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Welcome and Introduction:

ALICE M. RIVLIN

Senior Fellow, The Brookings Institution

Panel Presentations:

JOSEPH R. ANTOS

Wilson H. Taylor Scholar in Health Care, American Enterprise Institute

GAIL WILENSKY

Senior Fellow, Project HOPE

ALAN WEIL

Executive Director, National Academy for State Health Policy

SUSAN D. HOSEK

RAND Corporation

PAUL GINSBURG

Center for Studying Health System Change

DONALD W. MORAN

The Moran Company

Commentary:

ROBERT D. REISCHAUER

President, Urban Institute

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P R O C E E D I N G S

MS. RIVLIN: Good morning. Thank you for coming. I'm Alice Rivlin, and it is my pleasure to welcome you not only to the Brookings Institution, but to our forum on Restoring Fiscal Sanity, the Health Spending Challenge. We are launching a new book today. This is the third in our series called Restoring Fiscal Sanity. We think it has not happened yet, so we are trying again.

The first book dealt with the shorter-run fiscal crisis in the federal budget. The second one showed very clearly that the long-run problem was largely a health care problem, that the problem of controlling federal deficits over the next several decades is dominated by health spending. So we decided to devote this book to the challenge of rising health spending.

But the challenge is not just a federal budget challenge. Health care spending increasingly dominates all of our budgets: states, localities, companies, universities, think tanks, families, whomever -, it is the big challenge. Americans are spending a rising proportion of everything we produce on health care at every level. We spend almost 17 percent of our GDP on health right now. That is likely, according to the Council of Economic Advisers, to rise to 20 percent or more in less than a decade, perhaps on to 25 or 30 or who knows how much after that.

That is not surprising and it is not necessarily bad. Medical care is much more effective than it used to be. We are healthier and we are living longer

partly as a result of better medical care. As incomes rise, we want to spend more on health care. But this rising spending does raise two very important questions which we will be dealing with for a long time in this country. First, how can we be sure that we are getting our money's worth, and second, how can we divide the cost: who is going to pay and how?

There is plenty of evidence that we are not really getting our money's worth at the moment. We spend a lot more than other advanced industrial countries. Our almost 17 percent of GDP compares to 9 or 10 in most industrial countries, and we do not have better outcomes to show for our higher spending. Moreover, there is highly persuasive evidence of huge differences within the United States in the effectiveness of spending for care among hospitals and among cities. For the same diagnosis, your cost can vary by a factor of 2 or 3 with no difference in the outcome.

Overall, Americans pay a high price for a fragmented health system that delivers uneven care at high administrative cost and fails to cover some 46 million people with health insurance. So there is room to deliver care more efficiently and hope for slowing the future increase in health care spending.

Health care relates to fiscal sanity simply because it dominates the federal budget. Medicare and Medicaid alone are now 21 percent of the federal budget and growing faster than other spending, and more importantly, faster than federal revenues. Projections of current trends show rapid increases in Medicare and Medicaid spending over coming decades. It is usual to blame the baby-

boomers and the increase in longevity, but that is actually a rather small part of the reason. The more important reason is that per capita health spending has been rising about 2-1/2 percentage points faster than other spending, and that differential affects Medicare and Medicaid, as it does other payers.

If these trends continue, Medicare and Medicaid alone – according to the Congressional Budget Office – will be more than 20 percent of the GDP, that's not 20 percent of the budget, it's 20 percent of the GDP, by the early 2040s. That's more than we spend for the federal government right now, and we are not paying for that. To pay for that amount of Medicare and Medicaid, we would have to close the rest of the government including Social Security and defense and everything else or keep raising taxes continuously.

It is not going to happen that we spend 20 percent of our GDP on Medicare and Medicaid, but the projections illustrate the unsustainability of current trends in health spending. Moreover, we cannot solve the budget problem just by slashing benefits under Medicare and Medicaid because that would shift the problem to the states and to the private sector who are already struggling with health care spending, it would not make the system any more efficient, and it would exacerbate the problem of the uninsured.

The problem we set ourselves in this volume was how to reform federal programs in ways that make the whole health system more efficient and effective, how to use federal programs to slow the growth of total spending while improving health outcomes. That is a large order, and I have to warn you that we

do not have any easy answers. We have a long list of reforms that we think would help. We assembled a very able team to tackle the problem and there is no ideological bias here. This team includes experts from think tanks of varying orientations and people who have served in Republican and Democratic administrations. And we did not, I must add, just focus on the federal government. We also focused on the role of the private sector in slowing costs and on the politics of the situation.

I will hand off to my colleague Joe Antos in just a minute. Joe is a well-known health scholar from the AEI. We will then hear from Gail Wilensky, also a well-known health scholar with Project HOPE, and a former head of what we now call CMS. We will hear from Alan Weil who is the Executive Director of the National Academy for State Health Policy and has also been a state Medicaid director. We will hear from Sue Hosek from the RAND Corporation who is an expert on veterans and the military health system, now very much in the news; it was not quite so much in the news when we recruited Sue. We will hear from Paul Ginsburg, who has focused on the private sector. And we will hear from Don Moran, also a health scholar, who founded the Moran Company a few years ago after quite a long career in Health and Human Services, part of it in the federal government. So let me hand off to Joe.

MR. ANTOS: Thank you very much, Alice. As a commuter on the Red Line, I'm surprised to be here.

(Laughter)

MR. ANTOS: As Alice said, we set ourselves and more importantly we set our co-authors quite a considerable task, and we are not apologetic that we do not have the cookbook because there really is not a cookbook. We are also not apologetic that we cannot tell you precisely what everything is going to save and what precisely all the impacts of all the policies are because, frankly, in most cases, nobody knows enough right now, but that is not an argument not to proceed.

As Alice said, this is a financial problem, but of course it is more than just money. If it were just money, we probably would not be sitting here. We would probably have simpler solutions to think about. But in fact, it is a question of value, as Alice said, and it is a question of values as well. We have some fundamental decisions to make about how we want the health sector to operate. The premise of this book, and I think it is the belief of all of the authors, is that the federal programs can absolutely take the lead in helping to, not redefine the health sector, in a way that can make not only the money go further, but also make the whole system more equitable and provide more appropriate care to more people.

As Alice said, there are on easy answers. You can pick up respected journals and find some really wonderful articles that promise you that you can save hundreds of billions of dollars over some unspecified time period if you only did, and you can fill in the blank with any of your favorite policies, but it is not that easy. Take Health IT, for example, the analogy there is that when you

look at other industries, bringing technological innovation to the production process elsewhere has really enabled much more efficiency, has enabled higher-quality products. For example, in the auto industry it produced better products more cheaply because of computerization.

So one might hope that that analogy would carry over into health care, and it probably would, except it is not that easy. It is not just giving every doctor a Palm Pilot, it is not just putting the Star Trek version of the computer into every hospital, the real payoff would be in changing the way health care is delivered, and that is a much taller order than simply buying some hardware or software and counting on Bill Gates to take it easy on the upgrades. A few of you have been upgraded recently, so I guess you know what it means.

A philosophical point: we are in Washington, Washington is one of the great places for political debates, and most of us in the room have partaken of these debates on health reform. The debates have gone on for decades, two polar sides, the folks who argue that we have to have a pure market solution and the folks who argue that we have to have a single-payer government-run system. Those debates are a lot of fun, there is no doubt about it, but they have not led us anywhere, and I think our point is that the time for simply running a debating society has long since past. We need to get on with exploring ways, in small ways and in large ways, to improve the system.

Do we know a way to slow the rate of growth in health spending? I would argue that we have a lot of leads but we really do not have one way, or we

do not even have 20 ways to do it. We have a lot of possibilities, most of them need to be developed, most of them need to be experimented with, and we need to learn more. But if we were to embark on the vast array of possibilities in an aggressive way with the government taking as appropriate the lead in some areas and as appropriate not taking the lead in other areas of facilitating progress in the health system, we think that we can make some progress.

