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BITING THE BULLET ON HEALTH CARE COSTS

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C O N T E N T S

P R O C E E D I N G S

MR. TALBOTT: Good afternoon, everybody. If those in the back who are getting some coffee could sit down, please. Thank you all for being here to launch our health policy forum. I'm Strobe Talbott, and I just want to welcome you on behalf of my colleagues here at the Institution.

Brookings has had a commitment to study and policy recommendations on health policy virtually for all of its existence. That commitment is personified by a number of people here in the room today, particularly Hank Aaron who you'll be hearing from during the course of the program.

Given the importance of health policy as an issue facing our nation, we feel that we need to enhance the institutionalization of our capacity in this regard, and what we are going to be hearing from many of you during the course of this discussion will be very helpful to us in the brainstorming that we're doing here at the Institution.

I'm going to ask my colleague Belle Sawhill who is the Vice President and Director of our Economic Studies Program and who has done a great deal of work in this are herself to come with her panelists and get us started. So thank you, and over to you, Belle.

MS. SAWHILL: I want to suggest that the panelists come on up and sit in these chairs and get yourselves a mike while I'm making some introductory remarks about you. Liz and Dean, I think you probably ought to come on up and get yourselves a mike as well.

Let me add my welcome to Strobe. Earlier this year we released a volume called Restoring Fiscal Sanity, the Long Term Challenge, and in it we showed

that under some quite realistic assumptions, I think, about the continuation of current trends, there is going to be a yawning gap between projected federal expenditures and revenues several decades from now. I'm talking about a gap that might be as large as about 10 percent of our GDP.

For today's purposes, the important thing to know about that is that the primary driver of that gap is escalating health care costs, combined, of course, with an aging population that is demanding more care. So unless some way is found to slow this growth in a substantial way, we're either going to have to raise taxes to the level of most European countries or else we're going to have to drastically curtail the kind of health care benefits and other benefits we now provide especially to the elderly.

It's in that context as well as many others that I'm very pleased we're having this forum to discuss Biting the Bullet on Health Care Costs, a Long Term Policy Perspective.

Many people have suggested ways in which the current system might be made more efficient, everything from malpractice reform to the greater use of information technology and more choices for consumers. These kinds of reforms are important and are badly needed, but most experts think they would only reduce costs and slow growth temporarily. In the mean time, medical advances which have been a wonderful benefit to most of us keep pushing these costs up, so slowing the growth rate over a longer period is much harder.

I'm now going to turn this over to the real experts. I think you have seen their bios. Henry Aaron is a Senior Fellow here at Brookings and has contributed hugely to this debate over the years. Rudy Penner is a Senior Fellow at the Urban Institute, a

former Director of the Congressional Budget Office. After they've spoken we'll be hearing from Liz Fowler from the Senate Finance Committee, and Dean Rosen who is the Health Policy Director for Leader Frist. I want to thank both of them in particular for taking the time today to be with us because I know something about what it's like in their jobs on the Hill.

Finally, we're going to open this up for a discussion with all of you. There are a number of faces that I see out there in the audience of people that I know who are as knowledgeable about this as anyone up here and we want to get all of you into the conversation.

So with that, let me turn this over to Henry and Rudy, and then we'll move on to hear from the people from the Hill.

MR. AARON: Thank you very much, Belle. To begin with, I would like to acknowledge that a fair bit of what I'm going to say today is the result of collaboration with Jack Meyer (ph) to the chapter that was in the book that Belle and Alice Rivlin co-edited, Restoring Fiscal Sanity. Jack isn't here, but if there's any credit to be given, he deserves it. If there's any blame, I'll take it.

As I look around the audience, I see a lot of faces of people who I would rather listen to than stand up here or sit up here and try to speak to, but that's my job, and so let's move ahead. There are a set of charts which I hope you all have that will prove useful as a guide to what I have to say.

The starting point of all of this, I think, is that we are entering or are in an era of truly extraordinary opportunity for the transformation of human life through advances in medical science. There are realistic prospects of identifying cures for major

debilitating conditions, the debilities of old age and major causes of death. We may well see major increases in life expectancy in the course of the lives of people here in this room.

One of the leading demographers in the nation, James Vaupell of Duke, admittedly an optimist, commented at a recent Brookings conference that he thought newborns today had at least a fifty-fifty chance of celebrating the beginning of the next century.

We are at the early stages of a period of enormous potential gain for human welfare precisely because of the attractiveness of those advances, they are things that we are all going to want to have and they are things that are unlikely to come inexpensively.

Historically, health care spending in the United States for about the last half-century has grown at an average annual rate of about 2.5 percentage points a year faster than the growth of income. That was a period of substantial technological advance. It was a period of some population aging on the average. But there is no reason looking ahead to the future to anticipate any particular reason given current policies, current ways of paying for health care, that that rate of increase in health care spending will slow down significantly.

Admittedly, it is mechanical, but the first chart in your package contains the implications of continued growth of national health care spending at an average of 2.5 percentage points a year faster than income growth from now through the year 2040. As you can see the implied increase in the share of national income devoted to health

care if that differential is maintained is enough to get one's attention; more than a doubling of the share of GDP going to health care.

Around 2022 health care would be absorbing half of the annual increment in real incomes. By the year 2050 outside this window, it would be claiming all of each year's growth in income if that differential is maintained.

This is not simply an issue of overall income shares going to health care; it is also a fiscal challenge because much of health care and a growing share of it is channeled through government budgets, the federal government and state and local governments.

The next chart, chart 2, shows the implications of that continued gap between the growth of health care spending per capita and the growth of income per capita in the share of GDP absorbed by just two of government's programs, Medicare and Medicaid, and that doesn't include other health care activities financed by government.

As you can see, the combination of increasing per capita spending and increases in the number of capitas, specifically, the aging of the population into increasing participation in Medicare and Medicare and a growing projected disabled populations, would cause a quadrupling of the share of GDP devoted to just those two programs.

At the bottom of this chart I included the current total share of the personal income tax so you can get some feel for what's involved here. There is a 12 percentage point increase in the share of GDP going to just Medicare and Medicaid. The current take of the personal income tax is 7 percent of GDP.

Confronted with this kind of growth, the inevitable reaction and my reaction is something has got to give. Obviously, something has to give. It is either higher taxes or cutbacks in the range of benefits provided through Medicare and Medicaid, and cutbacks engineered in some fashion in how much we spend privately on health care.

The final chart in this package contains a menu of 10 different ways, not designed as somebody pointed out at a recent meeting I attended, not likely to win David Letterman's next 10 ten list for most popular things to do, but a list of 10 different initiatives that various people have suggested would contribute, some have suggested in a major way, to a slowdown in the growth of health care spending.

In the book that Belle and Alice edited, Jack and I discuss each of these and we suggest that most of them have a good deal to recommend them. They could in moderation help deal with some of the projected increases in health care costs. In total, however, they are not likely to make a major dent in the growth of health care spending.

In my remarks now I'm not going to go into detail on each one of them. I'll mention a couple of them briefly when we come to questions and discussion. If you want to get into any of them, I hope you will raise them and I'll try and respond.

But if Jack and I are right that any collection of these initiatives implemented in moderation is not likely to have a material effect on the growth of health care spending, then we do face some very fundamental choices as we move ahead with respect to the financing of health care, both publicly and privately.

If we were to rely exclusively on higher taxes to pay for the increases in health care spending that are shown in the second of the charts that I distributed,

combined with reasonable projections of the rest of government operations, it would be necessary by the year 2030 to double the payroll tax and increase the proportion of income collected by the personal income tax by two-thirds. By 2040 it would be necessary to increase the payroll tax two-and-a-half-fold and to more than double the take of the personal income tax to pay for the added costs that are projected here.

Those increases will strike many including me as not very plausible. Then one is pushed back to consider the implications of restraints on the growth of health care spending.

Official projections of Medicare assume that the growth of Medicare per capita spending will slow to 1 percentage point faster than income growth. Even with that, one would have to raise income taxes by about 4 percentage points by 2030 and 6 percentage points of GDP by 2040 or find some other revenue source that could fill in the gap.

