THE BROOKINGS INSTITUTION

HAMILTON PROJECT FORUM

HEALTH CARE RECONSIDERED: OPTIONS FOR CHANGE

A TWO-PART SERIES ON HEALTH CARE POLICY

Washington, D.C.

Tuesday, April 10, 2007

Opening Remarks:

ROBERT E. RUBIN
Citigroup Inc.

Panel One: Improving Effectiveness and Addressing Costs in the Health Care System

Moderator:

HENRY AARON
The Brookings Institution

Panelists:

JASON FURMAN
The Hamilton Project

RICHARD FRANK

Harvard University

JOSEPH NEWHOUSE
Harvard University

JEANNE LAMBREW
George Washington University and Center for
American Progress

* * * * *

P R O C E E D I N G S

MR. RUBIN: I think we are a few minutes late. I just said to Henry Aaron, I remember this from 1993, every time I look at health care I get a headache. It's so bloody complicated and I never know how to start or how to finish, so I look forward to today and the wisdom that we will all be receiving. I am Bob Rubin, by the way, of the Hamilton Project, and I welcome to what will be our first event of two that are scheduled, the second one being July 17, on health care.

Let me just make a comment or two if I may about the Hamilton Project, though most of you know this. We started about 2 years ago. We were a group of financial people, of academic policy experts, and policy analysts, a group that was unique at least in my experience around politics and policy. We started with the conviction that our country was at a critical juncture economically and that there was a great need to put together both a strategy and policies congruent with that critical juncture. We believe that this country could thrive and there was a transforming economic environment

globally, but that we needed to have huge change with respect to our country's policy regime and that if we failed to meet the challenges that we faced, hugely consequential challenges, challenges that we had to meet if we are going to meet our potential, then we could have serious difficulties.

We also believed that this transformation that was underway heightened both the opportunity if we met our challenges and the potential difficulties if we did not meet our challenges and that made, among other things, for an extremely difficult decision-making environment for policymakers, but also I might add for investors and business people.

Our first act was to put out an economic strategy paper which brought together in a broad sense all of our thoughts with respect to where this country should be headed strategically with respect to economic issues. Since then we have as you know been putting out policy discussion papers with respect to policy issues pursuant to that strategy, and then we present them at events like the event that we are having today. The objectives in our judgment of economic policy should be threefold and we felt they could be mutually reinforcing, not antithetical, and those three were strong growth, broad-based participation in that growth, and increased economic security without undermining the incentive to work.

Very, very importantly from the very beginning, all of our work and all of our papers are based on facts and analysis, not opinion and ideology, and our whole process has been conducted with strong academic rigor. Our overall purposes were to contribute substantively to the nation's policy deliberations and at the same time to stimulate serious debate about serious issues at a critical time.

That takes us to today's event, health care. Health care is obviously a critical social and moral issue, but in our view, and it has been very much my view ever since I first started focusing on this, it is also an absolute economic imperative, health care reform, for four reasons: adequate health care for all of our people for a healthier population promotes productivity and competitiveness. Number two, our health care costs as you well know as a percentage of GDP are far higher than any other developed nation. And while to some extent that may involve social choices, our system is also highly inefficient with respect to processes and as measured by outcomes, and that clearly undercuts competitiveness and productivity when the costs fall on business or undercuts standards of living when borne by workers.

Number three, the rapid increase in federal health care programs is the central cause of the very serious fiscal issues that we face over the years and decades ahead, issues which are a deep threat to our economic well-being if not addressed, and underlying that increase in the federal health care costs are our health care system and the rapid increase in its costs.

Finally, health care security is one very important piece of the broader question of economic security which in our judgment needs to be one piece of the set of objectives pursued by the powerful domestic policy agenda, that is to say productivity, broad participation in growth and economic security, that can then be aligned with market-based economics and trade liberalization as a broad structure for our nation's economic strategy.

Plus the Hamilton Project has a two-part series as I mentioned a moment ago on health care. Today we are presenting three papers on ways to improve the effectiveness of health care expenditures, followed by a panel that will discussing health

care reform more generally. Then in July we are going to be presenting four different approaches to accomplishing a universal coverage, we will also have an overall health care strategy paper, and once again we will have a panel to discuss health care reform more generally.

Let me turn to a brief snapshot of today's event. On the first panel we will hear from the authors of three discussion papers, new discussion papers, that we are offering in the effort to promote discussion and debate about possible ways forward with respect to effectiveness. First, Jason Furman, who as you know is the director of the Hamilton Project, will discuss better and worse ways of introducing more cost-consciousness into the health care system. He will argue that his proposal to introduce progressive cost-sharing could make health care more affordable, increase financial security, and improve health outcomes.

Second, Jeanne Lambrew from George Washington University and the Center for American Progress will unveil a bold new proposal for promoting and financing preventive services to a public Wellness Trust fund.

Thirdly, Richard Frank and Joseph Newhouse of Harvard University have developed a proposal to fix the Medicare prescription drug benefit, and most particularly to address the donut hole, which as you know prevents many seniors for getting coverage during some parts of the year.

Then following this first panel which will they will discuss their respective papers, we are privileged to have a distinguished panel of experts to discuss the U.S. health care system more generally. Let me briefly introduce the three members of that panel, our second panel. First is Andy Stern, President of SEIU. As you know, Andy recently formed a partnership between SEIU and the CEOs of a number of major

companies to work together in a project called Better Health Care Together to work toward providing affordable access to health care for all Americans by 2012.

Secondly, Ron Williams, President and CEO of Aetna, who has won enormous respect for his work in turning around Aetna and going from great difficulty to what is now a very successful company. Ron is going to bring his expertise and his knowledge with respect to health care from the perspective of the insurance industry which is obviously an extremely important participant in the health care industry.

The third participant is Bob Reischauer who just joined us late. He tried to sneak in the front. Usually you sneak in the back, Bob.

(Laughter)

MR. RUBIN: He is president of the Urban Institute, a fellow member of mine of the Harvard Corporation, and a member of the Hamilton Project Advisory Council. Bob as you know served with enormous distinction as the director of the Congressional Budget Office, a job now held by Peter Orszag, the first Executive Director of the Hamilton Project, and Bob is currently the Vice Chairman of the Medicare Payments Advisory Council.

Let me say we appreciate enormously the work and attendance today of all the speakers on our two panels, and on that note let me turn the floor over to the moderator of our first panel, Henry Aaron, Senior Fellow of the Brookings Institution, and one of the nation's most distinguished health care economists. Henry?

