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ASSESSING THE AFFORDABLE CARE ACT'S EFFICACY, IMPLEMENTATION, AND POLICY IMPLICATIONS FIVE YEARS LATER

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PARTICIPANTS:

A NEW WAY OF COVERING THE UNINSURED -- HOW THE ACA HAS CHANGED AMERICAN HEALTH CARE & THE REVERBERATIONS TO COME:

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Douglas Dillon Chair and Vice President and Director, Governance Studies
The Brookings Institution

Speaker:

ANDREW SLAVITT
Acting Administrator, Centers for Medicare and Medicaid Services
Department of Health and Human Services

EXAMINING THE ACA'S IMPLEMENTATION, SUCCESSES, AND FAILURES AND EFFORTS TO MODERNIZE HEALTH CARE DELIVERY:

Moderator:

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HAS THE ACA SUCCEEDED IN BENDING THE HEALTH CARE COST CURVE?:

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P R O C E E D I N G S

MR. WEST: Good morning, I'm Darrell West, Vice President of Governance Studies and Director of the Center for Technology Innovation at the Brookings Institution. And I would like to welcome you to our A. Alfred Taubman Forum on Public Policy. This is the sixth year of this conference and it examines different public policy issues that are important to the future of the United States. So we would like to thank Mr. Taubman for his generous support of this forum, and also the assistance offered by his wife, Judy, and children, Bobby, Bill and Gayle. We're very grateful for the support that they provide.

We are webcasting this event live so a warm welcome to our audience from around the country. And we will be archiving this so anyone can view the video after today through the Brookings.edu website. We welcome any comments or questions that you have. We have set up a Twitter feed at #ACA5yrs. So if you wish to post any questions or comments during the forum you're welcome to do so there.

So on March 23, 2010 President Obama signed the Affordable Care Act and this law put in place comprehensive health insurance reforms to make healthcare more affordable, accessible, and of a higher quality for families, seniors, businesses, and tax payers. And this includes previously uninsured Americans and Americans who had insurance but that didn't provide adequate coverage for their families. The U.S. Department of Health and Human Services has reported that the ACA already has reduced the number of uninsured Americans by about 10 million people, but we also know that the Act has been plagued by criticisms about its implementation and its impact on patient choice. Critics continue to complain about the legislation and argue that it is not the right direction for American healthcare.

So today's discussion will examine the Affordable Care Act on its fifth anniversary. We're going to look at its impact, the implementation, and the policy implications of this effort to change American healthcare. We're going to have three different panels that bring together a diverse set of experts from various sectors. They come from different backgrounds and have different perspectives, and so they will help us examine the current situation as well as the future trajectory of the Affordable Care Act.

Joining me for the first session is Andrew Slavitt. He is the Acting Administrator of the Centers for Medicare and Medicaid Services in the Department of Health and Human Services. And in that position Mr. Slavitt is responsible for overseeing the programs that serve millions of Americans that access healthcare services through Medicare, Medicaid, CHIP, and the marketplace. He and his CMS team are focused on improving health outcomes, access, and affordability while also reducing health disparities and combating healthcare fraud. He joined CMS as Principal Deputy Administrator after spending more than 20 years in the private sector. Most recently he served as the Group Executive Vice President for Optum where he oversaw the delivery of clinical technology and operational solutions.

So please join me in welcoming Andrew Slavitt to the Brookings Institution. (Applause)

MR. SLAVITT: Thanks, Darrell; and thank you to Brookings for hosting this great even today. You know, today I want to take the opportunity to share with you where we are on the journey to health reform and realizing the promise of the Affordable Care Act.

The opportunities we have to improve people's lives by expanding access to high quality affordable healthcare are significant and there are occurring against a landscape of change for both the consumer and the care provider. We at CMS also find ourselves in the middle of these changes. With the opportunity to expand the impact we have as never before, as we cover new people in new programs and as we change the way we purchase care.

When the ACA was passed five years ago we had a set of chronic problems in access, quality, and cost that have plagued us since before each of us in this room starting working in healthcare. First was the stubbornly high uninsured rate and all the byproducts that come with leaving millions of people on the sidelines of our healthcare system, lack of access to primary care and chronic care management, persistent health disparities, bad debt, cost shifting to the private sector, and the lack of job mobility. So when now we finally see that the uninsured rate is decreasing, as Darrell mentioned, from over 20 percent in 2013 when the law's major provisions started to under 13 percent today, and that over 16 million people have gained health insurance coverage since the passage of the Affordable Care Act, there's reason to believe we're on the right track. And perhaps more importantly, according to commonwealth, of those adults who gained new coverage two out of three say they are now taking medicine and seeing doctors they couldn't afford before.

Next we had a healthcare system that was not consistently delivering safe, high quality outcomes. Early post-ACA evidence is demonstrating clear progress in improvements in quality. We see evidence that through the combined efforts of CMS and care providers we've seen a 17 percent reduction in harm for hospitalized patients over a 3 year period. This represents an estimated 1.3 million injuries and adverse events

avoided, 50,000 lives saved, and $12 billion in cost savings. The first generation pioneer ACOs are producing demonstrable improvements in quality with improvements in all 15 clinical quality measures in the first year, and further improvements in 85 percent measures in the second year. And third, we had costs that we could not and cannot sustain. Over the last several years we've seen historically low levels of per capital Medicare cost growth, with healthcare price inflation at its lowest rate in 50 years, and growing slower than per capital GDP in the last 4.

Importantly, affordability also extends to consumers, with eight in ten federal marketplace consumers having the option of selecting a plan with a monthly premium of $100 or less after tax credits and with benchmark grades flat to subtly down on average in 15 large markets. This evidence shows that our implementation of the many provisions of the Affordable Care Act, exchanges, the innovation center, Medicaid expansion, new authority to reward quality and cost, are beginning to have an impact against long stubborn problems. But we also know we've only begun to scratch the surface. Our agenda now is to get busy strengthening these gains and making sure these initial changes will be sustained.

So let me give you a sense of our priorities at CMS as the team works to build on what we've started. It begins with first meeting the needs of the evolving consumer. Second, working with care providers to help improve cost and quality outcomes, and third, it also means adapting to how we work at CMS given the same opportunities and challenges. Today our new consumer is at once more diverse and more demanding, and with a broad spectrum of affordability and health concerns. The CMS consumer is the Medicare patient who seeks care in a community hospital, the newly-65 baby boomer who expects choice and service and technology in everything

they do. The dual eligible patient who is now able to be treated in a home setting, and the young single adult living in the city and bouncing between jobs and therefore between Medicaid programs, a QHP in the exchange, and back again to Medicaid. Whether in institutional facilities as part of a retirement benefits package, in a rural community hospital, through (speaking foreign language 09:07), well over 100 million people are interacting with CMS and depending on us in new ways. What remains constant is that many are in highly fluid life situations with unpredictable incomes, often managing multiple conditions, and that many go without a regular relationship with the healthcare system.

So while we focus on reducing the number of uninsured our priority must also to be to help newly covered people with the tools to seek the best care for themselves and their families. We have launched From Coverage to Care, a program to educate people on how to access the right benefits for their families, but we obviously cannot do this alone. The delivery system must meet the primary care and chronic care management needs of this new population. And health plans must provide more transparency into their networks, formularies, and benefits to make it easier for consumers to get what they pay for.

We also need to finish the job on coverage expansion. We measure this by every individual who signs up for coverage in the marketplace, and we're learning that the marketplace consumers are smart, active shoppers who value their benefits. In the second year of open enrollment 25 percent of returning consumers shopped for and changed coverage. This is better than double the participation rate we see in other settings where consumers are renewing coverage. The implications of this to me are very positive. As health plans compete for new membership they'll need to offer

affordable high quality options and better and better service. And over the long-term value based payment levels and quality scores should become prominent indicators in educating consumers about their choices.

But the job also means addressing the remaining pockets of uninsured Americans. There are over four million adults in the coverage gap in twenty-two states. We're committed to working with states to make sure they receive the full benefits of covering their expansion eligible population. In the State of Kentucky alone it's estimated that in 2016 federal dollars for Medicaid expansion would support nearly 15,000 jobs across all sectors of Kentucky's economy. With expansion hospitals are better able to make their operations work by seeing patients and getting paid for it as opposed to relying on supplemental payments. In 2014 there has already been a 15 percent decline in uncompensated care, and that's just the beginning. Expansion from here is a state by state effort. States that find their path there are likely to find everyone benefits, their residents, their providers, the state budget, and the state economy.

Now as more consumers gain access to care our priority is to drive a delivery system that provides better care, a smarter payment system, and one that keeps people healthier. In many of the 300 markets across the country we know the challenges care providers face, living in a fee for service world today while preparing for the more accountable, more coordinated, more value oriented payment system that is emerging. We understand that these shifts require cultural strange, infrastructure investment, and new capabilities like managing risk, sharing data, and redesigning clinical processes. And often it comes down to very practical decisions. Should we invest in that new MRI machine or should we instead invest in a population health surveillance system. So covering better than a third of all Americans and growing, in January we decided it was

time to clarify our expectations so that we can achieve a better, smarter, healthier healthcare system and help the care community with these types of decisions. This is what prompted us to announce our goal, that 30 percent of Medicare fee for service payments should be tied to models that reward quality and value by the end of 2016, and 50 percent by 2018. And we are making it easier for states and commercial payers to do the same with delivery system reform incentives at the state level and models easily adaptable to commercial contracting.

So the message should be clear. The tipping point is near if you're providing care. You will do better with more appropriate care, better coordinated care, higher quality care, and more satisfactory care than by simply providing more care.

Now as we face both an aggressive agenda for changes in the delivery system, and a rapidly expanding set of consumer needs, CMS is also evolving. More than ever we must earn a reputation for great implementation which means we must continue to listen and adapt, we must work to foster simplicity and transparency.

The Affordable Care Act contains the seeds to dramatically improve our healthcare system, but it depends on us, all of us implementing it well. The new ACO models, new payment bundles, new forms of tax incentives, websites, call centers, to say nothing of ICD-10 and many other changes to come. In 25 years in the private sector I never had a bigger and more important execution agenda, and this change will keep coming. As we learned each program we implement is a new opportunity to gain confidence or lose confidence in an exacting climate and with the demanding consumer. Good implementation takes planning, takes commitment, takes transparency, and importantly it takes a collective desire for us to improve what isn't working. Each element must be measured and improved. And in our unique American healthcare system no one

ever acts alone. We can't succeed if we don't act in concert with the myriad of other participants it takes to deliver care, hospitals, health plans, physician groups, advocates, states, and more.

Next we must foster simplicity, a critical and difficult responsibility. Because we know that change is difficult enough we must simplify whenever possible so more time and resources can be spent on improving care to patients instead of with armies of consultations helping to keep up with the change. There are a number of areas we are now focusing on. Streamlining meaningful use requirements where we recently removed redundant measures and added flexibility, to aligning clinical measurements across multiple programs, and beginning to clarify how Medicaid, QHPs, and Medicare rules connect so transitions could be made easier for people. We need to engage with all of you in the community to listen and learn how we can continue to do this better.

And finally we must continue to release date to drive more transparency and more innovation. CMS continues to make significant strides in making more data available to external stakeholders to help empower consumers and assist in delivery system reform. Nursing home compare with more than 1.4 million visits per year, it's one example of how we can give data to consumers so they can make an informed choice. We also released near real time feeds of Medicaid data to support care coordination. We launched the virtual research data center to facilitate lower costs and timelier access to CMS data for researchers. We are committed to this path and expect to defuel the next round of innovation to keep improving care for patients.

So as we close out our fifth year of the ACA I often think about how our implementation now will impact what the healthcare system will look like 50 years after ACA. As we celebrate now the anniversary of Medicare and Medicare, remembering that

prior to Medicare and Medicaid a third of the country's elderly lived in poverty, and 50 years later, thanks in large part to these programs that's reduced now to 9 percent. And so today as I visit call centers and read emails from consumers who are just beginning to experience their new benefits for the first time, I'm reminded of how embedded Medicare is in people's lives with over 85 percent levels of consumer satisfaction. So after the first five years of the ACA we all must realize we have the same opportunity to impact people for many years to come. Execution, listening to our consumers and partners, and improving will be the keys to our shared success. Working with you on complex, important programs that make a real direct impact on people's lives, what our jobs at CMS is all about.

Thank you. (Applause)

MR. WEST: So thank you very much for sharing your thoughts on both the current situation as well as the future priorities facing CMS.

So in your remarks you mentioned the goal of getting to 50 percent of the payments through value based models by 2018. Is this realistic and what are you doing to actually be able to meet those goals?

MR. SLAVITT: Yeah. Well, it is realistic. I think if you would have asked the question a few years ago when CMS had zero percent of its payments connected to cost and quality would have been even more daunting sounding. Today we're at about 20 percent and I think, you know, gratefully the team has introduced a number of critical tools that I think will help get us there, and I think these are -- the great news today is there are tools available for small primary care physicians, there's tools available for major delivery systems, there are tools available for specialists. So I think through the hard work I think we're going to see that continue to accelerate.