Slowing the growth of health care spending to 1 percentage point a year faster than income in the face of the technological advances that medical science holds out for us would be a very heroic achievement. I'm not sure we know how to do it, but my point is even if we did know how to do it, we are looking at very sizable required increases in revenue just to pay for added health care spending, and I haven't talked about the added revenues that might be needed to close the currently existing federal budget deficit, and that deficit currently if one excludes the surpluses temporarily being accumulated for Part A of Medicare and Social Security, the federal deficit is about 5 percentage points of GDP. So we face a fiscal challenge.

Finally, let us suppose one wanted to make changes in Medicare and Medicaid financing. In the face of an underlying cost pressure of the magnitude I've just described that was large enough to hold the growth of Medicare and Medicaid spending to the growth of per capita income. To give you a sense of what it would take to achieve that objective, if one relied solely on increases in the age of eligibility for Medicare and one wanted to hold the growth in Medicare spending to the growth of income, one would need to raise the age of eligibility by 2030 to age 79, and by 2040 to age 83.

If one wanted to rely exclusively on increased cost sharing, one would have to reduce the share of medical expenditures covered by Medicare from 60 percent of medical outlays of the covered population, that's today's value, to 29 percent in 2030 and 23 percent in 2040. Obviously, one could do some combination of both of those or of other modifications. But again, the point is that if one wants to hold down the growth of health care spending to the growth of income in the face of both rising technology costs and rising numbers of enrollees, one is talking about very drastic changes in the Medicare program.

I haven't talked about Medicaid. I think I've talked long enough, and I'm sure that Rudy will have more to say on this subject, so perhaps the best thing I can do is shut up.

MR. PENNER: Thank you very much, Henry. Henry started with the really good news that the quality of health care is improving, the technology keeps advancing, life expectancy is going up, and health care at any age is probably improving. Only practitioners of the dismal science could extract and emphasize the bad news inherent in all of that, and that of course is the implications for public budgets.

Just to put some numerical flesh on the budget skeleton that Belle began with as implied in Henry's figures, Medicare and Medicaid together could go up somewhere between 4 and 7 percent of the GDP in the next 30 years, and Social Security could add another 2 percent to that. So if you look at the standard kind of budget projections by GAO or by CBO, and they tend to assume we keep the historical tax burden and keep other programs more or less constant relative to GDP, you get the kind of deficit numbers that Belle mentioned, but I think more important, the debt accumulates at a very, very rapid rate, in most projections reaching 100 percent of the GDP sometime in the 2020s and just exploding thereafter. Clearly, not a sustainable scenario.

To me, what we face is really a cash flow problem. There is a lot of debate these days about the so-called trust fund problem, the fact that the Social Security trust fund will be emptied in 2041. That's not at all relevant to me. I think the world will end long before we get to 2041.

[Laughter.]

MR. PENNER: Most of the emphasis has been on the public budgeting side of the Medicare/Medicaid program. I thought today I'd talk a little bit about the private costs implications of all of that because it isn't discussed as much. But my colleague Richard Johnson and I at Urban recently projected the private out of pocket expenditures by the elderly implied by current law, and there are really three kinds of these.

There's the Part B premium in Medicare for physician services and we'll soon add the Part B premium for the drug benefit. There's the kind of private insurance

that the elderly buy a lot, the so-called MediGap insurance. Then of course, they're responsible for the deductibles and copayments inherent in all of these insurances, and for paying for things that are not covered by the insurances.

Since current policy is certainly not sustainable without the kind of tax increases that Henry talked about, what we do is we look at the effects of the out of pocket costs on the one side and what we would consider to be reasonable tax increases on the other. How do we know what kind of taxes would be increased? We didn't, of course. So as cowards we used what CBO calls their high tax path in the various budget projections they make, and in that the Congress does absolutely nothing at all, something the Congress has a comparative advantage at. What that implies is that the President's tax cuts are allowed to expire, the alternative minimum tax keeps becoming more and more oppressive and real income growth pushes you into higher and higher tax brackets. So in other words, most of the tax increase with the exception of the estate tax being restored is borne by the income tax and the burden goes far, far higher as Henry implied than anything we've seen in past history.

So you could make alternative tax scenarios, but they wouldn't affect the basic conclusion very much. The numbers are really quite horrifying.

For the bottom two quintiles of the elderly population, the income left after taxes and after out of pocket health care expenditures actually goes down between 2000 and 2030, and for the very lowest quintile, about 50 percent of after tax income in 2030 goes for these out of pocket health care expenditures compared to about 20 percent in 2000. And for the median elderly couple, after tax, after health expenditure income goes up less than 1 percent a year.

So these are the kind of projections that one makes. It's sort of the opposite of the forecast. It's to project something that just really can't happen. Again, it's just more evidence on the private side that this system of ours is not sustainable.

What do we do about all of this? Henry gave his list of 10 options. Though I follow Medicare and Medicaid more than most people I suppose on the outside world, I hesitate to call myself an expert in this field because I don't have much of a clue as to how much money different options would save, or maybe my ignorance makes me an expert by definition. I'm not sure.

Turning to the budget side of all of this and putting something more radical on the street than Henry did, I think it's really important in looking at the Medicare situation to emphasize that it's really unsustainable by design. It wasn't necessary that we designed our entitlements in this manner. What our laws do is specify an eligible population for Medicare and Medicaid, lets them consume pretty much as much of a specified set of treatments as they like. As the technology progresses and the system becomes more expensive, treatments are rarely excluded or rationed in any way. In other words, the budget for these things is pretty much open ended.

So contrast that with the budgeting approach used in countries like Canada and the United Kingdom that have a national health service. There they provide a fixed budget from year to year and health care providers; of course, they're rationed sufficiently to live within the means provided by this budget. I've never been sure exactly how they do it since the rationing rules are not explicit, but the queues that develop for certain kinds of treatment I think clearly show that a rationing does occur.

Maybe it isn't all that different from our system because there are enormous political pressures in these countries to continually increase those fixed budgets whenever the quality of health care starts to deteriorate. But nevertheless, I do think there really is a profound difference between starting with a budgeting system where the budget is essentially open ended and starting with one that's fixed.

Indeed, before the recent Canadian Supreme Court decision that might alter their health system in important ways, the minority liberal government desperately seeking political support tried to be generous by actually promising that their federal fixed budget for health care would be increased 6 percent per year over the next 5 years.

Compare that with our situation. Our Medicare plus Medicaid budget is projected to rise 9 percent per year over the same period, albeit partly because of the drug benefit we're adding, but it would most certainly grow more than 6 percent per year even without that expense, and we're not considered to be all that generous.

So because of the way that Social Security, Medicare and Medicaid are designed, it's almost inevitable that spending on the three programs is going to rise faster than the GDP and faster than tax revenues.

There's a sense in which we've created a budgeting system in which the budget becomes more and more irresponsible of the Congress does nothing or, in other words, becomes more irresponsible by default.

Gene Sterling and I in a recent policy brief suggest approaches which we call radical that tries to convert the situation to one in which the budget becomes more responsible rather than more irresponsible by default. We focus on the two programs causing most of the trouble, Social Security and Medicare, and we suggest automatic

ways of slowing their growth when they come under financial stress. I won't bother you with the definitions of financial stress that we use, but we change the indexing of Social Security automatically to either increase the retirement age with life expectancy or price index initial benefits or do some of both.

Automatically altering the growth of Medicare of course is a lot more challenging. After searching for a good way to do it, we gave up and chose a bad way to do it which was essentially to slow the growth of provider payments.

I have to emphasize it's not out intent to see these programs evolve according to the way that we choose to adjust them automatically. The main point is to create action forcing events for the Congress that hopefully would provoke them into conscious reforms that would make these programs more equitable and efficient than they would be made by the automatic changes that we promulgate.

The basic point is that just don't think it appropriate that the budget become more irresponsible through a lack of action. If the Congress wants to be more irresponsible, they should be forced to do it consciously.

[Laughter.]

MR. PENNER: While our policy brief has "radical" in its title, it's mainly radical by American standards and not by international standards. The Swedes I think have a fascinating Social Security reform where the system automatically adjusts for longer life expectancy by making the annuity upon retirement depend on the life expectancy of the age cohort that is retiring at that time. Also they automatically reduce the indexing of initial benefits whenever their trust fund gets into financial difficulty.

