, maybe a tax credit approach rather than the tax deduction and the credit against payroll taxes. I think in the long run we must go in that direction, and it's discouraging that the Administration didn't focus on that so heavily. Admittedly, of course, there is a tax credit for low-income people, but generally moving in the direction of a tax credit and a more targeted tax approach I think would have made a lot more sense.

Secondly, with regard to the health savings accounts, I thin HSAs are valuable for the reasons that Kate outlined. I think having a tax system that is more neutral with regard to insurance or out-of-pocket expenses is a very

important step, and we must continue in that direction. I do feel, however, that providing—or having a requirement that this new tax treatment could only be obtained for individuals for specific kinds of HSAs rather than saying let the market decide what structure of out-of-pocket and insurance makes the best cost effective opportunity for people, I think the tax—any tax treatment should be as neutral as possible about the form, the combination, of HSA out-of-pocket and insurance rather than trying to kind of drive people in one particular direction.

I think it's also another element of the Administration's approach which is important is trying to create new forms of groups so that one doesn't have to have only the pooling that takes place at the place of work as the way of pooling people for insurance. I support those general approaches, although I think association plans and other kinds of approaches like that that are focused only on—only through employers or groups formed through employment is not the best way to go. I think over the long run, we want to make the place of employment less and less a factor in what is available to you in terms of coverage and kinds of groups.

And that's why one of the pieces I do like is the Administration's proposal for association plans does favor or does go towards the idea of saying not just employment-sponsored groups, but other kinds of organizations and associations. I think when we think about the role of intermediaries in the health care system, not just for insurance purpose, but in order to enable people to navigate the health system, to have organizations that are on their side and are trusted, the ability to obtain insurance via organizations that they trust is a

critical step in the long run to restructuring the health care system, and I think that' a very, very important step to take.

I think it's quite possible to have people choosing plans and signing up for plans through associations, through organizations, via their place of work as a simple bookkeeping process. I think that can be very efficient. We do that already in the tax system generally. People almost always pay their taxes through the place of work, because it's a very convenient way to do it. I think we're seeing, in fact, Brookings and Heritage and Georgetown have proposed an employment-based sign-up system for IRAs in order to expand pensions. So I think using the place of work to sign up is one thing. But it's very important to have kind of new groups and associations that are tax preferred as general and open as possible to allow new forms, new organizations, to move into the market that way.

The last point I just make quickly, which I don't think was touched on by Kate, is the notion of giving grants to states to encourage innovation in the treatment and coverage of chronically ill people. I think that makes a lot of sense. Certainly, it makes a lot of sense and recognizes that we don't know the answer to exactly how best with the particular problems of the chronically ill; and, therefore, the Administration is encouraging experimentation at the state level to move in that direction.

I favor doing that in a much more comprehensive way. I think there's lots of aspects of the health care system where we don't really know what

the right answer is, even the debate between HSAs and other forms of insurance and so on.

So I would actually like to see more money or more encouragement of these kinds of innovations and these kinds of experimentation as a general strategy of the Administration, and I think there's a lot of support for that on the Hill in both parties, and it could be—we could see significant movement in that direction if the Administration was to push even harder in that area.

So, in conclusion, I think that just to reiterate the point I made at the very beginning that I think it is critically important for us to try to address the general problem of health care costs as a proportion of GDP and the inefficiency of the system by trying to change the microeconomics of decision making within the system. I think that makes sense economically. I think that makes sense in terms of leading to the changes that we need, and I think it makes sense politically in the sense, as I said, that people do fear large changes in the health care system if they are advocated up front and imposed upon them. I do think that if the Administration's proposals were to go into law, we would see gradual and profound changes in the health care system.

And I think if we're going to achieve big change, whatever the big change is that we support, it is more likely to occur by changing those—the actual incentives for people to make day-to-day decisions on health care rather than trying to impose big changes and structural changes. I think that's one of the big lessons of the Clinton debacle that this Administration and others have learned, and I think it's more likely to lead to success. Thank you.

[Applause.]

MS. SAWHILL: Thank you very much, Stuart. Marilyn?

MS. MOON: Thank you. I'm in the nice position this afternoon, going last, that there are number of things I don't have to talk about that I thought I might, because actually, and Stuart will probably be surprised to hear me say this, there are a lot of areas of agreement I have with what Stuart had to say.

But as you might expect, I also have a few things that I'd like to make some distinctions about as well. First of all, let me say that I think that the chapter that' in the Economic Report of the President is a very interesting one, and I find the analysis of source of growth and so forth very insightful, very careful caveats about a lot of issues that people need to take into account.

And I was surprised—pleasantly surprised—by how reasonable it was. What I found, however, though, I think that there's a big mismatch between what the solutions are to the problem and what the problem itself is, and that is because I think that there's a little bit too much emphasis, particularly on price kinds of issues in terms of health care and the use of health care.

For one thing, I have to admit that I'm a little bit of a defrocked economist these days. I don't believe in it quite as much as religion as some folks do, so that's part of it.

But I think even then, even going back to my economics roots and talking about it from that perspective, there are a lot of things to keep in mind.

The first of these, for example, is that one of the very important things that was a result of the Rand economics—the Rand health insurance study that's referenced in the chapter and that I think is still kind of the gold standard for looking at these things is that not only did it say that price had an impact, but it said that price doesn't have as much of an impact as many people had hypothesized, and, moreover, it was confounded by the fact that you got a very large income effect in terms of these kinds of changes, and that is that people faced with higher deductibles and cost-sharing are much more likely to change their behavior if it's a large share of their income than if it's not, which I think makes perfect sense in terms of economics, but is something that often gets forgotten, particularly when we talk about broad-based approaches to solving the problem of use of health care services in the United States. And that is—comes back again to this whole notion that, for example, high deductibles and high co-pays will be great and that will solve the problem, and indeed you will find a reduction in use, but then you need to worry about how much of that was because people aren't getting necessary care. People are sacrificing because they can't afford it.

So I think that's one very important thing that people always need to keep in mind, and although Kate did a nice job I think of trying to talk about helping low-income individuals, I think she missed the point in a couple of cases.

One is that people aren't very interested with low incomes in buying high deductible plans, even if the premiums are less, because they're not going

to be able to take advantage of those plans if they use a lot fewer health care services, as they often do, and never reach the deductible in a given year.

So one of the things that a number of studies have indicated is that when you offer bare bones policies a lot of people don't sign up because they don't want the bare bones. They know they're not going to get as much out of it as other people would who can afford that.