It might be a series of one-off savings. Instead of that grand dream that especially budget analysts have that we are going to shift that curve down permanently, maybe we will just take nicks out of that cost-growth curve. If we take enough nicks, we will at least buy ourselves some time, although maybe that will be a continuing process for the foreseeable future.

What kinds of things should we be looking at? There was a handout out there that captures the main themes that we thought that we should hit upon. I think a key element which may in fact supersede all of the other ideas is that we have to learn better what we should do on health care. We need to know more what works under what circumstances; how to deliver the care; how to get people's behavior to change, that also includes physicians; how to reorganize the health workplace so that it produces the kind of care that we want; how to avoid providing care where it is of marginal use and marginal effectiveness, but very high cost. That is a critical point, and in this case, I would point actually to the Medicare program and other programs, but Medicare in particular. Medicare, as you know, is the insurer of health care for 43 million Americans, essentially the

entire elderly population, who are of course the big users of health care. We can learn a lot if we take the step to compile the information on what is happening to those patients, follow them longitudinally, and release that information to researchers, to other entities that can preserve the confidentiality that we all need in these data, but that can mine the data to actually understand better not just what works but who is working and how are they doing. I think that is probably one of the major themes.

There are a whole bunch of other issues, improving the delivery system, making the payment systems work so that they compensate for what we want, which is good output rather than simply services, promote competition where appropriate, promote information, and where we can see it, limit unnecessary spending. There are literally scores of specific policies that can be developed and we are arguing that we should give a big push in that direction.

With that let's turn to Gail Wilensky, who will speak on Medicare.

MS. WILENSKY: Thank you, Joe. I am going to assume for this audience I do not need to reiterate the point or statistics that Alice was citing about the importance of getting Medicare spending to slow down in its growth rate because of its otherwise likelihood of overwhelming the federal budget and health care in general, overwhelming how we allocate resources among uses in the economy.

When you look at the options that are available, there is a set of three that we have been primarily relying on. While I am going to sound

dismissive, I will acknowledge that these options will be part of our short-term future, and that is constraining benefits or limiting those benefits, constraining payments, and increasing financing. I think to be honest all of those will be part of our future, particularly with regard to the constraining payments and potentially considering whether or not benefits need to be limited as ways to reduce the absolute amount of spending on Medicare. But we have had more than enough experience to know that these are not areas that will fundamentally solve the problem of figuring out how to slow down the spending growth rate in Medicare. And similarly, I think it is unrealistic to look out into the future given the likely increasing share of both Medicare and health care spending no matter how successful we are in slowing it down, coupled with the baby-boomers reaching retirement, to not acknowledge that increasing financing will also be part of our future. It is my belief that should not be first off because it will lull us into ignoring what we ultimately have to do which is to find strategies that will help slow down the rate of growth and spending. There are two broad categories that I focused on with some attempt to come up with some sensible next steps. I would not have the hubris to say these are solutions.

The general areas are finding ways to increase efficiency by changing the incentives within traditional fee-for-service Medicare, but more importantly to my mind, by redesigning incentives with regard to both Medicare and the health care system in general. The short view of what that is all about is

consistent with what Joe has just said: we need to know more and we need to pay for it better.

What I mean by that would require the following steps. We need to move as quickly as we can both technically and politically toward ways of changing and realigning financial incentives for providers, and to the extent feasible, making patients more cost conscious and quality conscious. That is not an easy step to say, it obviously is very difficult to, because it means changing almost everything about how we pay clinicians and institutions in Medicare, and physicians most importantly where there are incentives to be efficient, nor are there incentives to provide high-quality health care. That is true for the rest of Medicare in terms of quality, at least in terms of areas where there is bundled payment; there is an incentive to be efficient.

Second is to improve the availability of comparative effectiveness information. It is impossible for institutions and clinicians as well as patients to understand better what works when and under what circumstances if the information is not available. I mean that not just for drugs and devices, I mean that for medical procedures broadly defined.

The third is to have more competition into Medicare. I am enough of a market-oriented economist to believe that too is an important element.

The fourth is to recognize that our obligations in the future may need to show some variation in terms of the needs of patients - full benefits for those with health-related disabilities, but gradually to begin increasing the age of

eligibility for those who do not have health disabilities. And finally, extending the Medicare principle of relating incomes to premiums beyond those in Part B.

The big question that I was asked to ponder in addition to those issues of options is where can Medicare lead and where must Medicare follow. In terms of having information available, doing demos or pilots, disseminating that information, for sure Medicare can lead. I have been a little dubious about whether Medicare can seriously change the payment system when it involves paying differently for what are nominally similar services. In the past it has not been very successful. Selective contracting has had a very hard time taking root in Medicare. But perhaps if it is well enough accepted through the experiences being done in the private sector, it can take the lead.

And a final point: Medicare cannot go it alone in this area. I was asked also to opine on this notion of where has Medicare been more successful and where is the private sector more successful, and the answer is, over the long-haul they move together at about the same rate of increase in spending. So if Medicare is going to be successful in slowing down its rate of spending, it is going to be because similar types of pressures and activities are going on in the private sector, and Paul will have more to say about that later. Thank you.

MS. RIVLIN: Now we hand off to Alan.

MR. WEIL: Good morning. It is a pleasure to present the chapter on Medicaid which I wrote with my co-author Lou Rosseter. The importance of Medicaid in a book like this is probably obvious, although it might not have been

obvious a decade ago. Medicaid now represents 9 percent of the federal budget, but 23 percent of the typical state's budget, and 17 percent of the typical state's general fund, so it has been on the fiscal radar screen for states longer than it has been for the federal government.

In addition, CMS projects an annual growth rate of about 8 percent for the program which is faster than for Medicare and other sectors in the health care economy, though I should note that that is largely due to enrollment growth. And just as Medicaid was about to pass Medicare in overall size, Congress adopted that fiscally irresponsible provision called Part D, and now Medicare has pulled away, but were it not for that, Medicaid would have won the race by now.

Medicaid serves about 55 million people, and it is important not to generalize about the program because it is so many different programs wrapped into one. About half of the enrollees are moms and kids, but fully 42 percent of the spending in the program is on behalf of people with disabilities, and that is a tremendous range of conditions from severe and persistent mental illness, to traumatic brain injury, to HIV and AIDS, to debilitating diseases of the body and mind, and that is an important backdrop for a discussion of Medicaid.

Medicaid is affected by the same factors that affect the rest of the health care system, but in our chapter we identified five unique factors that are important in thinking about how Medicaid contributes to the fiscal circumstances. First is that the program is jointly funded and administered by the states and the federal government. Second, its means-tested eligibility means that the

population is serves is very low income, and uncovered services essentially automatically translate into lack of access to services. Third, the program is countercyclical in nature because the demand for the program increases as family earnings decline in an economic downturn. Fourth, in certain sectors of the health care system, Medicaid is the dominant payer. This is most notable in areas like nursing home care where more than 50 percent residents are paid for by Medicaid. Finally, where Medicaid is a co-payer along with other financing sources, Medicaid is usually the lower payer.

With those in mind, Lou and I identified four approaches to controlling costs in the Medicaid program. The first is to change state incentives since states make many of the decisions with respect to the program. The obvious proposal here is to block grant the program to states which would clearly work from the perspective of restoring federal fiscal sanity and would solve some of the fiscal shenanigans that states have undertaken to maximize federal dollars. But without a model of how states would then convert their flexibility into a more efficient program, we conclude that this would primarily just translate into reduced services for the population which would solve a fiscal problem but not really do anything more than that.