I've just learned that the Japanese introduced a system into their 2005 budget that slows the indexing of Social Security benefits as life expectancy rises and if their population decline accelerates.

What else could society do to mitigate the fiscal storm that's coming? Getting people to work longer would really help a lot on the revenue side and convert them into taxpayers for a longer period of their lives. That really shouldn't be that hard since people used to work longer. If you look back at 1950 and application for Social Security, the average application occurred at about age 68. More recently, it's age 63. From now on, given we've eliminated the earnings test, that won't necessarily be coincident with retirement anymore. But if you compare us now to 1950, the average male is spending about roughly speaking twice as long in retirement as they used to even though the health status of individuals is better on average at every age and the number of demanding jobs in the economy has declined relatively.

I've probably talked too long, but very briefly, we can get people to work longer using either carrots or sticks. Sticks involve things like increasing the normal or early retirement age or otherwise lowering benefits at every age. The increased out of pocket health benefits will also do it.

With regard to carrots, I won't go into detail here, but I do think there are a lot of things we could do to encourage people to work longer. The main point I think is that we used to consider early retirement to be a good thing, to make room for the baby boomers as they were working their way up the career ladder, it was a humane way to downsize for firms. Now it's a bad thing because we're going to have a shortage of workers.

Our laws and institutions both encourage early retirement and make it difficult to have the kind of flexible work arrangements, part time, longer vacations, et cetera, that might induce people to work longer. Those laws involve our tax laws, our ERISA, our age discrimination act and so forth. If you put them all together, they're a horrible mess that employers and employees have difficulty working their way through.

We think that all of those three sets of laws should be amended to make it easier and to protect employers especially against age discrimination suits if they create special arrangements for older workers. I'll stop at that point.

MS. SAWHILL: Liz, what are you hearing on Capitol Hill that relates to this unsustainable health care cost situation?

MS. FOWLER: First of all, thanks for the invitation to speak here. I'm honored and humbled to be on a stage with I think two of our most influential thought leaders in this country and am so glad to have been asked.

I just want to make a brief correction which is that I recently left the Senate Finance Committee and started just today with Health Policy Alternatives, so I can tell you maybe with a little bit more candor what I think is happening. I also think what that means is that any criticisms directed at Congress instead of pointing the finger at me, I think you can look at me. In terms of what Congress is or isn't doing, I'll leave it to Dean at this point.

[Laughter.]

MS. FOWLER: The thoughts I share instead of coming and representing the Senate Finance Committee are my own.

Thinking about rising costs and the implications of the crisis that I think this country faces, one important thing to keep in mind is that it's not just a problem with health care entitlement programs, it's a problem with the health care system as a whole. I think what that means is that we need to look at broader solutions and not just looking at some of these difficult choices which I think will be on the table also.

One thing from my perspective, I'd say that virtually every CEO that came in to meet with my boss, Senator Baucus, or my former boss, would raise health care costs as one of their top priorities, not just maybe a third or fourth priority, but in many cases was the number one thing that they wanted to talk about and so I was often included in a lot of those meetings.

I think again what that means is that we need to look broader at solutions, and I think on the list of what Dr. Aaron has provided, there are things that I think we can think of in a broader sense which is thinking about fraud, thinking about more efficient purchasing and thinking about broader use of medical records and technology and computers, as you mentioned, as a way to try to get at some of the maybe less efficient uses of health care.

Some of that work is going on in Congress and I'm sure Dean will talk about the bill that his boss recently introduced with Senator Clinton. A similar effort is underway in the Finance Committee and the Health, Education and Labor and Pensions Committee. I think within the next couple of weeks there will be a bill introduced by Senator Grassley and Senator Baucus and Senator Kennedy looking at quality purchasing in the public programs, specifically in Medicare, and looking in that direction at Medicaid, and also broader use of health technology.

Those are important steps that we should be looking at, but I also think it's not a silver bullet and it's not the be-all, end-all solution. I think the good thing about solutions along these lines and paying based on quality is that it's a bipartisan solution and there is pretty broad agreement. As you can see, Senator Frist and Senator Kennedy and also the Chairman and Ranking Members of the committees of jurisdiction all are interested in this and I think there is interest in the House side as well. So I think because it's bipartisan it probably gives it a greater likelihood of happening, but again I don't think it's the silver bullet that everyone is looking for.

Some of the hard choices that have been mentioned also give pause and we need to think not only of the hard choices but also the potential secondary consequences of any of those hard choices. For example, raising the eligibility age could have a dramatic impact on the uninsured as the near elderly are one of the growing populations of the uninsured. I think if you're going to look at raising the eligibility for health insurance, you should also think about potentially a Medicare buy-in or some other means for people to buy health insurance that might be losing that coverage, so throw that out there.

When you think about increasing cost sharing in both Medicare and Medicaid, you have to think about the impact in Medicaid in particular what that means for postponing care, delaying care or disenrollment from the program in terms of increased premiums, you might end up with higher costs in the long run rather than lower costs.

On the Medicare side what we see a lot is that people are able to make up the difference in their costs by buying secondary insurance of MediGap, and I'm not sure

that solves the problem either as a lot of that coverage ends up being first dollar coverage and not necessarily the most efficient way to purchase care.

Thinking about the Medicare Bill that was passed in 2003 which both Dean and I had the opportunity to work on, everyone looks at the increased cost in the new drug benefit, but there were a couple of elements that looked down the road of long term financing.

First of all, there is income relating for the Medicare Part B program that will go into effect in 2007. It's not a huge element, it's at a fairly high income level and the cost increase in premiums for those folks won't be significant, but it is a step in that direction. What will be important also is how easy that is to administer and what the impact will be on participation because as we were looking down that road in the Medicare conference, what we didn't want to do was decrease participation in the program and undermine its long term popularity and long term—we just want to potentially end up with an income related program that excludes middle and upper classes.

The other thing that we did, and Dean may talk more about this, is to put a trigger in, that once Medicare spending is financed by general revenue by over 45 percent a couple of years running, then Congress is supposed to start looking at potential solutions. If you read the bill closely you'll see that it doesn't have any teeth and there is no required action by Congress, but at least it starts the ball rolling in conversations and looking down this road.

Why does it not have teeth? I think that's because that gets back to the problem that Congress has difficulty making difficult choices, and that was certainly

something that I learned in my 6 years working on Capitol Hill is that a lot of times it is hard to make difficult choices.

That's where places like the Brookings Institution can come in handy. I think that your thinking and your input into this process is a very important part of the dialogue because we need solutions to be put on the table and we need people to be thinking about these long term solutions. There potentially hasn't been enough of that going on at least when we were looking down the road of adding the drug benefit and what reforms we might look at. I'm not sure there was enough thought into a lot of the solutions that might be on the table.

Raising taxes certainly is a solution. I didn't see it on the list, and obviously that's a hard choice as well, but that ought to be considered. I can say that now that I don't work for Senator Baucus who probably wouldn't want me to say that on a panel in this sort of setting, but I can say that now.

Let me just emphasize that I think it's really important to keep these dialogues going and to have these discussions and I look forward to being part of the solution at whatever point in whatever role that I' playing either here or back in the public sector which I hope to be at some point soon.

Thanks again for the opportunity and to Jeff Meyer who is a tremendous asset to those of us on Capitol Hill. He has been a tremendous resource and we've really appreciated his work as well.

MS. SAWHILL: Thanks, Liz. Over to you, Dean.

MR. ROSEN: Thank you, and thank you also for inviting me today. I feel honored and privileged as well, and really welcome the comments of Mr. Aaron and

Mr. Penner because I think we do need to think a little bit more long term about some of the short term impacts of what we're doing on the Hill in Congress as policy makers.

What I was going to try to do is to give you a little bit of a look into what some of the perspective is of Congress as we confront these health policy issues and talk a little bit about how some of the specific policy debates link up to some of these longer term concerns. I do want to say that I also want to join Liz, I really welcome Brookings into this debate and I think the focus on quality and on cost is the right one. It's the one that shows up when members of Congress right now are out talking to constituents and out talking to folks outside of the Beltway. It is the number one, is health care costs, the number one health care concern anyway is health care costs, so I think this is very timely and very responsive and it's something that we're definitely going to be dealing with.