MR. WEST: And what are the tools that you are finding to be most effective in being able to meet this goal?

MR. SLAVITT: Well, so, you know, I think the context that we take as we look at these tools is many of them we're just beginning to get our first and second years of data, but, you know, for example the first year of the pioneer ACO program, even as we know the pioneer ACOs really broke ground on how to operate an ACO with an interactive data and really sort of a first level set of measures, the results were actually quite promising. You know, we saw all quality measures increase compared to benchmark. We saw on average cost improvements that were up very meaningfully on a per capita basis, and perhaps even more interesting to us was that the second year costs continued to improve on average by about an additional 50 percent. So I think it tells us that, you know, in that particular case of population health, we have -- we know that providers know and have known probably for some time that if they could only get rewarded for it, they have the ability to take better care of patients. Likewise I say we're excited about the work going on in bundled payments. You know, I heard an interesting conversation the other day with a cardiologist who was remarking that because of bundled payments they were beginning to talk to people who were doing pre op planning and also rehab work, and starting to see data on how long length of stays were pre and post for the very first time. And, you know, those dialogues are really I think what this is all about. I think as these things begin to get encouraged there's really no telling how far this can improve.

MR. WEST: So you also mentioned the CMS goals of releasing data to empower consumers and researchers. So can you talk a little bit about what you've done so far and then what you're expecting to be able to do in the future?

MR. SLAVITT: So several months back we appointed a Chief Data Officer for the first time in our history. He happens to be a Brookings alum, Niall Brennan. And I think whether it's durable medical equipment, physician, hospital payments, or even the new open payments regulations where people can for the first time see what contributions from life sciences have been made to a provider community. I think our expectation is we're living in a world where we can increasingly take all the information we have and put it out. Our challenge to others, however, is that we need to have people take that information and make good of it. And rather than living in a world where we know exactly the benefit of every piece of data the idea behind publishing it is so that innovators, care providers, consumers, others can build tools and can do things that will further develop innovations. So I think we have begun to meet the challenge. I think there's more to do, but I also think this is a call out to everyone else to start taking advantage of this data and to really make good of it.

MR. WEST: What role is CMS playing in developing future delivery systems? What are the types of things you're doing and how do you envision these delivery systems changing?

A Well, I think the thing that's most important for CMS to do is to provide as much clarity as possible on what our expectations are for the beneficiaries of our programs as they meet and live in the communities that they live in. Our sense is that it's very important to recognize that we live in a country with 300 often very different markets. And in some markets that have experience with capitation and have a good primary care system and a well developed post acute system, they will be able to rapidly evolve their delivery systems. And in other markets and other locations they're just getting started. I think in those areas and in those locations I think there are tools for people to do things

there. So I would say it's important for us to get across that CMS isn't trying to dictate through our goals what the delivery system should look like. We're actually in fact we believe giving the opportunity for the delivery system and for patients and consumers to really do that on their own, but in ways that make it very clear that for those care providers that are improving quality and are hitting performance measures, and are improving satisfaction, we will continue to reward them. And I think that shows that it's been effective.

MR. WEST: So I have one more question and then we'll open the floor to questions from the audience.

So there are a couple of things coming up with potentially great impact on healthcare. One is the Supreme Court decision that potentially is going to be important for the state exchanges, and then of course the 2016 election which could produce a republican administration in 2017 committed to repealing of the ACA. So I'm just curious how you see the possible impact of each of these, the Court decision and the election.

MR. SLAVITT: I think the first thing I'd say is -- and it's a little counter to how people think in this town -- but we're at a stage with healthcare reform where we are heads down, focused. Now we have the opportunity now to focus on delivering the real benefit for consumers and individuals. So many of the things we're doing I think are universal kinds of things to improve the delivery system in the ways that need to be improved. And so unlike perhaps when people struggle and battle over whether or not to pass legislation, we believe and we hope that we're moving to a world where we can really all focus, not just CMS but others in that arena.

You know, I think we've said as it specifically relates to the Supreme Court case that there is no administrative action that we can take that would impact a decision from the Court. And just to be clear, an adverse impact would impact -- first of all it would remove subsidies for millions and millions of people. It would also make the cost of insurance for healthy people much more expensive, which would keep healthy people away from being insured which I think hurts the mobility in the economy. And, third, it would bring people back to the ER to seek care again, all of which will drive up costs for everybody. There's nothing that we from an administrative standpoint can really do to change that.

MR. WEST: Okay. Let's open the floor to questions. There's a question right here on the aisle. And if you could give us your name and your organization please.

MS. FOOTE: Heather Foote. I've just returned from eight years in California working at a community health center. I'd like you to speak a bit about the opportunity and challenges for community health clinics in the future and their role in Affordable Care Act implementation.

MR. SLAVITT: Thank you, Heather. I think that this is a good example to your earlier question. Community health clinics are an area that I think enjoy really good bipartisan support. I think if we're going to focus on improving care delivery and making healthcare sustainable, we're going to have to not just focus on the younger, active, healthier people who already know how to take care of themselves and bring new wearable technology to those folks, but we're going to have to make sure that we are helping to meet the needs of people that are most short in access to care and access to high quality care. And so I think those remain critical to us because that's both where the greatest need is, but it's also where the greatest cost is. And I think our focus squarely

on dual eligible patients, you know, and our sense is being able to solve those problems, being able to provide care to the most difficult to treat folks, is the key to being able to make the whole system work in the long-term.

MR. WEST: Right here is another question on the aisle.

DR. POMPLIN: Dr. Caroline Pomplin, I'm a primary care physician. My question is about the ACA and that swath of people who make a little bit too much money for subsidies but have to get their plans through the ACA and the trend towards what you call consumer driven healthcare, high deductible healthcare. What's happening to those people who buy insurance, don't get a subsidy, so they're not paying $100 a month, they're paying $500 a month, and something happens, they're in an auto accident and they're hit with a $4,000 deductible?

MR. SLAVITT: So I think -- thank you for the question. And I think the problem you raise has always been a problem and I think it's one that's only getting better with the Affordable Care Act and the extension of subsidies. And I think ultimately the marketplace is going to do a number of things. One, I think providing a solid set of preventive benefits and essential benefits to everybody, having out of pocket maximum and caps, lifetime limits, I think are important reforms. But then ultimately we're going to have to have a marketplace where the choices the consumers face are going to at the very least have to be readily apparent to them in much more higher transparencies so that consumers in various situations with various family conditions can decide between high deductible plans, higher premium plans, and so on and so forth. But, look, we recognize that no piece of legislation is going to solve every individual's problem immediately. I think there are steps we can continue to take that will gain on it.

MR. WEST: So you have made the move from the private to the public sector. So now that you're inside the belly of the beast of government what has surprised you the most about healthcare from the inside?

MR. SLAVITT: I have been dealing with and working with CMS as an outsider for 20+ years, so wasn't surprised by all of the -- the thing that I love best about CMS which is the talent of the people and how committed people are to the mission of service. You have to remember I got to CMS at a bit of a time of crisis in the fourth quarter of 2013 and so what I experienced and what really attracted me here was the focus on making sure we implement the law in ways that brought it all the way to the consumer kitchen table. And our focus since at least I've been at CMS has really been on how to make sure that we as a workforce are taking all of the power and potential that's in legislation and figuring how to create maximum benefit for people and changing the delivery system. So I'd say that when I go back home to the Midwest where my family is and I tell them that we are fast moving and we are working hard and we are working on making an impact and we are working with urgency and boldness, people don't believe me. And maybe I wouldn't have believed me either.

MR. WEST: Right here is a gentleman with a question.

SPEAKER: I'm the retired Dean of Medicine at the University of Chicago and an oncologist. And I was taken by your comments and taken by the fact that your organization as an M in the middle, Medicare, which as you point out was a great success. And so those of us more naive about the economics end of healthcare were very pleased with Medicare and thought a rational way to address this problem of universal access was to increase and build on Medicare. Well, you have both of them now. You have the Affordable Care Act and Medicare. And I would like to hear your

comments on the comparison, is one more difficult, should we be making the Affordable Care Act move toward a Medicare model? Those kinds of questions.

MR. SLAVITT: It's a great question. And I think -- what I tried to apply to my remarks is the incredible diversity of the types of programs that we live in and live with today. So I think even Medicare isn't Medicare any longer. We have Medicare Advantage, an incredibly popular program that provides consumers with choice. We have Part D, we have different accountability mechanisms in Medicare, we have Medicaid and CHIP which are also are undergoing -- are morphing from kind of their original kind of programs into ones that both expand as well as provide different types of incentives and care. And if you think about it from an individual's point of view, in their lifetime they are going to go through and have a number of choices. Largely, many of them will have been employer sponsored coverage, but increasingly they want choices, they want to make sure that the benefits are there for them when they need them. And so I think our opportunity is to really manage the complexity in the array. And I think that is -- because what doesn't change is the set of needs that consumers face when they hit the delivery system are going to be the same. And the delivery system itself, how well it works, are the kinds of things we can impact and I think we can impact them well across all of those programs whether it's through the delivery system reform on the Medicare side or through the power of the consumer that's coming to the marketplace.

MR. WEST: Other questions? Right here, up front.

SPEAKER: I'm someone here from Hispanic (inaudible). And I want to ask you what happens if you increase the quality and the number of consumers I guess you said, but the numbers of doctors is not increasing at the same rate?

MR. SLAVITT: It's a good question. I think we have I think in particular a need to make sure that the delivery system provides enough capacity in primary care. And I think there are a number of things at work there, I think are -- the medical homework and pilots and the use of technology I think is expanding what we all believe about panel sizes that physicians can use and take care of. It's also more work getting done in teams. And I think more work as the next generation ACO model allows through other access points, telemedicine and otherwise. But we, to your point, particularly in rural communities and particularly in targeted urban areas, we need to make sure that the delivery system and those that sponsor it are continuing to put the capacity we need where we need it. And hopefully the incentives of the Affordable Care Act will allow that to happen. But it's something we do watch.

MR. WEST: If we came back here in five years from now and just kind of projecting based on the innovations you're undertaking and changes that you're seeing, what do you imagine the success stories are going to be? And then also what are the areas where you think are going to need some serious change at that point?

MR. SLAVITT: My hope would be that many of the successes we're seeing through care providers who are taking the first early leaps through bundled payments, through medical homes, through accountable care organizations, those lessons will have learned and been spread into communities in areas that haven't had as much historical experience there. So I think we're as much today about scaling and operationalizing what we know works, and that's a great place to be. Relative to five or ten years ago if we had had this conversation I think there would be plenty of debate about what could work, about how to cover people, about what models might work. I think we sit here today in a fortunate place where I would say in private sector terms, we

are getting past proof of concept in a number of domains. And so how we bring those things out to people using things like the Learning and Action network that we just announced, and how we help states and local communities take full advantage of some of these innovations, I think that's where the real action is going to be over the next five years.

MR. WEST: So you mentioned scalability and this Learning and Action Network. Can you describe how that is operating and what the potential is in terms of making meaningful changes?

MR. SLAVITT: Well, the response has been extraordinary. For anybody that was at the kick-off event, thousands and thousands of people getting involved. And I think there are opportunities to just make sure that we don't innovate in isolation. I don't think it will do a hospital any good if one payer, whether it's CMS or anyone else creates a brilliant new way of reimbursing for care and providing support for care unless the provider could really scale that across their practice. It becomes quite frankly maybe better but also more complicated for the care providers. So I think the real opportunity is to look at best practices, look at alignment, and then look at some of the core areas that will nag folks individually if they struggle, but if we put our minds together for one solution will be better, like patient attribution and many of the other technical things that will come up. So this network I think is something that we've launched to enable, but I think quite frankly is going to be driven -- my prediction is it will be driven much more on a community level and much more by the actual participants in the system.

MR. WEST: All right. You mentioned the coverage gaps that exist in 22 states and we're all aware of the past Supreme Court decision on Medicaid expansion.

What can CMS do in those states in particular? Is there anything you can do to provide coverage or expand the options?

MR. SLAVITT: Well, so I think we have to remember, and we didn't before, that these are state programs and they're integrated very much into state budgets and impact things like K-12 education and so many other things. And we respect the fact that there are some important local considerations and indeed innovations. And I think we have shown, whether it's the work we've done in Indiana or Arkansas or New Hampshire, an ability and a willingness to be flexible and to listen when states come to us and say we want to expand Medicaid to a broader swaths of the population. So those are dialogues that we hope are ongoing, but we also recognize that increasingly they are not going to be driven from here in Washington, but they're going to be driven locally by people in the community, by advocates, by hospitals, by legislatures. And our jobs, as I mentioned in my remarks, is to be good a good partner, to listen, and where possible to try to find meeting ground.

MR. WEST: You mentioned some of the successes of the ACA and certainly the drop in the uninsured is a huge success; the moderation of costs is certainly very significant. There are critics who cite problems in terms of people keeping their old physicians. So I'm just wondering how CMS is addressing that particular concern.