Certainly, a high deductible plan is great for me. I can do whatever I want. It won't change my behavior one wit, because I have the income to deal with a thousand dollar or $2,000 or even a $3,000 deductible, and that's quite different for other individuals.

So something that it's very important to keep in mind in terms of thinking about this.

The other thing that I think is an important issue to emphasize here is the question of how people get health care. And I think that's really important to think about. Most of us use care unnecessarily in many instances, but that's after the fact looking back and saying, boy, I didn't need that test. Boy, I didn't need that analysis.

[End of tape side 1, start side 2.]

MS. MOON: [In progress.] specialists. But a lot of times that's because not only did we not have the knowledge beforehand in terms of the good information that Kate was talking about, which I agree is essential, but because nobody had that knowledge, and we were operating on the basis of the best of

possible intentions, weighing our decisions, making a choice, and finding out after the fact that test didn't tell us anything, so we're going to use the next test.

And if that one doesn't tell us anything, we're going to use the next test. And those people who end up with very high health care expenses end up with very high health care expenses with all the best intentions, no intent to overuse health care services, but because they lacked perfect knowledge as they were going through the system. And after the fact, we can always sort out and say, one-third or 10 percent or whatever of this was unnecessary, but most people that I've ever talked to don't say, gee, just because it's free, I think I'll go and have that test, 'cause it's lots of fun to lie in the MRI and go through there.

Now, it is easier to do these days than when in the old days they said if we don't know what's wrong with you, let's cut you open and see what we find. That certainly has increased people's use of services when they're easier and less invasive and so forth. But I don't think that price is a major driving mechanism when people have a troubling problem. They don't know what to do with it. They're not sure what the right approach is, and they move ahead.

And, in fact, I think one of the very interesting things that Kate talked about was the study that showed that if you provide people information on spinal surgery, a lot fewer people had the surgery. But when you think about it, for most of those people that's counter to what their economic incentives are, because their economic incentives are to get it done quickly, to loose less work, which no one is going to compensate them for, and get it done quickly and have insurance pay for it. So people don't always need financial incentives. That's

not always the driving force, and, in fact, I often think that to a certain extent we've gotten to consumer driven health care by saying my goodness; we've tried having professionals do it through managed care. We've tried to inform hospitals and doctors and get them to be more conscious of care, and we've failed miserably on those fronts, so now let's stick it to the consumer, and, of course, they'll be much better consumers of health care. They'll be much better decision makers than our doctors, hospitals, other managers of services.

So I'm a little skeptical of this. I do think that some of it moves in the absolute right direction. I do think that we provide a bias in terms of the tax system, for example, to get too much insurance coverage, and I would like to see, for example, more deductibles. I think that's a useful thing, particularly in the United States, where people do like to think they're getting a little something for nothing. But I don't think it's going to have the kind of impact that a lot of people tend to put faith in.

The critical piece here, of all of that, is better information. And we better be willing to put a lot of investment, much more than I see from this Administration or from most Administrations that have talked about this, and paid lip service. All you have to do is look at how much information, for example, we're putting into the new prescription drug plan under Medicare to get a sense of how successful that's been at this point. And I don't think that we're going to be putting in the level of investment into AHRQ for cost effectiveness and what—and even just what works and what doesn't as compared to what we would really need to have a system that worked better.

I'd like to see a lot more effort in that direction, but that means some dollars up front, and I don't think as a society we're there yet.

So let me conclude by saying that I'm hot for HSA plans. I'd like to go that route, but only if everyone in the United States had pretty similar incomes, so we weren't asking low-income people to take it more on the chin than higher income people; secondly, that people were very knowledgeable about health care needs and we invested in it because I see that as a total public good. It's not something that makes any sense for Aetna to invest in for its enrollees, because it will have spillover effects and those people that are signed up for Kaiser will actually learn something and save some costs; third, where it is the only type of insurance that's out there, because of the risk pooling problems, and I don't buy the argument that it's already a problem so what the hey, we could just make it a little bit worse and nobody will notice, because I think it will make it substantially worse; and, fourth, where health care spending costs really reside is not in the first thousand dollars. And I don't buy the argument that 50 percent of the health care spending is for those under less than $12,000. I do think that that statistic is correct, but that doesn't mean that HSAs will then have an impact fully along the way there.

First of all, everyone who's now spending in that range already is paying substantial cost sharing, and the Administration's proposal for people in that range is essentially to allow them to deduct it from their taxes, making that worse, not better, and secondly, as I said before, I think it means that people are already who are spending $12,000 a year are already committed to dealing with

a substantial health care problem, and they're well on their way to trying to figure out what on earth to do. They're part of that 70 percent, and they've made that decision to move ahead regardless of price, long before they've gotten to $12,000 of health care coverage.

So I think we could help put a ribbon on this pig by making it tax credits, for example. We could provide some additional benefits to low-income individuals. We could provide a lot of investment, but I don't think we're going to do that first of all, and secondly, I still suspect that in many ways it's going to be a pig under all that ribbon and makeup and perhaps even a tutu or two here or there.

So I'm a little skeptical of this. I think there are ways in which we should make people more sensitive to health care costs, but I think in particular we ought to be talking a lot about bang for your buck and that bang for your buck ought to be emphasizing exactly what kind of care works and doesn't work. I'm all in favor of that kind of an approach. Thanks.

[Applause.]

MS. SAWHILL: Thank you very much, Marilyn. We can now open this up for some discussion and some questions. I have a few, but I see some eager hands out there, so let's start with this gentleman over here. A microphone is coming. Please introduce yourself and your affiliation before you make your comment or ask your question.

MR. SMITH: My name is Bruce Smith [ph.] from George Mason University. A question for Kate and perhaps the other colleagues, too.

If I understand the concept right, you're talking about something between Medicaid—this is not relevant to Medicaid—if you're poor enough, you're on Medicaid, or if you're old enough, you're on Medicare, or you're dual eligible—but the query I have is it envisaged that you have some application, for example, to either of these programs—Medicaid or Medicare? Let's just postulate, for example, in long-term care, how would the HSA concept fit into, say, an alternative to the spend-down and getting on to Medicaid for long-term care? Would it tie in in some way to the insurance schemes and plans and whatnot that are out there to help provide for nursing home coverage or something of that sort, and then perhaps on the Medicare end, mandatory—Part A is mandatory. But, as I understand, Part B and D you can opt out of.

