

NATIONAL
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OF SOCIAL
INSURANCE

For the Common Good: What Role for Social Insurance?
NASI's 19th Annual Conference

Session IV: American Health Coverage at a Crossroads

Friday, February 2, 2007

This session convened at 10:45 AM in the Ballroom of the National Press Club, 529 14th Street, NW, Washington, DC.

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Introductions

Kathleen Buto, Vice President for Health Policy and Government Affairs,
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KATHLEEN BUTO: If everybody can just take their seats, please. We're going to try to move right along because we want to leave plenty of time for questions for this panel. And some of the panelists have told me they're going to take a longer than we thought, so we really want to maximize their contributions and your opportunity for questions. So let me welcome you to the fourth session of this conference. It's "American Health Coverage at a Crossroads." And I don't have to tell this group that with 47 million uninsured, how important it is to look at this whole set of issues with fresh eyes and with an understanding of the issues.

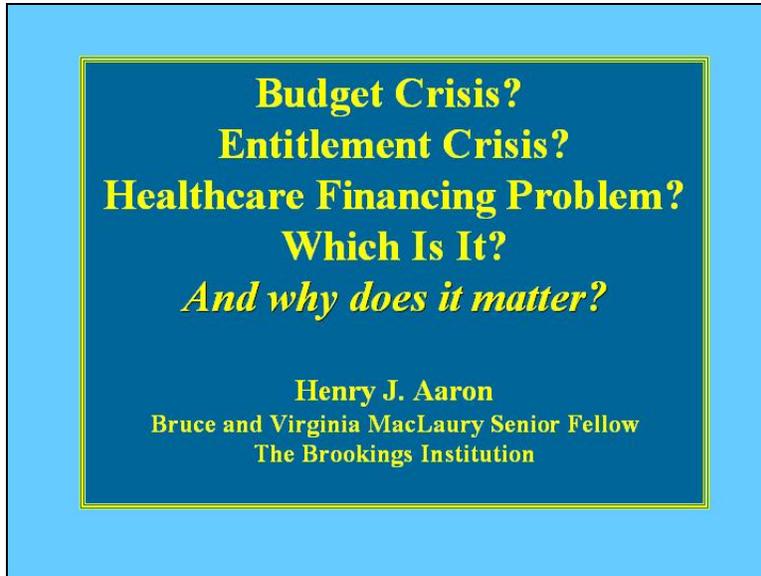
So this session is going to focus on how the U.S. can address our significant healthcare coverage challenges, which would seem to be intractable, but on the other hand there appears to be new energy behind doing something about them. We're going to look at best ways to engage both the government and market forces in addressing the issues, the financing questions and the policy issues that really attempt addressing coverage of the uninsured.

I'm going to introduce all of our distinguished panel members very briefly. You have their longer bios in your books, and you know many of them, so brief is probably all you need. Henry Aaron, a senior fellow at the Economic Studies Program at the Brookings Institution and I think all of you know Henry very well, a great contributor to NASI. Tom Rice is professor in the Department of Health Services and currently serves as Vice Chancellor for Academic Personnel at UCLA. Joe Antos is the Wilson H. Taylor Scholar in Healthcare and Retirement Policy at the American Enterprise Institute, an adjunct professor in the School of Public Health at the University of North Carolina, Chapel Hill. Mollyann Brodie is Vice President and Director of Public Opinion and Media Research at the Kaiser Family Foundation, and Maria Ghazal is Director of Public Policy for the Business Roundtable.

Following the presentations, we are going to have about 30 minutes for audience questions, but I'd ask that you give each panelist an opportunity to make presentation first. And with that, I'm going to turn the podium over to Henry.

**Budget Crisis, Entitlement Crisis or Healthcare Financing Problem:
Which Is It? And, Why Does it Matter?**

Henry Aaron, Senior Fellow in Economic Studies, The Brookings Institution



MR. AARON: I regret that I've become a slave to PowerPoints. (Laughter.) He just commented that the machine had gone to sleep; I hope that you will not. (Laughter.)