MR. SLAVITT: Well, I think the first thing I'd say is we have to listen to all of the criticism that comes with implementing a new program because in many respects they represent our opportunities for improved clarity, for improved execution, and improved delivery. So we spent a lot of time in the first year of the program in particular listening to consumers, listening to advocates, listening to the health plans, listening to the delivery system, and again will continue to make changes. One of the

things I think that happened particularly in the first year was some health plans launched new plans for the marketplace and those new plans had smaller networks than the old plans. And so one of the things we heard continuously and continue to hear physicians ask for is: is my doctor in the network and is the drug that my child is on in the formulary. And we believe that those questions need to be easily answered. They need to be as easy to answer as how big is the deductible and what is the premium level. And so that's a really important focus for us and I think we will see consumer tools and innovation, but also we'll see hopefully health plans compete based on offering more and more things the consumers want.

MR. WEST: There's a question near the back.

MR. HART: Hi, I'm Daniel Hart and I work at Herrick, Feinstein. And first question is of the 16 million who have been covered under the ACA how many of them are through the exchange and how many are through Medicare, Medicaid, and CHIP. And how will we continue the growth forward of the insured rate or have we hit a wall?

MR. SLAVITT: Thank you. I can get you those exact numbers, but I think we have -- it's close to half of the membership coming from exchange and half coming from Medicaid, although that's not exactly right. You know, one thing I tried really hard to do in this, and it's very tempting not to, is try not to predict the future, particularly the immediate future where I will look silly by being wrong. Certainly nobody believes we've hit a wall. That doesn't mean that I want to predict kind of how quickly it evolves or where it goes to next. I think our opportunity is both to make sure that we help people understand the benefits of expansion, and I think next year there will be a lot more reasons for people to understand why getting more access to care is good, but also I would say we are equally committed to a deep focus on making sure that the people who

actually have got insurance for the first time really value their benefits. And this is to the point of Medicare. You know, we want people to be able to have the tools, to use their benefit, to seek care, and to get the things they need for their family.

And I was at a call center not that long ago and I listened in on a call. A woman called in, she had a very complex family situation, four or five dependents, she worked I believe it was 70 hours a week making what was the equivalent of $35,000 a year, but covering 6 people with her family policy. After tax benefits she was paying $24 a month in premiums. And she was told that based on some changes she needed to make that the premiums were going to jump from $24 to $38. And I heard almost a deafening pause for like five seconds as the woman really considered where she was going to find -- at least the way I was interpreting it -- these other $14 a month. And she came back on the phone and said I'll find the money; we're going to do it. I've waited too long for this and our family values this too much. Okay, we're going to do it, I'm going to do it. And I think it was because she had to add additional people to her policy. But it's examples like that and letters that I read which tell me this is a benefit people have been waiting a long, long time for. And so however the number grows solidifying the experience people have with the benefit is a very high priority.

MR. WEST: I think we have time for one more question. Did you have a question? Yeah, right there.

MS. AMOROSI: I'm Christine Amorosi and I work on the VA Healthcare side. Just to answer the question. You know, CMS is going through their major reform obviously on the military health side and those seniors and elders who also have that benefit. Is there any cross pollination that the two agencies are looking at sort of

successes, especially on that senior side and that dual eligible category that we could, you know, benefit from on both sides?

MR. SLAVITT: So I certainly hope so. And I think we have -- you know, it's a really important part of the population that we cover. And it's a really important part of what you do for your constituents as well. So increasingly simplifying programs and multiple programs for consumers many of which started to individually meet a set of consumer needs, but weren't necessarily all designed to treat the considerations of the whole person and their life circumstances. You know, that's a lot of what we're dealing with. Even inside CMS where we are now making -- simplifying benefits for dual eligibles or making transitions between Medicare, Medicaid, and QHP programs work better. You know, these are I think kind of the vital opportunities that we have that I think we don't always think about in Washington, but they really hit people on the ground in ways that make their lives much easier, particular at times where they really need it.

MR. WEST: Okay. We are out of time on this session, but I want to thank Andy for sharing his thoughts and we look forward to continued progress in the future as well. Thank you very much. (Applause)

MS. KAMARCK: This panel is directed to the topic of the ACA and specifically the implementation, successes and failures. It's a hot topic and one that has been a hot topic for a while now. We've got two great discussants today and I'm going to ask them to open with some remarks and then we'll have a discussion and open it to the audience. To my immediate left is Niam Yiraghi. He is a Fellow here at The Brookings Institution Center for Technology Innovation. He's an expert on the economics of healthcare information technology, and he focuses on health information exchange systems. His research examines the network externalities in the healthcare market and

their effects on adoption and usage. And he's currently focused on analyzing the outcomes of health information exchanges in reducing the costs and increasing the quality of healthcare.

To my far left is Eric Patashnik. He is a professor of public policy and politics and Director of the Center for Health Policy at the University of Virginia. He's also a Non-resident Senior Fellow here at Brookings and a Fellow of the National Academy of Public Administration. And he's previously held faculty positions at Yale and UCLA. He served also as Dean for Academic Affairs at the Batten School between 2009 and 2012. His latest book is "Living Legislation, Durability, Change and the Politics of American Lawmaking" and he's also the author of "Reforms at Risk, What Happens after Major Policy Changes are Enacted", a book I used to assign to my students at Harvard all the time, because it's one of the best books ever written on this topic. So with that, I'd like to call on Eric first because in fact Eric recently wrote a Washington Post piece, that was quite intriguing, and it began with the question of, do government programs ever die? Which has always been one of my favorite questions and in fact started many decades ago by a political scientist who wrote a famous piece called "Are Government Programs Immortal"? And Eric has an interesting take on that, and given that a good almost half or around half of the political establishments in this town is trying desperately to make the Affordable Care Act die, I thought that might be a good place to open up, and then I'll move to Niam.

MR. PATASHNIK: Thank you.

MS. KAMARCK: Eric --

MR. PATASHNIK: Well it's a pleasure to be here, I think that conventional wisdom among many is that, when government starts a program, it's

impossible to unravel. And yet here we are talking about the durability of the Affordable Care Act, and its fate and what will happen. When President Obama signed the ACA into law, both supporters of the act and detractors made bold predictions, and as we take stock of where the ACA is today and its trajectory going forward I think what's striking to me is how many of those predictions turned out to be wrong.

So on the Republican side, Paul Ryan and many other conservatives argued that the law was going to collapse under its own weight. That public outrage over the law, that the inevitable insurance death spirals would lead Congress to repeal the law. They were making this prediction early on, that this law will not -- this will not stand. This will not last, and yet what's striking I think to me is that despite Republican congressional victories, damaging supreme court decisions, website failures, and so on, the law survived. And advocates could point to key achievements -- including big gains in healthcare coverage, improvements in the access to health services and whether it's due to the ACA or not, historically low growth in healthcare costs. And so that's really I think pretty striking, that these initial growth predictions that the law would quickly unravel turned out to be wrong. And yet at the same time, if we look at the predictions that were made on the Democratic side, the optimistic (inaudible) of supporters that the controversy would die down and that the law would be subtly entrenched as soon as it was passed also, I think turned out to be wrong.

People knew that when the ACA was passed, that it was controversial, not overwhelmingly popular. It was an amazing thing just that the law passed, and yet the prediction I think of supporters was that, yeah this is the politics of enactment, but once we get to the implementation stage, once we see that the benefits are flowing, people are going to love this law. Presidential advisor David Axelrod said, as the

American people become familiar with what's in this program and what isn't, they're going to be very, very happy with it. Well here we are five years later, and public opinion on the law remains mixed. Opposition among conservatives remains intense, and the law still faces existential threats.

Even if the Supreme Court upholds the subsidies flowing to Americans who get their insurance through the exchange, I think the fight over Obamacare is not over. And why is that? Well in a nutshell, I think we have to realize that the ACA is a very unusual law. It's really hard to point to another example of something just like it. A lot of supporters of the ACA compared it to Medicare. They said this is going to be like Medicare. But the reality is this analogy was never a particularly a good one.

The two laws are really different. Medicare was fully operational after only a year. I mean the law passed in 1965, by 1966, 1967 this thing was going -- very well. Yeah there were difficulties getting doctors to participate initially, there had to be desegregation of southern hospitals -- there were important obstacles that had be overcome, but they were overcome. And here of course, there have been many more glitches and difficulties rolling out Obamacare. Medicare was also passed with strong congressional majorities. It was somewhat partisan but there was some Republican buy-in from the start. We didn't have the same kind of razor thin acrimonious party line votes to pass something as sweeping as Obamacare.

Medicare was built on the popular Social Security model. It was a huge immediate benefit to the elderly. The ACA is very different. In contrast to Medicare, as John Overlander has pointed out, the ACA is not a social insurance program with a clearly identified constituency that has a clear connection to benefits. It's not really even a single program, it's rather a series of subsidies, taxes, rules and regulations, that treats

different people, different groups of Americans, differently at different times. Some people are benefitting from the ACA because they're kids and they can stay on the insurance, some people are protected in other ways, but it's not like everyone sort of says, I'm an ACA beneficiary the way peoples think of themselves as a Social Security beneficiary. So this is a very distinctive law, it’s unique in the way it was passed, it's unique in the way it's designed, and it's in some ways unique in the way the fight over enactment has continued.

MS. KAMARCK: Great thank you. I would just add to that, that it's really interesting the way you have looked at this, because one of the things that has struck me about the law is that it actually affects a relatively small number of people in America. The elderly have Medicare. Most people in their prime working lives are covered by employer provided health insurance. And so we really are talking about 14 to 15 percent of the population, and one of the things that's always struck me about that 14 to 15 percent is that they go in and out of the healthcare market. So it's not like it's a permanent -- it's not like that 15 percent are the same people who can always be mobilized. But a lot of these people are people who are in between jobs, then they get a job with healthcare. Then they go out and maybe they become an entrepreneur or something, and then the ACA is great for them, and they buy it through an exchange. But it's not a permanent class of people, in the way that the elderly at any given time can be mobilized to protect the Medicare benefits.

MR. PATASHNIK: I think that's exactly right, small constituencies sometimes can be powerful. There aren't that many farmers left in America.

MS. KAMARCK: Not many.

MR. PATASHNIK: Because they are a compact group. They are well

organized. They know their interests. They monitor Federal legislation. This is a program, as you say, the percentage of the public that directly benefits, is not overwhelmingly large, it's not like social security, but it's also not well defined.

MS. KAMARCK: Yeah.

MR. PATASHNIK: People don't know when they're going to become a beneficiary; they're not counting on it in the same way. The reality is, there's many, many millions more that are benefitting indirectly through the ACA. The fact that you have a child, that you know that someday when they're an adult, might have secure health insurance. The fact that you have a relative that might have a pre-existing condition, you can rest easy at night knowing that they will be covered. Well that's a benefit for sure, but people don't see the connection.

MS. KAMARCK: Right.

MR. PATASHNIK: Political scientists know that what matters in politics is not simply the benefits that flow to people, but how visible they are, how traceable they are, how reliable they seem. In all those ways the ACA is problematic, and I think what's key to see about the ACA is that the ACA was not designed actually, to make it as transparent as possible, as easy for people to buy into it. Rather the ACA was designed primarily with passage in mind. It was designed to make it feasible to reform the pre-existing employer based healthcare system -- to retain that system but to bring more people into it. Because of the overwhelming need to adapt to those enactment barriers, the policy itself is not structured in a way that promotes its own sustainability.

MS. KAMARCK: Interesting. Niam, what do you have to add to this conversation?

MR. YIRAGHI: Well, I would like to look at Affordable Care Act law from

a completely different perspective. And say that it's a law that has different components. And although not all the people may like all of its components, there is one aspect that I believe every person loves. And that it's a promise for promoting innovation.

In the previous panel we were talking about the reforms in payment models, and financing health care. And the reason for the fact that we can now claim that we have started to be successful in that area. There's the fact that we really needed to be innovative in that area. If we could not reform how we finance medicine in this country we would have major problems in terms of financial -- we simply couldn't afford to continue the fee for service payment model. So we could successfully come up with a model that different players in the system are agreeing upon it and we can now say that in 2018, 50 percent of our medical providers would be a part of this pay for value payment model.

The other areas that the Affordable Care Act was initially designed to improve was the efficiency of healthcare. So through Obamacare, we are not only intending to provide universal health care for every American in the United States, but also we would like to reduce the cost of healthcare by increasing efficiency and increasing quality. Although we are celebrating the success of the Affordable Care Act in many ways right now, I think we are not able to say that we have also been successful in implementing the policies to make the medical practices more efficient, because we forgot that the critical success for every innovation to succeed is to have a need for that particular innovation. The payment reform succeeded because we needed to reform the payment system, but the other innovations in particular, the information technology implementation in healthcare has not been as successful as we planned because we forgot the critical fact that it may not necessarily be in the best economic interest of many

different players in the United States health care system to adopt such systems and thus become more efficient. So --

MS. KAMARCK: That's very interesting. Can you give us an example of a sector in the healthcare economy that's resisting innovation -- where it's not in their interest.