The second option is to change how health care is delivered in the program. This is a recurring theme through the book. Medicaid already relies heavily on capitated managed care but has not used it as much for its high-cost populations. It has made investments in disease management and high-cost case

management for its high-cost populations. The investments in pay-for-performance concepts have been more limited, and we see opportunities for all of these approaches within Medicaid.

The third approach is to change beneficiary behavior. We are more skeptical about the defined contribution and purely financial incentives as they may play out for the population because of their low income but are intrigued by more what we would call patient-engagement models which may have a financial component but are really about actually engaging the patient and consumer in how their care is arranged and delivered.

The final approach is to reduce demand. People have suggested increasing the reliance on private long-term care insurance, or integrating Medicaid financing with employer-sponsored coverage. These are vehicles that have some potential, but in our review of the literature, that potential is limited.

Ultimately, we view these four approaches all as having some potential, less potential than their strongest proponents would like, and all requiring some serious caution if they are to be pursued.

Flipping to the final question in the chapter, how could Medicaid contribute to overall improvements in the health care system, we see a great possible role here, again, in the areas of pay for performance, health information technology, chronic care management, consumer engagement; these are all areas where Medicaid has a great deal to contribute. That contribution has been constrained, however, by two features of the program. The first is a very limited

investment in the data associated with Medicaid, partly associated with the fact that the program is fragmented across the states. Second is the program's long history as a low-cost payer, making it hard to leverage your investment because you are starting too far in the hole. It is hard to move people when they are mostly complaining that you are not giving them enough to do their job.

So our conclusion is that Medicaid can very much be a part and should very much be a part of an overall system-wide approach to controlling health care costs, but it cannot and really should not bear that burden alone.

MS. RIVLIN: Thanks, Alan. Sue?

MS. HOSEK: Good morning. Most of the federal health care dollar goes to purchase health care, but there is a fraction of it that is spent delivering health care, and the Veterans Administration and the Department of Defense Military Health System account for most of the health care delivery in the federal government. So it is interesting to note that they are on the same cost trajectory that everybody is on and have been for 50 years, which is as far back as I could find the data to do that kind of comparison.

In case of both the VA and the military system, a major component of the cost increase has come in the form of expansions in eligibility over time, and in the benefit package that is provided to eligible beneficiaries. These changes have occurred in the Congress, and over the past decade in particular we have seen an enhancement in both systems. At the same time, as Paul will describe, the private sector health coverage has become more generous, in

particular, premiums have gone up. So there is evidence that both veterans and military beneficiaries, particularly military retirees, have shifted their health care from private insurance, particularly employer insurance, to veteran and military coverage. So that has been a component in the increasing costs along with all the other factors that are driving up costs for everybody else.

In response to this evidence that there has been some shift occurring, both the Veterans Administration and the Department of Defense recently proposed modest changes in cost sharing in their programs. These proposals, however, were not well received in the Congress and no changes were made. I do not know whether anything will be done this year, but I think it is safe to say that significant cost sharing is not going to be a solution to controlling costs in these two programs.

I have been talking at this point about cost growth, but it is interesting since these are public health providers to ask the question, are they cost effective, that is, how do they compare with the private sector? The evidence is limited, but there is some, and what it suggests is that both the VA and the military health system deliver health care services to their patients at approximately the same cost as the private sector. We have evidence that in the military system the beneficiaries get more care than comparable people would in the private sector, and cost sharing may actually be responsible for that difference.

We only know a little bit about quality of care, but there have been some well-publicized studies on the VA using state-of-the-art assessment methods

that suggest that quality is quite good in the VA. Similar studies have not, to my knowledge, been done for the military system.

Finally, as I think is generally well known, access in some parts of the country to the veterans' system has been problematic largely because the Veterans Health Administration has to operate under a discretionary budget. Access in the military system, in contrast, has actually improved over the 10 years that the Tri-Care Plan has been in existence and compares favorably with civilian health plans these days. So we do not know a lot, but generally it seems like these systems may actually be about as cost effective as the others, as the private sector.

I think where the VA and the military health system can make a contribution is by leading the way as Gail said with respect to Medicare. These are highly-integrated health care systems and they have in recent years been innovative in certain ways. Both of them have electronic medical records now and that is unique in our country, and both of them have taken significant steps particularly in the military, but the VA is following suit, to find better mechanisms for coordinating the care that different providers provide so that their patients do not waste resources.

The VA has been a leader in quality improvement. I think that from a federal perspective it would be very useful to encourage that the innovation continue and even expand, and most importantly, that the innovative programs be carefully evaluated and the results disseminated so that everybody can learn from the experience.

MS. RIVLIN: Thanks, Sue. Paul, let's move to the private sector.

MR. GINSBURG: The challenge of limiting the impact of rising health care spending on the federal budget is very much intertwined with trends in spending that are supported by private insurers. There are both direct and indirect interactions. The most obvious direct interaction is that the revenue loss, or the tax expenditure from employer contributions to health insurance, totals $147 billion in the current fiscal year 2007. This is expected to rise 45 percent by fiscal 2011, compared with a 26-percent increase in overall revenues. Also, rising private health insurance premiums which make private coverage less affordable to many people leads to enormous pressures on governments to either expand public programs or to subsidize private coverage, and any realistic projection of what the federal budget will look like in the future probably should factor in that there probably will be some expansion in support for coverage by those who are unable to afford it now.

There are indirect interactions as well. For one thing, the publicly and privately insured use the same delivery system and the policies of one will influence the spending of the other, and where there are differences in the incentives to providers between public and private payers, that only makes the responses to these incentives much weaker.

The other indirect interaction is that developments in medical technology affect all patients. It is the same technology. Its virtues or lack of virtues apply to publicly and privately insured patients. There are opportunities

for the federal government to have positive influences on what is happening in the private insurance market. For one, the president has put on the agenda again the issue of revisiting the tax treatment of private insurance. I believe that reform of provider reimbursement in the Medicare program can have some very positive, important impacts on spending covered by private insurance because particularly in physician payment and payment for outpatient care, private insurers tend to follow Medicare's lead, and today the incentives for physicians in particular are really toxic. In a sense, physicians who want to do the right thing —make their practice more efficient, deliver care more efficiently, deliver care of higher quality—often are penalized from the business perspective as a result of the distortions in our payment system today.

The other key thing that the federal government can do that would affect private insurers as well is to expand federal support of research on effectiveness of medical services. This is likely to have an influence on both Medicare and private coverage decisions and also on what services are provided to patients, and Gail Wilensky has done some very interesting work sketching out the mechanisms by which this might happen most effectively. Thank you.

MS. RIVLIN: Thanks, Paul. Finally, let's turn to the politics of the situation. Don?

MR. MORAN: Dr. Feder and I were commissioned for this by Alice and Joe I think because we were both former political hacks, so unlike Judy, I have been continuously in recovery for close to 22 years.

Our assignment was to sketch out why health care reform has been the top of the agenda of the American people for the last 40 years and precious little has ever been done about it. In doing so, we trace a little bit of history over the last 16 years. First, the Clinton experience of the early 1990s when we tried to do health care reform as a comprehensive zero-sum gain and decided that ultimately the 85 percent of the voters who were going to give something up to advantage the 15 percent of the voters who were going to be advantaged was a complicated thing where at the end of the day, as Stuart Altman and others have said, everyone's second choice was to do nothing, and so that is what we did.

The next adventures that we recount are the events leading up to the Medicare Modernization Act. It was originally framed by the famous bipartisan commission on the future of Medicare as an historic quid pro quo where we were going to offer a Medicare prescription drug benefit as a carrot in order to induce everybody to vote for conversion of the program from a defined-benefit to a defined-contribution model called premium support and that was going to be the Gordian Knot. Of course, as we saw, the political system said no thank you to the stick, but bought the carrot and everybody rushed to the finish line, and in fact, enacted the drug benefit, and so that effort of reform was expanding the entitlement base on which we are all now struggling.