That last talk was rather a tough act to follow, I must say. My comments today are addressed primarily to those among us who are interested in long-term budget questions, who focus on the looming deficits that are widely forecast for the federal government. My purpose today is very simple: I want to argue that we have been presenting that issue in exactly the wrong way and that we have to change the way in which we present that issue if we want to have a constructive national dialogue on that problem.

A consensus has emerged...

- The baby boom will soon be retiring
- Pension and health benefits will grow much faster than the tax base

Therefore, it will be necessary to

**...cut aid to the aged, disabled, and poor;
...reduce all other public spending;
...raise taxes;
...or do some combination of all three**

As you probably know, a consensus has emerged in this nation around certain basic facts. The facts are that the baby boomers are coming. They are going to be retiring. Pension and health benefits are going to boom and become unaffordable. The implication is that the United States must therefore deal with a wide range of budget questions, that we must consider cuts in virtually every federal government expenditure, and increases in virtually every federal tax as well.

I think that this final inference is incorrect and that instead we should frame the issue differently. What the United States must do is reform its overall healthcare financing system, public and private. If it does so, there is no remaining long-term budget problem. What I want to do with my few minutes today is to try and persuade you that if we tackle the healthcare financing problem, public and private, in a sensible way and deal with it, that there is in fact no long-term budget problem.

Simply put, our nation's fiscal policy is on an unsustainable course. ...[B]udget simulations ... show [that] over the long term we face a large and growing structural deficit due primarily to known demographic trends and rising health care costs. ... Nothing less than a fundamental reexamination of all major existing spending and tax policies...is needed

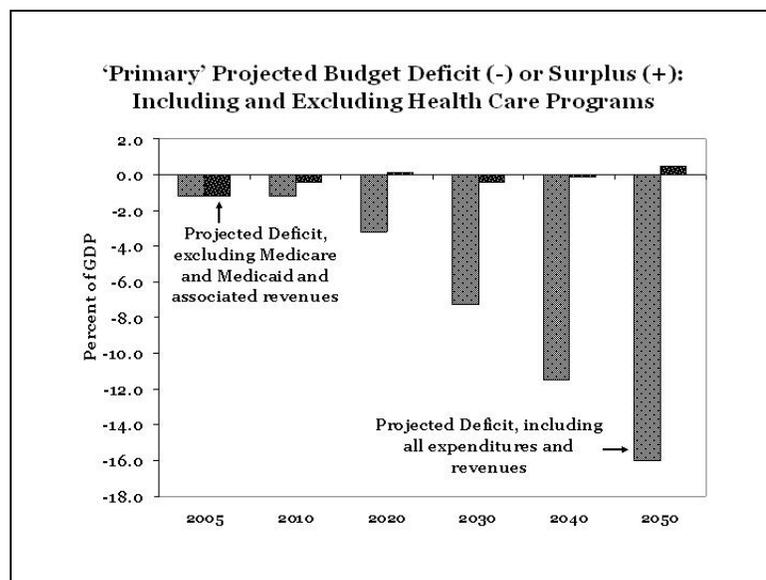
**David Walker,
Director, Government Accountability Office**

To start with, though, I'd like to give you an example of the consensus that I described. Here's a quotation direct from the comptroller general, the head of the Government Accountability Office, David Walker. This comment, I want to stress, is not unique. Similar statements can be found in the press and even in academic writings.

Such commentaries share three features...

- They characterize solely a *public* problem, not a private one
- None acknowledges that *private and public* health care spending are tightly linked
- None recognizes that if the health care problem is addressed responsibly, there is no *long-term* fiscal problem

These statements have three features in common. First, they always characterize a public problem, not a private one. Second, none of them acknowledges that private and public healthcare spending are tightly linked and that slowing the growth of public healthcare spending without reining in private healthcare spending as well, or alternatively abandoning our commitments to the elderly, disabled, and poor, is impossible. And finally, most importantly, none recognizes that if the healthcare problem is addressed responsibly the long-term budget problem goes away.