MR. PATASHNIK: So the High Tech Act, enacted in 2009, allocated 35 billion dollars so that HHS can come up with incentives in order to drive medical providers to adopt electronic healthcare record systems, so that they can capture the patients' data in an electronic format and then exchange it with other medical providers. I think we all agree that if doctors have access to your medical records they can make much better decisions and thus they can avoid redundant tests and provide care at a higher quality which all means that they would become more efficient and reduce the costs.

We have now spent 28 billion dollars out of those initial 35 million dollars and about 90 percent of, or more than 90 percent of the medical providers in the United States have an electronic health record system, but the surprise is none of them can exchange their medical data with each other. So instead of having a copy of your records in paper, now your doctor has it in his computer but that's it. We spent 28 billion dollars so that writing on a piece of paper, we have it in a computer and we cannot exchange it with each other. So why this has not been successful and now this is the debate over the interoperability issue and why these different kinds of electronic medical systems cannot talk with each other, and why can't doctors exchange the medical records with each other.

Apart from the technical issues, another aspect that you're forgetting is that if you're an owner of a radiology center, if you have invested in a lab center, in

medical testing center the last thing that you want to let your patients have their records electronically in order to reduce the likelihood of re-doing a bloodwork. The current system of fee for service model incentivizes the labs and radiology centers to do as many redundant and repetitive tests as they can. And now you're going and telling them hey, why don't you put your results electronically on a system so that the doctors can have access to it and avoid re-ordering it. I mean that's the last thing that they would like to do. So now we are facing a situation in which all of them are potentially providing it in electronic format, but none of them can exchange it with each other and the reason is if they want to exchange, it means that they are intentionally cutting their potential market and nobody wants to do that. Regardless of the type of the business that you're working in -- if you have a restaurant you will never want to reduce the number of potential customers in your restaurant, so if you are a testing center you would never want to reduce the number of test orders to your facility. So you don't want to be successful in that part, so when you're talking about innovation, we should ask this question, do we need this innovation? Is it going to help us economically or not? In the caring system, no we don't need it, we really want to kill it and everybody wants to do that. It doesn't matter whether you're a democrat or a republican. It is targeting the bread and butter of your business; it depends on your monthly and annual income. Your return on investments and that's a bad innovation. So it's like going to the taxi unions and asking them help Uber. They would never do that and the same is happening here.

MS. KAMARCK: The same is happening here. This is fascinating. Did you want to add to that Eric?

MR. PATASHNIK: I did so, although I think the primary goal of the ACA is to expand access, one of the things that is distinctive about the law is its ambition to try

to improve the delivery of healthcare. Not simply to bring you into the system but to make the system more efficient. And we need to remember that the U.S. spends dramatically more than any other country on health care -- 18 percent of GDP around, and yet it's clear that a lot of what we spend money on is not high value. There are many reasons for that, we've already talked about fee for service. One of the problems that the ACA is trying to target is the problem of weak evidence supporting the health care that actually is delivered by doctors. Some studies show that less than half of all the treatment that patients receive is based on an adequate base of evidence. There has been significant work by economists that show we have a lot of regions in the country that spend much more than other parts of the country on healthcare. Controlling for the kind of patients they have that aren't producing better results. So that was the promise of the ACA. But there's a lot of waste in the system, if we could identify the waste, perhaps we can make it more efficient and we could use those savings to expand access. That was the hope for it.

The ACA includes a number of reforms that were directed to try to promote more evidence based healthcare delivery. One of the most important was setting up a new agency called the Patient Centered Outcome Research Institute. That is a non-profit entity that is supposed to fund research on what treatments work best for different conditions. And the idea is, you have back pain, what's best? Is it surgery, is it physical therapy -- what's best? For a lot of common illnesses, we actually don't know the answer to that question. We don't have good evidence on what works best. When the FDA approves a drug, normally it just looks whether the drug works better than a placebo. We often don't know, what is this? Is drug A better than drug B or better than treatment C? For patients we need the answer to those questions. For your loved ones,

you certainly want them to get the best possible care. So from a quality standpoint and from a cost control standpoint that's important. And so this agency has been around for a couple years and the question is: is it beginning to have any impact? Is it actually making any difference?

There was a recent survey done of key stakeholders in the healthcare sector, by the National Pharmaceutical Council, and the answer was basically no. Overwhelmingly, I think it was more than eight in ten of key stakeholders saying that this effort to promote evidence based medicine is not yet changing how our healthcare system is working. Everyone is hoping that it will, but it hasn't yet. And there are a couple of reasons for that. The law itself, because of all the controversy over the death panels and a concern of rationing -- it limits the authority of the agency. So the agency can't mandate Medicare coverage decisions for example. The information could be taken into account by CMS, but there's nothing requiring it to. The agency was also heavily constrained from performing cost effectiveness analysis -- the way it is done in European systems.

We're very, very concerned about anything that interferes with a doctor-patient relationship. A lot of doctors will say they want better evidence. But of course, if you look at how it impacts their own practice, they're very reluctant to change the way they deliver medicine if information suggests that some of the things they're doing might not be as effective. This agency is only authorized for a couple more years. It's not clear that it will be reauthorized. So far, the agency has not had a big impact, I think most Americans, even those who follow it have not been aware of it. The studies that are being funded are taking a while to have an impact, it's not clear that anyone's going to really feel that this agency is adding value when it comes up. This is no fault of the

people who are running the agency; it just is underscoring how difficult it will be to transform the American healthcare system. Not only to one that covers more people, but to one that is higher value and more affordable.

MS. KAMARCK: So this is kind of analogous to the -- to what you just brought up, that basically there's reforms, they are implicit or explicit in the law, they are intended to bring us in the right direction, but they don't fit the incentive structure of the current system. So you've got doctors resistant because they don't want to be told they interfered with their practice, you've got doctors not using this -- the electronic systems. I've also been told that the doctors feel that the electronic -- entering the data interferes with their actual patient relationships and some of these people are hiring note takers to come in and put it in the computer, et cetera et cetera.

So there's a lot of resistance to getting us to a place where we can have basically better health care, better quality.

MR. PATASHNIK: One thing we haven't talked so much about is the larger context in which these reforms are taking place, and that is a highly politicized context. What's really I think been striking is that many of these reforms that are intended to promote cost control quality -- these are not democratic reforms. These are not republican reforms. They really are bipartisan, technocratic, good government reforms.

The agency I was just talking about originally, that whole idea actually predated the Obama administration. The earlier Bush administration was trying to promote evidence based medicine. One of the key advocates of this agency was Gail Wilensky, who had been John McCain's healthcare advisor. And yet the problem was some of these quality reforms got wrapped up in the broader debate over Obamacare. And therefore they became polarizing. And this is one of the problems we're seeing in

Washington now, is that even when there is a bipartisan consensus on efficiency, on problem solving, if it gets caught up in these currents, we lose that bipartisan support for it that we need in order to bring about transformational change.

MS. KAMARCK: Exactly. Niam, did you want to add to this?

MR. YIRAGHI: I just wanted to confirm, as I said at the beginning -- almost every initiative about making healthcare more efficient and reducing the cost of healthcare, has not only bipartisan support but also very strong bipartisan support. Everybody loves it, but when you look at it, unfortunately the economic incentives are designed in such a way that even with very strong bipartisan support in Washington you cannot do anything in the actual practices.

MS. KAMARCK: This reminds me about an old, old piece of political science that talked about street level bureaucracy. Remember that, so there are the policymakers saying yes of course this is the right thing to do, this is the right thing to do. And then you get down to the street and the actual implementation and it just doesn't work. It doesn't fit the way people are behaving or the way people think they ought to be behaving.

MR. PATASHNIK: I think the hopeful news here -- the good news is that these changes in the payment models that are promoting value and quality would have a side effect and the side effect is that the medical providers will now understand that it's in their best interests to become more efficient.

Now the payment reforms have created that missing need that they required for having successful innovation in other areas and now that by 2018 they say that 50 percent of the payments would be in a format of payment for value system rather than fee for service system. We're going to have a completely different landscape in

which now it is in the best economic interests of medical providers to become more efficient, in order to increase their margin of profit. So we're going to observe so many different changes in each of these medical providers towards becoming more efficient, however I highly doubt that those changes would be the changes prescribed from Washington. Those changes are the changes that are grown naturally within each medical organization based on the needs and characteristics that are unique to that specific organization. Those changes will then be attesting to meaningful use, stage 1 or 2 or 3 criteria. Those would be the actual real changes that information technology may or may not be one of them in order to become more efficient. And as a side effect patients would benefit.

MR. YIRAGHI: Yeah, so I'm picking up on that last point, I think that one of the problems with the ACA is that it was designed to make sense technically. But thinking about, as we've been talking about it, how do you build a durable coalition to make this stick and to bring about change is really an exercise in political entrepreneurship and political creativity, not simply technical design. And so the agency I was talking about, that hasn't made a big impact yet. It's unclear even though it should have bipartisan support, whether it will even be authorized.

Well we can't rerun history, but for example, what might have been another way to try to make that whole effort -- to make our system more popular, more engrained into the system? Well one idea would have been for example, instead of having an agency in Washington that's a non-profit entity, to sort of give out this research, maybe we should have used a more federated design, to try to have for example, twenty different centers around the country. And so in Virginia it would be for cardiology, and in North Carolina it would be urology, right? And those would be the

centers of evidence based medicine excellence. And they would be getting the billions of dollars, the hundreds of millions of dollars. And every time they get the grants, the members of congress from those districts would say, "I'm so proud that my area is supporting this research."

We need to think much more in a polarized age, of how we can build the new coalitions of support, because we can't count on them naturally arising. It's going to require much more strategic agency building I think, if we're going to actually transform the healthcare system over time.

MS. KAMARCK: Yes. That is a great point and I think the other thing people are fearful of is that if the Supreme Court goes against the ACA, then it just peters out -- it just peters out without the subsidies, but you'll still be left with some good pieces of it. You'll still be left with the exchanges, and the notion of having a place to more efficiently shop for health insurance. You'll still have something, but I think that the Supreme Court could be fatal.

MR. PATASHNIK: The Supreme Court case is fascinating because it's such a shocking event, and it's also I think, its effects are unclear. I could see it cutting both ways. On the one hand it could be exactly what you say. It could, it would be devastating to the exchanges in those states. It may be that this will be the end of it and that we'll end up with a two tiered system. There will be some blue states that will have sort of Obamacare, we'll have red states that won't. It will be quite ironic because it will be subsidies from the red states to the blue states and in many ways the law was intended to be the reverse. So that's one scenario, that in five years from now we're looking at actually the United States does sort of have a healthcare system, but only in some parts of the country. Undermining the idea of sort of, we're all one country.

On the other hand, one can tell the story -- I don't know how likely it is -- that actually, if the Supreme Court rules against these subsidies, it could be exactly what is needed in order to finally entrench Obamacare. Because Republicans and conservatives have been mostly opposing Obamacare in the abstract, at the level of ideological principal. Well now people in those states -- in the red states that have the federal exchanges are getting those subsidies. And these are middle class people -- and some of those states with Republican governors have expanded Medicaid at least. There's going to be tremendous pressure on those states to somehow come up with a way of making it work. And so the real question is going to be, who is going to be blamed? Will Obama be blamed for designing a bad system, or will those Republican states be held accountable if people start losing their coverage? If they are accountable, and they have to adapt to the system, that finally, I think will give Obamacare the kind of bipartisan support it will need going forward.

MS. KAMARCK: Because those red states will then start developing their own state exchanges -- in order to be consistent with the law.

MR. PATASHNIK: That's right.

MS. KAMARCK: I mean that's very interesting because you're exactly right. This could really go in one of two ways. Before we open it up to the audience, very quickly, I mean as of this point -- what do you see, Niam, as the biggest success and the biggest failure of the ACA today?

MR. YIRAGHI: I think the biggest success was that they could enroll as many people as we are seeing now, despite the fact the website was really cranky at the beginning, but still we're seeing the enrollment number much more than initial expectations.

MS. KAMARCK: And biggest failure so far?

MR. YIRAGHI: As I said, implementation and information technology in various sectors.

MS. KAMARCK: Yeah.

MR. PATASHNIK: I would say the biggest success is the fact that we've been able to expand insurance without a dramatic increase in healthcare inflation; whether Obamacare gets credit for healthcare cost control is still a matter of debate. But the fact that costs are under control more than what was predicted is a tremendous success. The biggest failure in many ways was the surprising Supreme Court decision making incent to the Medicaid expansion optional.

MS. KAMARCK: Optional, yes.

MR. PATASHNIK: I think in the last panel there was a question about building on Medicare as a way to expand to reach national healthcare coverage. That was the dream of liberals and progressives for generations -- Medicare for all. What's striking about Obamacare was it went another route, it expanded Medicaid. Medicaid had been seen as the welfare program and Medicaid became the vehicle for national health care insurance for all sorts of reasons. And yet that has been stymied and blocked in ways that no one expected, ex-ante, and as a result of that coverage expansion has been less than was anticipated in those states and we don't yet know if we're at a holding pattern now where other states finally will begin to come on board.