MR. AARON: Thank you very much, Bob. I thought I was going to introduce the speakers, but you have done that, so I can skip that and go on to the one privilege that I have been waiting for a long time to be able to do as the chair of a group such as this, would anybody who is considering using their BlackBerry during the course

of this meeting to do instant messaging please leave now? But more particularly, would you turn off your cell phones or any other devices that you may have for communication?

We are going to begin with Jason who has just joined the Hamilton Project. He is dividing his time now between us and teaching at New York University. The paper that is co-authored by Richard Frank and Joe Newhouse will be presented briefly by Richard, and they will be followed by Jeanne Lambrew who will present her idea for a Wellness Trust. So why don't we begin now, Jason, with your presentation?

MR. FURMAN: Thank you, Henry, and thank you, Bob, for the introduction.

Health insurance is of course meant to promote health and increase financial security and do it in an affordable manner. Right now it is not doing so for many people. Most dramatically, it is not doing it for the 45 million who do not have health insurance. It is also not promoting financial security for people who have policies that are called health insurance but do not, for example, cover chemotherapy, have unlimited out-of-pocket expenses, or pay only for five doctor's visits a year and nothing beyond that. Twenty-two percent of people in employer-sponsored insurance have plans with no out-of-pocket maximum that expose them to unlimited financial liability, and probably a larger percentage of people in the individual market do. Finally and most dramatically, health insurance is failing a lot of people on the grounds of affordability.

I think this challenge is so large that it defies one single explanation and defies one single solution. What I want to talk about today is what I think is one important cause of the problem and one important part of what I would like to see be a broader solution to this health problem. This part of the solution and this part of the

problem, I will first sketch out a little bit of the history on this part of the problem, then talk about a specific proposal, and then talk how we could get to that proposal.

There has been an amazing transformation that has almost gone unnoticed, and some people actually think it has gone the other way, in terms of how we pay for health care in this country. Back in 1965, the typical person, the average person spent $1,000 a year on health care, that's in today's dollars. Half of that they paid out of pocket, $500, and other half of it was paid by insurance companies. Fast-forward to 2006, health care has been transformed. The average person now spends $6,500, more than six times as much. The amount spent out of pocket has increased over that time from $500 in 1965, to $800 in 2006. So we have de facto shifted more and more to a health insurance system where people are not paying for health care throughout the year as they buy their health care and use their health services, but is paid by third payers. The first slide this over a longer period of time. Starting in 1960, half of health costs out of pocket, by 2006, 13 percent paid out of pocket.

In many ways this is a very good development, and one of the important causes is that coverage has been expanded. Back in the 1960s, coverage often did not cover doctor's visits, did not cover prescription drugs. Over time, more and more things have been added to insurance which has helped health and it has helped financial security. It also reflects an expansion of public programs. That line drops enormously after 1965 because Medicare and Medicaid were enacted and they picked up a lot of the costs and most people would describe that as a good development.

Part of what you see especially in that part of the line from around 1985 to 1995 is the transition into managed care where people are shifting from plans that restrained their use of health care with deductibles and co-payments into plans that had

more utilization review and fewer choices in terms of the doctors they had seen, but taken together, it has been a profound transformation. You see this transformation also looking at health spending out of pocket relative to income, relative to total consumption, and one way to illustrate it is just this next example. In 1984, the typical person spent $1,200; again, inflation adjusted, out of pocket on health care, spent $1,100 on entertainment durables, things like TVs. By 2005, they are spending actually about the same amount out of pocket in inflation-adjusted dollars, but the amount spent on things like TVs and entertainment durables had gone up 40 percent. So while spending on a lot of things in the economy has gone up including spending on health care through your premiums and through the amount that your employer subtracts from your wages and health spending has gone up enormously, it is the way in which we spend that money on health care that has de facto changed and shifted toward insurance and away from out of pocket.

Finally, you see this also compared to other countries. The United States actually spends a lower fraction out-of-pocket than the average high-income OECD country. So this is not a debate about HSAs versus single payer, even if you had single payer you might choose to implement single payer in a way that had different cost-sharing rates.

Why does this matter? There is a common theme here which is that people do not care about prices when they think about health care, or that all the spending in the health system is driven by just a few people with the very highest costs, and they are above the range of any possible deductible. That common wisdom has a few shortcomings. One is, if you look at total health spending, 41 percent of it is below the cost-sharing thresholds for most high-deductible policies; at the margin, 61 percent of it in total is below those. But more importantly, we have actually done an experiment, and

when I say we have actually done an experiment, it was Joe Newhouse over here who actually did the famous RAND experiment. We went out and actually saw how people responded if they had to pay more for health care, and to normalize the numbers, if people had free care, they would spend $100, you put them in a plan where you have to pay 25 percent of our care up to a certain amount, $81, so a 19 percent reduction. Shift them to 95 percent coinsurance which is basically the same as a high-deductible plan, it is as if you are paying all of your health care until your reach a certain maximum, and spending is $69, so a 31 percent reduction.

Also notable in this experiment is that out-of-pocket limits you had in the RAND experiment were linked to your income, so the higher your income was, the more you would be exposed to out-of-pocket spending. As a result of that feature, if you looked at people being switched into coinsurance, high-income people ended up reducing their spending to $65 on this scale, while low-income people reduced it to $74. So the reductions among low-income people in total dollars of spending were actually smaller than the reductions for high-income people.

Second, and more importantly, the RAND experiment found that for the vast majority of people, there was no difference in their health outcomes whether they were spending what I am calling $100 or whether what I am calling $69, and this is on a whole range of objective and subjective indicators. The important exception was low-income people with chronic conditions were less likely to have their hypertension diagnosed and treated and that increased their mortality, and this is a very, very important exception because an important part of what health insurance is about is about sick people and you want to make sure it works for low-income people as well, so I will come back do that, and that is part of what motivates the proposal.

The last thing that motivates my proposal is, so everything I have said so far you might say, the solution to this is health savings accounts and just give everyone a high deductible and be done with it. That has two problems. One is this health point I just made that for low-income people in the RAND experiment their health turned out worse, and a whole bunch of evidence since RAND is consistent with that, especially a number of drug studies including in Canada. The second problem is just the nature of risk itself, and the risk of having a $4,000 fluctuation in your out-of-pocket payments is an enormous risk to a low- or moderate-income family, enormously high relative to their income. That same risk to somebody with a very high income is not only not that much of a risk, it might not even be enough of a risk to even affect their health spending. So if you quantify it, and in the paper I show how you can do this, the costs associated with great risk are very high for lower-income people, and they fall down as your income goes up.