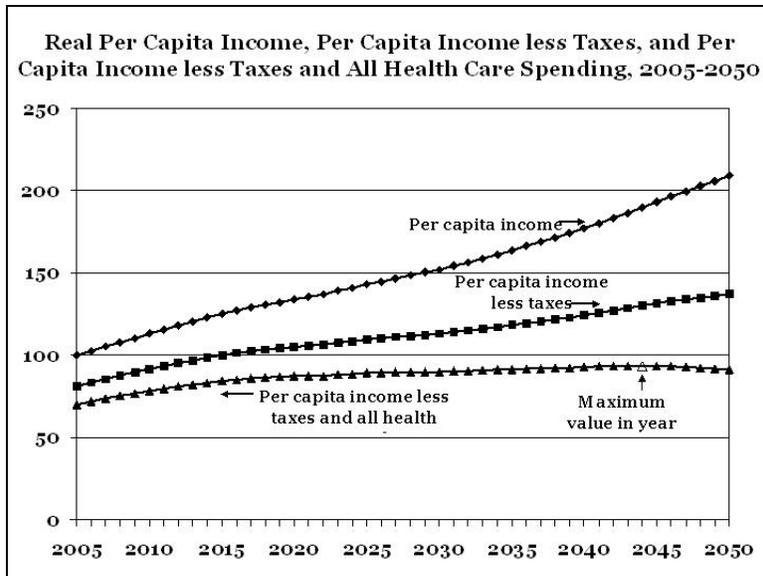
So let's turn to the numbers. This chart is not my work. It is simply a graphical representation of the report of the Congressional Budget Office on long-term budget prospects. Those big vertical bars that jut out downwards are the projected long-term deficits as estimated by the Congressional Budget Office under the assumption that healthcare spending continues to grow faster than income by 2.5 percentage points a year --a large number, but actually a little bit smaller than the actual excess of healthcare spending over income growth over the last 45 years. If one subtracts from the expenditure side, all spending on Medicare and Medicaid and if one subtracts from the revenue side, the payroll taxes, the earmarked income taxes, premiums and general revenue support at the same share of GDP as is presently devoted to those two programs, you get the little tiny bars that bump along the zero line. There is, based on CBO's long-term budget projections, no long-term deficits apart from the additional impact of Medicare and Medicaid on the general budget.



Three ways to close the fiscal gap

- **increase taxes to finance government**
- **curtail Medicare and Medicaid benefits**
(there isn't enough in rest-of-government to solve the problem)
- **health system reform**

Now, there are three ways to close that fiscal gap. One is to increase taxes for the general government. Second is to curtail spending on Medicare and Medicaid. The simple fact is there isn't enough left over in the rest of what government is doing to deal with deficits of the magnitude shown in that previous chart. The third option is to reform the overall healthcare system. That would entail both spending controls and additional earmarked taxes, but most importantly it would encompass both the private and the public sectors.



Now, make no mistake, projected budget deficits pose a vital challenge. It is, not one that we can avoid – we must address these issues. The point here is that the tax approach – tax our way out of these deficits –cannot work and here’s why. If one allows healthcare spending to grow and simply raises taxes to pay for it, there will be no economic growth left over for anything else. The top line of this chart shows per capita GDP as projected by the Congressional Budget Office. Again, I’m relying on CBO. The middle line shows the growth in per capita GDP net of all the taxes necessary to sustain currently projected federal outlays under current policy. That still shows a fair bit of growth. But then the bottom line shows the trend of GDP net of taxes and net of the increase in private healthcare spending as well: growth stops cold. You be the judge of the politics of asking the public to pay added taxes that have the effect of eliminating all income growth to sustain general government.

You know the line? “I’m here from the government. I’m asking you to pay higher taxes– to help them.” I just don’t think that that line of argument is likely to be very fruitful.

