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MEMO TO THE PRESIDENT: REFORM HEALTH CARE

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P R O C E E D I N G S

MS. DENTZER: Good morning, everybody. I'm Susan Dentzer, Editor-in-Chief of *Health Affairs* and I have the pleasure of welcoming you here this morning to the final session in a series of 12 events designed to offer ideas to President-elect Barack Obama and his transition team -- soon to be the governing team as of early next week. The Brookings Transition Project is an attempt to refine the policy agenda following what was obviously a watershed election in the onset of a few interesting issues that we now face -- among them the global financial crisis. Some of you have joined in these previous discussions on poverty, on climate change and other issues and we appreciate your being with us again today.

This is, of course, a time of memos and lots of advice to the incoming administration on matters large and small. Some of you may have seen a series of memos that appeared in today's *New York Times*. One of them came from Matthew Wong, age 8, of Chicago. Dear President Obama, the first thing you need to do is put your stuff in the White House -- an important piece of advice. Catherine Galvan, age 6 -- obviously a young woman wise beyond her years -- wrote dear President Obama, if I were president, I would tell people to not talk too much. It wastes time. So these are obviously people with lengthy experience in

government and obviously she obviously did a stint in the U.S. Congress among other things to have walked away with that wisdom.

Well, we have a very succinct memo today to speak about which is Henry Aaron's memo to the President-elect and the incoming administration on another small matter which is this small matter of what do we do with a $2.2 trillion health care system that is growing on average two percentage points faster than real GDP, arguably delivering less value for the money than we would hope, not managing to distribute the benefits equitably across the population leaving close to 46 million people uninsured at any given point in time, lots of incentives pointing in the direction of overuse as opposed to wise use and about 400 other problems that we could think of to highlight.

So let me introduce both Hank here formally now and the respondents who will be discussing and amplifying on some of these things. Henry Aaron, of course, as you know is a Brookings Senior Fellow. He's followed efforts to reform health care since the beginning of time I believe -- at least the 1970s. He's The Bruce and Virginia MacLaury Chair here at Brookings and he has an article on healthcare reform in the current issue of *Health Affairs*, that is to say a special package of inaugural perspectives which we released at midnight tonight and I'm very proud to say that Hank's is among the wonderful perspectives that we are

brining out. Those are available for free on the *Health Affairs* website at www.healthaffairs.org.

After Hank has a chance to lay out what he says in his terrific memo to the President-elect, we'll hear from Alice Rivlin, who is also a Senior Fellow here at Brooklyn -- Brookings -- Brooklyn, whoa. Did you land in the Hudson River this morning? I guess I have New York on the brain. Alice was a Senior Fellow -- is a Senior Fellow here at Brookings. She was recently named one of the 25 most influential public servants of the last 25 years by the Council for Excellence in Government. She previously served as Director of OMB and was the founding director of the Congressional Budget Office. Notably her service at the CBO kicked off a tradition of Brookings scholars being named to that post -- most recently, of course, Peter Orszag.

Chris Jennings is a health policy veteran of the Congress, of the White House and the private sector. He currently serves as President of Jennings Policy Strategies -- a health policy and advocacy consulting firm in Washington. He currently serves as Co-director of the Bipartisan Policy Center's Health Reform Project along with former Senate Majority Leaders Baker, Daschle, Dole and Mitchell. And, of course, Chris having been a veteran of the last time we were assembling in rooms talking about the potential imminence of health reform is a perfect person to have commenting on these perspectives today as well. So, Hank, I'd like to

start with you. You lay out an agenda for comprehensive health reform, but you're not so optimistic about getting the whole thing done all at once. In fact, you suggest very carefully proceeding in steps. So let's layout for the audience what it is you suggest.

MR. AARON: Well, the starting point I think is that for those who hope for health care reform there is an awful lot of good news and reasons for optimism. But there are also reasons for concern and caution because all of the obstacles that have stymied previous efforts to reform our health care system are almost as strong as they were the last time. So I'd like to go through a bit of the good news and the bad news and then explain why I think one needs to be ambitious but cautious.

Start with cost. There have been a variety of estimates of the additional cost of health care to cover everybody in the nation. It's on the order of $100 billion a year. Until about three or four months ago, that number scared people. For reasons I think we all understand, it has less capacity to shock than it did back then. Indeed, the idea of spending additional money now in order to help spur economic growth is perhaps even a plus. So the cost obstacle is dramatically weakened.

A second factor is that as people lose jobs, they lose access to health care and they become fearful. Not just those who lose jobs, but those who fear they might lose jobs. So a dynamic that has occurred in the past may occur all too strongly now as unemployment rates rise. That

is a popular concern about securing access to one of the most important services people have. Business leaders increasingly recognize that they cannot control by themselves the growth of health care spending. We have entering the White House a charismatic president, supported by increased majorities, supportive -- in general terms -- of extending health coverage and reforming the system.

So, for all of those reasons, it's really not at all surprising that those who have been waiting a long time to see a bold thrust to reform the health care system are optimistic and want to go for broke. The obstacles, however, to action remain about as strong as they have been in the past when they succeeded in stymieing previous efforts. And for that reason, I think the central issue confronting the incoming administration is how to choose its strategy for making as much progress as possible. The reason this is so important is that there is one outcome that I don't believe either the nation or the administration for political reasons can countenance -- and that is coming away once again empty handed from efforts to reform the health care system.

What are those obstacles? First of all, the U.S. health care system is dauntingly large. My colleague Charlie Schultz pointed out it's as big as the whole economy of France. It is not easy for a democracy -- particularly a democracy whose political system is calculated to frustrate action when the population is closely divided. It is not easy for a

democracy in one bill to change something the size of the economy of France. The industry is enormously diverse. It employs a great many people -- probably more than 20 million in total, 700,000 physicians. There are 6,000 hospitals. Each of which, incidentally, supplies jobs to communities and therefore is very difficult to downsize when that may be necessary to save money. There is an important basic fact about health care reform and that is that first and foremost, since we're mostly going to be spending monies that we previously were spending, if it's reform, it's income redistribution. It's shifting spending. It's shifting power among groups that are going to be resistant -- at least those who would stand to lose -- resistant to action.

And the last point I'm going to mention is simply to remind you all of what you probably have thought about many times. Health care is very uneven and diverse across this nation. Per capita spending is 60 percent higher in Massachusetts than it is in Utah. The proportion of the population that's uninsured ranges from 25 percent in Texas, to now under three percent in the state of Massachusetts. So the problem of health care reform is distinctly non-uniform across the United States. It's important therefore I think for an incoming president to think about those specific actions which need to pass because they will set in motion a process of reform that is likely to continue throughout and beyond his administration.