I think again sort of big picture, I view this policy making apparatus as this giant ship with a very tiny wheel and we're now steering it, but I think we are now coming back to a real focus on concerns about health care costs. I don't think there would be anybody in this room who would disagree with me that if we had not passed the Medicare Prescription Drug Benefit in the last Congress that it would not become law in this Congress given increasing concerns about cost.

I think the mood has really shifted. It's taken a little bit of time to catch up with what's actually gone on on the ground, and I don't know whether Liz agrees with this or not, but I was talking to her earlier and preparing for this panel, I think that if somebody said today we're going to spend $200 billion, half of what we provided for Medicare drug benefits in this Congress that it would be extremely difficult and I think

that's because there is an increased focus overall on the federal side on concerns about the budget.

So the mood has I think slowly shifted and this year as one very concrete example, we just passed a budget resolution. We are in the fall at some point about to have a budget reconciliation process that for the first time in about a decade we will have a budget reconciliation bill that will propose to cut costs in entitlement programs to reduce the rate of growth primarily in Medicaid, but really it was 1995 the last time we had a partisan budget resolution, and 1997, almost a decade ago, was the last time we cut costs. And all the bills in the interim that were driven by budget from DIPA (ph) and BBRA and all these other acronyms, we were giving money back. So that just shows you there's a lot of members of the United States Senate who this will be the first time as members of Congress that they will be in a reconciliation process where they're reducing the rate of spending as opposed to increasing the rate of spending. So the mood is really different, number one.

Number two, I think the current debate, and we can talk about this a little bit more, about Medicaid which is a really interesting focus is one very small example of the difficulty that Liz and others alluded to in addressing these entitlement programs. We're talking about in this budget resolution, and I know Liz will probably disagree with me, maybe not with her current hat on, but we're talking about reducing Medicaid growth by $10 billion over a 5 year budget window which is just about 1 percent of projected federal spending during that period.

It's caused no end of gnashing of teeth and consternation and concern from a lot of folks in this room and others that this is going to be end of the Medicaid

program. In 2003, in one year, we gave the states $20 billion in money to make up for crises, and $10 billion of that was Medicaid. It just shows you when you look at the magnitude of the growth of the program, the magnitude in terms of percentages and what we're proposing to reduce in terms of the growth of the program, I think is relatively small. It's very, very difficult, and that will be inside this reconciliation debate that we're going to have in the fall, probably one of the biggest if not the biggest factors that will make passage of that resolution very, very difficult. It will be a very, very challenging debate but, again, it just shows you talking about reductions on that magnitude compared to some of the reductions in costs that have been talked about here.

Let me come back again to this broader picture for a moment which is, again, the mood has really changed to have focused on cost, and I think Liz is exactly right. It's not a focus on the Hill. I think it is for some people because we tend to operate in silos and the Finance Committee deals with Medicare and Medicaid and some of the other committees deal with private spending, but overall it really is a broad concern. It shows up in terms of pressures in entitlement program costs whether it be Medicare and Medicaid, but it's a system wide concern.

It's a private sector concern. The same factors that are leading to increased costs and increased growth in the private sector are also driving cost growth in the public programs. In terms of the aging population, the lack of information, I believe the lack of quality information, the lack of consumer involvement in decisions, and all of that is leading to overall growth. It's amazing for me, not only are there meetings with budgeters who are very concerned about Medicare and Medicaid growth, as Liz said, there are meetings with CEOs, and that's the number one thing they want to come in and

talk about is what they're trying to do to get costs under control and how Congress can help.

In every meeting I'm in, I was in a meeting with veterans the other day, my boss called me in and said, come on, sit in here, and the number one concern, this was all the leading veteran's organizations, was health care costs. So it is showing up in a lot of different places and a lot of these different siloed programs that Congress and the administration is dealing with.

Liz is absolutely right, the root causes are all very similar, the aging of the population, this constant tension between access to the latest technologies and the latest medicine and controlling the rate of growth in these programs.

There are top-down concerns that I think are driving us toward probably a more holistic or systemic look at reform, top-down budget concerns from the federal level in terms of the overall budget. If you just look at the growth of the budget, major components of budget growth over time, the largest component is the entitlements and the mandatory spending.

The largest component of that is Medicare and Medicaid and Social Security, but over the next few years Medicare and Medicaid are going to eclipse Social Security in terms of the impact of the cost. The difficult with health care is it's not nearly as predictable. We know people are going to retire, but we don't necessarily know who in this room is going to be the sickest 5 or 6 or 8 or 10 percent and how to allocate those resources, so it's a much more difficult problem.

I think the pressure is also coming from the bottom up both on the public side and the private side. On the public side, you've probably read I think it was today,

my days all blur together, but The Washington Post had an editorial about Medicaid costs and it you look at what's happening in some of the states, they are clearly feeling pressure. Tennessee which is the state that my boss represents is probably a unique example because of what's happening there with the TenCare program. Close to 300,000 people are about to be disenrolled from that program which is a huge number of folks because of, again, the cost pressures on the state.

But if you look at it, just one example, but I think this is happening across the board in terms of this bottom-up pressure, in 1983 and 1984 the Medicaid costs, this the state budget in Tennessee, were about 6 cents of every dollar. Ten years later they had more than doubled to 14 cents, and 10 years later in 2003 and 2004 they had more than doubled again to about a quarter of the budget.

What's happening? The overall budget is getting bigger, but other things are shrinking, transportation, education, those other things. So the states in addition to the federal government are feeling cost pressure.

Then finally, I think as everyone said, there is this pressure in the private sector, too. You see it with large employers, you see it with small employers. There was a recent survey where two-thirds of small business owners said that their premiums were too expensive. It's the number one concern when the National Federation of Independent Business comes in. If you look at what's happening in the large employer market with the airlines, General Motors, Ford and others, those are just the leading examples, but the large employer market is having trouble as well, so the pressures are coming in all kinds of different directions.

Let me close in terms of where I think we may be in terms of the policy response which again is always lagging these leading indicators, but nonetheless trying very hard to keep up and I'll take whatever blame that Liz has now shuffled on me because she left the Hill.

One is that I think we are in an era where both parties have a long term vision of where they want to go. For a long time I think the Democrats had a much clearer long term vision, and this is overly simplified, but Ted Kennedy would give a speech every year at the Press Club and say everything would be great if we just put everyone into Medicare. I'm simplifying his speech and I'm being overly simplistic, but in general I think the Democratic Party for a long time wanted to get more people covered under public programs and you saw a lot of that play out in the last presidential debates. Senator Kerry's proposals, a lot of them were expanding Medicaid and expanding government proposals and programs.

On the Republican side, I think in the last couple of years we have a much clearer vision. If you look at the vision that President Bush as articulated, if you look at the vision that my boss has articulated in the New England Journal and some other places which is a much more consumer driven, patient centered kind of system where there is more information, there's more choice, there's more control. None of these are silver bullets and none of them are going to happen overnight, but I think the bottom line is there is a clearer vision of where I think both parties want to go.

Unlike a lot of issues in the last presidential election, this is one where I think there's a great deal of differences still between the parties. Liz and I worked together on Medicare where I think it was a unique example, but in a lot of other areas

you wonder why we haven't moved ahead. There really are in addition to these cost issues I think remaining deep philosophical differences in general between where the parties want to go. They can come together on certain things like information technology, on maybe expanding Medicaid outreach to kids who are eligible for programs, some of the tax policy. But on issue after issue, whether it be small business association health plans or litigation reform or some of these other issues, there remain these very deep philosophical divisions that are I think going to prevent broad either progress or lack of progress depending on your perspective for a couple of years until it all gets sorted out. So it's not that we don't see the problems, it's just that I think we different solutions.

What again we've laid out is that you've got to really try to deal with these things in a number of different aspects. It's not a silver bullet in terms of just dealing with the public program side or just dealing with the legal reforms, but it's got to be really a combination of tax reform, insurance reform, legal reforms and some of these other issues that really have to come together. You don't have to do them all at once, but they really almost all have to be on the table.