The cut Medicaid and Medicare strategy won't work

Medicaid is already thin in many states

Seven states limits doctors visits to 12 a year

Five states cover 4 or fewer prescriptions a month

Wisconsin limits substance abuse services to 15 hours a year

Medicaid patients have negligible capacity to pay cost sharing

Medicare can be cut in some places, but needs 'beefing up' in others

Hospital deductible is higher than in most private insurance

Negligible nursing home coverage

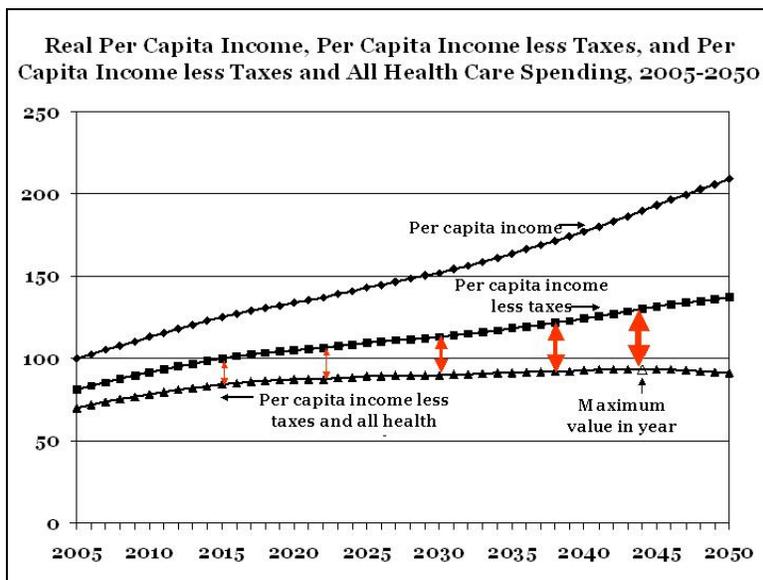
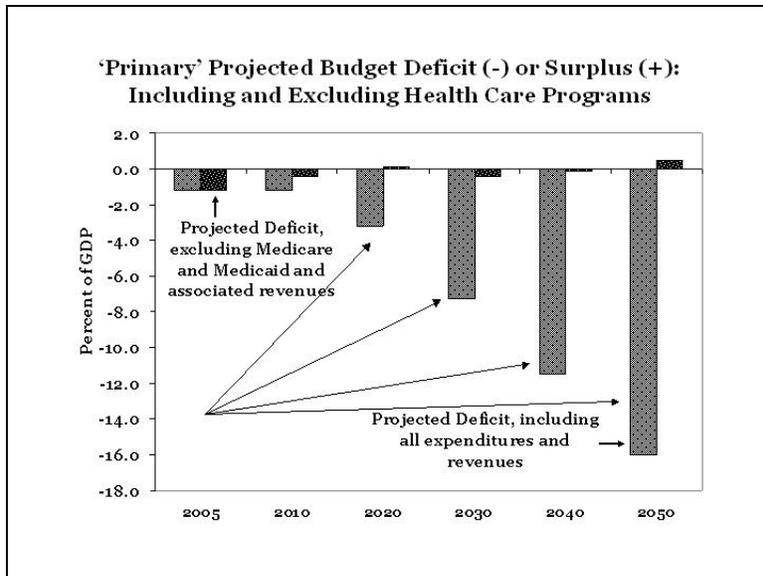
Drug plan problems: donut hole; liability for nonformulary drugs is unlimited

No stop-loss protection; total liability is unlimited

Increased cost sharing *is* possible for some beneficiaries, but median income of those over age 65 was **\$15,696 in 2005**

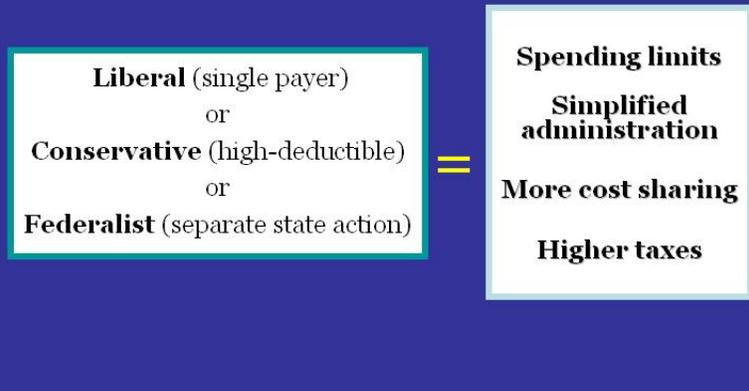
Well, let's turn to the second strategy, – the cut Medicare and Medicaid strategy. The cut Medicare and Medicaid strategy just can't conceivably close the gap. Let's start with Medicaid. Asking Medicaid recipients to pay significant costs– deductibles, cost-sharing– would, in all candor, convert the program into a sham, for the simple reason that Medicaid recipients do not, by definition of their eligibility, have the means to pay significant charges for those benefits.