So what are key strategic initial steps that should be in my view at the top of the agenda? The first is an item from President-elect Obama's agenda and that is his proposal to set up a health insurance clearinghouse to improve the extremely dysfunctional market for small group and individual insurance. And incidentally, to create a vehicle that could eventually become attractive even to those large employers who currently manage and self-insure their own plans. That kind of institution creates the potential for evolving into an instrument that could leverage system-wide reform in a way that no entity now in existence would be able to do. No entity I will say with the possible exception of Medicare, which unfortunately Congress has not been willing to use to leverage system reform throughout its history.

The second and third areas are ones that are almost so commonly discussed they have become genuine no-brainers -- vigorous steps, which include both money and regulatory leverage to introduce health information technology. It's easy -- those words trip easily from the tongue. Exactly what the content of health information technology is is of critical importance and I will assert that as of now we do not have the software and the specific techniques that we should have to derive the maximum benefits from health information technology and that suggests a current risk. That risk is throwing a lot of money at health information

technology in the stimulus package before the knowledge about how to do it right has been fully developed.

Third, evaluation of medical technologies -- both new ones and ones that are already in practice. That involves both comparisons and it involves cost. Congress has been very chary about doing that, although people left, right and center give lip service to the importance of such evaluation. The history of our efforts to implement such evaluations is dismal. It's sad and it should give caution to those proceeding ahead.

Just as an anecdote, last year Senator Baucus introduced a bill -- the first year appropriation for which on health evaluation was to be $30 million. For those of you who think about the magnitude of the industry, the range of techniques and the cost of research, you will appreciate how grossly inadequate that kind of a down payment would have been. In addition, the legislation barred discussion of cost effectiveness and instructed attention only to comparative effectiveness.

And finally I think -- although it's difficult to imagine at this point in time -- there was until recently a great deal of interest among the states in trying to proceed to extend health insurance coverage. One state -- Massachusetts -- moved boldly ahead. A number of other states discussed it -- revenues proved inadequate, the risks too great, the political energy behind it not sufficient. I think it's important in view of the probability that full reform will not be enactable in the near term at the

national level, that the Federal Government supports such state efforts -- and that means regulatory flexibility, legislative waivers where necessary and some financial support as was available in Massachusetts to help states implement and take on the risks of covering additional people. Now a lot more may well be possible. Some is certain. Congress is going to enact an extension of the state child health insurance program probably within a matter of weeks. It's entirely possible and likely that Congress will reform the way in which physicians are paid under Medicare and still other steps I am sure will be -- there will be an effort to achieve including, quite possibly, the provision of subsidies to make health insurance affordable for more American families -- possibly proposals to reform the way in which the tax system is used to encourage employer sponsored and supported health insurance. These are difficult areas. I feel like the princess who was sending away the prince who was going to try to do the impossible task to break the spell that prevented her from saying anything but I wish you well.

MS. DENTZER: Okay. Well, and on that optimistic note, Hank, just, I guess, as the way -- similar to the way Matthew Wong advised President Obama, first thing you need to do is put your stuff in the White House, you're advising that the first thing that we need to is to put some of the stuff in place that can evolve the system over time -- health insurance exchanges or an exchange, as you said, health information

technology -- although the devil is truly in the details and the technological devil is massively in the details of HIT, comparative effectiveness -- although as you suggest, 30 million isn't going to get you very far. We will just note that the Women's Health Initiative set of studies carried out by NIH, when they are over, will have cost $1 billion, so it gives you a sense of how much you find out if you expend $30 million on finding out information when you're comparing technologies against each other. And then, of course, as you mentioned, supporting some of this data for -- that have been underway and may get underway on reform. So, Alice Rivlin, is that in your view an ambitious enough agenda? Or in addition to moving this stuff into place and avoiding the other set of advice of talking too much and wasting too much time, what should the administration be doing? And the Congress?

MS. RIVLIN: I agree with much of what Henry said as I usually do, but I'm a lit bit more gung-ho at the moment. I think this is the moment for new administration and new Congress to undertake comprehensive health reform. Now, I don't mean it all has to be wrapped up in one bill. In fact, I think that would be a bad idea. But I do think they have to layout a blueprint. And what I mean by comprehensive health care reform means how we're going to get to universal coverage where everybody has basic health insurance at an affordable price -- and we could argue about what basic and affordable mean -- but, and second, a

system that's more effective, more cost effective, more efficient, less wasteful and has some way of controlling the -- controlling or at least deciding on the top line -- how much is health costing the Government. The reason I think this is such a good moment is the essence of health reform is that you have to do a lot of investing up front in all of the things that Henry was talking about -- data collection, IT, experimentation with delivery systems -- and we need to create a new institution or institutions to do all of that. Sometimes Senator Daschle has called it a health-fed . I'm not sure that's the right analogy, but we do need a new institution with some independent. To do that, that's going to cost something and have long run benefits and the expansion of coverage -- even if gradual -- will cost something and have long run benefits. Now, the fiscal situation is ideal for that, just as it was absolutely wrong at the beginning of the Clinton Administration. At the beginning of the Clinton Administration, we were trying to do comprehensive health reform at a moment when we were trying to reduce the deficit in the budget. So we couldn't do the upfront investment and we had to pretend that the efficiency was going to come faster than anybody realistically thought it could. Now, I think we're in a better situation and politically also, as Henry has said, there are going to be a lot of forces that will be saying let's do it. There are lots of ways to go toward universal coverage. I think that the President-elect in his campaign actually chose the right one -- build on the employer-based

system because that's what most people have and, but provide an alternative in the form of being able to buy into an exchange or a clearinghouse where you can get insurance if you are outside the employer system or even if you just have inadequate employer coverage, set up a major exchange or exchanges, as Henry has said, for people to buy into and at a subsidized rate. So, I don't think we have to get there all in one bill, but I would like to see the President layout -- with the Congress -- a plan and show how it's going to -- how we're going to get there over a period. I think Obama made two -- President-elect Obama made two mistakes in the campaign. One was he trashed the idea of restraining the exclusion of employer-based coverage from the tax. I think we ought to cap that because it is anti-progressive in a big way and is a source of possible revenue. And he also said something much too optimistic. He said I'm going to be able to bring down your health premiums next -- he didn't say when. I'm going to be able to bring them down by $2,500 a year. I don't think he's going to be able to do that. He better back away from it real fast or people will be disappointed.

MS. DENTZER: Pigs don't fly (inaudible).

MS. RIVLIN: Pigs don't fly actually. The best we can hope for with a good, solid set of investments in doing this whole system more efficiently, more cost effectively is that gradually we will reduce the rate of

growth of health spending, not that it will actually come down. Enough for me for the moment.