Now, would you envisage that there might be some application where as an alternative to Part B or D in your drug coverage or your hospital or your doctor visits, not your hospitals, could that have some application as a supplement or alternative or something to Medicare?

Do those questions make any sense?

MS. BAICKER: Those are great questions, and you raise a lot of interesting issues that I won't be able to fully address.

One small point I'd like to make is that certainly there are lots of low-income people who are eligible for Medicaid, but there are lot of low-income people who are categorically ineligible or who are just above eligibility thresholds, where having affordable private insurance available would play an

important role in adding to their options, because they can't be on the Medicaid program. That's one small point I'd like to make.

The broader point about how these proposals interact with Medicaid and Medicare spending I think is very important because half of our spending is through public programs, half of our health spending. And I think there's some good evidence that changes in the way health care is provided to some segments of the population has effects on the way health care is provided to other segments of the population.

There's a lot of evidence, through the Medicare program, for example, of geographic variation in the treatment patterns that are used that have nothing to do with the underlying need of the population or population illnesses or characteristics or even preferences, but are just about treatment styles in different areas. And I can imagine that anything that rationalizes treatment in the private sector would, in fact, have positive effects on spending through public programs by making treatment patterns better for all the patients who walk through a hospital door, and that relies on better information being available, both to the patients, but, as Marilyn pointed out, to doctors as well. Better health information technology and more money devoted to quality studies would make physicians and providers in a position to make, to advise their private patients and to treat their public patients in ways that made health care dollars go further.

So I think there are important interactions between those programs.

Then thinking about how Medicare enrollees might be able to take advantage of some of the innovations proposed here, Medicare—there are experiments with letting Medicare enrollees get HSAs or participate in alternate forms of health care by choice. They can get their traditional program or they can sign up for different forms of care that might be more effective for them. And those small trials could be expanded to let all Medicare beneficiaries choose the traditional program or choose an alternative way, such as keeping an HSA that they already had from their private coverage before they were eligible for Medicare, and that would let people have better continuity of care as they move from age 64 to age 65. They should be able to keep their same, for example, high deductible policy and HSA and continue to use it, subsidized through Medicare.

And most people, although people have a choice about signing up for Part B or not, most people do, and we're seeing lots more people signing up for Part D, and if all of those people could make their dollars go further by getting more choice in their insurance coverage, I think that would be great.

The last quick point to make is that the same kind of experimentation that Stuart was talking about is now being expanded in the Medicaid program, letting people who are eligible for Medicaid take those resources and use them in a way that suits them best, so letting them get money to go out and get private coverage or to get coverage from their employer that they otherwise wouldn't be able to afford taking up or to enroll their whole

family instead of just the kids who are eligible, that kind of flexibility would make our public dollars more effective as well.

So I think all of those pieces work together to make our health care dollars go further.

MS. SAWHILL: Bill?

MR. GALE: Thanks. Two questions for Kate.

MS. SAWHILL: Tell people who you are.

MR. GALE: I'm Bill Gale [ph.]. I'm at the Brookings Institution.

Two questions for Kate.

One is I think I agree with the comments that both commentators made about the mismatch between the problem and the solution. As I see the problem, summarizing from what you all said, we're spending too much. Spending is going to go up too fast. It's going to create big long-term deficits, and on top of that people face distorted choices because of the way the systems are set up.

So the solution is then A, get better information, which no one can really be against; B, give better incentives, which again there are debates about whether that would increase adverse selection and stuff like that, but let's let them pass; and, C, increase the tax subsidy.

And it's the third part that I don't understand. Reducing the tax subsidy here would reduce health care spending. It would reduce the distortion between health care and other spending, and it would cut the deficit. And raising the tax subsidy, of course, has all the other opposite effects. It raises

health care spending. It increases the distortion between health care and other spending, which is another way of saying it increases overall spending on health care. And it increases the deficit.

So it seems to me for micro and macro reasons, the obvious policy here is to reduce the tax subsidies for health care. Now, that's not independent of the incentives of the information, but why are we increasing the tax subsidy for health care given the micro and macro circumstances that we face?

I had a second question, but that was long enough. I'm going to stop.

MS. BAICKER: Okay, because I've already forgotten the beginning of the question. Another one there would have been no hope.

No, I absolutely agree that lining up the incentives so that people are choosing the right care for them rather than choosing to pre-buy all of their care because of this differential, this unlevel playing field, is key. And you're raising the point, you know, you could level up or you could level down. And in my world, I don't know which one is up and which one is down, but you could either make purchases through insurers not tax—through employers not tax preferred, or you could make purchases made with out-of-pocket spending tax preferred.

And what I've been talking about by letting people spend out of HSAs with tax-free dollars is making it all tax preferred rather than making it all not tax preferred. And I think there's a legitimate debate about which way you want to go.

And one of the rationales for thinking about making out-of-pocket spending tax preferred as a way to level the playing field is that as a society we do have an interest in having people have health insurance; that there are spillover effects to you being insured to me.

And you can imagine that this is an activity that we would like to subsidize. If you're not insured, irresponsible person you, whether you go to the hospital, taxpayers have made a decision that we're not going to let people with critical health conditions not get care because they can't afford it. And I think that's a good decision.

So we're on the hook for people's care, so we have an incentive for them to be insured, to not spread communicable diseases, to get their kids insured—all of those things.

So that's one argument for subsidizing this activity more broadly when we all agree that you don't want to differentially subsidize parts of it.

You could make the argument that you should, in fact, level down and that we should not subsidize health care consumption relative to other kinds of consumption, and I think that's a consistent argument to make, and I'd want to weight it against the benefits to society of having more people insured.

MR. BUTLER: If I could respond to that, too. I mean I agree broadly with what Bill said in terms of one's looking at what would you really want to achieve. You really would want to try to make sure that we don't artificially through the tax system encourage an over consumption and a lack of

sensitivity to cost by shielding people using the tax system, which is one of the points I made.

And I think the Administration is engaged in a gamble as to whether of making people more cost conscious and increasing competition will be greater than the pressure up, you know, of the tax treatment.

I think also it's important, as I also try to say, to recognize that we live in a political environment, and this is part of the problem. I mean that when you—I've always been a supporter of leveling down in the sense of I don't think—I think to the extent we use the tax system to help people get health care, it ought to be for the ones we think need it most, and that's why I do support a tax credit approach.