To a first approximation, the benefits associated with shifting people into high-deductible plans are about the same by income, they might actually be lower for lower-income people, so if you look a typical high-deductible plan, people with low, moderate, and maybe middle income will turn out to be losers because they will be exposed to all this greater financial and get these relatively small benefits to it. People who the risk is not a big issue will get some of the benefits from the greater efficiency you get with the plan and will not be paying much of a cost in terms of risk.

There is an obvious solution to this problem, and it is obvious enough that it has been proposed by many people before, which is to link the amount of cost-sharing that people have to their income. In my paper I propose a model plan where you would pay 50 percent of your health costs until it reached 7.5 percent of our income, for low-

income people you would not have any cost-sharing whatsoever, and at the very high end, almost for optical reasons, no one would pay more than $15,000 out of pocket.

If you do this proposal, according to my simulations you could reduce health care premiums by 22 to 34 percent. Part of why premiums go down is because people are paying more out-of-pocket. When you take that into account, the total amount people are spending on health care is going down by 13 to 30 percent. Low- and moderate-income people face less financial risk than they face today under this proposal because it exempts them from cost-sharing or limits it to their income. Middle-income people face modestly more financial risk at the low end, but no financial risk at the high end, no risk of having an insurance plan that does not cover them out of pocket at the maximum, and they are paying 13 to 30 percent less for their health insurance premiums.

Finally, we should look at how to do this carving out exceptions for preventive care and for high-value disease management, and especially certain drugs, and those do not reduce the total amount of cost savings very much if you put some of this money back into the things we know can lead to better health care for people.

So this is a model plan, the final question is how to implement it, that is something we could do more in the Q and A, but I think there are a number of ways. One of the most promising ways if we are doing a broader health reform that had universal insurance, we could make the affordable pooling option that people have to buy into in that plan something that looks like this. So this could be the way to create an affordable template to do as part of a broader health insurance plan. Thank you.

MR. AARON: Thank you very much. Richard is going to make the presentation for the Newhouse/Frank team.

MR. FRANK: Good morning. Our paper focuses on three areas where we believe that the Part D benefit under Medicare may be underachieving. The first has to do with the evidence that the complexity that is faced by beneficiaries in the Medicare program and the incentives for plans to compete for good risks may be leading to a set of options in the market and a set of decisions made by consumers that may lead to errors in some optimal outcomes.

The second area is focused on two particular areas where purchasing and pricing may be yielding prices and claims on the federal budget that may not be consistent with efficient outcomes, and there in particular are the prices paid on behalf of the duals and what to do about unique prescription drug products.

The third area has to do with risk bearing and the benefit design, in particular the donut hole, and some rules around how we define actuarially equivalent plans.

We have developed some steps in each of these areas to help amend the Medicare drug benefit. To address the complexity in the selection incentives, we suggest three steps. The first is to standardize the benefit designed to between seven and nine plans, so that would be a major reduction in the number of plans, and allow each firm to have one so-called wild card plan. The way this would work would be there would be a standard benefit package, there would be three or four actuarially equivalent plans offered, and then three or four enhanced plans, and wild card plan is one where an offerer would be allowed to offer an innovative benefit design in order to encourage innovation and creativity in this market.

The second step would be to reorient competition from competition for enrollees right now which leads to potential selection incentives, to one where we would

have competition for contracts where there would be competitive bidding in each region for a single offerer of all the separate health plans. This would really be targeted to reducing incentives for selection and gaming.

Then the third piece or the third step would be to assign every new Medicare enrollee to a default plan and allow them to immediately choose a way if they do not like where they are assigned, and this is aimed in part at dealing with the fact that much of the lack of take-up in certain segments has been among people who have absolutely nothing to use by taking up which is people who qualify for low-income subsidies. So that would guarantee a higher take-up rate that the people who are entitled to low-income subsidies and free drugs and free coverage would be more likely to take up.

The second area is to improve purchasing. The first action that we propose is based on evidence that for the dual eligibles that government is paying considerably higher prices on the Part D than it did under the Medicaid program. So the idea here would be to return prices to something that approximates the pre-Part D prices but not to use the Medicaid best price mechanism so as not to enter back into some of the distortions to private-sector behavior that resulted.

The second act in this area really focuses on unique drugs. The entire Part D benefit is predicated on the notion of competition and for competition to occur and for the prices of competition to result you need competitors. There are unique drugs that are continuously coming out and hopefully they will come out at higher rates than they recently have been. In those cases, the combination of dramatically expanded insurance coverage particularly for the most expensive drugs when you hit the catastrophic limits along with a lack of competition suggests that you have taken the patent system and you

have put it on steroids and that then creates distortion in prices and claims on the federal budget. So here what we would propose is to put into place some temporary price controls until competition builds up and they would potentially be based on a system of binding arbitration where the companies and the government are encouraged to negotiate private settlements.

To make risk bearing more efficient, we propose two steps. The first one is that currently the rules for defining an actuarially equivalent plan preclude PDPs from increasing the deductible in order to offer coverage into the donut hole. We think that is unproductive. The basic notions of insurance is that the most value coverages are for their higher-end coverages and so this rule constrains the ability of plans to offer that more efficient type of risk bearing. In addition, we propose redefining the standard benefit to include at least generic coverage into the donut hole, and this could presumably be paid for in part by savings made on the pricing side particularly for the duals.

Finally, just a separate administrative matter that also potentially changes the incentives to game and to offer different forms of drug products to meet reimbursement rules rather than appropriate delivery of care, we propose moving the drugs covered under Medicare Part B into Part D even if that means that you might want to grandfather in certain kinds of cost-sharing arrangements in order to continue to serve the beneficiaries who are now under Part B. Thank you.

MR. AARON: Jeanne, you're up.

MS. LAMBREW: Thank you. And thanks to the Hamilton Project for supporting this work, and I also need to thank the Center for American Progress, in particular John Podesta who contributed to the intellectual development of this work as well.

What I will be talking about today is an idea that really tries to reflect what is a change in the disease burden in this country. If we look at what has happened over the past century, we move from the major cause of death being acute illness to chronic illness. In the year 2000, we had about two-thirds of our deaths associated with chronic illness, and the prevalence of chronic illness is growing. About 45 percent of the population today has some form of chronic illness, and that will grow to 50 percent of the population over the next 20 years. And the number of people with multiple chronic conditions which are quite costly will also grow.