MS. DENTZER: Okay. Great. Well, Chris Jennings, Mark Twain famously said history doesn't repeat itself, but sometimes it rhymes. And you must be doing -- you must be composing sonnets in your head at this point as you hearken back to much that befell the Clinton Administration. Now, as Alice pointed out, some things are different. For some reason, when we were facing in '92 and '93 $200 billion deficits, we felt we had to act immediately to reduce the deficit, but now that we're only facing a trillion dollar deficit, we feel released from that obligation. And, of course, I understand we're somewhat at a different phase -- cycle of the economy and, of course, the magnitude as opposed to shared GDP is very different. But, that's a sort of non-rhyme that is an interesting one to explore here. What do you think the agenda ought to be based on your historical perspective on this subject and based on our current realities? And how do you respond to the visions that Hank and Alice laid out?

MR. JENNINGS: Well, I guess I spend a lot of my time talking -- people like to hear about the similarities and differences and I try to focus on the differences because that means that there's the possibility for successful outcome. And I do believe there are some and I'm going to talk about them. But, I hearken back to something that -- Alice used to call herself a radical incrementalist. And I used to talk about that in the cold

days when we didn't have a Democratic president and we just had aspirations and so that was the best we could hope for. Now I've turned into a pragmatic radical and so which is to say that I do believe this is the time to do broad reform and -- but I don't believe that it's impossible to reconcile what Henry is saying and what Alice is saying and what I'm about to say -- which is to say that I think what we're all saying is we better know where we're going and we should have a broad vision and I believe that that broad vision should be a blueprint and that blueprint should be legislated. Now that does not mean that that legislation has to answer all the question -- all the questions at once. Nor does it mean that each of the policies have to be implemented in year one. Clearly that is impossible. It won't happen. But, I do believe if we start down the road of just saying incremental without that broader vision, we'll just continue to have this conversation and not know where we're going and everyone will sort of think they know where they're going, but it will be all filtered through their own personal views. And I think that doesn't do well by us historically or in any other context. The reason why maybe I'm a little bit more optimistic than Henry is that I believe that we only do big things in this country when we are in crisis. And I think that by any definition, we are facing a crisis. I don't think we would have done in Social Security without the depression. And I don't think we'll do health care reform without something big.

MS. RIVLIN: We've got something big.

MR. JENNINGS: And something big linked to the economy. And I think something else very different than '93-'94, perhaps for the very reasons Alice suggests. The economists really were never very comfortable with the broad health reform focus -- particularly they thought the first priority should be deficit reduction -- and there was a delinking of health reform from the budget back in 1993 and that may have been the right fundamental policy call, but the consequence of that was that it pushed off the timetable for doing health care reform and it also required that we spend a lot of political capital to pass the deficit reduction. And now I think both the economists and the health policy advocates within the White House are all simpatico. They believe that in order to have long term economic growth -- and in particular even fiscal health -- we're going to have to deal with health care and that also means we're going to have to deal with Medicare. That's very, very different I think. I think we had debates in '93-'94 which we're not having now. I think the application of the experiences of '93-'94 -- both in terms of policy and messaging -- is notably distinct and different and I think it provides a great deal of comfort. We don't have the same policies that we were talking about premium caps or small business mandates or mandatory alliances. These types of policies that subject yourselves to very, very, very difficult political criticisms are no longer in existence. In fact, both Hillary Clinton and Bill

Clinton -- much like Alice Rivlin has been talking about -- talked about we're going to have to build up with what we have, looking at the current system and if you want to keep what you have -- keep what we have -- we're going to provide you more options. So, I guess, both from a policy perspective and a messaging perspective -- and I would agree with much of the outlines that Henry lays out about his vision we should incorporate in the policy, but I think that we build on up from there. I also believe that in this town and I think, in reality, that comprehensive reform is far more rational than incremental reform, which is to say that it's very difficult to do insurance reforms without covering everyone. It's very difficult to do prevention well and is very difficult to do chronic care management well if you have people outside of the system. You cannot coordinate care well. You cannot do insurance reforms well. You can barely do HIT well without having everyone within the system. And I think there's also a greater sense amongst the stakeholders that in order to -- for them to trade -- in order for them to compromise, they have to see other things on the table. In other words, incrementalism in Washington -- this city is set up to defeat incrementalism. They don't deal well with comprehensiveness. It's harder for them to defeat because they all want to see well, maybe we should hang around for the debate and see if we can get anything out of it and they're not dumb. They see the growth rate. They see that over the long haul there's going to be enormous pressures to cut and they want to make

sure we have a far more rational system in place when that occurs. And then let me conclude with this because I know I don't have much time and we want to do Qs and As -- but, I think with each passing day we are sensing an increasing discomfort with the amount of resources being thrown out the door. Now, that will not preclude a stimulus economic recovery package and I hope it does not preclude a substantial down payment on a comprehensive health care reform. But I will say this. Regardless of what happens this year, in 2010 and beyond, assuming the economy starts getting better, there will be enormous pressure to do deficit reduction. And if I am a stakeholder, which is to say if I am a physician, if I am a hospital, if I'm a health plan, if I'm a pharmaceutical manufacturer, if I'm a consumer, if I'm a laborer, if I'm a business -- if I see it as important element that there be some Federal investment in the health care system in order to constrain health care costs over the long haul, it scares me to no end to think that we will not act this year, because if the only debate in next -- in 2010 and 2011 -- is deficit reduction, then they will have lost out on a huge opportunity to position themselves in a much better place. So I'll stop with that. Thank you.

MS. DENTZER: Great. Well, thank you all. Chris, just to quickly follow up on your comments. You said that we should have a blueprint that is legislated. What -- how would you think of operationalizing that? Is that like having -- adopting the budget in the

spring and then sending the outline to the appropriations committees to flush out the details? I mean what kind of a structure are you talking about?

MR. JENNINGS: Well, of course, I have the benefit of not being -- neither being within the administration or in the Congress, but -- and so whatever they say it is, it is and I'm far more irrelevant than relevant. But to answer your question, I think what I mean is that you have to have a structure in place as to how you are going to cover people, which is to say I believe you need to talk about all the tough issues including issues like an exchange, a clearinghouse -- how that would work. I think you have to have insurance reforms. I think you have to have a mechanism by which you get people covered, which includes both incentives and subsidies and maybe even a requirement. Now that doesn't mean that has to again be in year one. But I believe you have to talk about what those are. Now you can't answer every single question about exactly what the benefit package is or exactly what the subsidy level will be. I suspect you could look at other processes that put a timetable in place or empower an entity to do. But I don't think I'm prepared to say that you don't even -- you can't come to answers on those things. And I believe it would be irresponsible not to try.

MS. DENTZER: Okay. Alice -- and then Hank, we'll come back to you.