But politically, this is a very difficult situation. We do know that because Americans don't see themselves as a problem in the health care systems of over consumption, if you then start changing their tax treatment so that they feel they're paying more and getting, you know, a tax hit in some way, they don't like it. And all the votes show you that. All the polling shows you that. So I think that's—if you can figure out a way to solve that particular problem, I think everybody would be, you know, with you, and we'd all be, including Kate, I mean we'd all be supporting bringing down the tax treatment.

MS. MOON: I'd just like to add that I think leveling down makes a lot more sense, and it's not as though you're eliminating the tax treatment. I wouldn't go that far. I would simply reduce it and find a reasonable way to put a cap on it perhaps with the assumption that you would pay—that people

could—that what was deductible was what was the equivalent of something with a large deductible, for example, and then use some of those savings for low-income individuals.

But it is very difficult to move in that direction because we have the health care losers that are going to squawk a lot, and one of the problems I believe, though, is that this kind of an approach really rewards them, and it rewards them disproportionately, and I just don't think that that's the way to go.

I think it's better to do nothing than to go that direction.

MR. GALE: Thanks. Let me just follow up. If we really want everyone to have health care, we could do that with a combination of a mandate and a refundable low-income tax credit. We don't need the hundreds of billions of dollars in deductions for employer health insurance.

So if the argument really is coverage and low income, that's a $50 billion a year problem, not a $300 billion a year problem. It's just like car insurance. We mandate that people have it rather than trying to subsidize it to encourage people to have it.

MR. BUTLER: But the critical point is how you build a political constituency to achieve that objective. And that's where the problem is, and that's I think what has to constrain this Administration and the Democratic Party—

MR. GALE: No, that's a political—

MR. BUTLER: —I understand it's not the same.

MR. GALE: —but part of the sheer economics of it are concerned—

MR. BUTLER: No argument.

MR. GALE: —we don't need the multi hundred billion dollars in health care insurance deductions in order to A, get coverage, and B, subsidize low-income people.

MR. BUTLER: Yes, that's correct.

MS. SAWHILL: I want to bring in some more people, but if I can just piggyback on this last conversation, I think that Stuart's point about the fact that you have two offsetting pressures here, extending the tax preference going in one direction and a consumer choice going in the other, and then you have this estimate that maybe you could reduce one percentage on the growth of spending, is that just a hypothetical or is there some analysis behind that?

MS. BAICKER: So first of all, the one percent number that was in my slide was just meant to be an example of—

MS. SAWHILL: It's a hypothetical?

MS. BAICKER: Right. If you're going to think about the effect of all of this on health care spending, there are three different, if I've pre-counted correctly—I reserve the right to change the number of fingers I'm holding up—mechanism through which this would affect spending.

So there's the quantity mechanism that we've all been talking about that people will make different choices about how much health care to consume, and there are absolutely these two countervailing effects.

And I would argue that the more important one is people no longer having a preference for one kind of health spending versus another. So there are certainly reasons to think that people might, in some instances, consume more health care with more information or with more control over that matter, and if they're being rational and forward thinking about it, then that's not so much of problem for me. But that's one effect; is quantity.

Another effect is on the overall prices of the goods that they're consuming now. Now, why would there be any effects on price? Well, because nobody is actually in a position to—because individuals aren't in a position to monitor price, there's less pressure on providers to compete.

Now, insurers do have some incentive to monitor price, but less so when they don't have to reveal their prices, and when it's difficult for people to compare across insurers and when their insurance purchases are subsidized because they're getting them through their employer. So I think there will be increased pressure on prices, which will also then decrease total spending. And, you know, the quantity effect we're not exactly sure how big that will be. The price effect will, you know, mostly lower things, but, in turn, might enable or incentivize or make it cheaper for people to consume stuff, so they might consume a little bit more, but again that would be a rational decision.

Then the third effect is in the long run the cost saving technologies. And I think that's actually enormous, but very difficult to measure.

So if you think of the quantity effect as happening almost immediately. The price effect is happening over five years or something like

that. But then over the next 20 years, the driver will be the incentives to create better ways to do the stuff we can already do, and that will certainly bring down expenditures for the same bundle of health goods.

Now, in the long, long run, as, you know, in general when nations and people get wealthier, they consume more health goods relative to food, and as technologies are developed that are life-saving, people will consume more of those, so that isn't to say that we're going to consume less health care in the future. I think the growth of it will be slowed, and we'll be getting more for of it because of three avenues.

MS. SAWHILL: I see a lot of people out in the audience who are quite knowledgeable in this area. If anyone has done any modeling, maybe you know something about this, Marilyn, of what the actual effects would be given all these hypothesized effects, I think we'd all be interested.

MS. MOON: I haven't done modeling. I just wanted to make a point about prices and that is one of the areas in which we're getting a very good deal for the most part right now is in the prices for primary care physicians, where insurance companies have ratcheted them down just about as low as they possibly should go I think. My favorite example was the—is Blue Cross/Blue Shield of Maryland, also known as Care First, which decided a few years ago that a visit to a primary care physician in downtown Washington was worth $32.10. And personally what that means is that you don't very much time with that particular provider when they're getting $32.10 to serve you. And that's exactly the opposite of what we need.

We need people that are spending more time at the very basic level, as Kate herself said, in terms of some of the very effective, but low-cost areas. And it's the very expensive technologies that remain—the very high-cost technologies that remain very expensive and continue to go up in price, and this kind of a proposal doesn't really do anything about that.

MS. SAWHILL: Greg?

MR. BLOCK: I'm Greg Block [ph.]. I teach law at Georgetown, and I'm visiting at Brookings this semester.

First, I want to say as a sometimes skeptic of these ideas, I think, Kate, that you did the best single job I've ever seen of laying out the story, and pre-empting the possible critiques. And there is so much I'd like to say, but I won't.

I just want to raise one question. I'm not an economist, but when I teach law students, I sometimes pretend to be one, or at least I try to teach them to follow the money. And I wonder if you might be underestimating the cost savings from the strategy in the following sense: that particularly for lower wealth folks, not only are they going to be spending less in that deductible range, the cost-sharing range, but as a consequence of that, they're going to be drawing less upon the insurance pool, since when you do less diagnostic stuff, you find less stuff that leads to follow-up that insurance will cover.

And aren't we there by introducing a large cross subsidy from the poor to the wealthy in the form of insurance coverage itself. And another aspect of my background, I served in the IOM, the Institute of Medicine, Racial

Disparities Committee, and isn't this system, because African Americans and White Americans of similar income have wealth disparities, differences in household savings, isn't this system likely to expand the health care disparities between disadvantaged minorities and White Americans even after one controls for income, because these differences in wealth will lead to differences in spending both in the co-payment and cost-sharing part of the story and in the draw in the insurance pool?

