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DOMESTIC POLICY IN PRESIDENT BUSH'S SECOND TERM

PANEL FOUR: HEALTH CARE

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PANEL FOUR: HEALTH CARE

MS. MACGUINEAS: Okay. We are quickly now going to move on to the final panel of today's session on health care. And just to let you know--thank you, Alice--what a large task these two panelists have. There's almost no sort of budget or fiscal policy meeting which I go to these days where somebody doesn't quickly make the comment that the real problem is health care, and everybody nods knowingly, like, Social Security is just a drop in the bucket, and taxes--we can reform those. The real problem is health care. So, luckily we have two people today who are going to tell us what we're going to do about the real problem of health care.

The first is a senior fellow from Brookings Institution, Henry Aaron, quite an expert on health care, and likewise Joseph Antos from the American Enterprise Institute, a scholar there--has been an expert in the field of health care for quite some time, and we will draw on both of your wisdom. Henry, do you want to go first?

MR. AARON: During the last political campaign, John Kerry made health care the number one domestic issue. George Bush did not. George Bush won.

That I think it tells us a fair bit about what the relative standing of health care will be during the next four years.

President Bush has made the addition of a drug benefit during his first Administration to Medicare a major priority issue. He had run as a compassionate conservative, and support for this drug add-on was exhibit one in his case that his self-designation was not empty. It worked.

John Kerry was never able to gain much footing during the campaign with the issue of health care, in large part I think because President Bush could turn and face him and say, you talk health care. I did it, referring, of course, to the Medicare

Modernization Act. Whatever one may think of that particular piece of legislation, and I'm sure opinions differ here in this room, the riposte was certainly an effective one.

So, what should we expect from the second Bush Administration in the area of health care policy and what developments should we expect from health care as far as health insurance costs and health insurance coverage are concerned?

These are two very different questions. Let me take the second one first.

The underlying trends are not really rather favorable. On costs, technological change shows no signs at all of slowing, nor is it likely to do so, and technology is the major driver behind rising per capita health care costs.

Furthermore, rising costs are a significant, perhaps the leading factor causing employers to curtail the availability of health insurance coverage, and also equally important in discouraging employees from accepting coverage when it is offered.

The big question mark, to which reference was made in the prior session, concerns health savings accounts. These were authorized under the so-called Medicare drug bill, and my own view is they are probably the most important title of that bill, notwithstanding the attention that has been given to the cause of the name, namely the extension of drug benefits.

This is a provision that authorizes individuals and their employers to make deposits into highly tax favored savings accounts on one condition, and that is that the individual is covered by a high deductible health insurance plan. The provision, therefore, means that individuals will be spending their own money for a larger initial amount of any health care episode, and the outstanding question is what the impact of that provision is going to be, first of all in encouraging people to make use of it, and secondly, if they make use of it, on the growth of health care spending.

If President Bush succeeds in encouraging Congress--or in persuading Congress to institute tax credits for the individual purchase of insurance, another provision that he made part of his 2004 campaign, I personally fear that we may actually see a narrowing of health insurance coverage as a result of that provision. Why? Because I fear that many employers will take this as a signal that they can get out of a business that really isn't their business in the first place, going through the administrative pain and suffering of dealing with rising health care costs and disgruntled employees. The employers can simply give employees an initial wage increase representing their current cost of insurance, and then employees will be free either to buy or not to buy insurance on their own. Many will. I fear too many will not.

That's one of the main initiatives that President Bush had announced during his campaign. Tax credits for individual purchase of insurance. The impact may be more favorable than I've just suggested, but, at best, nobody has made a credible estimate that it would have a significant effect in increasing the numbers of people with health insurance.

A second provision in the President's program was to encourage so-called association health plans. These are arrangements under which usually relatively small employers can group together to buy insurance, hopefully at a discounted price. These--this policy has been tried in a number of states, and has an unbroken record of doing very little.

There's no reason, in my view, to expect that a national program would be materially more effective.