MS. RIVLIN: I agree with Chris and I think for example -- I don't know whether they'd come down -- but, you could legislate a pay-or-play plan and a mechanism for setting the benefit package and a mechanism for setting the subsidies. And you could have quite a structure in place much as was done in Social Security -- although this is admittedly complicated. They legislated it in 1935. Most people weren't covered for about 10 or 15 years. But -- and I'm not suggesting we go that slowly -- but, I think we can phase in the various pieces of it and have the plan in front of us.

MS. DENTZER: Now, Hank, why would that not be the way to go?

MR. AARON: I think the idea that President Obama must articulate a vision, a set of principles -- a general strategy -- is absolutely right. The idea that we are going to make any significant progress without the energy that comes from a shared vision of this kind I think is just no realistic. It does take the kind of statement of principles that both Alice and Chris have emphasized. I am more skeptical about either the possibility or the desirability of trying to incorporate that vision into legislation. My reason is that once you have to put down draft legislative language, you are forced to make -- people are forced to make hard choices about issues that they are not -- that are not going to be addressed in practice in the near term, but that are going to be highly

divisive. It seems to me the art of making progress in this area is to get people who don't necessarily share the same overall philosophy of how the health care system should evolve to agree that specific steps are ones they can support and will take in the near term. More generally, I'm not sure -- I don't think I agree, Chris, that we don't do incrementalism well. If I look back at the last decade or so, what is the one significant progress we've made in terms of health insurance coverage? It's that several million more kids are covered than were covered 10 or 15 years ago. And why is that? It's because of incremental legislation of various kinds. I think that we can -- the SCHIP Bill promises to cover another four million kids -- two-thirds newly covered. There are other steps of that kind that don't go the whole hog, but that will make real progress and we need to pay attention to those that create the tensions necessary for further movement down the road. But if we're forced to debate specific legislative language that incorporates the whole plan, I worry that the effort might fall apart. I do want to call attention to one point which I think is absolutely central. We were talking about it among ourselves before we came in here. There is a real tension between the short term fiscal imperatives and the long term fiscal imperatives. Both Alice and Chris called attention to it. In the short run, to spread coverage we need to spend money. To do almost anything in the health care area, we're going to need to spend additional money. In the long run, health care spending threatens to eat

all our lunch and dinner and breakfast besides. And so limiting the growth of spending is of critical importance. The art form in this whole enterprise -- and it's going to be fascinating to see how they do it -- is how does the Obama Administration blend these two conflicting imperatives -- spend now, save later. That's going to be really tricky.

MS. DENTZER: If we take the example of Massachusetts -- which, of course, took the approach of expanding coverage and only now is seriously about to tackle the cost containment issue -- you will hear obviously different perspectives on different sides. But I think the people who are in charge of the system -- most particularly Jon Kingsdale who runs the Connector, Authority -- says the advantage of proceeding as they did is by getting by everybody coverage, they got massive buy-in into the need for change. And now they have a better platform than ever before that everybody is covered to make the really hard calls -- which, not insignificantly, are going to go right up against the interest that you talked about, Hank -- hospitals. *The Boston Globe*'s been running a series that basically shows that a lot of Massachusetts health spending problem is due to one large system called Partners, which is the Harvard dominated system. So their argument is that the staging -- he would have agreed with you on the staging, but he would have taken the opposite tack issue. He would have said first go for coverage, then tackle -- then you've got the political support to tackle cost reform. Why is that not (inaudible)?

MR. AARON: No, I quite agree. I think -- and he said at an Oregon forum that I was in just 10 days ago, Kingsdale said the secret in Massachusetts was we talked about cost control, but we did coverage, and we really didn't pay any attention to cost control at the front end. There is a debate -- insiders debate among health policy types. Should we put cost control first? Should we put coverage first? Do we have to do both simultaneously in order to make coverage affordable? I believe the right strategy is you do coverage in order to get everybody under the tent and with the objective of trying to narrow the number of payers who supply funds to hospitals and physicians. Only when the number of payers becomes manageably small, it seems to me, does real cost control become a practical realistic possibility. And that, incidentally, is one of the reasons why I think encouraging the development of the health insurance clearinghouse is from along the run, strategic standpoint, central -- not to coverage, but to cost control.

MS. DENTZER: Alice.

MS. RIVLIN: A couple points. I think one thing we wouldn't disagree on is we don't really know how to do the cost control well yet, and the investments in learning, in collecting the data and processing it and analyzing it and trying to find out what treatments work and what don't, that -- and what is wasteful -- that has got to start now and will eventually feed into better reimbursement rates. So that has to go ahead. On the

Massachusetts thing, I think the Connector, which is their word for what Henry is calling a clearinghouse and some people call exchanges, is working in the sense that is simple to access and it gives you a limited number of choices. I suspect there are a lot of people in this room who are in the Federal exchange, which candidates always say -- candidates especially if they're Senators -- say, well everybody should have a system like the one we're in. But, the one we're in is God awful complicated and it doesn't have a standard benefit package and it should be simplified if it's going to be extended to a wider number of people. It should be more like the Massachusetts Connector.

MS. DENTZER: One -- the old joke about the Democratic party is that the Democrats formed their firing squads in circles, and one potential shootout that looms among Democrats is over the issue of a public plan in the health insurance exchanges. That is to say making available through the health insurance exchange a Medicare-like program or indeed Medicare itself, or -- stopping somewhat short of that as Senator Baucus has proposed -- allowing a Medicare buy-in for people 55 and older. Chris, how do you think this will play out because of the concern about Medicare as it is now, the long term fiscal challenges posed by Medicare, the concern about the crowd out of private health insurance by virtue of introducing a new public plan, etc., etc.?

MR. JENNINGS: Well, the debate around the Federal plan option I think is unhelpful at this point. Not -- and I don't mean -- you know, I'm not picking on the Democrats or Republicans. I think it's almost --it's unfortunate that people spend all their days talking about this issue because, of course, I don't even know what we're talking about. When we talk about Federal versus private, in Medicare we have fee for service. We have managed care, PPO, HMO. They're all private planned administered entities. Even our fee for service program is administered by intermediaries and carriers who are private plans. Our -- we just talked about -- we just had this big debate about SCHIP just yesterday where we're expanding coverage and one of the big debates was -- in fact, Henry was -- one of his concerns about having the broader debate, is he thinks that will -- that will -- that the President-elect and soon to be President will be accused of taking over the health care system, Government run. Well, we're already -- even in that debate around SCHIP we were having -- I don't care what that debate is, people who are very, very far right are going to say that's a Government expansion.

FEMALE VOICE: But it's not just the right.

MR. AARON: But the reality --

FEMALE VOICE: It's also the conservative Democrats.