MS. SAWHILL: Why don't we collect a few more comments before you have to come back in? Yes, right here.

MR. MILLER: Tom Miller [ph.], Joint Economic Committee. A quick statistical observation, which I'll weave into a related question to Kate.

Marilyn exhumed the body of the Rand Health Insurance Experiment. It seems like the autopsy always changes depending on who the medical examiner is. With regard to the impact of cost sharing on low-income individuals, the experiment was designed to—we may do it differently in the marketplace—the maximum dollar expenditure was adjusted to income. It was five percent or 10 percent of your income or the thousand dollar deductible, so, in fact, it was already tailored to someone's income, so it was not hitting the poor more extreme.

Now, there are some questions currently under whether comparability rules as to whether employers could be that customized, whether it would be administratively feasible, but there is a way to adjust cost-sharing to deal with that issue.

Pirouetting on that, though, Kate had some numbers, and it's also in the Economic Report, about the effects of people demanding more health services; that it really wasn't more office visits.

Now, Rand said almost all the savings were from folks just not showing up at the doctor's office, and given that it was a random walk back then, about half of what you would get would be bad care or the wrong care; half would be good care. It didn't hurt anybody's health in the average.

When we are trying to change intensity, we may need some other tools beside the crude front-end cost-sharing to suppress demand, which gets to the information piece.

You talked about price. You're trying to climb that mountain. You talk a little bit about quality—check all the boxes on the process end.

You even talk about cost effectiveness. What you didn't talk about is the cost effectiveness of different providers, which is probably going to be the key ingredient in terms of whether you end up only for an episode of care pay more or less. That's going to affect quantity. That's going to affect intensity, complications, than outcomes.

You hinted that kind of you're willing to kind of have Medicare put out, you know, more price data and FEHB. There are folks who'd like to Medicare claims to deal with this cost effective analysis, and you've got enough claims there to be able to do it if folks could crunch it.

So that's my basic question: If we want to get at this upper end of cost, isn't that the type of metric we're really going to need so that people make the broader decision that saves money in the aggregate?

MS. SAWHILL: Other people want to get in? Okay. Why don't we take up these last two points?

MS. BAICKER: Great. I'll go in reverse order.

I absolutely agree. We need cost effectiveness measures, and so the components of that are cost and effectiveness. And the easier piece to start with is prices, because kind of all know what we mean by that and there's less disagreement. If we could have it all right now, absolutely. And the one thing that I resist is waiting until we have it all to publish any information.

So the first push I think should be on prices, because that could get done quickly, and I think providers are—and insurers primarily are reading the writing on the wall, and we will have price information very quickly. And some insurers have already moved to provide information to their enrollees despite the spillover effects to other providers. There's enough demand being pent up for that that I think that will happen very quickly.

The question is getting people on board for quality measures that you can then put the quality and the price together and then get cost effectiveness, and that—you know there's a recent Institute of Medicine Report, different from the racial disparities one you mentioned looking at different ways of measuring quality and having some uniform standards for that and then starting by requiring, say, insurers participating in FEHB to report that, using

the Medicare data to help develop those measures because that's where we have the best data. All of that I think is absolutely necessary to having an efficient, rational health care system.

So any ideas to push us further along in those directions would be much appreciated. It's certainly something that I place a lot of value on.

Going back to your questions, I'm very interested in the racial disparities literature and have worked a little bit in that area, especially coming out of Dartmouth and looking at the geographic disparities in the Medicare Program, and one thing that's very interesting to me is looking at the source of differences in treatment across race and across income, but particularly across race.

One of the major sources of differences is the difference in quality of providers located in the areas where different—people have different racial backgrounds are living. So it's not that people of different races or ethnicities go to the same provider and get different treatment. Everybody who walks through the door gets treated the same way. It's just that, you know, and my information comes mostly from the Medicare Program, because that's where it, you know, I have the most data . Medicare recipients who live in predominantly Black neighborhoods have lousy hospitals, and they go to those hospitals and get lousy care. And then you look at people who are living in predominantly White areas. They have better hospitals. They get better care.

So it's not that any individual provider is racist or biased. It's that the quality differentials are coordinated with income, but also with race conditional on income.

So getting the lowest quality hospitals and other providers up to national averages would do a world of good for people who are getting the worst quality care, who often unfortunately happen to be minority recipients in the program.

So information available about the quality of the hospitals is the first step towards getting the low-quality hospitals to be better, and that goes hand in glove with what we're talking about here; that we really—we need to identify the hospitals that are lagging behind in meeting best—first, we need to know what best practices are, and a health IT helps with that, but we're making great strides. We need to figure out which hospitals are complying with best practices and which ones aren't. I focus on hospitals, because that's where a lot of the most health-costly decision problems get made, but the same applies for other providers as well. And then we need to create incentives for those hospitals to do better. And one of the tools we have at our disposal is the Medicare Program, and there's some interesting demonstration projects going on right now through Medicare to reward high-quality care in centers of excellence rather than just to reward the quantity of care.

So you need to pay hospitals more when they give people effective care, even if it's not the most expensive care, and if that's the case, then I think the lagging hospitals will be forced, through public pressure and through

financial pressure, to come up into the mainstream, and that will do a world of good at reducing racial disparities.

So I think we need to target low-quality providers, not necessarily target providers who serve particular populations and bringing the low-quality ones up will go a long way towards reducing racial disparities, by bringing everybody up, not by leveling down.

MR. MILLER: Agreed. But what about this reverse [inaudible] cross subsidy filled in.

MS. BAICKER: Okay. I'm working my way backwards. So now, I'm back to your first question, which is, if I recall, that, in fact, if people consume less care, they get less stuff done to them downstream as well and that wealthier people are going to choose more tests, et cetera.

So the first point that I'd like to make is that there is clearly a clinical cascade, as you describe; that if you have a test done, you know, chances are you're going to have another test done, and to get back to something, a point that Marilyn made earlier that I think is important, I would not label a test as unnecessary if you discover ex post that you didn't learn anything from it. Of course, that's a lot of what we do is exploratory and that doesn't mean that it's a bad idea. An unnecessary test is one that is medically contraindicated; that is very unlikely to produce any information that is unlikely to lead to any treatment difference.