Dr. Feder and I spent a fair amount of time talking back and forth about what we think about the thing going forward, particularly in the fairly polarized environment in which we find ourselves. I think what we concluded is

the most important aspect is to figure out how to internalize the concept of saying no inside of the health care system itself in terms of both the people who invest to the build the armamentarium for the system, those who make decisions about what services to offer, and those who make those decisions about what services to receive.

We have tried deeming private insurers as the mechanism by which we say no and that has been blown off the political landscape. I think we both agree that any attempt to put public servants in the position of private insurers would have the same unhappy ending. We cannot say no from outside, we have to figure out a way of getting people to economize from the inside in terms of the hundreds of thousands if not millions that get made in America every day which determine the course of how much all of this costs.

In thinking about this I think we have decided that we might not personally always agree on everything that we might think of as a way to get to the incentive structure required to internalize no inside the system, but I think we both agreed that the biggest single impediment to that is the astonishing lack of evidence that exists in America about whether any of this stuff is worth the money that we are paying for it. So we spent a fair amount of time arguing that we probably need to build a cost-containment strategy around a very substantial public investment in the development of the information base and I think that thought is echoed by many of the other authors in this volume that there is a substantial public good associated with finding out what works.

There is a conflict of interest we acknowledge between government as payer and government as information merchant in this world, but we conclude that that potential conflict cannot be avoided. The government is going to have to be in the position of investing substantial amounts generating information, that as a payer it is going to have to use, and those of us who do not like that are just going to have to get over it.

So that is the challenge that we all face going forward, that was a brief summary of our assignment, and thank you very much for giving it to us.

MS. RIVLIN: Thank you, Don. Now we get some reactions from Robert Reischauer. Bob is a former Brookings person, now president of the Urban Institute. He is a former CBO director, a distinguished thing to be, and perhaps most relevant has been his long-term and I think quite arduous service on MedPAC which makes him an expert on medical reimbursement.

MR. REISCHAUER: Thank you, Alice. I want to commend Alice, Joe, and all the other authors here for putting together what is truly a timely volume that makes all the right points and does so in a remarkably readable and concise fashion. From my perspective, there were seven major takeaways from this book all of which I agree with, so now you can calm down.

They are first and really foremost that the nation's future budget problems will be largely if not exclusively associated with the growth of expenditures of the government's major health programs. There are some long-run projections by the Center on Budget and Policy Priorities that really bring this

out in a very, very clear fashion. What those projections show is that if somehow we could hold the growth of government health expenditures down to the growth of GDP, we would achieve a balanced budget around 2015, and we would have surpluses growing out beyond that, and this is even assuming that all the tax cuts that we have enacted in the last decade are extended, the alternative minimum tax is fixed to keep about the same fraction of people affected by it as is the case today, and that we allow discretionary spending to grow with both population and inflation. In other words, the whole story really is health care.

However, if health spending continues to grow at 2 percentage points faster than GDP which as Alice said is the historical experience, we are going to have deficits that grow to unsustainable levels in roughly two or three decades, and even this timeframe is optimistic because it rests on a very unrealistic assumption which is that foreigners will have an insatiable appetite for dollar-denominated assets and will continue to buy at existing interest rates our debt. If that proves as I suspect to be wishful thinking, we will face a day of reckoning long before that two or three decades.

The second takeaway is that solutions to this federal budget problem as you have heard are not going to be found solely within the federal sector, that is, by tinkering with existing federal programs, or even contemplating very fundamental structural reforms of those programs we are not going to solve the problem for three reasons that are brought out in this fine book.

The first, as you have heard, is that the same problem of rapidly growing spending on health afflicts the nonfederal programs, the private sector as well as the government, so this is a societal challenge, not a public-sector challenge.

Secondly, as has been pointed out, Medicare and Medicaid beneficiaries use the same providers and delivery systems as the rest of us and providers do not practice two flavors of medicine, what they do for one they will do for the other, so if you change one you are going to end up changing the other. And as Gail has pointed out, there is really a relatively limited range of policies that we would consider when we are thinking about reforming Medicaid or Medicare because we are not going to offer the elderly, disabled, or vulnerable groups insurance that in breadth, depth, or cost is markedly inferior to the opportunities that are available to the rest of our society. What this really means is that if we are going to constrain spending in the public sector, we are going to have to do it somehow in the private sector at the same time.

Fourth, and mostly encouraging, is the message that the federal programs can play a very instrumental role in pushing change forward, they are big, they are large payers, they exert a lot of market power and they can shape the future. There are of course places where for political reasons they cannot lead, but they can follow aggressively. When the private sector does something that makes sense, they can reinforce that decisively by coming in quickly behind rather than lagging many years as they have so often done.

Fifth, as Joe said, there are no silver bullets. There are lots of ideas that sound good, but very little way in the way of proven solutions. We have had a tendency in the past to expend a lot of effort, use up a lot of political capital, on approaches that are acceptable to various stakeholders, but if anyone thinks them through completely, they really do not offer much hope for achieving the major breakthroughs and changes that we need. We have a long list in the book and elsewhere of approaches, competitive bidding, IT, electronic health records, pay for performance, disease management, chronic care, coordination, malpractice reform, value-related provider payment systems, simplified administration, and so on. And I think we should do a better job of thinking which of these is there likely to be a big payoff from because we cannot do them all, and I will talk a little bit about that next.

The sixth important point, and one that is touched on in several chapters, including the one by Judy and Don, is that it is very difficult to envision moving forward as we must as long as we have 46 million people uninsured. We are really going to probably have to extend the tent over the entire population before we can lower it down or constrain it.

Seventh and finally, I point out that there is a very important message in this book which I do not think any of the authors stressed which is that successful approaches are likely to be a blend of market-oriented and regulatory strategies. Too often we have had an insistence on ideological purity which sounds good but does not get you to the promised land.

When Alice asked me to participate in this event, she told me that my charge was not only to come and praise the book, but also to go the next step and suggest where we should go from here.

I felt that the book presented really a balanced analysis of the dilemma we find ourselves in and discusses a whole lot of good ideas for ways to make things better, but I came away with no clear roadmap of what to do next except maybe to do it all. In short, this was a good diagnosis of the problems we face, very insightful, sophisticated and correct, but unlike modern medical practice, the recommended course of treatment seemed to be throwing everything in it. Joe said this is not a cookbook, but is not a menu, and what we want is a menu, not a cookbook which has everything you could ever want in it. Given that the attention span of policymakers is rather limited and that resources both fiscal and political are finite and the tolerance of the American people for change is somewhat constrained, I think we do need to set some priorities here or else we are going to find ourselves a decade from now in the same relative position that we are in today. The various strategies that are discussed in this book will have tamped down the growth of spending a bit and improve the quality of care modestly, but these achievements I suspect will be overwhelmed by the exploding demand created by the genomic revolution, new nanotechnologies, and the ability to devise personalized solutions to our individual health care needs.

While my views might generate some disagreement with the authors of the book, I think when we look out to the future that we are not going

to make much progress on the health care challenges that we face unless there is greater societal acceptance of several things that I will call realities, and others might disagree with me on.

The first of these is that efficient, high-quality, and accountable health care can only be achieved as a team sport, not an individual sport. It is an enterprise that involves many different inputs that must be coordinated, there is no way to do it effectively or efficiently in a system that is made up of fragmented, uncoordinated providers from which we purchase services on an a la carte basis. To get good outcomes, the system has to have general managers, it has to have coaches, it has to have quarterbacks who call the plays, and everybody has to know what the play is and follow the same set of instructions.