One study estimates that the cost of chronic illness accounts for about 78 percent of all of our health-care spending today, and this does not just manifest itself in cost. We have studies that suggest that the obesity crisis could mean that the next generation of children could have a shorter life expectancy than that of their parents. That will be a trend that changes our century old improvement in life expectancy in this country. It is a dramatic health as well as cost problem.

The good news is that we actually know a fair amount about what works. The U.S. Preventive Services Task Force has been synthesizing research on what services have the weight of evidence to work both in terms of clinical effectiveness as well as cost effectiveness. But the bad news is that we do not do a very good job of delivering preventive services in this country. For example, 20 percent of children do not receive recommended immunizations and vaccinations. About two-thirds of adults who should be getting colon cancer screening are not getting that cancer screening. And we also have a problem in the health care system. We do not have the kind of primary care providers who should be providing these services, we do not pay for quality of services. We pay for quantity of services. A physician who delivers an imaging service gets paid about

three times the amount that a physician who does counseling gets. And we have an insurance system that frankly does not always cover these services. What this chart is showing is that very sporadic in terms of what insurance companies cover in terms of recommended preventive services, and I think there is a valid case to be made that they have no real financial incentive to do so.

Today the typical 40-year-old has had 11 jobs in his or her career, meaning that people are constantly churning in and out of coverage. So the idea that any single insurer should be investing in prevention that will benefit some other insurer later does not seem to make a lot of sense.

I will say that we also have other public policies out there intended to promote prevention. We certainly have the public health system that is designed in part to fill these prevention gaps, we have many dedicated primary care and preventive specialists who are really trying to do this, but the system itself does not seem geared toward really trying to promote wellness rather than treating sickness.

We would argue that we need a new system. The gravity of this problem and the inadequacy of the current system mean we should be really thinking radically about how we finance and deliver prevention. What the Wellness Trust would do is consolidate funding and responsibilities from private insurance, public insurance programs, as well as parts of the public health system in a new agency called the Wellness Trust. This would be within the Department of Health and Human Services but would have a fair amount of discretion and independence. It would have trustees, it would have its own trust fund, and would have five main functions.

The first function is defining what prevention priorities should be. Prevention could be anything from fitness clubs to wellness diets to really proven clinical

preventive services. What this trust would do first and foremost is figure out what the most cost-effective and high-priority preventive services that this country should be providing.

It would then try to use these priorities to allow form to follow function. What this chart does, and I will not read this all through, is really tries to say that we have three different types of major preventive services, immunizations which try to actually prevent a disease from happening in an individual, screening to try and detect early on asymptomatic disease, and counseling to try to avert risky behaviors that will lead to chronic illness. What the trust would do is try to use a delivery system to wrap around these things. For example, it could develop an infrastructure at the national level to, for example, do planning, do standards, do toll-free numbers and centralize some of the main prevention priorities at the federal level.

It could develop a new and broadened prevention workforce. The truth is we need to go outside of the health care system to get at people who need preventive services. To do so we need to get into supermarkets, schools, and work places, and to do that we need some new workforce which requires standards and training, and this is something that the prevention trust could do.

We also should and could work better with our state grant programs and our local public health departments who are critical when we think about how do we address, for example, regional disparities, rural preventive services, mobile technologies. This is kind of a multipart system that we would try to need to develop to get a multiple dimensions of the prevention problem.

This is a delivery structure. Clearly we need to have financing follow the form. I think that if you are creating a new Wellness Trust, you could start and try to

figure out to realign the financial incentives with this sort of system. For example, immunizations should be mass-produced in low-cost settings. Could we figure out a financing system that would reward volume for high-quality providers? That could be a way you would use your payment systems to promote immunizations. With screenings, some of this does need to remain in a clinical setting. Imaging probably needs to remain in the clinical setting, but we often have repeats done because of low quality. Pay-for-performance models could be used to align again our incentives with our goals.

In terms of counseling, friends of mine in tobacco cessation say that doctors are not actually the best counselors in terms of trying to get people to quit smoking. Get those kinds of motivational counselors who make you buy products or do better at business, get them on the phone with people to try to really incentivize them to quit smoking, but do not pay them by the minute, pay them by the outcome. You could imagine how you could figure out these different dimensions of prevention, design the delivery system to get there, and use your financing to move the system in that direction.

In addition trying to figure out how we design this system in this new way, how would you pay for it? There is no good estimate on how much we spend on prevention today. Partly it is because of the amorphous nature of prevention, partly it is because we just have not done good studies in recent years. But if you extrapolate from the last good study done in 1992, we are probably spending about $70 billion on preventive services today mostly in the clinical realm, about $34 billion of that is spent federally, with another $15 billion spent to the state and local level. If we were able to focus those dollars on high-priority preventive services through a national delivery system that is delivered to everybody, not just the people with insurance, it really is a

system that is outside the insurance system, I would argue that you really could get better outcomes.

What are the issues and opportunities for this type of proposal? Clearly there is this merging of health insurance, health services, and public health that is both an advantage and a disadvantage. It really is a model that broaches both the world of clinical services in health care, but also community-based services which is an advantage because these services often need to be outside of the health care system, but it will require things like information technology back in so it is not another fragmentation of the U.S. health care system.

I would argue most importantly that we begin to try to financially align what we want with our payment systems. I think we have to start from scratch when we think through how do we actually move our dollars to prevention and wellness, and I think that if you do start from scratch, you could do this right the first time.

It broadens the sites of care, and I think this is critical. Again we need to recognize that prevention is really different than most health care services. It is routine, it is for asymptomatic people, there is no diagnosis involved, and you want it to happen as much as possible within the category of people. To do that, we really I think need to go outside of the health care system.

Lastly, I think that this piece which is a Wellness Trust separate from but integrated with the health care system could be part of larger health reform efforts. I can imagine both a very market-based system with high deductibles and having the Wellness Trust associated with it, as well as a true single payer system in which this is a piece that is merging the public health and the health insurance system could have this as part of it. It could fit into larger health reform systems, but it also could begin today because we

really could begin now to think through what are we spending on prevention, how do we coordinate that better, how do we move beyond insurance regulation into a payment system that really does promote wellness.

There are lots of other details of this proposal, but that is a sketch that hopefully will get the discussion going. Thank you.

MR. AARON: Thank you very much, Jeanne, and thanks to all three of the presenters for being remarkably punctual. That is most unusual. We all tend to run on.