Well, what about Medicare? Medicare has a lot of inadequacies at present: the lack of catastrophic coverage; the high Part A deductible; the donut hole– which isn't quite as bad as many of us thought it would be, but is no prize to be treasured either– the lack of nursing home coverage for stays except immediately after a hospitalization. If we take care of those problems, any of the savings that we could generate from other sources are likely to be substantially – perhaps not entirely – but significantly offset. That means that any net saving from program cuts to Medicaid and Medicare are likely to be quite small.



So we come to general healthcare system reform. I'm back to this chart again and the reason for that is that we are not going to solve these very large public deficits by nickeling and diming Medicare and Medicaid. The increases in spending under current law are very large indeed. Furthermore, cutting Medicare and Medicaid will do nothing to reduce the problem depicted in this chart; decreases in Medicare and Medicaid will simply switch substantial portion of those costs to the private sector and the squeeze will be nearly as serious as it would have been if we had relied on tax finance methods to deal with this portion of healthcare spending.

That leaves health **system** reform...



So that leaves health system reform. We all have our favorite ways of achieving that objectives, but whatever strategy we may adopt, it is clear that if we reform the healthcare system in a way that balances the budget, we're going have to do a bunch of things. We're going to have to limit spending. We should simplify administration. We will impose more direct charges on the patients who can afford them. And we are going to have to raise taxes to pay for the subsidies that are going to be necessary to assure coverage to low-income households whichever of the three strategies – liberal, conservative or federalist – we adopt.

Which debate would you rather have?

-
- The diagram shows two blue boxes with red borders, separated by the word "or". The left box contains a list of four points: > We need to cut pensions and health care for the elderly, disabled, and poor. > We need to cut other government spending. > We need to raise taxes to support what is left. > Let's decide how much of each? The right box contains a list of three points: > All Americans want, and should have, affordable health care > Reforming health care will close the long-term budget gap **entirely** > Additional taxes will be necessary; how much depends on how much cost control we are prepared to accept.

So that brings me to the end of my sermon. Shifting the debate from how to close the deficit to how to reform healthcare has several key advantages. First of all, it does not ask a skeptical public to raise taxes to support general government, but rather to pay for something that everybody really wants, which is secure access to affordable

healthcare. Secondly, it does not threaten to shred the social compact so laboriously negotiated a generation ago to sustain for the elderly, disabled, and poor access to healthcare that is roughly the same as that available to the rest of the population.

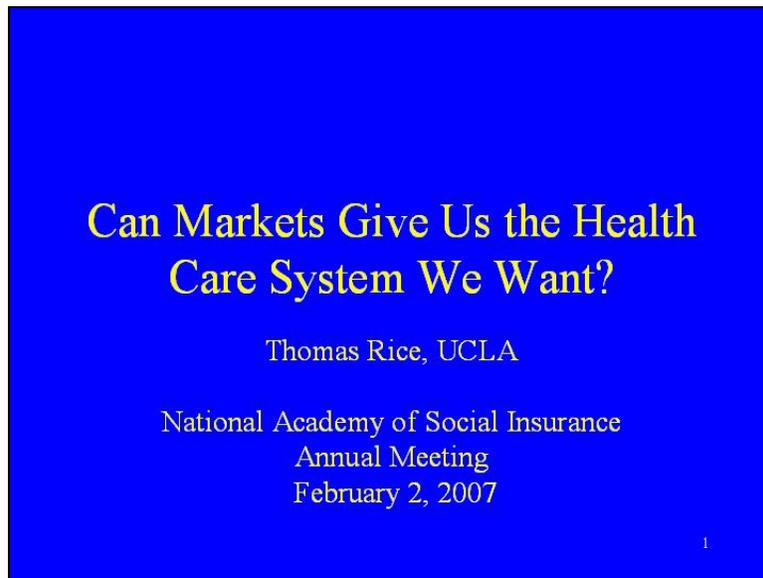
And finally, it is honest, because it focuses on the real source of the long-term budget problem – rising per capita cost of healthcare. It puts the choice honestly to the American public. You're going to have to accept some limits on healthcare spending or you're going to have to pay for it. But there is no free lunch. Debate how you want to pay for healthcare. Let's move on with the job. If we do that job, we will have taken care of 100 percent of the long-term budget problem.