MR. AARON: But the reality -- well, but the reality of the Medicaid program and SCHIP, of course, is that all those kids and all

those women in those programs are in private plans administered through HMOs and PPOs. So I want to first say that. The second point I want to say is even the Obama Administration hasn't said what their public program option is and a public program option could be one of many things. Now I think a Medicare option has pros and cons and I think it will be a difficult one to sell -- particularly if we're talking about Medicare for all -- only because you already have an entitlement debate around Medicare and even seniors will be raising some concerns and I believe the Obama Administration has not weighed in on this. And I guess the last point I'd just like to make -- just overall about this discussion -- and this is why I believe that incrementalism -- if we wait for, you know, the next kids expansion, then the next parents expansion, then the next whatever, we'll be waiting for 50 years. And I believe that if we want to deal with the issues of efficiency in the health care system, that you cannot do it without covering everyone as I've said earlier, and I believe also if you really want to engage in the debate for good or for bad about tax exclusion reform, that you can't even touch that issue without covering everyone -- politically.

MS. DENTZER: Alice.

MS. RIVLIN: I think there's some big down sides to expanding Medicare and even expanding SCHIP as a strategy -- let's get everybody into programs that we know aren't working very well now -- and

this is really true of Medicare. There -- it has been exceedingly resist -- the political system has been exceedingly resistant to making Medicare a more efficient and effective program. I wouldn't put a lot more people in it. I would try to work through this operation of the exchanges and I don't think we need a public plan. What we need is a publicly defined standard benefit package and subsidies for people to buy that who are outside the employer system.

MS. DENTZER: Hank, what would be your perspective on this debate about a public plan?

MR. AARON: Well, I was going to take up on the last point that Alice just made. One area where there was reform within Medicare of a part of the program that was working exceeding poorly and that was with respect to Medigap. A number of years ago private companies were offering a bewildering diversity of plans at absolutely absurd administrative costs with low rates of pay out of premiums. Congress came in and said if you're going to offer a plan, you're going to have to pay out at least a certain percentage of the premiums you receive in benefits and here are -- I think it was nine originally and it's recently been expanded or the number changed -- here is a fixed number of different plans. You can offer any one of those -- sort of a variation on Henry Ford's comment about you can have any color car you want, as long as it's black. In this case, you could have any Medigap plan you wanted as long as it fell within this defined list.

I think that is the kind of regulation that Alice was alluding to. It's a much more prescriptive approach than that of the Federal Employees Health Benefit Plan and if that set of choices is well crafted, the administrative rules are manageable and the overall costs are therefore well controlled. Not only will all individuals and small groups choose to buy their insurance through that venue, you're going to discover a lot of employers who are sick and tired of being bedeviled by the annoyances of administering their own health insurance plans will come to it. And over time, one could see that becoming the financial leverage point for the kind of cost control measures that I think all three of us agree are absolutely essential. My concern right now is we can talk cost control, but if you wanted to design a health care payment and delivery system that was exquisitely crafted to be resistant to cost control, you simply couldn't do a better job than the current U.S. health care payment arrangements. So, we've got to get beyond the point where all we can do is talk about cost control and the critical question is what is an evolutionary process that gets us to a payment system where there are -- there's a focus that can exercise power over the health care system. Alice alluded, I think during her comments, to trying to have a closed financial system in which there are revenue sources coming into this entity that establish a kind of overall limit on how much can be spent. That also is something that we need to think about down the road. But we're so far from that at the present time, that

what concerns me about discussions of cost control is that that's really all they are. They're discussions.

MS. DENTZER: Well, and before we open this up to questions from the audience, which we will momentarily, let me just (inaudible) down a bit on that because, Alice, the phrase you actually used was we need to decide on the top line. And I'm just wondering how you would propose that basically 17 percent of the GDP get together and agree --

MS. RIVLIN: We don't --

MS. DENTZER: -- on what the top line ought to be?

MS. RIVLIN: We don't have a mechanism for doing that now and that I don't -- I'm not proposing that we have one. I do think we can decide on the amount that the Federal Government is paying. We shouldn't decide it every year. Congress should -- every five years or so -- say here is the cost. The big ones are Medicare and Medicaid. And we're going to project that over a certain period and if we run over what we've projected, we're going to do something about it. Now what exactly the mechanism would be for -- but we've got to have something that forces a decision on Federal spending for health care. Now, if we do the things we're talking about up here, it's going to include my subsidies on my buy into the exchanges and some other things. But whatever we do, there has to be a periodic decision point for Congress. Is this getting out of control?

Now, that doesn't tell you what to do about it. It forces you to think about what to do about it and other countries do this. The French, for instance, have a commission that tells the Prime Minister -- their somebody or other -- that they're running over their budget and then they have to come back with a plan as to what they're going to do to control the cost. We have nothing like that and we need it.

MS. DENTZER: Well and indeed we did have this, until just a couple of days ago, a suggestion that if Medicare spending over the long term was to reach a certain amount, then Congress at least -- or at least the President had to propose to Congress what would be done about that. And that was, of course, dispatched --

MS. RIVLIN: It wasn't --

MS. DENTZER: -- was one of the first things --

MS. RIVLIN: It wasn't a very effective mechanism. I think we can do better than that. It shouldn't -- the automatic shouldn't necessarily fall on a particular set of providers, for instance.

MS. DENTZER: Chris, how do you see that, before we open it up to Q & A?

MR. JENNINGS: Well, I don't -- I believe that you can't -- I think this dichotomy of you can do coverage without cost and do cost without coverage -- is a false one and I think you have to do them together and, indeed, I think you can't do one well without the other. That's my

belief. I've mentioned some of the reasons why, but another one would be that if insurers aren't covering everyone, then they're spending a lot of money trying to avoid populations who are sick. I mean that's not how we want to spend our money in the health care delivery system it seems to me. But -- and I will say this, too -- I think that if you look at the debate -- you know, moderate Republicans who are serious about health care reform, conservative Democrats who are very open to it, they'll want to see some movement towards constraint and growth and I believe that's why we have to lay some of this infrastructure down in order to achieve some of those things over the long haul. And while we can do a lot of around the edges, you know, policy interventions and overpayment and inefficiencies in the Medicare/Medicaid program, we do have to change how we deliver health care across this country. Medicare can be a mechanism to help in that regard and I'm actually very optimistic because of what precisely Alice and Henry have said about the desire to have that investment up front -- not just in terms of the infrastructure, which I call HIT, but on the investment and information, which is comparative effectiveness and quality standards and measures, which now exists in a way that never has existed before. And, indeed, in the third eye, which is the desire to talk about incentives to implement those -- that information over a period of time. All those things, I think, can make major contribution to constrain costs and I think if you want to get these

conservatives to support broader health reform, you better have a message in that area. And here's the last point. This public, private whatever -- no matter what happens in this country, we are going to be spending per capita the least Federal and public expenditures in terms of percent of public versus private than virtually any other nation in the world. We still are going to have a dynamic substantial major private sector force. That's who we are. It may be inefficient, but that's who we are. And -- but here's the point. If we don't deal with this issue, we're going to be spending $4 trillion -- not $2 trillion -- in eight years. And it's worth having that upfront investment to slow the grate of national expenditures on health care. We shouldn't be all caught up in Federal versus private because -- and public versus private -- because in the end of the day, if we don't have more public investment, we will have more national cost.