Arthur Conan Doyle wrote a mystery in which the principal clue was a dog that did not bark at night, and that metaphor or parallel occurred to me in listening to and in reading the paper by Joe Newhouse and Richard Frank. The dog that did not bark in their paper was direct commentary on the very much alive political proposals today for the federal government to regulate prices of drugs more pervasively than the very limited dimensions that they described in their paper which were limited to unique drugs and for the institutionalized population. Perhaps we could get things going by asking them what they think of these broader proposals for federal involvement in drug negotiation.

MR. FURMAN: I'll start out. Let me make clear first that the proposal on the dual eligibles is not confined to the institutional population. The dual eligibles account for 29 percent of the dollars, so this is not a trivial issue. I think the main response to Hank is along two lines. A, we really borrowed from the commercial model of drug insurance, so if you think about for any of you who have employer-based insurance the drug coverage that you have, you probably have that through some kind of pharmacy benefits manager and everybody in your employment group probably has the same pharmacy benefits manager, or everybody in your plan has the same pharmacy

benefits manager. You do not have a choice independent of your choice of plan, if you have one, of a pharmacy benefits manager. That is our competition for contracts, and we think that has worked reasonably well in the commercial world and we think that there was some bipartisan agreement at least in the initial discussion of the MMA to use that model to try to avoid trying to set prices for drugs which we think is very difficult. Drugs are a classic case of a high fixed cost, low marginal cost industry and how you allocate the fixed cost can be quite arbitrary.

We are afraid, along with the industry, that if the Congress says this is how much we have for drugs this year as they do now with physician services that one could really kill innovation in this industry. The venture capitalists in biotech are certainly looking for what kind of return they are getting on their dollars. And we think also innovation in pharmaceuticals seems to have fallen off something of a cliff since about 2001. The rate of new molecular entities in the drug market is roughly now one a year with more like four-plus in the couple decades before that. So if anything, we need to see more incentives for innovation and the threat of negotiation would seem to point exactly in the other direction. But the basic answer is we would like to give the commercial model a run here. If there are problems with it, one can always resort to controls later.

The exception to that as Richard said is the unique drugs where there is no competition within the market. That is potentially an issue in the commercial market as well, but the commercial market has a little bit of a threat to say if it is a really ridiculous price, we are just not going to cover it. We think the government is in a much weaker position on that score. If you take the simple case of a drug that costs more than $5,450 in a year so that the beneficiary is paying 5 percent at the margin relative to a monopolist

that is facing a market with widgets that does not have insurance, the profit maximizing price is multiplied by a factor of 20 is what Richard meant by the patent system on steroids, and we think that is just not a position the government should be in, which is our proposal for some kind of arbitration which is again not really price setting by the government of course, although it clearly is not exactly the unregulated market either. But that is the rationale of where we were coming from.

MR. AARON: Let me press you just a bit on that. Let's take your argument at face value with respect to the new unique drugs, but you are talking about a very large portion, a significant minority, of total drug spending for the dual eligibles where profit margins presumably would be trimmed back. Given the dismal record of new drugs since 2001, aren't you a bit concerned that you are going to further dampen an already inadequate flow?

MR. NEWHOUSE: I'll take one. We are concerned about that. I think that is a real concern. But we looked at actually the pipeline and the history of the drugs that are heavily used by dual eligibles and looked at whether in fact there were high levels of innovation in those categories in the recent past assuming that if there were, then probably the Medicaid prices were way too low. In fact, what we found particularly in some of the antipsychotics and some of the neuroleptics and things like that was actually very high levels of innovation, fairly deep pipelines and a process.

MR. AARON: Of drugs that have recently been found not to be highly recommended, I believe.

MR. NEWHOUSE: Some yes, some no. We could argue about the details, but there is a lot of innovation in that area and there is actually a fairly thick pipeline which gave us a little bit of confidence that the prices on the Medicaid side for

drugs that are heavily used by the duals were not actually so low that getting them back into that neighborhood would be deeply detrimental to R&D.

MR. AARON: Everybody who does work on health economics at some point or another cites the RAND health insurance experiment which Jason did extensively in his paper. Since at the other end of the stage you have the person who managed that experiment, I would like to see if I can get a discussion going that involves at least those two.

One of the findings of the RAND experiment which, let's be clear, was 25 years ago and did not involve the elderly in the experiment at all, one of the central findings was that even with substantially increased cost-sharing, the health status of most of the beneficiaries who were subject to increased cost-sharing and whose use of health care services declined or was dramatically lower than was the use of health care services by people who received care for free, their health was basically just as good unless they were low income or had certain chronic conditions.

My question is this, and it is genuine uncertainty, is that experimental finding still persuasive in light of the substantial changes in the character of medical care that have occurred in the last quarter century, in particular, the dramatically increased reliance on maintenance drugs where experiments have shown optimal cost-shearing may be zero or even negative? I am wondering if you could defend the proposition of relevance and Joe could comment on your defense.

MR. FURMAN: Thanks for starting with me.

(Laughter)

MR. FURMAN: First of all, let me just say we spend over $2 trillion a year on health care. Spending $200 million on a one-time basis to rerun the RAND

experiment would repay itself several-hundredfold, and there have been a lot of calls for research on comparative effectiveness effectively at a clinical level in terms of what works and what does not for health care, figuring out what works and what does not in the context of health insurance and designing health insurance in a randomized way I think would be terrific.

Until we do that, though here is how I think about it. RAND has basically three findings, it has a lot of findings but three I'll talk about. The question is how we would update them. Number one is, if the price of your health care goes up, how much do you reduce its use. Number two is, given the distribution of all the health expenditures, if we made changes in people's cost-sharing, how much would that effect aggregate spending. And number three is, how would that affect your health.

Number one, price and your use, and it found that if your price went up, the amount you used went down. It's a common-sense finding and there have been a number of studies since then which have corroborated it and corroborated the magnitude, and in some cases found actually slightly larger magnitudes. One thing I didn't get into is that the RAND experiment took 1,000 in one area -- 7,000 in one area, put them in a new health plan and observed how their behavior changed. If you took the whole country and put them into a new health plan, the behavior of doctors would change, the behavior of people inventing medical technologies would change, the whole culture would change. So I think if anything the RAND effects understate the price and a range of studies we have had since the RAND experiment indicate that people are as sensitive to price or more sensitive to price than what that experiment found.

The second question is the distribution of health expenditures, and that is something I essentially address in my paper by using the microdata from the MEPs (?) for 2004 and using the distribution of health expenditures in 2004 to simulate what would happen under a different plan. And even though there is more high spending, there is somewhat more skewness of spending, it is still the case that relatively small changes in people's, or the changes that I talk about in people's cost-sharing could have a substantial impact.