Having toiled with Gail for several years on the Institute of Medicine Pay for Performance Report, I am convinced that it is difficult if not impossible to measure quality accurately and in a timely and meaningful way if we do this by provider type, physician, nursing home, et cetera, for a lot of reasons that are outlined in that report. I am also convinced that there is no way to ensure that incentives are aligned appropriately when payments are made to discrete provider types who have little incentive to steer patients to the appropriate setting to get the right care from the right mix of professionals. Furthermore, I think to be efficient and effective, health care needs an accountable party to spur high-quality care and you cannot do this in a disaggregated delivery system providing high-quality medicine. Nor can you achieve this I think through

virtual groups or even the mechanisms that Elliott Fisher has suggested of having hospitals and their affiliated staff. I have been given a sign that says 2 minutes by an individual who told me that I was supposed to ignore it.

(Laughter)

MR. REISCHAUER: I do not think this means that we are all going to have to be enrolled in tightly managed staff or group model HMOs like Kaiser. I think multispecialty group practices and coordinated confederations of providers will probably work just fine in the environment we are likely to have to move into.

The second reality I think that society is going to have to accept is that we are going to have to face the fact that we cannot afford nor should we want all of the medical procedures, compounds, and treatments that our immensely productive research sector is going to be developing over the next decade. Of course, we do not cover everything now, but we do have a hard time saying no, and medical necessity is often determined largely by a provider who has very limited appreciation for the evidence base of the effectiveness of what they are doing, if there is any evidence base and we subsidize that which is of high value and marginal value equally.

The third reality is that we are going to have to define to a greater extent than we have done to date the boundaries between health care that society feels is essential and that which is nice to have but discretionary. The former is the health care that we may want to limit to the guarantee for selected

subpopulations like the aged, disabled, and poor, or the care that we want to subsidize for everybody through the tax system, or mandate that all some citizens have as some states have done. There are various ways of doing this. My guess is that we will end up with relatively soft definitions, but that is a step farther along the path than we are today.

We are a long way from general acceptance of these three realities, but we can and we should build the intellectual infrastructure that might accelerate their acceptance or that would be needed to support new structures when the will to act comes around, and this is how I would based my priorities based on where I think we have to go. My first priority would be a massive effort to develop comparative effectiveness information, information on drugs, procedures, devices, practices, and delivery systems. Gail has written very insightfully about this. I have stronger opinions about the types of organizations that would be appropriate to do this kind of activity, but I think this is a first step and there is a lot of this running through this book, and I would just move it right front and center and up to the top.

My second priority would be to invest a great deal in the development of meaningful performance measures for providers and delivery systems and work on methodologies for aggregating these performance measures in meaningful ways. The Institute of Medicine produced a report on this, suggesting a national measurement and reporting system that I believe is a good place to start and what we need to do in this area is develop the evidence that my

first reality about the desirability in terms of both efficiency and outcomes of integrated delivery systems is correct. There is very little to sustain that in the way of hard evidence at this point.

My third priority would be to encourage the use of interoperable IT and electronic health records not just to improve the quality of clinical care, but also to develop the capabilities to generate the kinds of data that we are going to need both for comparative effectiveness analysis and provider performance measures. We need ways to gather huge amounts of information and analyze it in ways that do not burden providers excessively. We need to feed this information into databanks where people can use it to determine effectiveness in real-world circumstances.

Every morning I get up and I pop my Lipitor into my mouth and then I put into my mouth a vitamin C, folic acid, and a multivitamin and wash it down with grapefruit juice. I always think, do I know whether this combination is not impeding completely this Lipitor that I am taking. I suspect when we get seriously into a lot of these analyses, real-world applications of various procedures, we are going to find an awful lot of what we do is not as effective as we thought it was when we were doing those controlled tests that led to this as appropriate policy.

My fourth priority would be to continue to invest in research to develop better mechanisms for risk adjusting. Given political realities, it is likely that the American solution is going to allow more choice of providers, types of

delivery systems, benefit packages, or affiliated groupings than occur in other kinds of countries, and we should know better how payments or taxes need to be adjusted across these dimensions to make for an equitable system. I think the importance of this point really is underscored by the president's proposal to substitute a $15,000 standard deduction for the open-ended tax treatment of employer-sponsored health insurance that we have now. Of course, the president's proposal was just the latest iteration, we have had several proposals like this before, and they have all come to naught, and I would suggest one reason that they do not get where they should get, although I think a lot of this as all of us on this panel would say it is not a bad thing to think about this, that the variation in the cost of insurance is not solely related to the generosity of the plan that is being provided because a gold-plated plan, we can all sit down here and say, yes, we should begin to tamp down on the tax benefits that are provided. It also depends very heavily on where one lives, on geography; we do have a geographically based political system here, that the cost of insurance for the same person across Minneapolis versus Miami is probably about 2 to 1 for exactly the same policy because prices differ, because practice patterns differ, and because patient preferences differ. The cost of insurance varies tremendously for exactly the same policy because it is who you are grouped with. Are you grouped with a whole bunch of 55-year-olds or a bunch of research assistants who are holding up signs saying "Stop. Stop."?

(Laughter)

MR. REISCHAUER: Anyone looking at a cap is going to say, yes, the gold-plated limitation is okay, but these other ones, what ability do I have to change the practice pattern in my geographic area, not much, or the input prices? So we are going to have mechanisms for making adjustments like that and it is going to take a lot of investment.

My fifth priority, and last one, so you are about to be the winner, is that we have to begin to infuse a greater sense of accountability into the system for overall outcomes. What this means is encourage for those people who are in the fragmented system a medical home, somebody who is responsible maybe in a relatively loose way for guiding and coordinating care. This can be done in Medicare by paying for this function, number one, for giving beneficiaries maybe incentives like lower co-payments if they have such a relationship, and beginning to get everybody more used to the fact that there should be somebody, an individual, an institution, that has overall, weak maybe to begin, responsibility for guiding their care.

I will close by saying that I do not think we are about to have a huge change in this nation in our willingness to accept fundamental reform, but at some point that is going to change maybe in fits and starts, and I think if we continue along the let-a-thousand-flowers-bloom path we are going to find ourselves when we get to that point not having the basic intellectual or institutional infrastructure to do what has to be done and so we should focus our

energies on things that build that capacity so when lightening strikes we will be able to withstand it.

MS. RIVLIN: Thank you very much, Bob, for a very helpful and insightful both summary of the book and orientation toward priorities. I am struck that when you get a group of researchers to say what should we do about the problem, our usual answer is more data and more research.

MR. REISCHAUER: I thought I was more subtle than that.

MS. RIVLIN: But in this case, I think we are agreed that we just do not know enough at the moment to do many of the things that we think we ought to be doing, and that is a big problem to be fixed.

I think you have done enough listening; you have been a very attentive audience, so let us now hear from you. The young lady in black is advancing with a microphone, so stick your hand up and she will find you.

QUESTION: My first thought as a lapsed doc is to advise Bob not to take that Lipitor with grapefruit juice.

MS. RIVLIN: What's the charge for that?

MR. REISCHAUER: Is that evidence based?

QUESTION: The label is on the pharmaceutical. Where that comes from I do not know, actually.

There is general agreement that we ought to be moving toward coordinated care with increasingly standardized protocols and incentives and performance measures to move providers toward such protocols, et cetera. But

isn't this at odds with the push today in some sectors toward consumer-directed health care and consumer sovereignty not just at the outset of the choices about where to get coverage, but consumer sovereignty over care at every stage of decision making? And aren't we right now at risk of setting up a system at odds with itself if we go whole hog toward the consumer-directed model?

MS. WILENSKY: I do not see the contradiction.

MS. RIVLIN: I don't either, Gail, but go ahead.

MS. WILENSKY: The reason I do not see the contradiction is that patients as payers in the front part of an HSA, if that is what they choose, need to understand what works when and under what circumstances. That is number one. So a lot of the push toward getting more information on comparative clinical effectiveness, et cetera, is important. Second is they also need to have financial incentives aligned along with better alignment for clinicians and institutions. Third, and maybe in many ways most relevant, is consumer-directed health care assumes there will be a health plan. It is only a question about whether we go back to the more traditional major medical insurance that we all knew a generation or two ago and then become part of a health plan or not.