Thank you. (Applause.)

MS. BUTO: Thank you.

Can Markets Give Us the Health Care System We Want?

Thomas Rice, Professor of Health Services, UCLA



THOMAS RICE: Thanks very much. I'm really delighted to be here on this panel with so many distinguished and provocative thinkers and talk with you about, "Can Markets Give Us the Healthcare System We Want?"

I'm on a faculty of a school of public health, and when we think of outcomes, we think of three: cost, access and quality. And that's really different than what I was trained as as an economist, which the focus was entirely on utility. And I'm going to return to utility in a minute because it's very important. As you know, economics is much more interested in efficiency than equity and generally it espouses the view that except in cases of severe market failure, we should have the government butt out and only butt back in when we produce the most output with the fewest inputs and then somehow redistribute it through a system of subsidies and taxes. And I think economists' focus really leads to a mindset that what people want is more stuff, and I very much believe that markets do allow people to have more stuff, but it doesn't necessarily make people much better off. And that's probably true in healthcare as well. We have more stuff than any other country, but our outcomes aren't so good and people are pretty unsatisfied with our system.

So why is it that the extra stuff that markets bring us doesn't necessarily increase utility as I learned in graduate school? It's perhaps because utility tend to be determined not by what you have, but by what others have, as illustrated here.



Can you all read that? (Laughter.) So the value to me of my new Humvee or maybe even my new Prius plummets when my next door neighbor buys one, too. So let's focus for a moment on our outcomes of controlling cost and increasing quality as efficiency and access is equity.

$$D = f(\text{prices, incomes, tastes})$$

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So what are the traditional economic tools for dealing with this? So I wanted to begin with a simple demand function of prices, income and taste. And what's noteworthy, I think, is that economics has eschewed the last of these terms because it tends to assume that tastes are both exogenous and in some sense sacrosanct.

“Tastes neither change capriciously nor differ importantly between people... [O]ne does not argue over tastes for the same reason that one does not argue over the Rocky Mountains - both are there, will be there next year, too, and are the same for all men.”

-- Stigler & Becker, 1977

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Here's a quote that I think is particularly telling by Nobel Laureates George Stigler and Gary Becker: “Tastes neither change capriciously nor differ importantly between people. One doesn't argue over taste for the same reason one doesn't argue over the Rocky Mountains. Both are there, will be there next year, and are the same for all men.” Now, what I find uniquely insidious is when they try to make the case that tastes don't even enter the equation.

“The economist continues to search for differences in prices or incomes to explain any differences or changes in behavior”

-- Stigler & Becker, 1977

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And they also wrote this: “The economist continues to search for differences in prices or incomes to explain any differences in changes in behavior.” Anyway, this is just a way to have economists take over the study of social science and human behavior from everyone else. (Laughter.)



In this respect, I've been encouraged by the growth of behavior of economics which just focus on some of the social sciences like social psychology and it gives me an excuse to show you my one psychology cartoon here. (Laughter.)