I have been stalling on Henry's most important question which is the impact of this on health. The way I see it, the RAND experiment did not find that people were super rational geniuses who, faced with more cost-sharing cut back on all the stuff that was really ineffective and kept doing all the really high-value stuff. It found that people were actually pretty crude and cut back on everything, but some of what they cut back on were health treatments that were actually hurting them. At least that's how I interpret why it had no impact on health outcomes.

Since then we have had a number of studies which have validated and extended, that if you extend cost-sharing to drugs for chronic conditions for low-income people it is highly problematic, so I think cost-sharing in the Medicaid program for example makes no sense whatsoever on financial risk grounds and on health grounds.

We still have not found though a lot of evidence that outside of a few drugs and outside of a few chronic conditions and outside of low-income people that there are any broad impacts on health, and based on that I guess I would continue to read the evidence in the same way although with admittedly a little bit less confidence than on the spending side.

MR. AARON: Joe, do you have any comment on that?

MR. NEWHOUSE: I largely agree with where Jason is coming from. I think we can and should be more nuanced with cost-sharing than we were 25 years ago. It will probably require some trial and error/experimentation/studies to figure out what we're doing, but we could do those. So just the straight high deductible for middle income and above is probably not the best insurance policy.

On the health results, when I first saw these results, this was 25 years ago, it was actually a very uncomfortable feeling because the only way you could explain no effects on outcomes for the average person was either we had mismeasured the outcomes and there really were outcomes we had not picked up, or we had mismeasured the utilization and the high deductible really did not have the effect we thought it had, people just had not filed claims, or there really was no effect. I had a lot of reason to not believe the first two explanations, all kinds of validity studies, and so I was going to force to the third. The mindset I think of a lot of people is that if you go to the doctor, either good things happen because the doctor treats what's wrong with you or finds something that's wrong with you and treats it, or nothing bad happens and the doctor says you're fine, go home. Therefore, basically you want low barriers to care, high access to care which means cost-sharing.

The only way I could rationalize was, as Jason basically said, there were some good things that happened if you went to the doctor more and there were also some bad things that happened, and on balance they tend to offset each other. At the time, as I say, that was pretty uncomfortable. Since that time, we have a lot more evidence about poor quality of care, medical error and so forth that has come out, and even a few years

ago we were showing the RAND studies (inaudible) as most people know, half the care is not delivered, that's underuse, a little different, but basically care is still far from optimal and bad things do happen and I think that part of the finding is probably still there. Maybe over time if we improve the quality of care that will be less true and one would want to make people go more easily to physicians. But for the moment, I think some kind of finer-grained mesh which is where I hear Jason coming from generally is a good way to go.

MR. AARON: One more question before we open it up for you, so please be thinking of questions you would like to ask the authors on the platform. The last question is for Jeanne. As I was reading about a Wellness Trust, a cliché occurred to me which is that life is a chronic disease in the sense that we start deteriorating at least from adolescence and maybe before then. And furthermore, most of us do not now die from infectious diseases, we die from these cumulative illnesses over one's lifetime. Where that led me to was a question which is I understand the concept of prevention, but I am not sure I fully apprehend what the charter of a Wellness Trust would read like. What would it do and what would it be debarred from doing?

You mentioned the problem of possible further fragmentation in organization and financing, but I'm looking for one step earlier. What is the definition of the fragments that would be carved out? I won't go to the issue of details on financing.

MS. LAMBREW: It's a great question and I think this is where the advantages we have, and Jason talked about comparative clinical effectiveness research, is that have been sustained efforts to look at the evidence on what preventive services have, strong evidence, questionable evidence, weak evidence, or evidence that you

should not actually use them. So we have a step up in the U.S. Preventive Services Task Force doing these sorts of evaluations, there is a community guide effort that has really looked at community-based interventions that demonstrations and research suggest works, and we also have a new effort to really try to look at the cost-effectiveness of those services that rank on the kind of clinical side. So we begin to have an evidence base for it, but that probably will not be sufficient.

The reason why you want trustees is that there are probably other layers of judgment that would need to be involved. For example, are there any particular interventions that have such a potentially high yield that you really would want to prioritize them like cholesterol screening or high blood pressure screening which have potential true cost savings to the system and not just being cost-effective. Are there feasibility issues that you really want to address which is there is some opportunity for latching on to some different types of prevention so that you can couple things so that they work well together in terms of an intervention. So there is a judgment involved as well.

But I think the interesting part about this idea is the trustees would do this ranking of what should the prevention priorities be, and because you have a trust fund there would be a cutoff. It would fund what it could afford to fund, it would not fund services that it could not afford to fund, and the rest of the health system would remain primary payer for those services, kind of like a primary payer model, whereas the Wellness Trust would take on the payment for those things on its priority list that it could afford but certainly things that are not on that list could either continue to be funded by private insurance, paid for out of pocket, or delivered through the public health system.

MR. AARON: I have asked enough questions. You should have a chance. Please raise your hand and identify yourselves by name and affiliation. There's a lady in the back on the right-hand side.

MS. ANDERSON: Christina Anderson. I kind of have an armchair interest in this. I have a special-needs son so I have followed a lot of this with interest. One thing I've noticed is that over the last few years we have had a shift in the way new medicines are brought to market. It seems like a lot of that research is happening in the private sector, where before it used to happen perhaps over at NIH. I am wondering if there isn't a way to factor into this equation what happens if we make our government research entities a lot more vibrant, bring some of that research back to the government entities instead of now leaving it all in the private sector where it is subject to pure profit motive. Thank you.

MR. AARON: One comment before I ask Richard, and that is last I heard the NIH had a fairly considerable budget of nearly $30 billion, but Richard?

MR. FRANK: I think actually the government does have a vibrant research program and it actually does in some sense what it is best suited to do, basic research, the really high-risk research, and most of the costs in pharmaceutical research is really in human trials which is something that pharmaceuticals do well. It is not that sort of ground-breaking basic science, but it's just very extensive because it requires recruiting lots of people and running these really long and large clinical trials. So I'm not sure that the division of labor is quite as distorted as your question would suggest.

MR. AARON: Another question over here on the right.