MS. KAMARCK: My final contribution to this will be that given that tomorrow is tax day, what I'm curious about and it's a little bit as you were saying Eric, which, about the Supreme Court decision is how are the tax provisions going to work out? Because one of the things that I have been thinking about is, basically this is

enforced through the refund system. The basic enforcement for the ACA is not liens on your property -- they're in fact they are forbidden from doing that, but it's through the refunds. That's actually quite ingenious because most of this population, it would make no sense to go trying to put a lien on their property, but they do -- this population saves through refunds. Eight-one percent of American tax filers get refunds. So the penalties now will be enacted through the refunds. The question is, as the penalties increase, in the future, and even this year and as people get less of a refund than they expected, or in some instances, no refund because of this. What will it do? Will it increase opposition to the law? Or as you were suggesting in the bigger case, will it in fact incentivize people to finally buy health insurance and get that last whatever percentage through.

Now in Massachusetts, there's almost, these days, there is almost no one paying the penalty. It's down to 1.7 percent, 2 percent. It's very, very small, but that was a state that didn't -- it's a little different, it didn't have a large number of uninsured, and it didn't have the entrenched political opposition. So I think that there are a lot of things that could go either way in terms of the incentive structures that are built into this. Okay let's take some questions. Right here.

SPEAKER: Hi this (inaudible)

MS. KAMARCK: Yes.

SPEAKER: First one is (inaudible) resolve this by waiting, all you have to do is look at the medical students and look at the interns. Every one of them is carrying a portable electronic device, usually given out as a require -- either given out to house officers or as a requirement for medical students to input their information. Nobody goes to libraries anymore, the library is PubMed. It's there; it's available. It's people who like me who couldn't type so well, who had to take Mavis Beacon Teacher's

Typing so I could use email.

MS. KAMARCK: Yeah. (laughter)

SPEAKER: We're slow, so the docs that are out there are going to pass by and these young people are going to come in, completely electronically sophisticated and aware. And all you have to do is look to see them. That's the first point.

The second one is with regard to Professor Patashnik's comment about the difference between a Medicaid model and a Medicare model, I couldn't agree more. But I'd go further. If you want to look at where evidence based medicine took root first, it's in the National Health Service in Great Britain -- a national system, like our Medicare system only better than our Medicare. That can work, as long as you have a system based on federated involvement, based on going from the bottom up rather than the top down. You aren't going to be able to get good, in my judgment evidence based medicine promulgated throughout the system.

The third point has to do with economic motivation -- going back to your bothersome but maybe correct analysis, at least to me. Bundling, outcomes, payments have to be derived -- designed for that, rather than specific interventions. Your comment about tests and X-rays may be right, but we shouldn't be paying for tests and X-rays. We should be paying for heart care and so what -- you know what I mean. So I think all three are addressable, but without a national system we aren't going to get that. The first one I'm not worried about, kids get older and they keep their computers.

MR. PATASHNIK: Can I go?

MS. KAMARCK: Yes, go ahead.

MR. PATASHNIK: Great points. I have a few comments. The first one, of course when these issues of evidence based medicine and the need to have a more

efficient system were discussed during the debate, whenever England was mentioned -- and you're quite right, it's nice, the National Institute of Healthcare excellence in England, that does this work very seriously, well that was anathema. That is through American ears -- that is rationing. That was part of the reason why the agency that was set up in the U.S. was explicitly designed by Congress precisely not to be England. When Don Barack made some comments about praising England, well he ran into huge trouble.

We have a tremendous belief in the United States that rationing is wrong and that Americans should get all the healthcare that they want, and we have not wrestled with this culturally, and not really come to terms with this. So what's also interesting is that in the U.S. case, the part of the U.S. that's always the closest to England in an integrated health care system is the VA actually. And the VA is probably the part of our system that is most evidence based for all of their bureaucratic problems, which is so unfortunate. What is the most tragic thing about that is that the VA has done excellent work over the last couple of decades in transforming the delivery of health care in ways that are more evidence based.

The second point was I think you're right about this generational change and the young doctors. I see the same thing in evidence based medicine when studies find that a particular procedure doesn't work, the surgeons that are doing it, well they've been doing it -- they're used to doing it. They continue, but the young doctors, perhaps, that are learning it in medical school, well maybe they're not going to do it.

So on the one end you could say, see that's a positive, on the other hand, what kind of industry requires 30 years to incorporate information. (laughter) I mean this is even worse than higher education. (laughter) So the transmission of knowledge to better delivery is painstakingly slow in the healthcare system.

MS. KAMARCK: Niam.

MR. YIRAGHI: Two comments. Regarding the first one, I agree that you know, younger generations are more tech savvy, and they are more likely to use technology. But the problem that we have with these EMRs and EHRs is not that we cannot use them, the problem is that even though we are using them, they're useless. So they do not lead to any change because they cannot exchange information. It's like cell phone that cannot make any calls; it's not my problem as a user that I cannot make calls. (laughter) I know how to use a cell phone. It is because the provider of AT&T or T-Mobile, or whoever it is that doesn't let me make a phone call. So that is even, you know, twenty years from now, thirty years from now, no matter how young and tech savvy are those young doctors, they would be unable to make any change because how good you are in using your EHR, you would not be able to do anything.

And I agree with your comments about incenting the outcomes, rather than the procedures of course. And that's the main disagreement that I have with high tech incentives and meaningful use incentive programs. They are incenting procedures, they are looking at how many patients you sent emails to, and then if you have reached a specific percentage of the patients that you sent emails to, then you are qualified for these incentives. It's just like incenting doing radiology images in the healthcare.

MS. KAMARCK: Let's see. Richard here, and then we'll go there and there, okay?

MR. SKINNER: Hi. I'm Richard Skinner from American University, and my question is particularly, though not exclusively, directed to Eric. If you look at public opinion on the ACA, it is overwhelmingly driven by party and ideology, not by people's personal experiences. I suspect there are people who have had good experiences and

still don't like the ACA because they're good Republicans and I'm sure there are people who have had bad experiences and still support the ACA because they're good Democrats. And you mentioned for example the possibility of distributing these centers for evidence based medicine around the country, but look at the number of Republican governors who refuse to take stimulus money. Look at the number of Republican members of congress who are basically uninterested in traditional distributive politics because they don't like it ideologically. So my question, and I know you've done a lot of work about how oppositions in Social Security actually continued a lot longer than we remember -- why are people seeing the ACA in such strongly ideological terms when I don't think that was the same case with Medicare, but it did turn out to be that way for social security until it was expanded to cover more upscale workers in 1950.

MR. PATASHNIK: So these are great questions. I think one thing that people don't like to discuss about the ACA is, it is an extremely redistributive law. It is our most redistributive social law in generations. Social Security was a universal program where everyone is participating. The early generations of social security participants got all -- everybody, way back more than they paid in. So the self-interest was very, very strong.

In the ACA, this is part of why the subsidy issue with the Supreme Court is so important -- the ACA is giving resources at a time of rising inequality to people that are middle class, lower-middle class, and poorer folks. It is not built on the universal Social Security and Medicare model, and so even though we think of the law as in some ways incremental because it's not national health insurance, in terms of the financing, the benefits flows, who wins and who loses, this law is not a law in terms of the way it is -- its benefit structure, that a lot of Republicans would have designed.

In many ways the ACA really was addressed to two different problems. One was that the insurance market was not working well. There were people with pre-existing conditions, there were market failures, there are adverse selection problems. Economists and everyone agreed that the market wasn't working, and we needed some kind of system. And there perhaps you could have gotten some sort of bipartisan support. But the ACA went further. The ACA did not simply address the market failures; the ACA was also trying to remedy some broader social justice issues. And it combined, in other words, a solution to the insurance failures as well as these distributional concerns. And it did it in a way that added an element of coercion with the individual mandate that sort of provoked etiological concerns at a time when the country was coming out of the Great Recession and many people did not believe this was the highest priority. And of course the context is so different.

So all of those factors that actually make Obamacare very different than Social Security. But the question I think also raises another good point, that is also missed. And that is Social Security itself was not like Medicare. Medicare was popular pretty quickly after it was passed, because it had built on the social security model. But Social Security was touch and go for a long time. It was passed in 1935, it had to be amended in 1939 because the original financing structure was not popular, and that it really did not become fully bipartisan until the 1950s.

What made social security finally popular was that Republican president -- Eisenhower said, we, the Republican party are no longer going to fight the New Deal, we're going to accept this. And the program of course expanded dramatically and then built such a large constituency. What Obamacare will need in some ways, in order to finally be entrenched is for the Republican Party to say, we are no longer fighting

that. It's not going to happen in the next presidential election, and the question is whether it will happen in the one after that.

MS. KAMARCK: Yeah, you know this conversation brings up one of my favorite Franklin Roosevelt quotes in designing Social Security. He did this on the insurance model, not on the pension European model. Because he said, "No damn politician will ever be able to take it away."

MR. PATASHNIK: Yeah.

MS. KAMARCK: But it still took a good 15, 20 years because you're right, Eisenhower was the right transitional president to the modern Republicans. Because the Republicans before Eisenhower they fought it tooth and nail.

MR. PATASHNIK: (inaudible) landed, others, sure.

MS. KAMARCK: Yeah, they all fought it tooth and nail. Let's see, there was a woman right here, yes. And then we'll go to you.

SPEAKER: Sure, again, Christine here. I'd just sort of go back to our comment earlier about innovation and the need to change the business cycle. We talked about -- the comment was made about how slow we are in sort of adoption. I guess a question for either one of the panelists here is, what kind of drivers or levers of change do we have? In my view as a clinician, I'm thinking of the model of continuing education. That's something that's there, out there, that pins to the clinician from an accreditation licensing perspective. Are there ways to sort of bump, or improve innovation that can get things over these hurdles? Just some thoughts.

MR. PATASHNIK: I think in this day and age, honestly we don't need to have -- to force doctors to attend a class in order to let them know about this new medical innovation. They already have access to the most recent medical findings. Of course

some of the journals will still require a fee or to access, or to provide access to those latest publications, but I think both NIH and other large medical granters are going toward the way in order to make it public access. So as was mentioned, every doctor now has access to internet, to tablets, to computers, to anything. So if they want, they can have the best and most important innovations out there. They can have access to that.

The reason that they don't adopt it is that, as I said, they don't need to adopt it. Every change is hard, no matter who you are, or where you are doing it, in order to adopt a change you have to overcome some initial backlash. But the point is, as I said at the beginning, the reason that these different innovations have not been successfully adopted by different parts of the medical system is that they don't need to. If there is a doctor that doesn't like to change the way he treats a specific kind of medical condition, and he argues that I've been doing it for the last 40 years and I would like to continue to do it the way that I started doing it, and he can get away with it, because he's going to be paid for what he is doing. If there is a system that says that if look, if you want to treat your patient like that and have a risk of readmission of that patient of up to 20 percent, but there is another model that reduces the risk of re-admission from 20 percent to 10 percent and if the patient is readmitted then you have to redo what you did. But we're not going to pay you, then that doctor, I will guarantee that he will say, okay, you know, I've been doing it for 40 years, let me see what others are saying if there is any way that I can make my business a little bit more efficient.

So to answer your question, not the only, but the best medium of changing in the medical system, I believe, is the changes in the payment model.

MR. YIRAGHI: So I certainly agree that payment is crucial, economic incentives is crucial, but I would add one other point that I think is also important, and that

is leadership is going to matter too. We've been doing some public opinion surveys over the last several years to look at what the American public thinks about some of these healthcare changes on the evidence based medicine side. And what we see is there's a lot of concern about it. There's a lot of fear, a lot of anxiety. But what pushes the public to support -- what makes people much more comfortable, is physician leadership. If we tell people doctors believe these changes are important, we see transformation in people's willingness to embrace these shifts.

Physicians really are going to be key. We still have a healthcare system. That is way the Medicare system was designed, even though physicians in many ways -- it's not the Marcus Welby era anymore -- they remain the most important actor in the American healthcare system. We delegate professional authority to them. They are the leaders of our system.

In the Progressive Era, the turn of the century, there was a kind of debate in American medicine about the need for reform. There was leadership that was emerging to try to make healthcare more efficient, more quality based. We're seeing some of that now in the healthcare system -- people like Atul Gawande and others. But it's still a debate in the medical system, about what should the norms of the healthcare system be. What is the responsibility for doctors to be stewards of healthcare resources to control costs? We did recently some surveys of physicians and what we see is physicians themselves in their view of what is the responsibility of their own medical societies, we don't see them fully embracing these ideas.