MS. DENTZER: Alright. Well, you can see in our health reform task force of three, there's just great consensus already on how to proceed about this -- not. But, that's, of course, par for the course in any discussion about health reform. Let's open this up to questions. I would ask you please to identify yourself by name and affiliation and also to speak into the mike so that we can record these questions. And we'll start over here.

MR. LEVIN: Thank you. My name is Peter Levin and I last was the Dean of the School of Public Health in Albany which made me a

member of the Health Department as well as the school. New York spent about $42 billion a year on Medicaid. I was very outspoken both in the Health Department and with the legislature. There was no analysis of that. There was no transparency. There was no attempt to use it creatively. I'm glad if at least we're not looking for the states to solve this problem. If the states can do things like Massachusetts, wonderful. Second thing, you can keep patients alive and we're going -- and from an economic point of view, we have -- I've reconnected with a friend who -- we were -- went God forbid to Dartmouth, and we've reconnected. He was one of America's most famous pediatric cardiac surgeons who has had a transplant. It's wonderful to work with a surgeon who has experienced something. And he says you can just people alive. He said I can keep children alive for months. Somehow we have to deal with that issue and if it's an office of technology assessment again, fine. But, I'm a Car-White Program graduate. Henry probably knows who that is. And I can tell you that we did studies in the '60s on showing whether physicians paid any attention when they ordered sensitivities for antibiotics and they didn't. This is for urinary tract.

MS. DENTZER: So --

MR. LEVIN: I'm going to keep going. I'm sorry. I never talk in public.

MS. DENTZER: But, but --

MR. LEVIN: Now the issue of this is when you even know these things -- look at the aspirin in an emergency room. Can you get the physicians to pay -- to pay attention?

MS. DENTZER: Okay. So quickly --

MR. LEVIN: The next thing is primary care.

MS. DENTZER: -- we really -- you have a lot of other people who want to ask questions, too.

MR. LEVIN: And we are moving -- I think it may have been your program -- two percent of medical school graduates are going into primary care. All of what you said is relevant, but we have to be aware there are other things going on out there and on the primary care issue, we're in real trouble in this country.

MS. DENTZER: Okay. So, let's try to distinguish those comments. I think one issue was about even if you decide what is the right thing to do, can you get physicians to actually do it? Chris, could you --

MR. JENNINGS: Well, that's the third "I". There's infrastructure, there's information, but then there's incentives. And that means there are reimbursement incentives. And if you don't have reimbursement incentives -- if we only reward volume and not value, we will continue to get what we deserve. But I do believe that there's a greater recognition of that fact and I think there's a significant openness to

discussion. Now -- and by the way, that even includes within the physician community. And we will not be able to do it outside of the physician community. They will have to be invested in this outcome, too. And I think many of them are because they are seeing the long term consequences of so not doing. And similarly -- and your question about primary care -- you're absolutely right. We have a diminution -- if not total dismantlement of primary care. We don't have the family docs that we're going to be needing to manage the costs that we have. And if we really are serious about what we so-called think -- that's the so-called entity called medical homes -- we will not have the workforce necessary to -- to attack that head on. And workforce has to be part of it and interestingly enough, in the stimulus package -- at least the Obama Administration folks and people on the Hill are already beginning to address that.

MS. DENTZER: And just quickly, let's take up the question about the states -- whether -- as was mentioned -- New York was spending $42 billion in Medicaid and nobody has a clue what they're buying for it. How much authority should we vest in the states? Or should we assume that more states will follow the line of Massachusetts and proceed with reforms, Hank? Or should we assume that they can't do it and won't do it well?

MR. AARON: I think like many other people here, I would view as the preferred option that the Federal Government take the lead in

instituting reforms. The -- in any case -- whether we are ready to take the larger steps that Alice and Chris have outlined, or not, it is going to be very important to keep the states actively participating in the process of reform. In a larger role, if the steps taken at the national level are smaller, but in any case, states are going to have a lead roll in efforts to promote improved quality. They are going to have differing interests in providing additional services beyond a basic national plan. So, having and encouraging the states to take an active role in the process of reform, I don't think is a choice. It's a matter of what role they play in all of this. Now, the comment -- I want to make one comment about the primary care. I think the comment about primary care is really a specific summary version of a statement that we think we're -- the initial contact point for individuals with most conditions doesn't need to be a person who has spent 12 years acquiring some specialty credentials. And that's a broader point than simply primary care physicians. It means other health professionals, but it also drives home the point that that point of contact has to be well connected to the subspecialists who have the knowledge. Sometimes it's called medical homes. I call it networking of physicians. And in the service of that quality objective, the kinds of health information technology that we've been talking about in loose terms, is absolutely essential. Something else is essential, which was driven home to me by Denis Cortese of Mayo , which was we need an end to the idea that the

physician is the captain -- the solo leader of the operation -- but instead you are cared for by a team. There's an initial point of contact, but the team is brought to bear in recognizing the specific conditions that each person has. And that's the kind of cultural change that public health schools can play a -- and medical schools can play a critical role in.

MS. DENTZER: Let's -- let's recall the advice of Catherine Galvan. If I were president, I would tell people to not talk too much. Let's move through these remaining questions as expeditious as we could -- can, because we do want to get as many of you involved as possible. So, please keep your questions, if you would, rather crisp. Let's come over here on this side.

MALE VOICE: Whether you're talking about incrementalism or pragmatic radicalism, all the options seem to depend on maintaining or increasing Medicaid and SCHIP and that leads to a three part question. The take up rates in those programs is at best 50 percent. And so I'm wondering as you look at scoring of the bills that offer coverage how you see that taken into account, if at all. And then secondly, are you aware of any evidence based methods to increase enrollment? And finally, getting to Chris' point, if people are continually churning, then how do you affect prevention, chronic care management, and so forth?

MS. DENTZER: Alice, do you want to take that on?

MS. RIVLIN: I actually think we're going to have to go -- in the end, if we're serious about universal coverage -- to some kind of a mandate and that it probably should be a combination -- since I think we have to start with the employer-based system -- of an employer mandate in the form of pay or play and an individual mandate. We've got -- we've got to make sure that everybody has coverage. Now, you can't do an individual mandate unless you have a better individual and small group market for people to buy into to and unless you have subsidies for low income people. So --

MS. DENTZER: That would be your notion --

MS. RIVLIN: That would --

MS. DENTZER: -- of how you would address the --

MS. RIVLIN: That would be --

MS. DENTZER: (inaudible) take up of Medicaid and SCHIP, which is you basically you mandate -- in effect, the parents would have --

MS. RIVLIN: Yes.