So I would say all of the issues that Bob Reischauer was raising about the desirability of an integrated health plan to me is just fine with having people pay some of the upfront routine expected health expenses, so I do not actually see them as inconsistent, and in fact, the whole drive toward accountability and integration involves a much more activated consumer. So I see

the potential for actually having this all be regarded as a part. You could have a world in which people go off in different directions and act as atomistic individuals in which case it would not be helpful, but I actually think getting consumers to understand prices are important, quality variations are important, who they go see when for what is important, and they ought to be part of the decision making as critical and integral to moving toward are more accountable health care system.

SPEAKER: I just want to follow-up, and I think what Gail said makes a lot of sense, but I think what Greg was reflecting is some of the more ideological advocates of consumer-driven health care who really see consumer empowerment as in place of everything else that influences health care and the notion that if consumers were in power, it would all be right, and it is just not realistic to discount the potential that health plans can play and the fact that you are still going to want accountable providers to be making a lot of the more technical decisions and medical care and just get the big picture input from consumers.

MR. GINSBURG: Let me defend if I may Gail's conclusion in a slightly different way in response to the question you raised. One could make the argument that the persistence of a fragmented and inefficient delivery system is a logical consequence of using the property casualty insurance model to pay for most of this stuff for the last 50 years and that in effect if you can stay in business and do reasonably well in a very inefficient framework you face no incentive to

change your structure and go into a more efficient mode. I think as we see the world going toward more and more catastrophic designs, whatever else we think about that, it will begin to expose some of the challenges and the cracks associated with some of the inefficiencies in the existing structure. So I guess I am not as pessimistic about the consumer-directed thing as some are, understanding it is being oversold to beat the band in many different ways.

MS. RIVLIN: I think we all have opinions on this, but let's go to another question.

QUESTION: Almost everyone here had this disclaimer that there is no silver bullet, but what I hear, and I think Joe Antos knows, everybody I think could probably agree that computerized medical records are essential to all of this data that you need, that the lack of any record makes the integration of medicine impossible. People talked about what you have talked about integrating medicine in 1926. The American Medical Association went through the roof when they suggested that health care ought to be coordinated, but in order to do this, you need the records that we do not have now. So couldn't that be a central priority? I think everybody here probably thinks that this is essential and it seems to me if everyone focused on it you might get there.

MS. WILENSKY: The question is how to pay for it and how to move there. I do not think any of us disagree that this is really critical and that we may or may not agree on the best way to try to get to that position.

SPEAKER: I think it also has the virtue that it is concrete, everybody can visualize it, and it seems to be nonthreatening. Of course, ultimately nothing is nonthreatening yet.

MS. WILENSKY: One other comment, and that is that I actually think it is hard to do. If you look at the VA and particularly the military experience, they have been trying to do this electronic medical record thing forever. It is very hard to do particularly when you do not have an integrated health system. Kaiser has tried to do it and I think they are on round two now or round something. If these organizations are finding that there are some challenges, then promulgating it into the less well-organized part of the system will not be easy, but it is not going to happen unless people learn how to do it from the experience that is out there and build on that experience, and then we will find that it works the way it does in our other consumer purchases. But it is not easy to get these things in there and get people adapted to them and so on.

MS. RIVLIN: Nobody thinks it is easy, but I think we all think that it ought to be done and we ought to sit down together nationally and figure out what are the barriers, some of them are incentives, some of them are standards, and how we get this done.

SPEAKER: If I could say something else, what I have been struck by is the consensus almost among the various people who have spoken about where they would like to see the medical care system headed long-term and also perhaps their lack of confidence that they know how to force it to go there. As

Bob pointed out, one of the biggest challenges now is making some priority decisions about which of these various directions we should put our emphasis on.

QUESTION: Just to follow-up on that point, there does appear to be this consensus in the room on the panel about the importance of data and data management and research. There also seems to be this recognition that change will be incremental, and looking out 50 years is a good way to highlight the problems and challenges of the system, but we need change now.

Since we do have an election coming up, a presidential election and congressional election, and since data collection and management and research appears to be a number-one priority, how would you simplify it for the electorate into three bullet points that you could get congress people of all sides to agree on and presidential candidates of all sides to agree on such that some change however small and incremental on this point would occur in 2009 after the next inauguration?

MS. WILENSKY: I do: know more, pay better, and be more accountable. Those would be my three bullets.

QUESTION: But you need the data first.

MS. WILENSKY: As a couple of people have mentioned, I and several other people are trying to lay out a roadmap with regard to creating comparative clinical information, how to do it, where to do it, how much to pay for it, how to finance it. This is a very active area. Shawn Tunis has been working on it, Steve Pierson, a number of the industry groups are working on it.

So I think there actually are many of us and surprisingly across the political spectrum and across the aisles of Congress who are trying to lay out very specific steps about how to create or to begin the creation over the next 3- to 5-year period along with the performance measurement system that the IOM reports have laid out, where is what you might be able to do and in 2 or 3 years, here is how to set out a 3- to 5-year. Are you going to create this in 1 year or so? No. None of these are going to get resolved. But it is how do you move forward in the next 3 to 5 years, and one of the things I am worried about now is what is the critical mass you need to start this effort off, which I am not sure I know the answer to, but I am talking to people who I hope can help me figure it out.

MS. RIVLIN: We need to work on the three bullet points for the candidates. I think that that is clear.

MS. MULLEN: My name is Mary Mullen. I was just wanting to ask Mr. Reischauer when you said we should only pay for certain types of medical problems, you were saying that there were some that were necessary, and I was just concerned about who makes the decision. Now it seems as though the insurance company makes the decision as to what medications you will take and what is important and what should be done and should not be done and it seems that that takes a lot away from the doctor and as you were saying, the doctor's proficiency in what he wants to do.

MR. REISCHAUER: What I was saying was that we are going to have to draw a brighter line, I do not think there is really a line at all, between

types of medical care that we regard as essential and those that we regard as more discretionary, and that is going to be sort of a very fuzzy line and might be drawn by individual insurance companies and what people want to pay in the way of premiums, but as a society we have an obligation to do that. With respect to the government health care programs, we need a lot more information now and I think there is a lot of realization that there are some things that are very expensive and provide a very marginal positive improvement.

You asked are there things that have no value at all or negative value, sure there are, but the people who go out and say we are going to solve this problem of rapidly growing health care costs by eliminating the negative-value or zero-value stuff I think are wildly off base. There are systems in the world obviously that do make these decisions for the whole of society, I do not think we are ever going to get there, but we want to have the information available where both individuals and people proving insurance coverage can set that line where they want to set it.

MS. RIVLIN: One example is that it has to be done by the patients themselves. We do spend a lot on extraordinary care at the end of life and there is not a big solution to that other than the patients themselves at a stage in which they are capable saying I do not want this and saying it clearly to their doctor and to the next of kin in writing.

MR. REISCHAUER: There are ways of making this a very soft kind of decision by changing co-payments or co-insurance according to the value

of the procedure and the drug, and reference pricing the respective drugs is one way of doing this which does not say you cannot have this or we will not pay for it, just that we will pay a smaller fraction of the total cost for it.

MR. MILLER: Tom Miller. Listening to this morning's discussion, I thought perhaps some mental-health imagery would be appropriate in framing some questions. The title of this is "Restoring Fiscal Sanity." If the definition of insanity is doing the same thing over and over again and expecting different results, what is being proposed here in terms of an execution strategy? These ideas have been around, some of them are a little fresher, but they are not particularly novel in the last year of being discovered in terms of what would put this forward to actually reach a different point than we are otherwise destined year after year.