So for example, we ask them questions of, well, what happens if a medical study suggests that a treatment doesn't work so well, should the medical society be educating its fellow doctors? Or should it be fighting that study and trying to maintain

Medicare reimbursement? Do you see your society as kind of an advocate -- a lobbyist? And a lot of doctors sort of say, yes, that's what I want my medical society to do. And so we don't -- we certainly don't see any wide embrace of why medical societies should be making sure that all of us are really practicing best, the best way and conserving resources. We haven't seen that cultural shift. So we're at a time when I think American medicine is at a hinge point, like we were at the Progressive Era. And trying to decide, well, what is the responsibility of a doctor? They know the responsibility of the individual patient, but what is the responsibility to the broader system?

MS. KAMARCK: You know it's interesting to me, doctors -- when I talk to doctors these days, they sound to me like federal bureaucrats.

MR. PATASHNIK: They feel beleaguered.

MS. KAMARCK: Yes, they feel beleaguered, yes. They feel put upon and beleaguered and the system is doing this to me and it's a real sort of resentment, that they feel like they've been just beat up.

Yes the one on the right here.

MR. YIRAGHI: Just one comment before the question, sorry about that. The unique characteristics of doctors is that others have usually very high levels of trust to their doctors, for good reason. You should always trust your primary care doctor, whatever he says; you're going to do that. But the interesting point is that doctors almost do not trust anybody unless it's a doctor. (laughter) It's the truth. The very first -- this social networks analysis started from the social networks of doctors to see how they adopt medical innovations. So they ask doctors, what would drive you to adopt this medical innovation. Is it being published in JMAR and NEJM, or is being advertised on TV? Is it through pharma reps, or is it through the recommendation of your peers? That

is the strongest driver of adopting innovation. If some other doctor tells the other doctor, hey, I used it on my patient, it was good. And what we are missing here is that, as was mentioned, all of these innovations are forced to doctors from Washington -- in Congress we have a lot of physicians you know, so they feel that it's coming from somebody who doesn't understand medicine so I completely agree with the notion of leadership from medical professionals. If it's a primary care doctor, like a tool, saying that hey, these EHRs are a good thing, let's use them. I guarantee that the adoption rate among doctors for that specific EHR system would be much more for other types of medical innovation, whether it be in prescriptions or other surgery methods or anything. If it's advertised through word of mouth of doctors then it's going to have a much higher success rate.

MS. KAMARCK: Yes right over here.

DR. POPLIN: I'm Doctor Caroline Poplin, a beleaguered primary care physician. (laughter) This business of paying for outcomes -- let me make it concrete, you have a woman with metastatic breast cancer, she has failed first line and second line treatments. There is a third line treatment with a median survival improvement of six months and a price tag of a hundred thousand dollars. And there is evidence supporting that, it's been done by the pharmaceutical company and it's been published in the New England Journal. You are asking us to ration. What would you do in that situation?

MS. KAMARCK: (laughter)

MR. PATASHNIK: I think you underscored what makes the need to reform the healthcare system so urgent -- is we are now beginning to have come online new innovative products that have two features. They actually work really well, and they're really expensive. If we're going to have the headroom in order to allow the healthcare system to have those kinds of procedures, we're going to have to get rid of the

stuff that we're paying a lot for and doesn't do very much. We're going to have to figure out where is the low hanging fruit, where is the waste. Where is there something that costs more and is it any better than something else? Or something that's unnecessary, because those kinds of products, we have to figure out a way to make affordable.

DR. POPLIN: (off mic)

MR. PATASHNIK: Yeah. It's difficult, I know and when this was proposed, this already created a backlash. And there was one study that suggested it had no impact, and I'm not sure about that because some of the broader benefits of the relationship with the doctor, it leads to the hypothesis that maybe they're there. But you're right, that's exactly the kind of issue that we're going to have to be confronting. How do we have the room for some breakthrough drugs that are expensive, Hepatitis C, other types of areas, unless we eliminate the things that are clearly not working very well?

MS. KAMARCK: Last question right back here, yes.

SPEAKER: Hi, Julie Cantra-Weinberg, Business and Health Policy Solutions, a comment and then a question. I think one of the challenges over the last several years in healthcare policy making, and your comments reflect this, to a certain degree is that there's an assumption that doctors are monolithic. So a primary care physician at the Cleveland Clinic is the same as a rural pathologist. So I wondered A, if you could address that, and B, the center is supposed to vote on the SGR package today, which builds on some of the things in a bipartisan manner that were in ACA. What are your predictions for the ability to change anything else in ACA?

MR. YIRAGHI: So I think my comment to your question also is a comment to the previous question. In the SGR bill, one of the, I mean the most important

change in the SGR bill is that, it's proposing the merit based incentive payments, and also the Affordable Care organizations. And for those MIPPs payments they are saying that okay, as long as you are above a threshold of quality you are going to have this kind of reimbursement, and as long as you are below that threshold of quality you are going to have some penalty. But interestingly, they do not talk how to measure equality. They do not talk about how to identify equality. So it's a very big question so, and because of that reason, I honestly don't know about what's going to happen in terms of success for this SGR bill. Obviously doctors love it for good reasons because it gets rid of this doc fixes every year, and gives them a good raise but -- and also it tries to solve the problem of interoperability and electronic health record system by introducing economic incentives for people to become interoperable and actively engage in exchanging medical information. So with that regards I would say I am highly hopeful that we're going to see big changes and big improvements in terms of health IT as a result of passing SGR bill, in other areas I honestly don't know.

MS. KAMARCK: Great, listen, it's time for us to move on and I think Darryl, we're going to move on seamlessly to the next panel. Thank you to Eric, thank you to Niam, thank you for the great questions from the audience.

DR. RIVLIN: This is the final panel of this morning’s session. I am Alice Rivlin. I’m Director of the Health Policy Center in the Economic Studies Division. We do health policy all over Brookings Institution.

I’m delighted to welcome you to our final panel, which poses the question: Has the Affordable Care Act succeeded in bending the cost curve?

Five years ago when this Act was passed, we certainly knew that the American health system was very expensive, the famous 18 percent of GDP, which is an

awful lot to be spending, and at that time, we were really worried that it was on the track to 20 to 22, to whatever. It seemed like an inexorable increase in costs. We also knew that it was wasteful, and that it did not cover millions of Americans. This Affordable Care Act was a brave attempt to address all of those problems in one piece of legislation. We now know that we have covered millions of people, as the previous panels have talked about, and that rather astonishing, at least I think it's astonishing, what looked like an inexorable increase in the cost of health care year after year for a long time has moderated.

The question is why. We have had health care spending total going up less than the growth of the economy for the last several years. This was a trend which actually started before the Affordable Care Act, but despite lots of dire predictions that the Affordable Care Act was going to increase costs, the respite in the growth of health care costs has continued.

I think there are a couple of different views. One is the reforms are working, the reforms in the Affordable Care Act and elsewhere are really working to moderate the increase in costs. If you have that view, then you are fairly optimistic about the future. The future will bring higher quality at lower costs, or at least at sustainable costs, not growing faster than our economy.

Or the second view is this is temporary. We have had respites like this before. We had one in the 1990s when health care costs quite suddenly were not growing as fast as they had been.

You can look at upward pressures, not only the aging of the population but the increase, as has been emphasized in previous panels, in very effective health care coming online, individualized, and expensive. We are still stuck with the waste and

the politics of our situation.

We have the right people on this panel to have a good discussion. Jean Moody-Williams is the Deputy Director of the Center for Clinical Standards and Quality at CMS. She has been part of the leadership team at CMS for some years, working on improving quality and value across the spectrum of care. She knows what she is talking about firsthand. Jean is a nurse. She has worked at the state level and at private organizations. She wrote a wonderful inspirational book for caregivers based partly on her own experience with the care and death of her mother. I commend it to you.

Steve Brill is a journalist, an author, a lawyer by training, but we will forgive him that. I first really focused on Steve, although I think I had read some of his things before, when he wrote an astonishing article for Time Magazine a couple of years ago that brought together all of the things that those of us who study health care and those of us who have been patients in any kind of a health institution were astonished, but he brought them altogether in an article, an expose type of article, that just said look at what’s happening in American health care.

He has since written a book that came out very recently called “America’s Bitter Pill: Money, Politics, Back-Room Deals, and the Fight to Fix Our Broken Healthcare System.”

It tells you more than you wanted to know about the sausage making that went into the construction of the Affordable Care Act.

Let me start with a basic question that is posed by the topic of this panel. Has the Affordable Care Act bent the curve in improved quality? Jean?

MS. MOODY-WILLIAMS: Thank you for the opportunity to address the question and to address the audience and to be here today. You talked about you can

be an optimist or you can think this is a temporary slowdown in growth, I happen to be in the optimistic category, primarily because I'm here today.

If this were to occur many years ago, it is unlikely that you would have had a quality improvement professional sitting in this chair. I'm not an economist. I can't really tell you about bending the cost curve. I'm here because of the work that we are doing in the Affordable Care Act that is leading to changes, we believe, in the health care system, and I'm going to talk a little bit about some of the dollars that we are saving.

We frequently get to the question of attribution, particularly in quality improvement, where you are working in a collaborative manner and you have multiple parties working on the same issue, it is who is the one that is causing the change or what intervention exactly is it that made this happen. Frequently, we're not able to tease that apart, but we do know change is occurring, and that is the thing that a quality improvement professional will focus upon.

Some of what I will just mention -- of course, I'm glad that Andy opened up because he covered the entire waterfront, quality, spending, and the marketplace. I'm going to say what he said, that's our story and we're sticking to it. Really, he talked about better, smarter, healthier, and those are the terms we are using, that is what the Secretary introduced.

But those of you that are in health care and quality and improvement work, you know those terms, called the three goals, et cetera, it is many things, but they are all looking at how we really have smarter spending, how we improve the health of the population, getting to the point of not paying for lab tests but paying for the care that is provided, and how we really engage patients, families, and providers in smarter ways of delivering those care processes.

I had the privilege of standing up many of the sections of the Affordable Care Act that are rarely discussed. They stood up on time. They were up and running long before the Marketplace, but in fact are important pieces and in fact, did enjoy what we believe is bipartisan support, such things as the national strategy.

That was a part of the Affordable Care Act, which required the Secretary to come up with a framework whereby public and private purchasers and providers of care could have one look at how we were going to deliver quality of care.

Prior to that, CMS may have a strategy. The Agency of Health Care Research and Quality may have had a strategy, Center for Disease Control, and we had national priority partnerships. There were such so many.

What is it that we are trying to achieve? You can't get there if you don't know where you're going. Through this national college strategy, we were able to develop a common framework with goals and aims that included coordinated care, safe care, patient and family engagement, and the like.

Using that then as a framework for everything that we did, not just putting it on the shelf once developed, but our quality measurement strategy for our Affordable Care Act projects came under that rubric, if you look at our measurement strategy, it falls under there. Our contracting processes, for example, the Quality Improvement Organizations followed that same flow.

We were beginning to see results from that, results that I think can be quantified in terms of dollars in many respects. We had a reduction in readmissions just from the quality improvement work, nearly $1 billion from those communities that they worked with.

We saw a reduction in potential adverse drug events, about 44,000

events avoided, and you can attach a cost to that.

We worked on health care associated infections. We saw a decrease in central line associated bloodstream infections, but we started to see what looked like an increase in urinary catheter infections, and a lot of that had to do with better reporting, changes in the denominator. We can do better. We worked at doing better. One of the interventions is removing the catheter or not putting it in or remembering to take it out when it's time. We saw a reduction of 85,000 catheter days through some of this work.

In our partnership for patients' work, Andy mentioned this, but I just want to highlight it again, 50,000 lives saved, and we have been questioned about that through media and others, how did you document that, what are you talking about, where is that coming from. The President quoted that not too long ago.

It was through the work of partnerships, partnerships for patients, where we looked at the reduction of harms, and engaging hospitals and quality improvement professionals across the entire country, where we were able to see this reduction, 50,000 lives saved, 1.3 million patient harms avoided, and $12 billion in savings, as we worked with the Office of the Actuary. Numbers that are being validated even as we continue to speak.

Real harm, that means real things to real people, to real patients, to real families. Certainly, that is not what CMS did. CMS doesn't provide care. CMS provided the support, the leadership, the funding, and whatever it might take to support providers and clinicians who are in the field, who are the ones that are delivering that care.

We stood up the hospital value based purchasing program on time and in sync with the hospitals. It is a redistribution of funds. This year, we will be redistributing about $1.4 billion. That is a budget neutral activity. That doesn't

necessarily lead to bending the curve.

However, what the purpose of that is, is to look at the system of care to get folks talking, to look at how we get rid of those things that are causing harm and really working toward elevations in care.

There are a number of other things that maybe through the questions I will get to highlight. We stood up public reporting programs for cancer hospitals, inpatient rehab facilities, long term care facilities.

There are just so many things in that Act that we really don't spend a lot of time talking about but that are up and running.

DR. RIVLIN: Good. Thank you, Jean. I have lots of questions but I'll come back to you. Steve, I suspect you are a little less optimistic.

MR. BRILL: Well, I am, but I should start by saying as I hope you know, I have tremendous respect for CMS. In fact, the Time Magazine article sort of veered out of its way and demonstrated how much more efficient CMS is than the private insurance companies in almost everything it does.