So let me give an example of that. There is wide variation across the country in the use of PSA testing, prostate specific androgen. Yes. Look at

me. Testing—and a lot of what they're looking for with low PSA level detection is prostate cancer that is likely to kill somebody in the span of 15 to 20 years.

There's wide variation across the country in the degree to which this testing is done on people 80 years or older. You might say that a test that is going to discover something that is only going to kill you in 20 years is not a great idea for an 80-year-old. But there's wide variation in the rate at which these tests are done, and it's not because some people want them and some people don't. That would be perhaps a good reason. It's because some areas, they just test everybody who walks through the door, and in some areas, they don't.

And so thinking about what the likely benefits of a test are is a key first step, because we know that there are clinical cascades from the things that are done. Now getting people to consume less care overall is not necessarily the primary goal of any of these policies. The goal is to get people to consume care where the marginal benefit is greater than the marginal cost, and our strong suspicion is that that's going to be less based on the amount of wasted resources that we can see through duplicated tests, through tests that are very unlikely to ever find anything clinically informative.

And so I don't see the kind of cross subsidization that you're talking about as a necessary consequence of any of these policies. I see the idea that—and this goes back to the point you were making about low-income people who are not going to get a lot out of the policy, because they're not going to reach their deductible. I'm glad if they're not going to reach their deductible, and

they're not sick; that they end up with a policy that is providing them with financial protection and more income to use on other stuff.

So the goal is—and this goes back to wrap everything up—because we may be drawing to a close—to the point you were making about the invisibility of a lot of health premium spending that people do. When we think about, you know, low-income people being exposed to a higher deductible, that seems bad—a higher deductible that used to be not than a higher deductible compared to anybody else. That seems bad, because we think oh, well, that's risky. But, in fact, their premiums are much lower, and even if their employer were paying that premium that translates into higher wages for them to spend on food, shelter, any other family priorities.

So giving people control over those resources to use them where they're best for them, I think makes people better off. So it's not that people are getting less money. It's that people are having the freedom to use that as wages or as health insurance premiums to purchase health care now, to save it for the future, to use it for something else that the family needs. So what I'm trying to do is remove the forced pre-consumption of lots of health care through high premiums and instead let people get real catastrophic coverage that protects them from high expenditures, but at the same time gives them resources they need for other things.

MS. SAWHILL: I think that Marilyn made the point, though, that—'cause that'd a very convincing argument, and I hadn't thought about it much before. But I think the point she made was the problem of risk pooling, of, you

know, segregation of risk pools is—you made the point that there's already some in employer-based system, but I think she wasn't convinced that that was sufficient guard against the worry that many people have about there being more fragmentation of this sort. Isn't that still a big concern?

MS. BAICKER: So risk pooling is a good thing. If we could all purchase insurance when we were healthy and then some people would get sick and some people wouldn't get sick. In some ways I think that's the ideal insurance pool is all of us together pooling risk, and the fact that our risk pooling right now is tied to employers introduces lots of problems.

First of all, people may be unable or reluctant to switch employers if somebody in their family is sick and they've locked in a particular rate through their employer, and they would have to give up their insurance if they moved from one employer to another, they're less likely to move. And we have some evidence from the academic literature of this kind of job lock that people are—especially people with—who are sick or with sick family members aren't able to move between employers because of the employment-based nature.

Now, you need to propose some alternative if you're going to say that that's not the right way to do things. I think if we were designing a system de novo, none of us would say the right level to pool risk at is the employer. It's a relic of, you know, the tax law, post World War II that we have this employer-based system. Starting over, we wouldn't, but right now we do.

So the question is, would we make—would we undermine risk pooling by making it cheaper for people to get insurance in the individual

market. And the argument, if I can try to summarize, goes that if the individual market becomes relatively more attractive compared to how it was before, healthy people will leave the employer market to go to the individual market, which will leave only sick people in the employer, which will then mean that there's no risk pooling between sick and healthy.

I think there are—

MS. SAWHILL: And those premiums will go up.

MS. BAICKER: So the healthy people's premiums will go up. The sick people's premiums will go down, and you will have lost some cross sensitization.

MS. SAWHILL: And vice versa. Yeah.

MS. BAICKER: There are a couple of pieces of empirical evidence that suggest that that is not likely to happen.

First, the evidence on who's signing up for HSAs in the individual market, because they have this hard back stop of how much your out-of-pocket expenditures can possibly be, in fact, lots of people with predictably very high expenditures find HSAs more appealing, because they don't face the long tale of 20 percent of co-pays up to some very high out of pocket cap or some million dollar lifetime limit, et cetera.

Now, the evidence on that is fairly new and weak. I wouldn't want to hang my hat on what the enrollees look like. When we've done some back of the envelope calculations, though, to see at what point of expenditures would you be better off in an HSA versus better off in a traditional plan, what we see

is that especially if these proposed expansions of HSA tax deductibility go through, people at almost every level of expenditure save money on an HSA even in an actuarially fair plan.

Now, again, those are preliminary estimates. It's, you know, a couple years of data. So we're going to have to wait for sure to see what people's consumption patterns look like once they're in these consumer-directed health plans. We have some evidence.

That's one reason that I think risk pooling would not be adversely affected is that some really sick people are going to like the HSAs, some really healthy people are going to like the HSAs. The draw from the employer market is likely to be mixed bag, leaving a mixed bag left in the employer pool itself.

A second reason is that large employers are very unlikely to stop offering health insurance. They're likely to continue to subsidize it, and people are likely to stay in it. I think most people agree that for large employers, which is where the majority of people getting employer provided health insurance are, are unlikely to change their behavior.

So the group that we're worried about is small employers, small employers who might stop offering health insurance or who might see their premiums dramatically change when some people get siphoned into the non-group market.

You have to balance that against the small employers who might start offering health insurance, because there's now a more bare bones affordable policy available.

So again, we have to compare it to what's happening in the real world now with no policy change, which is a reduction in employer offering, an increase in costs, an increase in uninsurance rates. So I don't think we can compare these policies to if everything were perfect.

We need to compare them to what would happen in the absence of doing that, and I think that they could go a long way towards stemming that erosion.

So there might be some people who would lose risk pooling, and there will be some people who gain risk pooling. And my best read of the literature is that there would be no aggregate loss of risk pooling.

MR. BUTLER: But I think that hinges so critically on the underwriting practices of the insurer. If you have a situation where people are going to be individually underwritten, it's hard to conceive of somebody who has a very bad medical history with an HSA-based system somehow being equal in terms of out-of-pocket with somebody else.