Let me just end with something that Liz ended on as well which is in terms of addressing public programs. I think a lot of people when the Medicare law gets lost in the press debate and in the public debate and discourse over what was done in the Medicare Modernization Act in 2003 which is I think most people who know anything about that law, and it's astonishing how many people don't know anything about it, but most people who know anything about it think it was about a drug benefit and it was, and that's where the bulk of the money went.

People are concerned about the cost of the program or how it will be administered and it hasn't started yet. But there were a lot of other things in that law and I'm sure Dr. McClellan will talk about this a little bit later this evening. I don't want to step on what he would say, but I think our important little doors or important little avenues that we begin to open up toward I think a vision at least consistent with where we would like to do as a party and I think some from the other party as well, that you're really going to need to do much more aggressively to try to address these programs. Increasing choice in the program, increasing competition. We did affluence tests or means tests, the Part B premium again very gradually, but started that for the first time; making the Medicare program more of a means tested program. The drug benefit itself was means tested, the first time we'd really ever done that with the benefit. We linked payment to hospitals, payment to providers for the first time to quality reporting. We had E-prescribing provisions in there which I think you see echoes of that in these other electronic health information bills that are out there. We compared the effectiveness for prescription drugs; health savings accounts; tax free health savings accounts were part of that law.

So I think if you look my point is behind the drug benefit and look at some of these difficult things that we're going to have to do now, we didn't address raising the eligibility age and some other things, at least it's my belief that there is some level of bipartisan consensus or at least there's some concrete evidence of a vision there of how you might need to begin to address these enormous cost—

[End of side A, begin side B.]

MR. ROSEN: [In progress] —just in Medicare but across other public programs and probably against other private sector programs as well.

So let me end there. Again, I'm happy with everyone else to take questions, and thank you for including me on this august panel.

MS. SAWHILL: Thank you. Let me open this up now and I suspect there are some questions and comments out there. If there are not, I can start with some of my own, but who wants to jump in?

Let me pose one question while you are thinking. Liz and several of you made the point, I know Henry has made this point many times and he and Jack made it in their chapter that they wrote this year, that you can't separate out the problems we have in the public programs from what's going on in the private sector, that there are too many linkages between the two.

I think that in thinking about the kind of longer term reforms that may be needed, an interesting question to me is who takes the lead. Is it the public sector? Does it come up with plans perhaps along the lines that Dean was just suggesting but then push the private sector into some new modes? Or is it the other way around, that because this is a very large ship with a very small steering wheel, we're better off to let the private sector or perhaps the states take the lead in playing or experimenting with various reforms and hope that that eventually affects the public sector?

Does anybody want to address that question?

MR. PENNER: I don't see how the public can help but lead. It's what creates a lot of the incentives. It's pricing practices in Medicare and Medicaid to some degree, to some degree, to a considerable degree, that influence the private sector. But if

you just look at a few very basic policies like not taxing employer provided health insurance and look at the profound effect that has on our whole health system, I just don't see how you can avoid looking at such public policies.

MS. SAWHILL: But in your own scheme, Rudy, just to follow up quickly, your radical proposal that you put forward just now, if the people who end up being affected are providers, you're going to have a two tiered system and all the providers will leave the public system if prices have been reduced in that system and not in the private sector.

MR. PENNER: Again, it is not our intent to put into place a policy that would last very long.

MS. SAWHILL: Just to get people's attention.

MR. PENNER: Exactly. We would expect such a policy to provoke such howls of anguish that the Congress would be forced to do something else.

MS. SAWHILL: Henry, do you want to comment?

MR. AARON: Not particularly on that, but I want to inject perhaps a little bit of controversy into the comments that you've heard here.

First, with the point I think we'd all agree on, and that is the fundamental premise of I think everything we're saying is that over the next decades, next several years, there is no more important domestic challenge than reconciling the promise of advancing medical skills and medical technology with our budgetary requirements both public and private. It is a deep and profound challenge that holds greater implications for the welfare of every one of us in this room than any other domestic issue, in my opinion, that you could think of. Bringing those two sides of the equation, the benefits

side that comes from expenditures and the revenue generating capacity private and public to pay for it, into alignment is a first order issue.

I would like to put in a couple of comments about various statements that have been made. The first concerns the proposed Medicaid cuts that the administration has resubmitted this year after having submitted and having had rejected by previous congresses. They are small but they sit oddly with the recommendations for tax cuts in addition to those already enacted many times multiples larger than the spending amounts involved.

In particular, let me take one instance and that would be making permanent the repeal of the estate tax. There is something that makes one scratch one's head at proposals to cut back on Medicaid spending that benefits you know who at the same time that we make permanent cuts in the estate tax which benefits you know who.

The second point is that as former Senator Moynihan once observed, everybody is entitled to his or her own opinion, but not to his or her own facts. If one looks at the net cost to states of Medicaid, it isn't the largest item on state budgets, it's third, behind primary education, behind secondary education. Furthermore, over the past decade the increase in the share of state budgets going to Medicaid, yes, it's risen a little bit more, but not much more than the increase in the share going to elementary and secondary education.

What we're looking at here is not on the average an overwhelming problem however notable the increases may be in selected states, and it is odd to deal with the fiscal duress that the states encounter by cutting back on federal spending of grants to those states.

Just one comment about Rudy's admiring reference to the Japanese pension reform. I too admire it, but it's important to describe the whole reform. The whole reform included the items that Rudy mentioned. They also included an increase in the payroll tax from about 14 percent to more than 18 percent, a 4 percentage point increase in the payroll tax.

The Japanese did what I think we ought to consider doing seriously which is dealing with the projected long term gap in Social Security by some adjustments in benefits and by some adjustments in taxes, not by relying exclusively on benefit reductions. After all, when my kids grow up and get ready to go to college, I don't say I've been spending X percent of my budget on your education up until now. I'm holding it at that. One needs change and the needs do change because of an increase in the number of elderly. One does normally reallocate one's budget.

The Japanese reform did something that will move them into the same situation that we are here in the United States on pensions. In particular, everybody in this room under the age of 35 or thereabouts will over the course of his or her lifetime pay payroll taxes sufficient to pay for the benefits you're going to receive under current law in Social Security. The deficit in Social Security is exclusively a result of having paid very generous benefits in the past to people who were early in the system and who Congress and successive presidents of both parties rightly or wrongly wanted to treat generously. It's like the public debt. We're stuck with it. We're going to have to pay it off.

And the Japanese are now in exactly the same situation. Their workers today will pay taxes sufficient to cover their own benefits. They probably still have an

overall deficit in their pension system. What we should do is deal with this unfunded legacy debt of Social Security as the Japanese have done, in my view, by a combination of changes in benefits and changes in taxes in light of the fact that we're getting older just the way they are.

MS. SAWHILL: Let's bring in some people in the audience.

MS. RIVLIN: Alice Rivlin, Brookings. Listening to this very stimulating group, I heard a very different tone from Henry and Rudy who really see cataclysm, see something terrible descending upon us. Henry has a whole list of things we might do to reduce the increase in costs, but he says it won't in the end solve the problem. And Rudy has a very drastic set of proposals that I think he hopes will wake people up to the problem. From the congressional representatives, if I can call you both that, I heard much less alarm.

My question is, if Henry and Rudy are right, then why aren't we doing everything on Henry's list just to get that out of the way and see if he's right, that doing all those things won't solve the basic problem, but it surely would help? And does the Congress not see that we're in a crisis, that there is something terrible looming down the road or do they see it and just not know how to deal with it?

MS. FOWLER: My response would be a little from column A and a little from column B, that I think that Congress sees that there are problems but doesn't necessarily know how to deal with them. I think Congress is also hindered by the problem that we deal in it used to be 10 year budgets, but this year it's shrunk to 5 year budgets. So I think it's difficult sometimes for Congress to look even beyond the limited

budget window they have in terms of what potential solutions should be on the table or could be on the table. That's I think part of the problem.