And the final element, which may well be the first, is the imposition of limits on malpractice awards. Close studies of this subject have suggested that the

brouhaha about malpractice awards is a force behind rising health care spending; is not based on solid evidence; and that the likely effect on growth of health care spending will be quite modest.

So, what we're likely to see--one thing that I think we're likely not to see I should say is legislation authorizing drug reimportation. This was an issue that the Administration resisted, and felt it had to give ground on during the campaign. I see little indication that in the current configuration of forces, they will feel any renewal of that pressure.

We will see modifications in the Medicare Modernization Act as the inevitable glitches and problems arise in implementation, but I don't think that there will be any significant modifications in that bill until it has been on the books for several years and people have had time to develop a reaction to it.

So, what do we--what do I foresee for the next four years? I see a good possibility of continued rapid growth in health care spending and a continued decline in the reach of health insurance coverage in the United States. What this means is that come 2008, there's a good chance, in my view, that health care will once again be a major central issue in that presidential campaign. And having said that, I realize that even before we have gotten over the orgy, the political orgy that we have just passed through, I have already alluded to the next one, so it might be best if I stopped.

[Laughter.]

MS. MACGUINEAS: Thank you, Henry.

MR. ANTOS: And who doesn't like a good orgy?

The next four years in health policy will provide very few opportunities for greatness, but plenty of opportunities to deal with difficulties and problems that didn't

just arise in the last year or two, have been in the system for a very long time, and aren't going to go away anytime soon.

The Bush campaign theme in health policy was the ownership society. And that's a very important concept. As Henry said, health savings accounts which were slipped into the Medicare drug bill last year are probably the key feature of that particular vision. I thought I'd mention a couple of points about this, since Henry mentioned technology as driving health care costs. The question is what's driving technology. By the way, we can't be too much against improving technology because that's one of the things that keeps us alive and healthier while we're living longer. So, we're kind of mixed here as to what we're really looking for. Do we want lower health care bills? Do we want longer and better lives? Mmm. Don't ask me to decide. I'll let you decide that one for yourselves.

But what's really driving the growth of technology? Well, I'm an economist; I can't help but say it's the economic incentives in the system. And those incentives are driving good things and bad things as well. We've developed over the last 50 years a health insurance that is a third-party health care system. That means that the patient who's getting the services is not directly paying for those services. The means the doctor who's providing the services is paid by somebody else.

And so, there's great difficulties with people evaluating, and by people, I mean patients and doctors, evaluating whether the next service is something that would be a good investment for this patient or for society as a whole. It's that third party insurance incentive that leads us to a situation where health care is really the only sector in this society where people who purchase services don't know what the price is, and they also don't know what the value of the service are, either.

It's a fundamental problem. It's something that we have been developing for at least 50 years, and it's not going to go away anytime soon.

Nonetheless, what are health savings accounts really about? And what is this ownership society concept that people talked about, and where does that fit in with this problem?

There's a fundamental difference between having the kind of insurance where you pay a low deductible and then the rest of it seems to be somebody else's money. Now, it might actually be your money, if you're in an employer-sponsored health insurance program. You're, of course, contributing some of your earnings towards the cost of that insurance. But we've developed a great system of veiling ourselves from the true cost of health insurance and the true cost of health care.

And so most people act as if that $15 co-payment at the doctor's office is actually what it costs. Well, of course, that's not true. But if you were to ask the doctor or his staff what is the cost of this visit, they wouldn't know either. They couldn't tell you. And if they gave you an answer, it wouldn't be right. So nobody really knows.

With health savings accounts, the principle is that you begin to act as if it's your money. Now, it was your money all along, but if you begin to act that way, you might become a lot more interested in what the real cost of the service is and what good it will do you.

It is true that every patient has, as they say in the insurance business, skin of the game. But they usually think of it as how's my health going to improve, and you can't really get a good answer from your physician. They don't usually think too much about the financial side of things if they have pretty good insurance.