MR. WILLIAMS: Claudia Williams, AGA Consulting. I was very excited to see Jeanne's proposal. I think while we have been moaning the lack of preventive and promotional care for a long time, there haven't been any concrete proposals out there beyond what we see in disease management and care management. I guess I would though question the structure on two opposing fronts. The first is that I think folks who have been working in the care and disease management field have developed a new, very almost religious belief in the importance of the medical home and that particularly for folks veering into a chronic disease, the importance of a medical home that doesn't just include the primary care doctor but also a bunch of other expertise is really important and I worry that by siphoning off these services into a different location we don't have a locus of accountability for individual care.

On the opposing side I would say that we have a really increasing understanding of the importance of environment and policy and social norms in creating the risks that we have whether it be obesity or lack of physical activity, so I think we risk taking an overly medical model in thinking about the solutions to particularly the biggest risk factors, lack of activity, poor eating habits and over consumption as well as smoking. And I think our success in reducing smoking really compels us to look at a much more comprehensive way to think about how we reduce those risks that moves well beyond medical care.

So I guess on the one hand I would urge you to look more closely at how medical care is structured and on the other hand to think more comprehensibly about how we really do reduce those three most-important risks.

MS. LAMBREW: Excellent points. I will just say very quickly that on the first issue about the medical home, I think this system is designed to be complementary and not a substitute for the existing primary care preventive services providers out there, and in fact if this is designed well, it would actually provide the resources for a well-run clinic to actually be providing this in house.

But I also think that it creates a little competitive edge which is if that same patient goes to the supermarket, it is more convenient for him or her to get the immunization there versus a doctor's office, the resources will go to the place where that person gets that intervention which I think is important. I think people always say that health information technology is the answer to every problem. In this case I think it's critical because you cannot have a system that broadens the boundaries of the medical system without having some sort of integrated system to track, to monitor, and to hold accountable the providers in the system. So that is one again maybe overused solution to this problem, but I think most people who really look at this think it can work.

On the other side of this, without a doubt there is this challenge of how do we address our health problems which really are not always health problems, they are community-based problems and they're societal problems. I would suggest that if we have a trust that is enumerating priorities and really trying to draw national attention to them, it could not just through funding of services but also through kind of a prioritization and coordination agenda really begin to think through how do we get at childhood exercise as well as nutrition programs, how do we really think through diabetes prevention, and I think that can happen if you have a single agency with responsibility for this topic.

MR. AARON: No questions from this side of the audience.

MS. SHANER: Louise Shaner from the Federal Reserve. I have a question for Jason. This question is really about the co-insurance or a related question. One is looking at the change in co-insurance as health spending becomes a greater proportion of income it makes sense that you would want to have more insurance coverage and have co-insurance rates come down. I think the evidence is that relative to income it even comes down, so it can come down much more dramatically than we could possibly understand. So one question is, is this telling us something about what we want as we get richer in society? Is it something about our fundamental desires? Because I don't think we can explain it with tax rates or other sort of -- my question is what do you think? Why has it happened?

The second question is similar which is going forward as health spending continues to increase as a share of income, even your proposal would presumably have a smaller co-insurance as you go forward (inaudible) when we get to a system where basically co-insurance is going to be such a small part anyhow, even though it makes so much sense to economists, but at some point are we going to say we want prevention to be 100-percent coverage and we want really good catastrophic, is it possible that it wouldn't even be worth for the institution to have it because it just wouldn't (inaudible) that much?

MR. FURMAN: Those are both great questions. On the latter one, if you carve out prevention, if you take out drugs entirely from the cost-sharing in the low elasticity estimates, total health spending is reduced by 13 percent. If you take drugs out entirely, total health spending is reduced by 10 percent. So you can still have a

substantial impact on health spending having no change in the cost-sharing whatsoever for one of the things where we have the most evidence. So I think you can have substantial carve-outs and still get a lot out of this to answer your second question.

The bigger question you asked is your first question which is if you ask people do you want to have a higher deductible and you poll that question, raise your hand, 100-percent of people are going to answer no to that question. There is another question we could ask people which is do you want to have a higher premium. My guess is 100-percent of the people are going to answer no to that second question also.

Often we in effect ask people that first question without asking them that second question. We ask them that first question because everyone sees their own deductible and knows what it is. They don't necessarily know their own premium because a lot of it is coming through their employer and coming out of their wages, I think they're 100-percent of that premium, but they're just not seeing it. So I think there is a reason to think that the way we've set up a system now and the lack of transparency in that system and add to that lack of transparency the fact that even if were fully transparent, a rational person for tax reasons that you have written about and a lot of other people in this room have written about would make a decision that wasn't economically optimal. So the lack of transparency and the tax incentives I think combine to basically ask people the question do you want a high deductible and not ask them the question of what premium they want.

So I think transparency by itself would help bring us to a better place, I think fixing some of these tax incentives would bring us to a better place, and I think using this type of structure for a new plan, maybe a new pooling option, the option where

people starting universal health insurance, and then we could see what people thought about it and whether they liked it.

MR. AARON: We may actually have a little disagreement on the panel.

MS. LAMBREW: I would just say I think we are only looking at one side of the equation through. If you are looking at the $2 trillion in our health-care system, there was a recent study by the MacKenzie Global Institute that tried to control for the wealth effect and say for a given GDP how much is our spending higher than other peer nations and why is that happening, and I think that we have to look at the prices we pay as well. Clearly we are paying higher prices for physicians, for hospital services, more intense hospital services, which may or may not be affected necessarily by some of the utilization effects of cost-sharing. So I think that this is part of the picture, but I think we need to look at the whole picture when we're talking about the $2 trillion in the health-care system.

MR. FURMAN: I guess I don't disagree with that because I think this is a part of the picture also. I also think it's important to think of how the whole picture fits together. So like a lot of people, I think one of the problems with managed care was you told people you can have all the care you want for free except we're not going to let you have this, this, and this. So there is this mismatch between stopping people from getting things on the supply side while not doing anything with the price mechanism and having a little bit more of an equilibrium between what you're doing on the demand side with prices and what you're doing on the supply side.

I also think some of the things like on the Dartmouth studies and the tremendous variations in care, I think part of why those variations in care can persist is if

people aren't paying much out of pocket, then minor differences in the culture of your physicians can translate into large differences in the number of angioplasties in different cities. So again I think some of this is about doing a lot of things that want to make sure they fit together coherently which I think is some of what was involved in the mid- to late-1990s and didn't and unraveled as a result.

MR. NEWHOUSE: I might make one point on this also which is something that comes up from time to time, that people think that if you have a large amount of cost that carries you past the stop-loss feature, that cost-sharing is irrelevant which it is at the margin, but you are say contemplating a $6,000 procedure that's elective and you have to pay $1,000 to get it because that's the deductible, maybe it isn't worth $1,000 to you and you don't get it. In fact, in the RAND experiment you see effects on spending that's well above the region of the stop-loss.