The second one is Joe talked about a polar political discussion here. I thought of bipolar, and I was wondering are the market individualists or the collective centralizers the manics or the depressives? If you could sort that one out for me I would like to know that.

Finally, a chronic condition in Washington is cognitive dissonance. Bob Reischauer said that we first have to make sure that we get all the uninsured cover in order to reduce the rate of growth of spending. Given that the uninsured consume about 50 to 55 percent of the care that the insured do and the rate of uninsured spending is much lower as a year-to-year than insured spending,

perhaps we could adopt Don Moran's vision which is if more people get uninsured we will eventually stop paying as much money for health care.

So the question is, aside from stopping when we cannot find enough people to afford this collectively, what is a different approach to change the arc of spending when all is said and done?

MS. RIVLIN: Let me start on that. I do think that probably we have not said anything that nobody has said before, but we are making a huge point of collecting the information on effectiveness, disseminating it, and using it in federal programs and nonfederal programs to improve the efficiency of the system, and I think that that is extremely important.

MS. WILENSKY: I think that financial alignment of incentives is something that requires a lot of change. If you think about Medicare, most change for the physician payment schedule where you have these very disaggregated micropayments that are unrelated to either efficiency or equality, so completely redoing that concept, but then within the broader frame of Medicare, realigning payments so that you begin to drive toward more quality and more efficient institutional providers and clinicians but recognizing that that kind of change has to occur in the private sector.

So because in part we were writing our chapters individually, we did not really have a chance to sit down and say how would we prioritize all that we have said, I actually think when you look at the chapters, it is easier to see them falling out in terms of the three, four, or five sensible kinds of next steps and

to array them. We did not do that as directly as we might have, but I think there is more here's what has to happen in the public programs, here's what has to happen in the private programs, and we can debate who leads where.

MS. RIVLIN: And I think the other theme is the one we have talked about, namely, let's stop this kind of silly argument about are we going to let the market do it all or are we going to let regulation do it all. Nonsense. We have to figure out how to use the market intelligently and use regulation intelligently, and we have some examples of how to do that.

MR. ROSENBLATT: Bob Rosenblatt, freelance writer. The governors of California, Illinois, and Pennsylvania have all announced very ambitious plans to cover the uninsured within a year or two. If each of you could sit down with the governors and they promise to put in their package one or two recommendations, what would those be?

MR. WEIL: Before I answer that very good question, I think it actually follows nicely from Bob Reischauer's point. They all begin with the notion that if you are going to move the system, you have to have everyone in it, and I think although politically that has not been a successful strategy at the national level, it is certainly the dominant political view at the state level and I think that is worth noting.

If you look at Governor Rendell's proposal in Pennsylvania, there was a headline in the Philadelphia Inquirer saying something like "Rendell's 47 Ideas for Containing Costs." My impression as governors have looked to each

other for their proposals is that the features around coverage are fairly consistent, there are limited number of ways we know how to do that, and then they are doing somewhere between a recipe book and a menu, grabbing as many ideas as they can find out there on chronic care management which was central to the Vermont approach, on hospital error reduction which Pennsylvania has been working on for years. I do not have the full list, but I think what these governors are trying to do, and I think it is the right approach, is that once you start saying we are going to bring everyone in, we are going to look as many of these ideas around cost containment, efficiency, streamlining information, as we can find, and the reality is we do not have a great evidence base for any one of these contributing overwhelmingly to the solution, but we need to borrow from as many as possible.

So I would say given the state role and Medicare and its financing role, I think the emphasis on chronic care and on high-cost management and coordination of services for people with high-cost multiple conditions, not single conditions, is where I would put the focus, but you have to do the obesity, tobacco, behavioral, and information technology and all of those and hope that somehow together they help you pay for your coverage.

MS. WILENSKY: I disagree with the premise though that we have to bring everybody in in order to move forward. I think we should, I hope we do, but I think you can move forward with this. As Tom has indicated, the uninsured actually spend and have for three or four decades no matter who they

are 50 to 55 percent less. I think we need to bring the uninsured into insurance coverage but that is a different decision, it is a political or value one, I believe we can go forward on these other issues. Whether or not we bring the uninsured in, I just hope we will do it.

SPEAKER: My point on that was I think that Don and Judy made which was that it is politically difficult to move forward on the rest unless this affecting the whole —

MS. WILENSKY: And I do not know about that either.

SPEAKER: We can disagree on that.

MR. WEIL: I would make one other point and that is that the governors should not just focus on Medicaid and their state programs. That is a big mistake. One of the biggest challenges for them and for their Medicaid programs is coordinating between Medicaid and Medicare. We have done a lousy job of that for the last 30 years, so they ought to be pushing the federal government to work on that.

SPEAKER: One last notion for the governors is that as they do these things, I think they need to be very fiscally realistic about what they are setting in motion here. Most of these designs that are now discussed talk about wrapping a public insurance market around whatever private insurance market exists and then create what is often called a pay-or-play variation where people make decisions whether to offer private insurance or go into the public pool. The experience we have had with that whenever we have tried it at whatever level is

that it is a boundary for what the economist types would call selection bias across the boundary between the public programs and the private programs and if by definition the people who go into the public program do so because the amount that they have to contribute from a tax perspective is less than the cost of covering them in the private market. So you are setting in place a fiscal antiselection against the public program that you have to be prepared for, and that brings us back to some of the points that Bob was making about the science of risk adjustment and other things along those lines.

MR. GROSSMAN: Jerry Grossman. I would like to come back to EHRs, electronic health records, and make the observation it is the one technology that is fundamentally 40 years old and it does not work because it is not modern. If you look at the installations of desktops written — it just simply is not there. If you look at modern technology, it would be less expensive, much more easy, to adapt and I do not know how we can engage in someone or a group of people looking at what — of other modern technologies are doing because I think it is a tremendous, painful barrier that we will not get to the end of unless we —

QUESTION: I wondered if anyone on the panel could point to ongoing demonstration projects in Medicare or Medicaid that might stand to be the answer to some of the problems or approaches you think that public health-sector programs should take to make changes?

MS. WILENSKY: I think there are in the chapter I reference some of the very large number of demonstrations that CMS has ongoing or is about to start. They are looking at how to encourage within the fee-for-service system more of the disease promotion or other strategies we normally associate with integrated groups as a way to try to mimic some of the outcomes that they would like. They are looking to bring in small groups of physicians, whereas the major physician payment demonstration involves 10 very large groups. I do not disagree with the desirability of having people primarily in integrated delivery systems with multispecialty physicians, but I think it is very important to figure out in the interim if there are ways that we can encourage some of the same behavior, and that demo is just starting or just started I think in early 2007, in case, it is relatively early.

The two biggest demos, the premier hospital demo, is going to be extended which was primarily looking to reward quality but is having the very nice finding that those hospitals with improved quality seem to be associated with lower cost. I mention the physician payment demo which is focusing on 10 large physician groups and will use some of the savings as the bonus money that will pay these physician groups after the first year or so. And there is a gain-sharing demo which I find very intriguing to try to see whether or not it will be possible to have physicians and hospitals with better-aligned incentives when they are not part of financial risk groups which means that they would be outside now of an allowed relationship to share savings because it would be violating the START

regulations or the antikickback regulation. So there are a number of demonstrations, some of them have started 2 or 3 years ago and the outcomes are beginning to be reported, and others are very early like 2007 start dates, but should provide important, useful information.

To me, what has been discouraging is the history of Medicare even in the face of useful outcomes in demonstrations has not been to lead to statutory changes and that is where there may be an important interplay between what the government is able to help discover and disseminate through demonstrations that could be more quickly adopted by the private sector which in turn could lead to the rapid follow-on once it became more or less used by major players or payers in the private sector because in the past this movement from demonstration status, even successful demonstration status, to statutory change has not happened easily.