If the underlying catastrophic coverage is underwritten by an individual, and that's I think the issue you've got to deal with—one has to deal with—as you move towards giving people greater control of the dollars themselves and so on, and that's why I do think that it's absolutely—that a critical piece of this is to explore alternative methods of pooling and to spread risk in other ways, and I don't think you have to do that by the federal government coming in and doing it. I think that is exactly where we should work with the states especially to explore that and to look at ways of refining

that coverage and to compare what goes on. You may be completely right, in which case we should see an evolution in that direction where we have a more light underwriting restriction, or you may be wrong, in which case we should have more. But we should see it in practice, and I think that—but I do think that it's—as you move towards more of an HSA-based system, that becomes more important. I think it's solvable, but it becomes a more important feature.

MS. MOON: I'd just like to say one thing and that is that I think it's a mischaracterization to say that the good thing for low-income people is if they pay less premiums and have a high deductible plan and don't hit the deductible that they're better off. In many cases, they're not going to hit the deductible because they use substantially fewer services not because they're healthier, but because they can't afford to use those services; and, therefore, they don't get into the system, and they don't get the health care, and they don't get overt the deductible. I'm not worried at all about the people who are only going to use $500 worth of health care and that's all they need and they have a thousand dollar deductible plan.

And, in fact, those are the healthy folks and those are the ones who are going to sign up for those plans. So we have to be very careful about being—I think the characterization here of insurance is something we ought to come back to the very basic principle, and I agree with the principle is that it should be protecting people against really high expenditures that are beyond what they can afford and that would cause them real problems.

But if we then characterize people as who's better off or worse off under an HSA plan on the basis of the average individual, you're going to absolutely find that it's better for a high deductible plan because most people on average don't spend that much on health care in a given year. It's again those few people that need the insurance.

So I find that some of Kate's logic is very convincing, but some of it is really mixing apples and oranges, saying on the one hand that it's going to not be a problem of risk pooling, but on the other hand it's going to be all these people who spend less, and they're happy to have less expensive premiums.

So it—there's just a certain disconnect there that bothers me in terms of trying to sort this all out. I think it's very complicated. I think it's entirely possible in a perfect world that an HSA plan would work well, although I don't know in that world why you would have an HSA. Actually, I think what you'd have is—you would largely have a—high deductible plans and some ability when people had to spend up to that deductible several times the ability to after the fact perhaps make some deductions.

But I don't think you want to have a plan that rolls over year after year after year for high-income individuals putting their money into the account. Great for me. Not good as public policy.

MS. SAWHILL: Steve?

MR. ZUCKERMAN: Yes, Steve Zuckerman [ph.] with the Urban Institute.

I guess one point I'd like to make that I think Kate and a lot of people who talk about HSAs and high deductible plans is that they kind of use them synonymously. In fact, the early evidence is that many people are opting for high deductible plans and not funding their HSAs, and they're just absorbing the out-of-pocket costs from the high deductible plan, and why are they going for a high deductible plan? Because the premiums are somewhat lower. But the impression that somehow the premiums fall by enough to fully fund the HSA is not actuarially sound.

In fact, increasing the deductible by about a thousand dollars might lower premiums by $300 or maybe a little more than that, but it's not going to lower premiums by enough to fund the additional thousand dollars in the HSA, and I think that that's in terms of thinking about HSAs and high deductibles, you have to really keep these separate; that it's not well instead of paying the money to the—you'd have the insurer spend the money, I'll have the money to spend. In fact, the individual will have a lot less money precisely because the skewed distribution of health spending precisely does not fall as much as the deductible increases.

MS. BAICKER: So first of all, a point well taken that I had been very loose with my use of the language of HSA insurance. There's the account, and there's the high deductible health policy insurance that goes along with the account and to the extent that I've created any confusion by using them too interchangeably, that's a bad thing.

But the underlying point that you're making: I think it is, in fact, surprising what a large fraction of the deductible the reduction in premium comprises. You might think okay to get a deductible—oh, you get a thousand dollar higher deductible. It lowers your premium by $300. In fact, if you look at plan offerings, it seems to be much more, and that's partly because they're incorporating the better use of resources that we're assuming people would—

MR. ZUCKERMAN: [Off mike.] [Inaudible.] favorable selection to this plan.

MS. BAICKER: Well, no, no. I'm talking actually—I've looked at actuarially equivalent. So take the same pool of people, situate them in a high deductible plan versus situate them in a traditional plan. So there's certainly some potential for selection, but even abstracting from that, holding selection constant, you see that people can make up for the higher deductible with about two years of premium differential.

So it's not that in one year, you are—you know, you don't suddenly get a pot of money that is greater than all the reduction in spending, et cetera. There's no magic to it.

But the amount of time that it takes to make up the difference is surprisingly small. It's more like two years, not three or four or five.

Then if you look at the actual data of employer offerings, employers do contribute on average about $1,200 to family policy HSA, the account itself.

So people don't—people who get their insurance from their employer don't have to fully fund their accounts themselves. Their employers

are contributing to it, because the employers have an incentive to get people into these more cost effective policies as well.

So I think the direction of the effects that you're talking about is all exactly right, but the magnitudes don't match the popular perception.

MS. MOON: One of the real problems, though, in doing risk adjustment is that we tend to do risk adjustment on the basis of people's health conditions and that's only part of the story.

And people who are attracted to high deductible plans are often people who also have a predilection to use less health care, 'cause it makes sense to them. It's only a rational response.

My husband is the perfect candidate for a high deductible plan, because if you risk adjust for him, he's been diabetic—Type I diabetic for 29 years, he ought to have a zillion problems, et cetera.

He doesn't have those problems particularly, but the important thing is he hates doctors. He hates hospitals. He does everything possible to avoid going. You have to drag him kicking and screaming, and he's the kind of person who would love a high deductible plan, because the incentive is to use less care.

So we have to be very careful about easy adjustments in terms of making comparisons again when people have a choice in terms of what they go into.

MS. SAWHILL: I have a question on another issue that you raised that I find very interesting and important and that is you talked about the long-

term possibility that technology would become cost saving instead of cost increasing as result of this.

I think that there's been a, you know, big debate—not being an expert—but my sense is there's been a debate about whether it's possible to get from cost increasing to cost saving technology.

Do you have any evidence or studies that would shed light on this sort of hypothesis this might happen other than just, you know, the logic of it?