Now, if you're spending your own money, you have an incentive to know all of these--or get answers to these questions, but that leads to the next problem: you can get answers to these questions. What we need is a revolution in information, in accessible information to patients and to doctors and to insurance companies for that matter about what works and what it costs.

We're very far down the road from that, and that's a part of technology, health information technology that sees every politician saying we're for that. Indeed, everyone's for that. It's probably coming. The government isn't doing much except possibly and occasionally standing out of the way for that development to occur.

But, nonetheless, we are headed in a positive direction. It's not clear to me whether Washington politicians will have a very positive effect on that, other than perhaps neatening up some of the sharp edges around the health savings accounts that might be done in legislation in the next couple of years. There are some problems with those things, but ultimately, I think this is not going to--government adjustments in that policy are not going to turn the tide. It's going to be what happens in the private sector with employers, with individuals who have health insurance, with the medical establishment, to try to make things better.

Now, another point on all this. People talk about increasing value, a very important concept. But let's keep in mind an increasing value doesn't necessarily mean that costs will reduce or the cost growth will reduce. You can have better purchasing of health care services, consistent with a lower trend in health care costs and a higher trend in health care costs. There's nothing that I see in the system, and there's nothing that anybody's going to address in the next four years that will get at this fundamental conundrum. We can improve the way we purchase health care, and we can improve the

information that we have, but, in the end, there's a societal decision that has to be made, and maybe it's made one person at a time, maybe it isn't, about how much do you want to spend. Ultimately, that's the question that we're going to be confronting, but probably not in the next couple years.

Now, what else does George Bush have on his agenda? I think the rest of what's on his agenda is forced by circumstances. Henry mentioned some problems with Medicare that will have be adjusted. Let me mention a few.

The Medicare program has essentially deferred some promises to health care providers that could not be met last year because of the Medicare drug bill, and it could not be met this year because of the election. Next year is the year that a lot of these promises will come due, except I don't think that they will actually be met. For example, physicians face a five percent payment cut in 2006. In fact, they face essentially a five percent payment cut from 2006 on out into the future with occasional several years of relief where there might be some payment increases, but, according to existing payment formulas, there's going to be an actual payment cut for visits to every--virtually every physician in America. And that is simply not sustainable.

Nonetheless, there isn't money in the system, and there isn't political will to reopen any part of Medicare next year to solve this problem on a permanent basis. One might predict in this case that a continuing resolution, you know, that's the bill that's passed in October when we haven't passed a budget, and we keep adding continuing resolutions until we get one, no matter how much time it takes to get there. So, in some continuing resolution, I expect that there will be yet another one year's reprieve. But fundamentally, this is a--this is a creature of the budget process.

Congress got big savings by passing this formula that they had hoped they'd never have to actually put into place back in 1997, and now that it's effective, they'd like to get away from it.

That's just one of many types of problems in the Medicare program that need to be resolved and probably won't be resolved very readily.

Medicaid. Same problem. States are feeling fiscal pressure. They'd like to see some relief. The Federal Government is moving in the opposite direction. They are looking carefully at how states use the matching rate program to creatively finance their health care and their stadiums and their roads as well.

We have major, major crises I think in regulation. The Food and Drug Administration will see continuing problems over the next year, not just because of its own incredibly complicated regulatory structure but because right now politically it makes sense to say let's do something with the FDA. Let's, you know, let's make sure that there's flu vaccine available to everybody, and the way we're going to do that almost certainly is we're going to change the regulatory structure; and we're probably going to have the government buy tens of thousands of doses of flu vaccine in the future to overcome a shortage that didn't exist this year until the government announced that there was going to be one.

So, I see lots of opportunities for legislation. I see lots of opportunities for the Administration to try to make some changes through regulatory action, but I don't see many opportunities to deal with the more fundamental problems facing us in terms of cost, in terms of coverage, and in terms of fundamental social decision making in health care policy.