MS. DENTZER: -- to provide (inaudible).

MS. RIVLIN: I mean the problem with SCHIP is, as the questioner said, it -- the take up rate is not -- is not 100 percent, although it's pretty good.

MS. DENTZER: Okay. Anybody else have any quick ideas on that?

MR. JENNINGS: Well, just, you know, the states actually vary somewhat significantly about take up rates and, of course, a lot of it has to do with the commitment to enrollment and creative ways to do that and places where to do it. And, as we've noted, even when states face substantial financial difficulties, they actually decrease their aggressive enrollment strategies and -- which is -- underscores something that both Henry and Alice have recommended and is included in this stimulus package or recovery act or whatever we're calling it today -- a substantial Federal infusion of dollars for the matching. But I think fundamentally, we're going to have to reform the delivery of health care. We're going to have to have something that moves towards individual responsibility. I will never use the word mandate. I never use it because it connotes -- that's the difference between Alice and where she comes from and where I come from. But, I do believe that there has to be individual responsibility and there has to be shared responsibility and that means there's got to be incentives, and if need be enforcement to achieve that end.

MS. RIVLIN: Well, I believe in individual responsibility for having car insurance to be fair.

MS. DENTZER: Alright.

MR. JENNINGS: We're in agreement.

MS. DENTZER: Alright. We're going to move over to this side of the room. Let's take a question right up here in front and then we'll work our way back.

DR. POPLIN: Thank you. My name is Dr. Caroline Poplin. I'm a primary care physician. I'm a visiting fellow at the Center for American Progress. My question is I was wondering what you made of the CBO comment on the Federal Employees Health Benefit program that, I think, a lot of politicians assume that if we expand the FEHB, it will look pretty much like it does to us. I'm a former Federal employee. I'm on it -- that the premiums and the insurance will look pretty much the same. CBO thinks, because of the problem of adverse selection and the difference in the -- in the population that you're drawing from, that the benefits will either be much smaller or the premiums will be much higher. And if that's the case, then does that -- does that affect how you think about a Federal program among other private insurance programs?

MS. DENTZER: Hank?

MR. AARON: I'm not familiar with the specific study, but the logic as you described it certainly makes sense -- that if you have voluntary enrollment from the general population, you're likely to get sicker rather than healthier people differentially selecting into the plan. That is an argument for why, whatever you call it, something that strongly

encourages or mandates participation is important to efforts to give admission to a currently existing system, such as the FEHBP.

MS. DENTZER: Dictated shared responsibility.

MR. AARON: Yes.

MS. RIVLIN: I think the point is correct and when senators run for president, as we've had two examples recently, they tend to be a little glib about everybody should have what I have. The cost of opening up FEHB to the general public would be very high and we've got to come to grips with what is a basic benefit package and how much is it going to cost before we open up these exchanges.

MS. DENTZER: Okay. There was a question right next there and we'll take that and then work our way back.

MR. SMITH: Bruce Smith, Brookings retired. I've been attending a lot of health care conferences lately, but I think with all due respect to my colleagues, what we've got a proposal here is a very narrow one. We're not going to do anything about Medicare. Leave that alone. We're not going to do anything about Medicaid. Leave that alone. We're not going to do anything about SCHIP except maybe expand it. We're not going to do anything about employer mandates except possibly cap them. We're just going to try to cover the people that aren't covered and how are we going to do it? We're going to offer subsidies, but only subsidies to the poor. How about the ones that aren't poor? And there are a good chunk

of those. Now, Alice, are you really going to mandate them? How are you going to get people to really join in there and how are you going to pay for it? If you look at that plan that Ron Emanuel's brother, the doc comes out with -- he's got a dedicated tax. Are you going to have a dedicated tax in here? And how can you possibly suggest that you're doing anything about cost, if you're leaving the whole thing untouched except provide subsidies to get more people to join in on the same basis we have now except that somehow this new bureaucracy? And who's going to run that? Is it CMS? Are you creating a new bureaucracy? How is this going to come --

MS. DENTZER: Okay. Let's give Alice at least 15 seconds to respond.

MS. RIVLIN: I don't think you were listening to what I said, Bruce. But your basic point is right. As the public part of this expands -- and I expect that it would -- we're going to need a new revenue source. And I think that we can't load it on the income tax. We probably should have a value added tax at the national level and I think we're the only country that doesn't do that. We're going to have to come to that. And it's a sensible thing to do if we want to be a country that consumes less and saves more -- that we go to consumption taxation. And if your objection to that is the states will kill it, I have an answer to that, which is you have the states buy in or you buy out the states. You have a national tax which you share with the state.

MS. DENTZER: And perhaps we should leave the debate about tax reform to another day, but you've heard what Alice's preferences would be in that regard.

MR. COWAN: Thank you. I'm Edward Cowan. I'm an independent editor and writer. And I have a question which centers on cost control which is primarily for Henry, but the other panelists as well are welcome to comment. Henry, I think you said something like this if I understood you -- that to get cost control, we have to reduce the number of payers. And I wish you would explain that. I didn't quite understand that. Also, I wish you would deconstruct your notion of cost control for us. Costs are prices times volume, and I don't know whether you're talking about controlling prices -- if you think you can and how. I guess you mean controlling volume, but I'd like to know how you expect to curtail volume when you increase the number of people with third party payment for their health care. It seems to me that there's a contradiction there. So perhaps you could address those points for us. Thank you.

MR. AARON: Right now, if you think about who is paying for health care, you start with Medicare -- big, potentially powerful, but disabled by Congressional restrictions that date back to the enactment of Medicare over any aggressive use of its powers to interfere with the practice of medicine -- specific language in the original Medicare Act. Then you go to 51 state Medicaid programs. Dozens, if not hundreds, of

insurance companies. Tens of thousands of self-insuring employers who hire agents to administer their own plans. And what you've got is this bewildering, overwhelming web of separate payers -- all but one of which is really too small to have major leverage and the one that isn't too small, is politically barred from using its leverage to either control prices or quantities. It's for that reason that I said earlier that I think all our conversations about cost control are nothing much more than just that -- talk at this point. Then add to that the point that Alice emphasized and Chris as well. We wouldn't know what to tell them. Our low priority uses are overpriced services, because we haven't done the studies to evaluate the comparative effectiveness of different things that are done. So you want to design a system that is not controllable -- you've got it right here in the United States. What I was trying to suggest is that one element of being able to bring about control is to have a single payment -- or a small number of sources from which funding comes. And it was that reason that I put such emphasis on the state clearinghouses that could become the conduits through which funds flow to the payment of health care. As to the question of whether you're controlling price or quantity, I think in the end you're talking about both. America -- at least some providers in the United States are paid significantly more relative to average earnings than they are paid in other countries that have first tier health care systems. In the jargon of economics, they enjoy monopoly rents. In addition to that,

there are some services that we over provide. We do too much of it. The current whipping boy is diagnostic radiology, where I can tell you personal stories that are really funny about MRIs that either I got or was offered that were really low priority uses. Not without benefits at all, but very low priority and not worth the cost. So in the end, I think what we're talking about is an entity with sufficient payment control to squeeze out monopoly rents and to leverage through incentives and regulations changes in practice so that we do fewer of those services that produce benefits that are not worth what they cost.