MS. BAICKER: Well, there are a couple different sources of potential evidence. One is from other industries altogether; that if you look at industries without this insurance superstructure associated with them, we see cost-saving technology introduced in all sorts of technological realms—computing, you know, electronics, even manufacturing. If you look at the productivity of the U.S. economy overall, a lot of the productivity increase that we see is driven not by having necessarily more capital or more labor or better educated, but better use of all of those things together to produce the same amount of stuff using less of those inputs or it's used those inputs to produce a lot more stuff, and that total factory productivity or sort of underlying efficiency is driven by cost-saving technological innovation.

So we see that across lots of different areas of the economy, and I can give specific examples from electronics, but that's I think about as far as that analogy goes in helping us.

That's one piece of indirect evidence.

Another piece of evidence is looking at spending on procedures that are not usually covered by insurance. So look at something like in vitro fertilization. Look at Lasik surgery. Look at dental care. If you look at the price of those things, they seem to have fallen as the technology has improved, as more people have been consuming them, and as more providers have been competing to provide them. And there we've seen, if you look at, you know, the example of IVF, you see higher success rates. You see cheaper and less invasive procedures, and you see guarantees, you know, more money back, blah, blah, blah. And I think that all of those things are driven by the different model of paying for and consuming those things. So certainly none of that tells us exactly how much money we'd save by the kind of innovation, but I think it's very promising evidence.

MS. SAWHILL: Okay. Well, I think we're getting near the bewitching hour here. Unless someone has one last—any up here on the panel?

MS. MOON: Somebody back there. He's been trying.

MS. SAWHILL: Would you come in? Yes.

MR. PETERSON: Chris Peterson with CRS. Kate you had mentioned something from the Kaiser Study that the average contribution by employers to the account in these HSA plans is about $550. There are couple other interesting points from that survey. One is that they said that only 30 percent of these plans actually exempted preventive benefits from the deductible, and the second point is that even thought the maximum out of pocket can be as high as $5,000 plus dollars, on average those out-of-pocket maximums

are pretty consistent with regular PPO plans, which to me demonstrates that those financial incentives may not be there as strongly compared to when we're actually using the $5,000, which gets back to in my mind whether there's really much leverage from these things, if your concern is controlling health care spending.

And you obviously apparently worked at Dartmouth with Wenberg [ph.], and I get tired of hearing the same thing over and over again, but if you're really trying to control health care spending, it seems like you're going to want to do something at the provider level.

And many of the examples that you gave, like, you know, showing people videos, well, I don't think a higher deductible is going to make people watch, you know, a video in their doctor's office. Maybe what you need to do is say let's pay doctors to do this or what happened in New York with the availability of that data. Doubling deductibles isn't going to matter for that. It was something happening at the provider level. And even with Wenberg's stuff, if you double the deductible in Miami, is that going to have a big impact there? I don't think so. It all seems to be to me provider level stuff, which kind of gets back to what Tom was saying. At least, there's an idea where we start to deal with this, and I'm kind of wishing that there was some more innovative thinking along those lines, where there seems to be more traction.

MS. BAICKER: So you raise a lot of very good points. I came out of Dartmouth, the Economics Department and the Medical School, where I worked before, and Jack Wenberg is the father of this literature in geographic

variation in health care, and I highly recommend the Dartmouth Atlas of Health Care that has these beautiful maps showing differential use of treatment, and he really has opened a lot of people's eyes to the fact that more care isn't necessarily better, and that goes along with all the things we've been saying about the incentives for people and providers to figure out what's effective, not just do more and more and more.

And I think the tools that we get through having cost conscious consumers have to be coupled with the things on the other side, like insurers negotiating with providers, et cetera. They—one does not replace the other. You need to use both tools together, and part of that is getting better information to providers about what best practices are. If you look at that variation in care that you're mentioning and see, you know, how much you might—the typical example is Miami versus Minneapolis, where the typical Medicare beneficiary in Miami cost twice as much as the typical recipient in Minneapolis. That person is no sicker, no older, not of a different gender, not of a different race, not with different illness patterns, not with different preferences, just in a different place, and you're spending twice as much. One of my colleagues used to like to put up a picture of a Lexus, and say you could give each person in Minneapolis, and that's the difference in cost that you're spending on these people and no difference in outcomes.

The people in Minneapolis, conditional on all the risk adjustments that we've talked about, don't do any better.

So what is it about this provider setting, given that everybody is on Medicare and everybody is, thus, facing the same financial incentives, what is it about the provider setting that's making the kind of care they're getting so different. And it's partly the lack of competitive pressure, because everybody is being reimbursed more for doing more, and the patients themselves have no incentive to say wait a minute, you're the more cost-effective doctor than you.

And it's not—again, they're not looking for the cheapest doctor, they're looking for the most—they should be looking for the most cost-effective doctor. Nobody is doing that and so these differences in treatment patterns are allowed to persist and, in fact, the reimbursement structure of Medicare encourages them to persist.

And I think that that provides another piece of indirect evidence of the systemic nature of the way that we provide health care that goes along with the racial disparities conversation we were having. When a patient walks through the door in the hospital, in some ways or you know worse is wheeled in on a gurney, it kind of doesn't matter what insurance that particular patient has. The hospital treats a heart attack patient who's wheeled in in the way that it considers the best protocol that it wants to use. And that may be affected by the mix of insurers—of insurance that the people have, the mix of ages and treatments and conditions that they see in people who walk through the door, but something that affects practice patterns in a particular area pervades the whole system.

So you look at Medicare beneficiaries who drive a lot of health care spending in particular areas, and you see that there is no incentive for cost effective care. Providing higher payments to centers of excellence, getting some patients into the system who are cost conscious, even if they're not cost conscious for all of their spending, and even if all of them aren't cost conscious are all forces moving towards more cost-effective technology; in the long run, more cost effective use of all sorts of treatments and new technologies being developed, and I think we need that kind of systemic change and the approach of using individual incentives to get that ball rolling I think is the most promising one for the long run.

MS. SAWHILL: Okay. I want to thank Marilyn and Stuart very much for being here this afternoon, and especially thank you, Kate. I think that if I may speak for myself, but I hope for others as well, it's very pleasing to me to think of someone with your level of knowledge and information serving in a high level in government, and I think this has been a tremendously useful session. So thank you very much for being here.

MS. BAICKER: Thank you for having me.

[Applause.]

[END OF TAPED RECORDING.]

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