MS. MACGUINEAS: Thank you. I'd like to kick off the Q&A with a question for each of our panelists. Joseph, I'll start with you.

It seems that there's a tension in the health saving accounts where you'd get rid of the problems of lack of price transparency from third payers, but you also might have an incentive for many people not to spend their own money on health care, and then avoid treatment, which ultimately would save money. How do you deal with that kind of tension if we move to a system of health saving accounts?

MR. ANTOS: Of course, that's a huge problem. We have that problem anyway. If health savings accounts didn't exist, every man in this room would fail to go to the doctor at the right time, despite what their wives would tell them to do, and despite that pain in their chest; right? We all know ourselves. So, you know, health prevention and these kinds of activities sound like a good idea, but only for Henry, not for me. So, we have a human factors problem here.

Now with the current health savings account regime, money can't be spent up front is exempted from this requirement that the insurance only kick in after a very high deductible, a thousand dollars or two thousand dollars. Certain preventive services are, in fact, allowed to be treated as first dollar coverage. So, that's a step in one--at least a financial step in the right direction. It's not going to change the way people act, but at least, under the current regulations, that problem has been addressed to some extent.

MS. MACGUINEAS: Thank you. And, Henry, it seems that technology is the largest cost driver, and in many ways technology is a beneficial thing. It's providing us better services in the medical field, and, as we become a wealthier country, we'll probably spend more resources on health care. One, do you see that as correct? And two, if you do, is the result or should the result be squeezing out other areas of the

budget or paying more, expanding the budget, and paying more for health care on the budget side of this?

MR. AARON: Yes.

MS. MACGUINEAS: Thank you.

MR. AARON: I think inevitably we're going to see the share of health care spending rise as part of the federal budget and as part of our total personal consumption, but it's also going to be necessary to exercise more discipline than the system has currently generated.

For a Brookings project, I've done a little exercise, which may be of some interest to you.

Let's suppose that one slowed the growth of health care spending, pardon me, so that the total amount that we spend on Medicare, just on Medicare, didn't grow any faster than the population served by Medicare does as a share of the population. So that the share of national income going to Medicare went up, but it went up in proportion to the increase in the population that's being served by Medicare. Just to cover those costs would require an additional three to four percent of gross domestic product by the year 2030. If we wanted to achieve that, but the underlying dynamics of rising health care spending were unchanged, which, to give you the specifics, health care spending on a per capita basis has for half a century grown two and a half percentage points a year faster than general income has done.

But let's suppose that over the next--from now until 2030 we wanted to slow the growth of health care spending so that it just, on a per capita basis, kept track with per capita income. Under the Medicare program, we would have to raise the age of eligibility from 65 to 77, and by 2040, to 81 or 82 years old.

The point I'm making here is that there is an underlying dynamic at work here called science; technological imagination that is producing an avalanche of new and beneficial things that physicians are able to do interacting with an aging population. That means that we will spend a significantly larger share of our gross domestic product on public programs for health care, for the elderly and disabled, and for the poor unless we want to dispense essentially in full with the social safety net that has been crafted.

That's the dilemma we face. And the sooner the nation begins to recognize it, the better.

MR. ANTOS: I would just add--I agree with Henry. It's a problem that can't be solved easily. It can't be solved with slogans. The Medicare program is already confronting this technological crisis, also opportunity, but let's call it a crisis for this purpose, in its coverage decisions. Increasingly, Medicare is moving away from the old system of having each of the basically state-level contractors make decisions about who gets what in health care under Medicare. Moving more to national coverage decisions, and several decisions recently, Medicare decided to cover certain new technologies--implantable defibrillators was one--with the proviso that since we don't know enough about how effective they are and under what circumstances, they would be covered for a selected group of patients, selected according to physical condition and all those patients who got that intervention would then be entered into a national database. That's a gigantic step in the right direction. To actually learn from actual experience what works in the field as opposed to might work in the lab is a big step forward, and it's high time we started to do that.