Having said that, I think the good news about Obamacare is it definitely has, as speakers on the prior panel said, allowed tens of millions of people to get health care coverage. The bad news is it did pretty much nothing to bend the cost curve.

There are lots of statistics, lots of data thrown around, and you did, too, and it terrifies me to quarrel with the former Director of the Office of Management and Budget, let alone someone as respected as you are, but the way to think about whether Obamacare really bent the cost curve is you can actually read the law and search in the law for anything that does anything even on paper to cut into the cost curve in any kind of substantive way.

For example, you talked about the efficiencies of CMS, a hospital based purchasing program. How about allowing CMS to negotiate with the pharmaceutical companies since they are the largest customer for pharmaceuticals on the planet? There is nothing in the law that does that. It is certainly not the fault of the Obama Administration, which would have loved to have been able to do that.

If you look through the law, you do see certain little attempts to sort of nip at the edges of the cost problem. For example, as you mentioned, the readmission, the penalties for readmission. If you then look at how the sausage was made, you find out that the original proposal for those penalties were something like six or seven percent. I think it ended up being one percent, which is to say you get a one percent penalty as a hospital on what you charge someone who has been readmitted when they shouldn't have been readmitted, and since the hospital makes about a three percent margin, they are still making money on the readmission.

On the other hand, that has focused attention on readmissions, and there is no doubt that readmissions have gone down and that has saved money. I think you said $1 billion.

MS. MOODY-WILLIAMS: That was just in one program.

MR. BRILL: Which starts to get us to one-tenth of one percent of what we spend. That's a start. There is nothing really substantive in the bill that allows us really to bend the cost curve. The data about costs, which keep referring to the cost curve being bent, more typically refer to the rate of increase has gone down.

I just saw something yesterday or the day before, the most recent numbers, I think, for the first quarter of this year, say it's back up to something like four or five percent growth rate. The Government's numbers, by the way, the latest ones refer to

2013, which is when the insurance exchanges just launched. There are other things that happened before.

There really is no evidence. The other way to think about it is just think about the city in which we are sitting. In Washington, it is hard to find minor legislation much less major legislation that cuts into the incomes of the people who have the most lobbying power. To bend the cost curve in this country, you basically have to attack the incomes of one-sixth to one-fifth of the economy.

That is a difficult thing to do politically, and it was not done, and the reason the law passed was in fact that it didn't threaten the incomes of that all important, all powerful sector of the economy.

The health care industry spends four and a half times as much on lobbying as the much feared military industrial complex, and five times as much on lobbying as the oil and gas industry. The results of that are the hospitals all supported Obamacare. The pharmaceutical industry all supported Obamacare. Every other interest group did. The insurance industry basically kept silent, but they loved it because it was creating all these new customers for them who were going to get a subsidy from the Government.

If you think about that, you say why would they be supporting something that is bending the cost curve since the cost curve that is going to be bent is their incomes. The answer is it didn't bend the cost curve.

I think we just have to look at that realistically, and we have to understand the job that the Administration had in trying to pass the law was really impossible because we have created since 1943, when the War Labor Board decided to allow employers to provide insurance and it wouldn't count as a wage increase, this very

different and complicated system.

I will close with just one illustration of just how monstrously complicated it is and how hard it is going to be to unravel it. When the Obama Administration released its first regulations after the law was passed, this was in May 2010 -- I've been waiting for an audience like this to spring this very interesting number on because you will appreciate it uniquely.

The first set of regs had to do with the aspect of the law that said children under 26 would be allowed to stay on their parents' policies. In issuing that reg, OMB said just matter of fact, as if this was just routine stuff, that this reg, just that one reg, was going to result in 1,290,000 man hours of paperwork. Just that reg. The regs that followed, you can only imagine.

This is what we are trying to unravel, and it's difficult. I think it's unrealistic to think this in any way has bent the cost curve. I don't know of any families that think their cost curve has been bent except of course for the families who now have insurance that they couldn't get before.

DR. RIVLIN: First, let's say what we mean by "bending the cost curve."

MR. BRILL: Good idea.

DR. RIVLIN: What I mean by it is the rate of growth has slowed, and that is demonstrable. It may not be permanent. It may not be sustainable. Certainly, we do know that what looked like a rapidly increasing curve that was propelling health care costs nationally and in Medicare and Medicaid upward faster than the economy could possibly grow, that has slowed.

MR. BRILL: Whether that has anything to do with Obamacare is a second question. For example, lots of drugs came off patent two and three years ago.

Now we know at the end of last year and the beginning of this year, lots of new and very, very expensive drugs are coming on patent, and again, as a result, the numbers I've seen for this quarter say it has resumed growing at a faster rate.

DR. RIVLIN: Let me stick with you just a minute and ask you about the effects of competition. It has been pointed out that in Obamacare we did the insurance reforms first. I think that was politically very clever, somebody was talking about how clever Roosevelt was in the way he constructed Social Security. I think this was an equally clever move.

Everybody wanted the insurance reforms, particularly not being denied on the basis of preexisting condition, and once you have done that, then you were imposing some costs on the insurance companies that they had been avoiding for a very long time, and the subsidies were necessary.

Haven't we gotten the insurance companies now competing on the basis of the things they ought to be competing on, they used to be competing to find people who weren't very sick and deny the rest. Now they have to compete because of the guaranteed issue on premiums and on the --

MR. BRILL: That would be the perfect analysis if it were the insurance companies that were driving the costs or if the insurance companies had any leverage in this equation.

If you step back and think about it, it is the height of absurdity to say if you have five insurance companies competing in New Haven, Connecticut to sell me health insurance and there is one hospital system called Yale-New Haven, and they own half the doctors and all the clinics in and around that area, including the hospital in Bridgeport, if you care, the idea that there are now five people they can divide and

conquer instead of two, that is absurd.

That is not going to drive anybody's costs down. It hasn't driven anybody's costs down. Yes, it is a great thing that the insurance companies have to insure you, whether you have a preexisting condition or not, but that only means what is inevitable, which is their costs go up.

If you look at the profit margins of the insurance companies and compare them to the profit margin of your favorite non-profit hospital, they are losers. It is a terrible business. They're not even in the insurance business any more. They are in the business of processing claims mostly, because the employers are self insuring.

It was a brilliant move when the Obama Administration in August of 2009 realized that health care reform was in trouble and suddenly the President started giving speeches about health insurance reform.

He reminded everybody, of course, if you liked your insurance, you can keep your insurance, and if you like your doctor, you can keep your doctor, but the tone shifted, and the reason is that everybody hates their insurance company because their insurance companies are the ones that bring them the bad news, I'm not going to cover this drug, I'm not going to cover this.

The only insurance company they don't hate is your insurance company. (Laughter)

DR. RIVLIN: Haven't we learned from the exchanges that people do prefer when they get a choice and they can see what the choice is -- they are quite likely to choose the lower premium, just as they are likely to choose -- let me just finish -- Part D of Medicare.

One of the reasons going off patent was so effective is Medicare people

got to see and choose the plans that had the generic drugs in them.

MR. BRILL: Just one last point on that. What you said, I think, is very important. You said people got to see and choose the lowest premium. Arguably, the least important part of your cost when you're buying health insurance is the monthly premium.

Every study done shows people have no idea what the co-pay means, what the deductibles mean, they certainly have no idea of who is in their network or if their doctor is in their network. They have very little idea even if their hospital is in their network or even if the hospital is in the network, whether the anesthesiologist is going to be in that network.

Yes, they can see a silver plan is $190 a month versus $210 a month. This is the central premise of the notion of let's have insurance reform, let's have these exchanges. The President often said that buying health insurance is going to be just like buying a plane ticket on Travelocity.

The simple fact is there isn't a single person in this room, I could quiz anybody in this room on four different key variables of their health insurance, and none of you would be able to explain it to me.

In fact, if you went, as I did, to the CEO of UnitedHealthcare and asked him to explain an explanation of benefits that I had gotten, I handed it to him. I said could you explain this to me. He sat there and said I could sit here all day and I could never tell you what this means, I have no idea what it means. (Laughter)

MS. MOODY-WILLIAMS: That is likely true, I'm sure. However, we could stay there and lament that or we can try to find ways to move forward on that. As the conversation started with insurance, insurance carriers, and the Secretary just

announced, now we begin to look at how do we really look at the delivery system and the reform of the delivery system, and moving to various alternative payment models.

In the Innovation Center, I'm not in the Center but I do follow the work, there are a number of models that are looking at the very thing, benefit design. You're right. Many people that are in an ACO don't even know they are in an ACO, so how do you begin to get beneficiaries to attest, yes, we're in the system, we made this choice, and you provide incentives for their participation in those programs.

There was a question that came up about primary care physicians and small rural practices, and how do we support those efforts. We did announce a transforming clinical practice initiative just recently in which we are working to do peer to peer learning.

We said physicians listen to other physicians. Clinicians listen to other clinicians. These networks will help support clinicians coach and mentor and provide whatever resources that are available to their peers so there can be these learning systems and learning organizations that would move forward in transformation. We are in the process of awarding those, and we expect those will be awarded sometime this summer.

In the same token when we were talking about continuing medical education, we're looking at maintenance of certification. How do you align some of these efforts that we are doing in quality improvement with efforts that are going on in maintenance of certification so there is not you have to do this for this and this for that, but if you do this one thing, it's going to help you improve your practice as well as get your continuing education and maintenance of certification.

I wanted to touch on the efficiency. A lot if it is about waste, and some of

that, you can't regulate, mandate and legislate. You have to use techniques and tools to look at where the waste exists and how to get rid of that.

CMS, we promote that, but we also have to live that. For example, we started to look at some of our measurement programs, using lean techniques that aren't new. It took five years from a measurement inception to getting it into a program. How do we learn that out, how do we become more efficient?

When we started working with industry, we had patients in the room, we had others in the room, we were able to decrease and save 9,000 hours per year in just that process, and eliminated printing of this manual of 95,000 pages down to -- I'm not exaggerating -- down to a few.

It is those kinds of things of internalizing and then promoting and supporting reduction in waste in systems that also can help reduce costs.

DR. RIVLIN: So much of the cost of health care is concentrated in people who are very, very sick, a minority of the patient population causes a large part of the health care costs, and then the other thing that people often bring up is so much health care cost is concentrated in the last year of life.

Do you have thoughts about how we reduce those costs or make them more rational?

MS. MOODY-WILLIAMS: Much of it lies in the reduction of the fragmented system of care that exists and looking at various payment models that look at multiple chronic conditions and behavior, including incorporation of behavioral health.

We are starting to do more work in our Quality Improvement Organizations with that, looking at how to bring in the behavioral hub. Whether it be global payments or through the Accountable Care Organizations, or even in the bundled

care systems that we are looking at, for a particular area such as end stage renal disease programs, to learn what we can about how do you connect the dots, and how do you get the incentives for all those that are participating.

Our last panelist talked about the fact that in his opinion there are no incentives to be efficient or to reduce costs. What is the model that would incentivize that reduction in costs, and those are some of the things we are looking at.

DR. RIVLIN: Steve?

MR. BRILL: I just wanted to add that if you focus on those two high cost categories, one thing it is important to focus on again is the cost of prescription drugs, in particular, specialty drugs.

There is a new study I just read. I think it's the American Economic Association. There is a chart, and I'm going to get the numbers slightly wrong, where the economists and a cancer specialist at Sloan-Kettering worked on this, where they costed out based on the efficacy of the drugs, the expected number of months life is extended, and the cost of the drugs, and in essence -- this is a scary chart to read -- 10 years ago on average these drugs cost $10,000 per extra month of life. I'm oversimplifying it, but I think that is what it was. Now, it is up to 30,000 or $40,000 for the same month.

That is not because it cost them more to develop the drugs, it is because they can, and they realize they can, and they can uniquely in the United States. That is one problem.

The second issue is when it comes to bundled payments or Accountable Care Organizations, all of that is great, but the targets that CMS has announced to get more payments into those kinds of categories and away from fee for service, those are targets, and I am astonished as I read about them, and my fellow journalists don't seem

to notice that they are targets and it is voluntary.

I have sort of a basic notion about how actors act in the economy, which is they are typically not going to do something unless they can make more money.

What you might have to pay for the bundled payment at least in their equation might end up being more than what you would have to pay or what they think they were going to get on the fee for service basis, so there isn't a lot of evidence yet that all those bundled payments with the ACOs are actually saving money. They do make people more accountable. They probably improve care, which is a great thing.

My skepticism comes out of the fact that I began my life writing about lawyers in big corporate law firms. There was always this notion we have to get rid of the hourly rate, which is the classic fee for service, and we're going to do bundled payments. You do that lease for that building across the street or you do this corporate takeover, and we will give you X dollars.

The corporations and their general counsel would insist on this, and this is a perpetual new reform movement now going on for 30 years, and it never takes hold because the law firms say okay, if you want a bundled payment, how's $100,000 for that lease across the street, because who knows what the landlord is going to be like, there could be all these arguments, we may have to do this, we may have to do that. We can't predict it.