Then I also think because it's difficult for Congress to make difficult choices, a lot of times they don't act until the problem is really upon us which is what happened, as Dean mentioned, in 1997 with the Balanced Budget Act where the Medicare Trust Fund was due to become insolvent in 2001. Part of that solution involved transferring elements of the program from the part that is covered by the trust fund into the part of the program that isn't covered by the trust fund. In other words, sort of a smoke and mirrors solution rather than a true solution.

Again this gets back to why it's so important to have these discussions and why it's almost that unless there is more of a public dialogue, and even then I would say looking at the public debate right now, the focus on Social Security is somewhat displaced because Medicare and Medicaid I think if you look at the numbers are in much greater crisis than the Social Security problem and due to come knocking at our door and become a greater problem sooner than the Social Security problem, and yet that's not where our efforts are.

Not only that, but the solutions that are on the table for Social Security aren't going to solve the problem if you look at, at least some of the proposals that are being discussed or outlines of proposals, not really proposals, but at least outlines of solutions, they don't seem to be getting at the long term problem.

So I think that goes back to the point that Alice was making about how Congress ignores problems and then doesn't know what to do about solutions.

MR. ROSEN: I would just add a couple of things. I think I agree with Liz that there is an awareness of the problem, but I think in part it goes back to this point I made about the philosophical differences between the direction that the parties would like to go in and in terms of the reforms.

Rudy talked about the Swedish system, but the fact is that Swedes don't vote in our midterm elections, and these guys have to run every 2 years and so they're not going to say this is a great idea, let's proposal global budgeting and raising the Medicare eligibility age by 10 years and increasing taxes. So it plays out against a backdrop of these broader political concerns which I think are real.

The one thing I would take a little bit of issue with said in terms of the focus on Social Security, these are all big problems and I get the feeling politically that if we as the leadership in Congress would have said let's really go after Medicaid this year or let's go after Medicare this year, these much more bigger daunting problems where the trust fund is going to go bankrupt a lot sooner, we would have gotten as much push back which was my example on Medicaid, whatever your facts are on it, the fact is that it is a relatively small portion of the budget. The governors themselves in a bipartisan way came up to Congress last week and said we want more flexibility with regard to some of the voluntary populations to look at things like cost sharing, increased flexibility on benefits and were roundly criticized on things like Social Security. You essentially have most of the folks in the Democratic Party say really weren't not going to come up with a solution and I think their political strategy is let's let the Republicans come up with all these solutions and then let's just foist them on those to be tarred in the election.

My only point is I think if we would have chosen Medicare or chosen some of these other daunting challenges the argument would just been slightly different, but the main point of it would have been you shouldn't do this.

So my point where I would disagree with Liz a little bit is I think we need to look at all these programs, frankly, and I think we need to look at them in the broader context of the health care system overall both public and private. And I think there is a degree of alarm but it hasn't reached that point yet. When I think we will get to that point, and Liz alluded to this earlier, is in part going to be driven by this trigger that was put into the Medicare program. We thought it would take place in 2010 or 2011, and it's going to trigger for the first time in 2007 and then 2008 which is, guess what, the presidential election year and at the time the trigger says if you're spending more than 45 percent of general revenues to finance Medicare.

So I think there are these little ticking time bombs out there that are going to force Congress to look at it, but until we get to the point where there is really those kinds of forcing mechanisms, it's easy in this political environment unfortunately to just ignore the problem and going to another problem and not deal with it.

MR. NICHOLS: Len Nichols (ph) from the New America Foundation. I want to pick up on Henry's point which I think is indeed the most important and as usual Henry said it better than most. We have to figure out how to balance the benefits of technology with the cost.

So, therefore, I was surprised to hear no discussion and not even to make your top 10 list there of technology assessment.

I want to ask in the spirit of Alice's question, if we all know that's what we have to do, can't we begin to talk about it now on the Hill, and how do we do that? Let me give you one example to react to.

If you think about the FDA, and that's just one example because it expands to all technology, and just to be brief, today you have to show that you didn't kill anybody and that the drug beats a placebo and then you can sell it. Prayer beats a placebo.

MR. AARON: It's very inexpensive also.

MR. NICHOLS: It depends on your point of view. But nevertheless, I will say why can't we have a requirement that says you have to beat an existing treatment or at least show how you do vis-à-vis the existing treatment for a particular population and then extend the technology abroad?

MR. AARON: I couldn't agree more with you, and my failure to include it was a gross error.

The failure of the United States to have a publicly funded organization dedicated to evaluating new technology is in my view a class A scandal. We did at one point. It didn't have extensive powers or a very large budget, but it came in on occasion with bad news that angered people and who in some cases had invested a lot and didn't like the negative appraisal. Congress did away with it.

The British have a publicly funded organization, the National Institute for Clinical Excellence, which is dedicated precisely to calculating the value in terms of improvements in human survival and the cost of achieving those from various medical technologies. In the British system, it carries more weight than it would in the United

States because of the central budgeting to which various people as Rudy certainly has referred.

But the power of information is not to be disdained, and in my view the absence of an organization with at least a ten figure budget is outrageous.

MS. SAWHILL: Just getting to the point, and you asked what Congress could do, I think that was the question you raised first, I think Congress could do more in this area and that would have been my answer. But I think Len probably knows and Dr. Aaron alluded to what the answer was. We have tried to do some of that in Congress and inevitably we fail because of other interests out there who don't want to go down this road.

I think there are some who are pushing for more work on comparative effectiveness, and Senator Frist is one of them, and my boss was interested as well, but you're going up against such entrenched interests that it's difficult to come with even a minimal amount of funding. I think last year we were looking at $50 million and I think that ended up getting cut down to $15 million.

So I agree that it's important and I wish we could do more of that, but I think we all know why we aren't.

MR. ROSEN: And I think it's one of those areas, back to Belle's original question, where I think there is a role for the federal government to play in helping to sort out the differences. People see these prescription drug ads and there is no way to compare one ad to what another drug might do or the clinical effectiveness of that new drug compared to other things, aspirin or other things that are on the market.

So I think it is a role for government in terms of providing information. The difficulty comes when we're also the payer. Mark is obviously more able to speak to that, but in terms of what we cover, and again it's this balance of you don't want the Medicare or the Medicaid programs to lag 10 or 15 or 20 years behind the private sector which we've been in that place in the past, too. But I think there certainly is a role for the government at least my boss has believed to fund more objective comparable effectiveness data, let the market use that information and be able to make better decisions.

MR. ORSZAG: Peter Orszag from Brookings. I am not a health care expert so I have the luxury I guess of oversimplifying.

It seems to me that there are three kinds of things being discussed, the things that both sides can agree on, information technology and some other things, but the two main thrusts for policy are either rationing, and I would perhaps include technology assessment in that, and cost sharing individualized approach. I have questions for those who see the system evolving in either of those directions.

For those who advocate the kind of individualized cost sharing kind of approach, do we have any basis for thinking that given an increasing share of health care costs are associated with the elderly and disabled that there will be a sufficient response to that to make a nontrivial dent in the problem? Henry pointed out to me earlier that the RAND study which is often used for making statements about cost sharing didn't cover the elderly and disabled. Do we know anything from managed care or anything else to make us think that that's actually a fruitful endeavor?

For those who favor the rationing approach, the question is are there any social implications that we haven't fully taken into account whether people will go to India to take up the not particularly high ranked procedures or other things? In the U.K. there is a private system that layers no top of the public system. Are there social implications that we haven't fully articulated here?

MS. SAWHILL: Joe Newhouse, you were talking maybe to Judy there, but the issue of what the RAND study showed about the effects of cost sharing has just been mentioned. Do you want to say something about your role in it?

MR. NEWHOUSE: In this context, I would say the larger point is not that the elderly were excluded but that there is no strong reason to think that more initial cost sharing will cost the steady state rate of increasing costs which are what are driving Henry's and Rudy's numbers as you go out in time.

I think the other dilemma here is one that keeps getting underplayed which is that there are real benefits, we think on average, from many of the cost increasing innovations and if we start back to cut back on costs which I agree it's hard to envision a scenario where we won't, how will we decide who gets what and how do we do it without taking some innovations off the market altogether that might not make it? That I think is the real dilemma here, and I don't know that any of us has a very facile answer to that one.