Nonetheless, suppose we found that something didn't work very well. Then we'd have the enormous political problem of how to get away from the coverage decision that we had already made. It's an enormous difficulty.

MS. MACGUINEAS: Peter?

MR. ORSZAG: Peter Orszag from Brookings. I have a question I guess on the empirical magnitude of the savings that one could expect from moving away from the third party system towards an HSA type of approach. The number I have in my mind, which you'll probably be able to correct, is that 10 percent of cases account for 70 percent or so of health care costs. So, there's a very high concentration of health care costs in large cost cases.

Presumably, our--I mean, maybe this isn't right--presumably, we don't want people who are having heart attacks deciding where they direct their ambulance based on the relative cost of the emergency room, or maybe we do. But I want to have that fleshed out a little bit more, and if we don't want that, then how much traction are we actually getting from the incentives that you're talking about if they're applying to a very small share of costs?

MR. ANTOS: It's hard to be a good shopper when you're clutching your chest and you're in the back of the ambulance. This is another case where some ideas have been oversold. The personal accounts idea was certainly oversold for Social Security, as Eric pointed out. This is another one that's a little oversold. The question really is not whether we're expecting really sick people to be careful shoppers. The question is, how will we change the way everybody looks at health care? Not the sick people. Once you're sick, you're kind of in a different world. But it really has to do with what are the fundamental behaviors that doctors expect when they see a patient; that

insurers expect when they sign somebody up; that patients expect when they interact with those other entities. And so, I don't view this as some kind of magic bullet that we're going to wake up in a couple of years and say, wow, we solved that problem because now, you know, 15 percent of Americans have health savings accounts. I think it's a much longer term issue, and, again, it has to do with what people expect. If people expect when I go to the doctor, I get what I want, if doctors expect that when I see a patient, I can do what I want, if insurers expect that when costs go up, I can pass it on to those who pay it, and there aren't any connections among those entities, well, I've just about--I've described the system we have now.

And, so, while one can't reasonably say what potential slowdown in savings could occur, the point is that this is at least an attempt to reopen the discussion about what do we mean by health insurance? What do we mean by health care, and who's paying the bill? And I think that's an important idea. Whether it actually pans out in 20 or 25 years is a good question, because that's a couple of decades of opportunities for all of us, and especially Washington politicians to make adjustments in what goes on in the health sector.

MS. MACGUINEAS: Yes. Right there.

MR. SILVER: I'm Howard Silver from the Consortium of Social Science Associations. Since Henry brought up science, I thought I'd ask this.

As most of you know, the National Institutes of Health was doubled between 1998 and 2003. The last couple of funding cycles that has been reduced significantly. In fiscal '05, they're down to about two and half percent increase. Where do you see sort of their future in terms of funding and contributing to the science, and

where it is--what are the implications for the things that you're talking about here this morning?

MR. AARON: Well, let me take that one. I'm something of a hawk on cost control but not on cost control in the area of research. I think the solution to our health care cost inflation problem, which is very serious, would be bought at too high a price if that price is significant curtailment of support for scientific research. The net benefits from investments in scientific research are enormous. The net potential for waste is equally enormous. We need to distinguish among those uses of particular technologies that yield high benefits and those that don't. The problem with our current system is not, in my view, as Joe suggested that doctors don't know the cost and patients don't know the costs. They don't know the cost in any medical system in the world -- any modern medical system in the world. The problem is that we lack, and I'm going to use the word, regulatory constraints that create incentives limiting care to relatively high benefit uses and discouraging application of medical technology in cases where the returns are low.

The United States is a very long way from having fashioned such institutions. Other nations have done so. The health indicators in many other nations are as good or better than ours. Expenditures everywhere are very dramatically lower than ours. The second most openhanded system in the world spends 30 to 40 percent less than we do per capita. And other countries trail behind that country, Switzerland.

So, there are real opportunities here that we, as a nation, have not grasped, both for improving care and, in my view, for improving its quality.