MR. AARON: We have a question. Jerry?

MR. GROSSMAN: Jerry Grossman. Jason, none of you have really looked at the supply side as a place where there needs to be a significant amount of work, that the productivity in the delivery system's operations are woefully inadequate, and I wondered if you had some thoughts about that side of the issue.

MR. FURMAN: My thoughts are two-fold. One is that it's very important, and two, that it's something I'm not such an expert on that I'm going to take up any more of your time to tell you what we should do about it, but there are other people who probably could.

MR. AARON: Are there any other comments?

MS. LAMBREW: I'll just add that I think the Dartmouth studies actually really do point to looking at supply as well as demand because the cost -- geographic variation often is linked not to cost-sharing and out-of-pocket costs but to supply patterns, and I think that's a clear area.

MR. FURMAN: I didn't say that the variation in care that you found at the places that used it a lot had lower cost-sharing because a lot of these studies are for Medicare where people are facing essentially the same structure. I'm saying that low cost-sharing can allow this variance to persist and with more cost-sharing you actually would see less variance because you would have two sides of the scissors sort of cutting and not just the supply side which is where a lot of this variance was coming, but the demand side would then damp it a little bit.

So again I think you would want to look at both sides of the equation, and in my paper and my work on this I have looked at one side of the equation, but absolutely that is not to denigrate the other side.

MR. AARON: Do we have a new question or a second one? The gentleman on the left over here, please.

MR. BUCKLEY: Ted Buckley with the Biotechnology Industry Organization. Actually, a question around the Wellness Trust. Would you support some sort of carrot and stick for consumers so that they would take better care of themselves so that if one looks at the rising epidemic of obesity and the prevention that could be taken by individuals themselves?

MS. LAMBREW: That's an excellent question and without a doubt I think half of this challenge is motivating people to reduce their risky behaviors and/or use

preventive services that are recommended for them, and I think you would have to look individual-level incentives to do that.

I would say I think there's been an interesting kind of development and divergence in what those types of incentives are. Some are in the vein of incentives, the frequent flier mile sort of model for giving people kind of a motivation to do things that don't have an immediate perceived value to them. The other is more what I call in the punitive mindset which is if you overeat, you pay more for your premiums, if you smoke, you pay more for your premiums, and there is a part of me that thinks that that becomes medical underwriting and you might be actually keeping people away from the kind of health care that they actually need even though there may be some behavioral component to their needing this, and I think that we're going to have to look at these proposals with great care because there is a slippery slope from trying to have behavioral incentives aligned toward the positive health behavior you want and keeping people who need some sort of tobacco cessation counseling from having financial access to it because there is an endless cycle of penalties involved.

MR. AARON: Yes, ma'am?

MS. LOPERT: Ruth Lopert at George Washington University. I have a couple of questions and comments on the Medicare Part D proposals. I'm interested in the discussion of calculating the improvement in incremental costs quality adjusted last year for unique drugs firstly because that presupposes that you have adequate evidence and comparative effectiveness on which to base it. But I'm also puzzled by how you would then that in a negotiation if you can't use a formulary and actually say no at some point. You may calculate your incremental cost per additional quality adjusted

(inaudible) but you don't have a lot of negotiating coin if you can't say no to coverage or you can't restrict coverage in some way. That was the first question.

The second question/comment was about who gets to define what is a unique drug because I would argue that for the pharmaceutical industry that a unique drug is anything which has a patent, and the example that you gave of atypical antipsychotic, so I would argue that if you look at the evidence of the comparative effectiveness between most of them, and there's not a lot of choose between them at least at a population level.

The third comment I would make very briefly is the proposal to mandate coverage of generics in the gap. I am all for coverage in the gap and the elimination of the donut hole, but I would argue that mandating generic coverage in the gap introduces a significant inequity for those patients with conditions for which there are no generic drugs and would significantly disadvantage people with things like hepatitis C or multiple sclerosis and a whole host of other conditions. I would just like to have a comment on that, please.

MR. AARON: I'm going to inject one other element on this. Some of the major benefits from new drugs come from learning by doing after introduction, namely by off-label use. If one bases the amount to be paid on the initial indications, one may be in effect underrewarding, undercompensating the developers of important new drugs.

MS. LOPERT: Or overrewarding.

MR. AARON: Or overrewarding, that's true, yes, as in the antipsychotics.

MR. FRANK: I'll start and Joe can jump in. There are two approaches in our paper. One is something that looks more like traditional administered prices which is

one place where -- so that wouldn't be really negotiation. So in that case it's just take it or leave it and so that answered that part of the question. The other approach would be if you have a system of binding arbitration, then one of the things that typically happens is that there is fact-finding or experts who advise the arbitrator and what you want to approximate is something like the uninsured monopoly price, but you've got to sort of take into account the relative effectiveness. Most countries do that as part of their price-setting process. This would be sort of an indirect application of that and you live with whatever evidence is out there, and that is true in any one of these systems.

Then the other question was the inequity of the donut hole. I guess our thought there was we're sort of trying to balance concerns of the federal budget which are actually quite real and we at least saw this as something that would improve matters even if it wouldn't make them ultimately the best possible. So it was an increment and it was something that was of a magnitude that sort of fit with the pricing policies on the Medicaid dual side.

Just because everybody seems to be giving the atypicals a black eye today, I just thought I would speak in defense of them which is there is a lot of evidence --

MR. AARON: As a user?

MR. FRANK: That was politically incorrect.

MR. AARON: Yes, it was. I'm sorry.

MR. FRANK: But these drugs I think, first of all, the quality of the studies in this area are just really below the typical standards and so I think that the evidence -- when you have an underpowered study and somebody stays on a drug 9 months compared to 4 months and you don't find a significant difference, then you throw

up your hands and you say they're equal? That's sort of the big piece of evidence you have. People on the atypical antipsychotics stay on a lot longer in treatment and certainly for treatment of schizophrenia and most other of these illness, staying on treatment is an incredibly important piece of the whole story. They are expensive and they are going to be a lot less expensive soon because a couple of them are going generic.

MR. AARON: Thank you very much. Apologies for that comment.

MR. FRANK: That's okay.

MR. AARON: Years ago one of our colleagues here at Brookings at a conference said there is no such thing as a 5-minute break. I am now going to announce a 5-minute break.

(Applause)

(Recess)

* * * * *