MR. PENNER: I think it is important to point out while it's hard to disagree intellectually with anything that Henry said about doing appropriate cost benefit analysis of new technologies and Liz talked, I do think we have to recognize the problem here. There is a group of people out there who think it's immoral to do cost benefit

analysis of environmental initiatives, and I think that's a minor problem compared to doing cost benefit analyses that involve valuing human life and suffering.

I don't think it's easy and I think that's why in the Canadian type system you don't see a lot of explicit cost benefit analysis. It's very implicit, it's not very transparent at least to me, but while I'd love to go down Henry's road of a more rational intellectual approach, I think if you see bureaucratic rationing it's going to be of a quieter implicit sort and we're going to have to live with that.

MR. MITCHELL: Gary Mitchell from the Mitchell Report. I should say at the outset that in these sessions there is inevitably always somebody who asks a question like this, so I'll be that person.

As I was sitting here I'm struck by the fact that the remarkable feature to me of conversations like this on health care policy are that we always end up talking about it as a financial problem as opposed to a problem about health. It seems to me there are two things that we know for certain. The first is that the system is unsustainable for reasons that have been well documented here today.

I would say that the second thing that we know for certain is there is one set of activities that we know will drive down the cost of health care and that is that if we could get at the question of personal responsibility for one's own health.

My question which is not intended to be a throw away is what is the likelihood and how might public policy begin to wrestle with the question of individual responsibility for personal health care and what are the leverage points that might be there to provide carrots and sticks ranging from presidential leadership on a scale we've never seen to stop making this a financial problem and to help people understand this is

really a problem about how they're living and that there are solutions that can, A, help them and, B, help the system?

MS. SAWHILL: If I can just piggyback on that, I was at a conference at Princeton recently in obesity and there are people in the obesity field that are now predicting rather seriously that the gains we've made in longevity will reverse because the obesity problem amongst children is now so prevalent and so serious. Comments?

MR. PENNER: Just one comment. The thing that comes to mind immediately to me at least when one brings up personal responsibility is the odd history of smoking in the United States.

Economists looked at cigarette taxes. They're now been raised fairly significantly. I don't know that anybody attributes any significant part of the decline in smoking, some perhaps, to the increase in cigarette taxes. It does have a deterrent effect on starting of smoking by teenagers.

A larger part is that it just became really uncool to smoke. It all started with those few little words emblazoned on the side of cigarette packs and a process began under which what had been primarily a habit of the well educated, well to do, almost vanished from that part of the economic and social spectrum, and became a habit of those with less education or remained one. But insofar as there was a spread of information and discussion, smoking substantially declined.

It was a change in norms I think that was the result of gradual public education and information. It didn't happen overnight. It took a generation. It's caused a large part of probably a 60 or a 70 percent decline in the rate of coronary mortality in

the United States. I think Joe shook his head no. Is it a smaller decline or do you attribute less of it to smoking? Still I've got the sign right.

[Laughter.]

MR. PENNER: In the case of obesity, I think it's going to be the same phenomenon. It's going to play out over time—Shansky (ph) has written a number of articles in Science and in other magazines estimating what he thinks will be the mortality increasing effects of obesity. He hopes it won't happen. I bet it won't because of changes in norms and behaviors over time.

I think there is probably a limited capacity of people to absorb sermons and, therefore, we may have to deal with only certain aspects of personal responsibility. But if we could stop smoking or at least reduce it and thin down, and I tell myself I'm going to do it every week, then I think we would have moved a long way in this personal responsibility direction.

MR. NEWHOUSE: But will we save many costs?

MR. PENNER: Probably not. We're going to die eventually and whether we die from coronaries due to smoking or other more costly causes down the road, unless medical science converts into us into one-hoss shays which would be lovely, you remember the one-hoss shay lasted 100 years and a day and then collapsed in a heap of junk? It would be lovely if we could all expire in that fashion, but until that happens, the savings are likely I guess to be modest. So good for our health, maybe not so good for our budgets.

MR. ORMUND: I'm Gil Ormund (ph) from the University of Michigan, once upon a time here in the Economics Studies Program and delighted to be invited to this session.

We've heard very cogent statements about very serious problems. I think the two big elephants on the table as some people say that haven't been adequately addressed although they've been mentioned are, first, the disrespect for balancing the budget and, second, the willingness to cut taxes progressively in very, very large chunks.

So the unwillingness of many Americans to undertake a sense of sacrifice or shared expense for something highly valued like medical care is very limited if the rational judgment is that unlike 1993 or 1997 or at many other times earlier where the Congress and the administration worked endlessly to balance the budget or make progress on balancing the budget, for the last few years starting from an enormous surplus that would have made much of this discussion quaint, we've been on a path to cut taxes and cut taxes further such that there is amount of sacrifice of programs that would be sufficient against that juggernaut. So the budget can be elastic and the tax cuts will eat up any savings that are made on programs.

Now on the specific title related to Henry's theme, I do think there is a great deal that innovation and new technology can bring to the value proposition, and you mentioned this, in health care. My own estimate is that a quarter of what we spend—nearly $2 trillion a year is the best we can offer presently chasing the symptoms for a variety of conditions where we really do not touch the underlying disease, that is, morally and certainly practically unacceptable for the long term. So the investment in

research and technologies to do it better and do it much more cost effectively is a noble and appropriate objective.

There are many examples where we now take care of chronic conditions very much less expensively than the case before by preventing them from being chronic like doing them as outpatients or in other ways actually being much more effective. The corollary to better treatments of course is earlier diagnosis so the condition is less advanced or, even better, prevention of the condition in the first place.

These interventions have to be selective, and Louise Russell in one of the most quoted books of all the economic studies here at Brookings put the death knell on preventive interventions on the notion that given the poor compliance and the overextension of the screening that it's very hard to recover up front costs with a decent discount value and save money for somebody's budget. But there is by now a very long list of conditions for which effective prevention can be recommended and the master of all these efforts is sitting right here, Mike McGuinness.

A couple of other dissonant points. What does it signal to Americans if the political leaders are determined to force medical care [on those] who have already made a decision in their own good thoughtful judgment and moral values that they've had enough medical care? Mr. Ashcroft's ghost is still upon us. The Supreme Court will take a case shortly for the fourth time I think, forcing the people of Oregon to justify their very careful and I think highly use of the Death with Dignity Law in that state. But it's a big signal to say that there should be no limits, there should be maximum expenditure even when the patients and the families have agreed they've had enough and that further care is futile.

We've had some discussion about raising the bar on evidence. That is a practical approach. I think, Henry, while I've been an advocate for decades of this kind of orderly kind of research on technology assessment and health assessment, I am not too keen about it as a fix for this problem. If we agree it's urgent and it's huge, we need to have some more bold decision making, and there are some ways that we could raise the bar on evidence. You've mentioned a couple, and I think that's a worthy subject for Brookings type activity.

Finally, there is all the matter of what we pay for and how we can control or negotiate payment levels. We sent a very poor signal on this in the Medicare Modernization Act when we protected certain major corporate sectors from any kind of negotiated price with the federal big buyer.

So there's a full agenda there and I think a lot of it could be quite useful. Thank you.

MR. PENNER: While it may be useful to expand on these two evils of slowing benefit growth or raising taxes, I guess Mae West said if she's forced to choose between two evils she'd pick the one she hadn't tried before.

[Laughter.]

MR. PENNER: There is going to have to be some balance here, obviously. I think Henry and I would probably disagree pretty vigorously about what weight you put on each side of the equation here, but I do think we would agree that if you want to solve a lot of this problem on the tax side, that it goes far beyond the question of just ending the President's tax cuts or continuing with them.

Indeed, I would argue that if you really want to solve a lot of the problem on the tax side we have to start thinking quite radically about the nature of our tax system. I think our current system is too rickety to tolerate big increases in marginal rates so that we would have to think about brand new taxes, maybe VATs or something like that if you are in fact going to work the tax side very hard.