MS. MACGUINEAS: Oh. Sorry. Did you want to--

MR. ANTOS: I would just mention two quick things. One is let's not forget that people are impatient standing in supermarket lines that have more than two people in them, so that's a bit of a problem. And the other more fundamental point is how do you pick a winner in research? Whose priority takes precedent over whose other priority? This is--this ultimately is the problem with all government industrial policy, picking winners, and it's even harder when it comes to basic research.

I agree with Henry. We shouldn't skimp on the basic science because there might even come a day when the basic science yields a kind of breakthrough that leads to cost reducing interventions rather than always cost increasing interventions. And maybe that's a pipe dream. But nonetheless, we won't know until we try it.

Bu I would distinguish between the basic research, which is what I think you were talking about, and the insurance markets' decision to cover certain interventions. For that, you do need to know something about how it works in the field, and what the price is.

MS. WALLER: Margy Waller with Brookings. Following Belle's lead, I wanted to ask a question as a member of the Welfare Reform and Beyond Team about Medicaid, which has benefited especially recently a lot of low-income working families in the states. The Bush Administration has previously proposed turning Medicaid from a state and federal matching program, shared cost program, into a block grant to the states, and I wonder if you all could comment on the prospects for that proposal as well as perhaps the pros and cons of that approach?

MR. AARON: I'm glad you brought that up. I feel remiss in having omitted it from the list of policies that we might well see during the next four years. Joe may have a better insight into what this Administration actually is going to propose, but

they did propose to convert, effectively convert Medicaid into a block grant, which would shift the financial, much of the financial risk from rising case rolls and increasing per capita medical costs from the Federal Government to the states. The likely effect would be states--that states which have severe balanced budget requirements would place more stringent limits on the availability of care to the poor and the elderly disabled, who are the principal Medicaid beneficiaries.

The budget pressures are going to be relentless, as the previous session emphasized. I would be surprised actually if we didn't see that proposal resurface, and it will have a much better chance in this Congress than it did in the last one because of strengthened Republican majorities in both houses.

MR. ANTOS: I doubt that we will see the White House pushing for that kind of bold change. I don't want to call it reform, because most people, half of the people in the room or more will say, no, it's not a reform; it's a deterioration of the program. But whatever it is, I don't see that for the reason that the first two items on the Bush agenda are the first two items on today's agenda as well--Social Security reform and tax reform. See, you don't start stirring up the troops over something that's going to get in the way of the two things that you really want to push for in the face of potentially a worsening economy.

Furthermore, you know, he was a governor, and every President who's been a governor is acutely aware of state fiscal problems. So, I think more likely we will see some statements in the budget, as we've seen in the last few years suggesting that states could volunteer for some kind of a modified block grant program with, you know, additional federal money up front and then having it tapered down over the years. A few

states have toyed with the idea, but, let's face it, if the state budget officer looks past three or four years, he or she will say, well, let's not do that until I retire.

MR. AARON: Could I add just one thing because this does get back to the previous session, where there was some discussion of budget process. Alive in Congress and the Administration now is an idea which is brand new to budget process, which is to put a cap that would include entitlement spending under it, as well as discretionary spending. That would mean that there would be pressure to slow the growth of Medicaid spending, Medicare spending, possibly even Social Security, although either of the latter two might well be excluded from such a cap. Were that to happen, and here you've really got to--Bill Niskanen was right that this is a genuine soporific, but you'd better stay awake if you're interested in budget issues for what's in the offing with respect to budget caps that might extend to entitlements. This is new territory. It would I think undermine and threaten the commitments that are represented by the word entitlement. So, stay tuned for that one.

MS. MACGUINEAS: And that will have to be the final word on the topic. I very much want to thank our two panelists today on health care and more broadly I want to thank the Brookings Institution for hosting this and some of their sponsors who are here today, the Welfare Reform and Beyond Program. It was an excellent session. Thank you, all.

[Applause.]

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