MS. DENTZER: This is a wonderful Brookings audience in that the questions are so intelligent that they are long questions and therefore they demand long answers. So, in the interest of time, let's limit ourselves to just two more quick questions and answers and we'll take one right there and then we'll come to the back.

MS. SEKHAR: Hi. My name is Sonia Sekhar and I'm a Health Policy Research Assistant at the Center for American Progress. And my question is primarily for Ms. Rivlin who mentioned several times about building on the employer based system and that was one of President-elect Obama's ideas, and I'm wondering how we could adapt that to the current situation where every month over a half million people are losing their jobs and how we could potentially build a system that makes insurance more portable?

MS. DENTZER: Alice, then Chris may comment on that too.

MS. RIVLIN: I didn't say that we did only the employer-based system. I said we -- the attractive idea, I think, for getting to universal coverage is not to scrap the employer-based system. We've got it. It isn't great, but it has -- the advantages what most people and most people are reasonably satisfied with. But then to establish an alternative system that you phase people into which they can buy into a larger pool -- whether you think of it as expanding the Federal exchange or starting a new one -- and buy a standard benefit package for an affordable price with subsidies for low income people.

MS. DENTZER: And Chris, do you want to add to that?

MR. JENNINGS: Yeah. I just will say that I think I'm -- I would be concerned if anyone leaves this conversation thinking that any one of us is relying on the employer-based system to be the ipso facto place to address all problems and health care and coverage. We don't. No one does. I think that we may have pretty much capped out where we're going in terms of employer-based coverage. We may get --

MS. RIVLIN: Oh, it's declining.

MR. JENNINGS: -- a little more. Well, it's completely declined. But even if you throw in all the subsidies and all the rest, I'm not sure a lot of new employees are going to say, oh, joy. But, so when the President-elect is saying you can keep what you have, I think one lesson

learned around health reform is that people do not want to trade what they have until they know what their option is. And they don't love what they have, but --

MS. DENTZER: Then they want to make sure the option is as good, if not better, than what they have.

MR. JENNINGS: Well, I mean, yeah. They want --

MR. AARON: And cheaper.

MS. DENTZER: And cheaper. Right.

MR. JENNINGS: They won't have to trade something that isn't better. So, but you have to have an option, because it's not sustainable over a period of time, nor is it desirable. And that's why I think you'll either have a Federal or you'll have a state-based or a regional or some combination exchange, or whatever you want to call it, that will supplement, but not supplant, employer-based coverage.

MS. DENTZER: Alright. Last question in the rear and then we'll move to wrap up.

MS. O'MALLEY: Kelly O'Malley, the Cohen Group. Mr. Aaron, you mentioned that one of the best ways to control costs is to control doctor's fees. This seems to be sort of taboo issue. But if we do move forward and we do provide funding for a program that researches cost effectiveness or comparative effectiveness and discover inevitably, as we will, that some technologies increase costs, but not quality -- what

next? What do you do? How do you confront the doctors? Do you do as De Galle did in France and provide some sort of cap on fees? Is this something that should or even can be done in America?

MR. AARON: Well, capping fees caps prices. It doesn't cap quantities and that's something that Medicare has learned to its distress with the sustainable growth ceiling on physician fees. I think the first step is to put out information. It may sound kind of wimpy, but the fact of the matter is you have a lot of private insurers -- companies, Medicare, state Medicaid programs -- that would like to be able to have some basis on which to provide guidelines, protocols -- even if at first they were simply suggestive. The power of norms over time is not to be sneered at. Eventually, such restrictions could conceivably become mandatory. It's not something that I would urge in the near term. I think the first step is to do a lot of research to provide us with information that gives rational cost-conscious payers the basis for confronting patients and physicians and saying you're good guys; we understand your plight, but this doesn't make sense -- and having some chance of winning that argument. Now they don't.

MS. DENTZER: Alright. To close, let us try to frame this as crisply as we can and let's do so in this sense. Let's say it's a year from now. It's January 16, 2010. We're on the eve of the first State of Union Address of President Obama. He is going to get up and claim that the first

year produced many victories. What will it be essential, Chris Jennings, that he be able to say about victories accomplished in health care in the first year?

MR. JENNINGS: Well, I predict he will say that we've made a huge step forward in achieving the promise of quality affordable coverage for every single American, and --

MS. DENTZER: By virtue of?

MR. JENNINGS: That's what he'll say.

MS. DENTZER: By virtue of a plan?

MR. JENNINGS: By virtue of success that he can point to already. He will already have -- look, if -- let's just rack 'em up. He'll have SCHIP. He'll have HIT. He'll have comparative effectiveness. He'll have workforce investments. He'll have probably a temporarily unemployed. He'll have the beginning of a process -- if not policy, if not legislative language -- towards covering every single American over a certain period of time.

MS. DENTZER: Okay. Alice?

MS. RIVLIN: Oh, I'd agree with that, but I think one could hope that he would actually have those things legislated and/or in the process of being legislated. It may take more than a year. And particularly the latter -- that the universal coverage -- we have a roadmap to how we're going to get there. And I would add one other thing. I'm not

as discouraged as Henry is about the possibility of using Medicare as a leader in more effective use of the health dollar and I would think they could do -- there are some specific things like competitive bidding of durable medical equipment. That's a no-brainer. That -- if we --

MS. DENTZER: A no-brainer that couldn't be passed last year we would note, but --

MS. RIVLIN: Yes. But, if there's no political will to do even that, we might as well give up. But, I think we may see a sea change in political will if we are seriously talking about how to get to comprehensive health reform.

MS. DENTZER: Alright. Hank? The 15 seconds Obama will say next year about health care in the State of the Union will say what?

MR. AARON: He will point to the millions of kids covered under the SCHIP extension the saving of loss of Medicaid benefits because of the stimulus package. He will talk about the emerging economic recovery and will emphasize the importance of the debate on his principles and program for health care reform that he will have submitted to Congress this year, but that will still be ongoing and it will be a pitch for that program.

MS. DENTZER: And I can assure that our discussions will be ongoing here at the Brookings Institution and the pages of *Health*

Affairs. I want to thank all of you for joining us this morning and have a great day. Stay warm and enjoy the inauguration. Thank you very much.

(Applause)

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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