I take a lot of that with a grain of salt.

DR. RIVLIN: Did you have targets?

MR. BRILL: Sure, you can have targets, and then you have to explain why you didn't hit the target, which is a good thing. It makes it more accountable. It has never really caught on.

DR. RIVLIN: Let's throw it open to the audience for questions, and then I want to come back to our two panelists for a final word. Questions or brief comments. Here's a microphone, and tell us who you are.

QUESTIONER: I'm Stu Guterman with the Commonwealth Fund. We spent a lot of time debating what the cause is of the moderation in health spending growth, but it is not a spectator sport. It is something that policy needs to be aimed at curtailing.

MR. BRILL: For me, it's a spectator sport.

QUESTIONER: I'm going to try to draw you out of that. What do you think should be done? You have talked about what you don't think will work. What do you think would work to help control health spending?

MR. BRILL: Just as a general matter, I think we have to acknowledge that this is in no way a market. There are not consumers who go out into this marketplace with (a) knowledge, that is usually required in a marketplace, (b) any kind of leverage, or any notion they have any options, or by the way, any understanding of what it costs after they have gotten the service.

There isn't any other country in the world as far as I know that has tried the experiment that we tried, which is let's make believe this is a commodity or a consumer good like any other consumer good, and let's just have a marketplace for it.

DR. RIVLIN: "This" is health insurance?

MR. BRILL: Health care. Health insurance is just sort of a way to hedge your bets to get there.

DR. RIVLIN: What they're choosing among now is health insurance plans.

MR. BRILL: Again, health insurance plans, I would argue, are the slave of the health care providers. I don't think health insurance plans -- when someone comes up with a Hepatitis C drug and says this is great, let's charge $1,000 a pill. It tells you something about the environment in which we live in where these people didn't even say let's charge $989.60 so that people will think we thought about what the price should be. (Laughter) On their way to the men's room, they said let's just charge $1,000, that sounds good.

They charge a round fat $1,000, and there isn't anything any health insurance company can do about it except that AHIP puts out press releases attacking them but they can't say let's have price controls because you can't be a private sector lobbyist in Washington and favor price controls. It is not a market.

DR. RIVLIN: To rephrase the question, do you have a solution?

MR. BRILL: If I could go back to the 1940s, the easy solution, our panelist here would be talking about what she's doing for health care for people who are 32 years old as well as 66 years old. I don't think politically that's viable in any way, shape, or form any time soon.

I've suggested a bunch of things. One of the first things is we have to control the price of prescription drugs. Second, I think in situations where a big hospital system has consolidated and you have a city where there is an oligopoly of two or three hospital systems, or in a place like New Haven, one system, you treat it like a monopoly or oligopoly, and you control the prices, and you urge them to sell their own health insurance and cut out the middleman.

If I lived in New Haven, Connecticut, I'd rather buy my health insurance from Yale-New Haven because I know everything I'm getting, I know who is in my

network, I know who the doctors are, than from some guy at Aetna. There, you wouldn't cut out all of the 23 percent that we now pay for administrative costs, but you would probably cut that in half.

That would bring it down.

I think at some point the costs are going to continue to go up, well, they are, and they are going to go up in terms of the bite they take out of every American family, out of every employer, because now the reason this is so relevant is that the co-insurance and the co-pays and the deductibles are now really high and getting higher.

At some point, there is going to be the political environment for real reform. I don't see it yet.

DR. RIVLIN: I didn't hear what "real reform" was. Let me go on to another question.

QUESTIONER: I just wanted to comment, how about if we look at it in another way, about the pharmaceutical companies, obviously, we cannot regulate the price of a pill, but how about --

MR. BRILL: Why not?

QUESTIONER: Right now we can because of the lobbyists, of course. How about introducing other pharmaceutical companies into the country?

MR. BRILL: So hearing that, it makes a lot of sense, and indeed, that $1,000 pill's price is under pressure because now some other drug companies come up with the equivalent.

QUESTIONER: Exactly.

MR. BRILL: That often doesn't happen, and when it doesn't happen, basically a patent is a grant by the Government of a monopoly. It seems to me that when

the Government grants a monopoly to a life or death product, it is completely appropriate to put some control on what the price you can charge is for that product.

Yes, competition there will work a lot, but there are lots of situations where there just isn't the competition, and there doesn't seem to be an appetite among the large pharmaceutical companies to engage in price wars with each other.

QUESTIONER: Mr. Brill, I read all the fluff that came out with your book, and most of it was very interesting. Unfortunately, I haven't read the book. It seems to me that you conclude, and you can correct me on this, that your solution would be for medically run corporations with physicians in charge who would be able then to control the quality of care and finance issues.

At the same time, we have seen like in Pittsburgh what is going on between the University of Pittsburgh Medical Center and the Blue Cross plan --

MR. BRILL: There is a lot in the book about that; yes.

QUESTIONER: I can only tell you I was the Director of something called New Haven Health Care, which was a federally funded thing in the early 1970s to try to rationalize the system, and at that time, Saint Raphael was independent.

I can't see at all the ACO drive -- I don't understand where it came from -- to reorganize physicians into groups where they are responsible financially to one another and also the hospitals, how this is going to drive lower costs in the long run and preserve some of the best things of American medicine.

MR. BRILL: Well, the theory is that if you have a hospital system that has a lot of doctors, a lot of clinics, labs, all the rest of it, all under one roof or under one P&L, the theory is you will eliminate the incentive to over test or over treat because you basically would just be billing yourself for that.

So, it’s the ultimate bundled product in that sense. In other words, I give Yale-New Haven $10,000 a year as my health insurer, and I say okay, you keep me healthy with your hospitals and your doctors, I like your brand, you keep me healthy, no questions asked.

What I suggest in the book is that might be where we have to fall back, since we are not going to get the kind of reform I guess I suggested, which is if we could go back and rewrite history, we would do what every other country does, which is have a single payer. I don’t think we are going to get there.

This to me is the fall back alternative provided that monopoly is regulated heavily, has ombudsmen there, so after I give them my $10,000, they can’t skimp on my health care the way we often think our insurance companies are trying to do.

That is an important caveat, and since the book came out, lots of people have been critical saying that is just way too naïve, you will never get that kind of regulation because just look at the history of regulation in health care up to this point, and I think that is a pretty valid piece of skepticism about that idea.

DR. RIVLIN: Jean, do you want to speak to ACOs?

MS. MOODY-WILLIAMS: Obviously, we are testing a number of models with ACOs and looking at the management of the population within, and just as was stated, looking at how do you deliver care in a coordinated approach, whether it be working with the home health agency or the community health center, however it is that you are going to be able to deliver what that patient needs.

Our Pioneer models, which we just announced, the request for applications is out, where we are increasing risk and the sharing of the savings, increasing those savings that are going to be available, to put some teeth into the model,

so there is an incentive to improve care on behalf of the patients and the families.

We also need to engage patients and families so they can ask the right questions, they can begin to understand what they are getting and what they are not getting. I think we are a really long way from that.

At CMS, we are starting to really work with patients and families. We bring them into policy meetings. We hardly ever have a conference where we don't have families there with us as we come up with policy decisions.

Monopoly aside, the approach we are taking is CMS is going to lead this way in this model. We have announced the goal for alternative payment arrangements. We are working with the other payers or stakeholders or people that can influence the direction of care, so there is some consensus or forward movement by more than just one payer, by multiple payers, so that you can get some inertia moving in that direction.

MR. BRILL: Let me just emphasize one thing. When we talk about cost control, the political reality is that the cost control in this case means taking what is typically the most vibrant, healthy, profitable, largest employer in most of the cities and towns across the country and cutting into their jobs and their incomes. That is a difficult thing to do politically.

If you don't like the idea that one-sixth of the GDP is going to health care and you want to make it one-seventh of the GDP, that means hundreds of thousands of jobs you are going to kill in health care.

We can use euphemisms like more efficient, more cost effective, cutting out waste, but you will be killing jobs. I think we have to acknowledge that if for no other reason than to acknowledge the political fact of life of how difficult that is going to be.

When Medicare announces the slightly reform on payment to hospitals,

you get stories in local newspapers all across the country, this is not only going to hurt patients, which it is not, but it is going to kill jobs, which it may in certain situations.

MS. MOODY-WILLIAMS: There are communities in the country, accountable communities or whatever, that are looking at the data and saying okay, if we don't spend this on health care, where might we redirect those resources.

MR. BRILL: Tell that to the MRI operator in a hospital who gets laid off because we give MRIs at three times the rate per capita as any other country in the world, tell that to that person.

DR. RIVLIN: One of the real worries about an expanding health care sector is that it squeezes out other things that we need for a more rapidly growing economy.

MR. BRILL: Exactly. Look at Pittsburgh. The University of Pittsburgh Medical Center, by far the largest employer in Pennsylvania, occupies the U.S. Steel Tower in Pittsburgh. In fact, it dominates employment in Western Pennsylvania more than U.S. Steel ever did, yet it is really hard to export what they do out of Western Pennsylvania.

DR. RIVLIN: It is sometimes mystifying why the U.S. economy is doing so much better than other economies around the world but actually they are. Another question?

QUESTIONER: This isn't actually a question. When people get to talking about cutting health care spending, I can't help but point out that if we succeeded in holding health spending growth to the same growth as GDP over the next 10 years, we're talking about spending 40 percent more on health care 10 years from now than we do now.

Only in health care would that be looked at as a shrinking pie. I think there are a lot of industries in the U.S. that would sign that contract right now.

We're really talking about a system where we are looking at spending 35 to $40 trillion over the next 10 years on health care, and instead, we are trying to get to where we are spending 30 to $35 trillion on health care.

MR. BRILL: Yes, if you ask any experts, such as Peter Orszag or Director Rivlin or anyone, they will tell you that we are wasting $600 billion to $1 trillion of that every year. For example, we spend $88 billion a year on back pain in this country. That is more than we spend on every state, city, town, local law enforcement agency combined. You ask any doctor who knows anything about back pain; they will tell you that half of it is wasted money.

QUESTIONER: We would consider ourselves tremendously successful if we just held that system growth to a level of 40 percent over the next 10 years. That MRI operator probably isn't going to be laid off. Those cardiac surgeons aren't going to be on street corners selling pencils. They are going to be doing cardiac surgery. They are going to be doing better hopefully cardiac surgery and more appropriate cardiac surgery than they are now.

It seems to me it shouldn't be that hard to decide how to spend 30 to $35 trillion to get the kind of health care Americans want.

DR. RIVLIN: That's a good point. No way are we going to see massive layoffs in a system where the population is aging so rapidly and health care is improving. The objective has got to be to hold the growth of the total spending to something like the growth of the economy, which is going to require some efficiencies in a lot of the things we are doing to work better.

Let me give each of you a very brief moment to say what point would you like to make that you haven't made already or what do you think is the most important thing this audience should take away from this session. Jean?

MS. MOODY-WILLIAMS: I think the point is there is no magic answer and it is going to take everyone in this room and beyond to really look at the complexities of the system, but there are things that are underway that are working, that we need to learn from.

Getting back to the point of does anything in Government ever go away. There are models that are not working, and we are not recommending necessarily that they continue. We have to be bold enough to do that. Those things that are working, learn from them and spread them.

DR. RIVLIN: Steve, very briefly.

MR. BRILL: Just one point I should have made before, which is what I found is that the only people who haven't been riding the health care gravy train through all of this, with some exceptions, are the nurses and the doctors who actually provide the care.

There was some comment before about the SGR, the permanent fix. What I found and what I report in the book is that part of Obamacare, until the very end, was a permanent doc fix, as they called it. Sort of at the last minute or the last month or two, suddenly the Democrats in the Senate, Senator Baucus' staff and the people on President Obama's staff, they threw the doctors overboard. The reason is the CBO score on the permanent fix was $170 billion or $200 billion over the 10 year period, and they suddenly needed that money.

They said to the doctors, to the AMA, don't worry, we are just going to do

it in a separate bill and it won't be scored against the Affordable Care Act, but we are going to do it immediately in a separate bill, which of course, they never did, and they never could do. It was a promise they couldn't keep.

What that really drove home to me was how the doctors, the AMA, had lost so much influence because if you go back to the Truman years, when President Truman was fighting for national health care, the AMA singlehandedly sunk it and singlehandedly stopped any reforms in the Nixon Administration and beyond.

Now, the doctors are basically bystanders to the device industry and to PHARMA and everybody else, so much so that they could simply be told. They weren't even called and called in, they just heard about it, oh, yeah, we had to throw you overboard, sorry, we'll fix it in another law.

DR. RIVLIN: We do have a free standing bill being argued on the Hill even as we speak. Hope for the best.

MR. BRILL: A few years later.

DR. RIVLIN: Democracy is a time consuming process.

(Laughter)

MR. BRILL: Exactly.

DR. RIVLIN: Thank you for being here, and join me in thanking our panelists. Darrell, did you want to have a final word?

MR. WEST: No.

DR. RIVLIN: Okay. I get the final word. I think it has been very stimulating. (Applause)

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