MS. RIVLIN: Alan, and also Paul.

MR. WEIL: There are three places that I would point to. One is there are a number of states that for quite some time have been trying to do Medicare/Medicaid integration, and Joe just mentioned this. This is a huge issue. These are the most-expensive populations for both programs, coordination is very difficult, of course from the states' perspective it is all the federal government's fault and I am sure the federal government considers it to be the states' fault. But there are serious incentive problems around savings as well as delivery system coordination issues and that has been something states have been working on for quite a while.

Secondly, they are very narrowly targeted demonstrations. I just keep coming back on this that we always go back to the language as the typical healthy user, and that is not where the money is. So if you want a demonstration that points you in an interesting direction, look at a state that is taking care of 20 people with traumatic brain injury with an annual average cost of $100,000 and doing something creative to try to actually improve their quality of life and their rehabilitation, or an HIV/AIDS demonstration with a population that again the per-person costs are two orders of magnitude higher than what we are looking at for the traditional population that we want to use consumer direction or whatever for. That is where you really get innovation that addresses the real underlying cost in the system and to me that is really all that matters and all the rest of this stuff is nice and it is fun to talk about but does not really move any money.

The third are not demonstrations. We use that term sort of as a formal structure for like a waiver and an evaluation, but with support from ARC there are states that are working on using care-management models for people with multiple chronic conditions. Again, chronic conditions drive costs; multiple chronic conditions exponentially drive costs. There is not a model out there. There is not a demo out there. We are trying to learn how to best care for this population. That is where the interesting stuff is.

MS. RIVLIN: Paul, do you have anything to add to that?

MR. GINSBURG: No.

MS. RIVLIN: We promised to get you out of here at some point, so let's take maybe two more questions.

QUESTION: (off mike) — close connection between your diagnosis of the problem and the solutions that we are talking about. You started by pointing out that we are going up GDP plus 2.5 and that that is happening because we have got more stuff, we do more stuff, and we have more technology every year and to change that we need to change the rate of growth of more stuff as you said to begin with.

The mean focus on the solution is comparative effectiveness research which is wonderful, and better information which we certainly need, but it is hard for me to see the connection between better information and comparative effectiveness research and changing the rate of growth of new stuff. That is, we get new stuff because we are willing to pay for it, and I have not heard much discussion of changes in the way in which we pay. There has been some around the integrated care, but it would seem that we would need some change there in order to really change the rate of growth at which we get new technology into the system.

MS. RIVLIN: There are several connections, but one is changing the payment incentives under public and private programs, and that is how you use this information, to make sure that you are getting cost-effective care and not getting a lot of stuff we do not need. The other is the consumer. It is the better-informed consumer. And there may be others.

SPEAKER: I think a lot of what we said about comparative effectiveness analysis is really code words for we are not going to pay for that anymore under clearly defined circumstances rather than what we now have in many cases which is, bluntly, a provider has a new piece of equipment and it has to be paid for and a patient just walked in the room. What we are hoping for is not the blunt edge of the ax, we are hoping for a little more surgical precision so that we do not cut too much off the meat off of the patient as we trim some of the cost.

MS. HOSEK: The consumer side of this is very interesting. The consumer-driven plans attempted to go after that, but I am struck by the fact that the original idea for consumer-driven plans was to give consumers incentives to pay attention and then to arm them with the information. Anybody who has had any exposure to more than a minor health event, even a minor health event, knows you have no idea what is anything is going to cost, you cannot even figure out after the fact what it did cost, and there is better information on effectiveness to the extent we have it, but if you go out into the Web, you will find some good stuff, you will find some bad stuff, I would be hard-pressed to be a well-informed consumer even if I were healthy, and it would be much harder if I were sick.

There is another program we have not talked about, and that the federal employees' program. They do have a consumer-driven plan, it is a commercial plan, and I do not think the enrollment in it is that large, but that is another place to learn, and the federal government could insist to whoever is

providing that plan that the information including prices, understandable prices, be made available to the people who are in that program and then we see what happens.

MR. WEIL: Just to be annoying, Rick, since you asked the pointed question, I think in a panel where there is all this call for data and evidence, I think it is important to say that we do not really have evidence that engaged consumers even armed with the theoretical bodies of knowledge that people we will provide them with will do anything about the cost issue that you asked, and we do have evidence from around the world that the way you address the cost issue is from external constraints. That may or may not be what we want in this country, but if we are going to draw upon the evidence, I think we have to acknowledge that that is where it sends us.

MR. MORAN: And part of this really goes to what you think the baseline going forward is going to be in the absence of any major change of action and we tend to talk in the policy sphere as if the ultimate of all this is that your grandchild is going to able to aspire to be the chairman of the subcommittee at the House Committee on Cardiology.

(Laughter)

MR. MORAN: The fact of the matter is I do not think we are going in that direction, and long before we get there, the other baseline that seems to be taking place is that whatever we call consumer-directed care, what it is is a very effective mechanism to get people to voluntarily cooperate in the

dismantling of their own private health insurance coverage and at the same time that the feds are figuring out how to means test Part D and other kinds of things to kind of ratchet back the fiscal commitment. So 30, 40, or 50 years out we are not just in a logical continuation of where we are, we are going to be some place radically different and the question is do we want to shape that radically different or do we just want to watch it happen.

MS. RIVLIN: Last formal question.

QUESTION: At the risk of sounding like the skunk at the garden party here, I hear a lot of discussion about information, collecting it, coordinating it, delivering it, and the value that information will return in terms of the outcomes in health care. I think we need to be a little cautious about what our expectations are, and I will give you an example. All of us in this room right now have access to accurate and current medical information every morning, it is called the bathroom scale. The fact of the matter is, I do not think the solution to the obesity problem in America is to buy everybody a free bathroom scale.

I was told a long time ago that 80 percent of health care costs are driven by one or more of five too's: too much drinking, too much smoking, too much eating, too much stress, and too little exercise. I have heard a lot of discussion here about how we deliver health care, but I have not heard a whole lot of discussion about the fact that at the end of the day it is those behaviors that ultimately are going to drive the cost of health care in this country and when do we get to talking about how do we correct those behaviors, because it seems to me

no matter how we deliver the care, if those are the drivers of the care, those will continue to go up.

MS. RIVLIN: Unfortunately, I think that is not really quite true as I read the literature. We would all be healthier if we did not drink too much, any kind of alcohol in moderation appears to help certain things, however, if we did not smoke, if we did not weigh too much, if we did not abuse drugs, et cetera, we would all be healthier, but we would not necessarily spend less in the long-run. We would live longer, we would be healthier for a while. The evidence that there is a long-term net benefit is not all that great because we are all going to die of something.

But you are absolutely right to point to those questions as reducing health costs for individuals in the short-run.

MS. : And I think the notion of can we begin to push people to being more accountable and not just have the provider world be more accountable is one that we find a lot of sympathy for, but we do know people will die ultimately. We now are worrying about diseases like Alzheimer's that we did not use to have to worry about because people did not seem to live long enough to get into that area. We do not know financially whether or not we will end up spending more or less or just differently if we could change behavior so that a lot of the drivers from the unhealthy lifestyles that currently drive the public were to become something else.

Whatever it is, health care spending is going to remain very concentrated as it is everywhere in the world, so learning how to spend smarter, how to take what we find out about what works when, under what circumstances, for whom, and begin to align financial payments so that it reinforces that use by both the provider world and the consuming world I think will be important no matter how much progress we do or do not make with regard to having people act in a more responsible way, although the latter does not seem to be the American way.

MS. RIVLIN: You did not hear here that we are in favor of obesity or excessive drinking or drug abuse.

Thank you, audience, for being a terrific audience, for listening carefully and for asking great question. So we thank you very much for coming.

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