MR. ROSEN: I'll make two quick comments. One is on the taxes as well. I think that it's a legitimate debate to talk about the tradeoffs between tax cuts and programmatic spending and reductions in the rate of growth, but I think the fact is, and you all have done papers on this and looked at this, you could as you say wipe out the President's tax cuts and increase taxes well beyond that, but that's not going to do a thing about the underlying factors that are driving costs in the entitlement programs in general or in the health care programs in particular.

Second, on the Medicare law, and I always hate to wade into this, but I think it's just a fact that people misunderstand or mischaracterize, but the fact is there is negotiation in the Medicare law, but some folks who are traditionalists in terms of the way the Medicare program worked didn't like the way the competition worked out, but the Congressional Budget Office where you used to work told Liz and smart people like Liz who worked on the committees that it would save nearly as much money or save as much money to have competitive plans with fixed payments negotiating costs as opposed to the government "coming in and negotiating." So I think that was one where we will see. The benefit hasn't begun yet, but at least the facts on the ground as we assess that, Liz may disagree with it, were that plans with an adequate incentive to go and compete and negotiate were going to do a better job at controlling costs and we felt

that was important not only from a cost standpoint but also philosophically in terms of moving the program forward.

I also wanted to add, because I don't want my comments earlier about Medicare to be misconstrued by anyone when I talked about some of the political realities of if we would have been debating the Medicare law in this budget context. I think the fact is a lot of folks including Senator Frist who I work for think that what we did in the Medicare law was a very important step forward and would have voted for the same thing today. I think it may well have passed, it was difficult and it might have been more difficult, but it was just an acknowledgement that the budget situation has changed. But I think I don't want anyone to misinterpret that as the people work for or represent thinking that it is a bad law or it was a mistake to do it. In fact, I think quite the contrary, so I wanted to just make sure folks understood that.

MR. AARON: I'd just like to say a word about the insignificance of the tax cuts relative to the entitlement issues.

Three numbers. The Social Security actuaries estimate the size of the 75 year Social Security deficit had an average over the 75 years of seven-tenths of 1 percent of GDP. The Medicare Modernization Act added to the 75 year deficit 1.2 percentage points of GDP, nearly twice as large as the entire Social Security deficit. The tax cuts enacted over the past 5 years have added 2 percentage points of GDP to the deficit over the next 75 years, three times as large as the entire projected Social Security deficit as estimated by the actuaries. And since CBO who has independently estimated the Social Security deficit places it at about half the size of the actuaries, the tax cuts are 4 to 5

times larger than the entire 75 year deficit as estimated by the Congressional Budget Office.

No, the tax cuts would not deal with the entire financing shortfalls that we anticipate in Medicare and Medicaid, but we're not talking about chopped liver here.

[Laughter.]

MS. FADER: I'm Judy Fader (ph) of Georgetown University. All of you seem to have agreed that the health cost problem is a problem of the whole health care system and not a problem limited to public programs, and yet know that the focus of public attention or of congressional attention is on public programs, it specifically is on the one serving the most vulnerable population, Medicaid. We also know that when you present the budgetary implications of cost increases that you focus only, you draw attention, to the public programs.

I wonder, Rudy, you alluded to the tax expenditure in terms of the tax preference given to employer paid premiums. I've heard the estimate that that tax expenditure is a couple of hundred billion a year, not chopped liver in Henry's terms. Although it does depart from the standard way that one presents the budget and from the budget process, might you all do a service by emphasizing that expenditure as well and changing the perspective that we bring politically to this issue?

MR. : Yes. Excellent point I would say.

MS. SAWHILL: I think just to add a footnote that that might be the way in which you keep tax reform revenue neutral. I can't think where else you go for money, and that means you can't use it for health care per se.

MS. FADER: I'd like to continue that discussion further.

[Laughter.]

MS. SAWHILL: I'm not seeing any hands at the moment. I want to go back to something that I think Joe Newhouse raised and which has been a constant in these conversations, and that is the idea that if you make various reforms you may reduce costs temporarily but you won't slow the growth rate over time. I've absorbed that point well myself and I find myself making it in various forums that are less sophisticated than this one.

It does occur to me that, first of all, we don't have a really good way right now, a sure way anyway, of reducing the slope of the curve. All we have is a lot of suggestions for reducing costs. But if we kept implementing them over a 10 year or even a 15 year period, it seems to me that that would over that period anyway reduce the slope of the line and might give us some time to figure out how to deal with the much longer term problem of technology pushing costs up and maybe technology eventually becomes targeted enough or different enough to actually be cost reducing instead of cost increasing.

I'd like comments from anybody up here or anybody knowledgeable in the audience about that.

MR. AARON: When I had my first paying job after I finished graduate school, one of my graduate school colleagues one time said to me, Henry, every month there is a nonrecurring expense that destroys my budget.

[Laughter.]

MR. AARON: I think another way of putting your point is perhaps every year there could be a nonrecurring savings that would save our budget.

MS. SAWHILL: Right.

MR. AARON: I think there is a lot to that, but the fundamental point here is that if one looks back over the past few decades, the force that has been driving outlays according to work that Joe did about 15 years ago has been predominantly factors that may be nonrecurring but aren't going to be undone like the extension of health insurance coverage that occurred. But if you take that out, most of what's left has been the steady accretion of more costly and beneficial actions that the health care profession can engage in.

Other work, again that Joe and colleagues have engaged in, documents that the net benefits despite all the waste that people talk about, the net benefits of these innovations vastly exceed their cost and may rival all other sources of economic growth combined.

So we're looking at a process that has gone on for a long time, and although one should be very modest in looking into the future given the unpredictability of the way in which technology is going to change, there really isn't any indication yet that it's going to begin to be saving us a lot of money so that one is swimming against a very powerful current.

MS. SAWHILL: Just to continue this discussion a bit, I am struck by the statistics that show that the U.S. spends twice as much or more as other advanced countries on health care and doesn't have better outcomes; the evidence from the Dartmouth studies that some states spend twice as much on Medicare as others and don't get better outcomes.

This suggests there is an awful lot of care that is not all that beneficial built into our system and that over time if we were able to ferret it out we would have that slope for that period of time anyway which might as I say take a decade or longer slow down.

MR. : There's a bit of a paradox here. On the one hand, if you look at the kind of budget indicators that I'm worried about like when the debt crosses 100 or 200 percent of GDP, the initial conditions are very important. So relatively small savings really postpone those kinds of dates quite a bit.

On the other hand, we all know that in dealing with the fundamental issues of Social Security and Medicare and the fundamental issue I think in Medicare is how the technology drives the costs, it would be a lot better to do all that sooner rather than later. So I'm sometimes torn in my own mind as to whether I'd like the financial crisis that I see coming earlier or later.

MS. SAWHILL: Liz or Dean, do you have any final comments or is everybody now ready to have a drink?

[Laughter.]

MR. ROSEN: I would only note really quickly at the risk of holding anybody back from the bar, I think one thing we haven't talked a lot about and I think it is something interesting for future dialogue is the way we pay for health care and the way we finance it, it's unique among the other six-sevenths of the economy in talking about technology as really being a driver of costs in the future.

If you look at the introduction of technology in the other parts of the economy, they tend over time to save through efficiency and part of it is that information

technology lags behind and I think part of is we have a system that one of the folks I used to work for say that the American consumer will consume as much health care as someone else is willing to pay for, and I think that third party payment aspect of the system and the fact that consumers are relatively isolated compared to other parts of the economy is also an important driver that we need to look at the comparisons here, too.

MS. FOWLER: My only closing thought would be thinking in terms of what Dean had mentioned about how the solutions out there are so partisan and the parties seem so far apart, it often seems we can't even agree on what the problem is much less any of the solutions. There also seems to be an unwillingness to even explore potential solutions that might represent middle ground.

It seems to me that one of my biggest frustrations being in Congress is that things are moving in the wrong direction and becoming more partisan rather than less partisan and even less willingness to try to work together to find solutions. I think unless that changes and unless the environment changes, there will be a lot more sessions like this and a lot less action in Congress.

MS. SAWHILL: That's a good closing remark because it suggests that maybe Brookings has some positive role to play in thinking a little longer term and providing some neutral territory where these issues can be discussed.

I thank both of you very much for being here. Thank you Rudy, and thank you Henry.

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