Resurgence of Interest in Higher Patient Cost Sharing

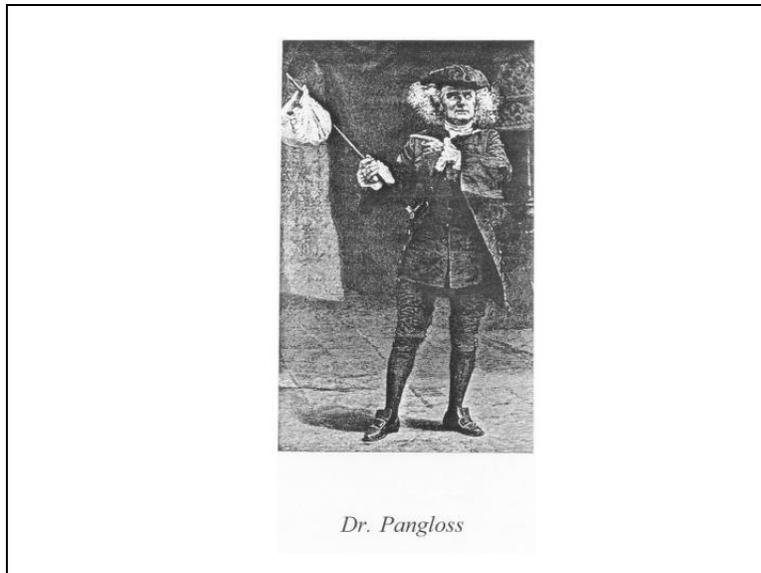
- Copayments and coinsurance rising in employer-sponsored health plans
- Renewed interest in high-deductible products like health savings accounts and consumer-directed health care
- Structure of the Medicare drug benefit

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So there are really two aspects to prices: the price itself and improving people's information so they understand what the prices in the marketplace mean. This is just where policy is going in United States. On the price side, we're seeing a resurgent interest in basically making people pay more: co-payments and co-insurance are way up, interest in high deductible plans like HSAs and the structure of the new Medicare benefit with the big donut hole. So what's my problem with this? What's the problem with giving consumers more sovereignty, increasing the choice set, then making them bear the

true cost of the medical decisions they make? I think it comes down to how much stock one puts on demand being a barometer of utility.

For over 50 years now, we've relied on this concept of revealed preference, which basically says whatever people buy in the marketplace is what's best for them or they would have bought something else. And the price is there for give them the signal, then they make the best choices and Paul Samuelson's given credit for this theory, but I think it can be dated by a couple of hundred years to this economic philosopher.



You remember Dr. Pangloss and in “Candide.”

Dr. Pangloss on “Revealed Preferences”

“It is demonstrated that things cannot be otherwise: for, since everything was made for a purpose, everything is necessarily for the best purpose. Note that noses were made to wear spectacles; we therefore have spectacles. Legs were clearly devised to wear breeches, and we have breeches... And since pigs were made to be eaten, we have pork all year round. Therefore, those who have maintained that all is well have been talking nonsense: they should have maintained that all is for the best.”

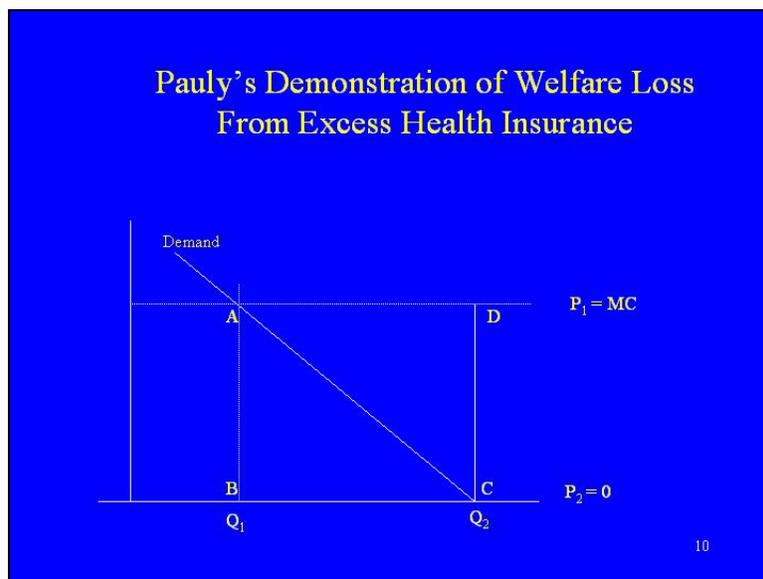
-- Voltaire, 1759

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He said this: “It’s demonstrated that things cannot be otherwise for since everything was made for a purpose, everything is necessarily for the best purpose. Note

that noses were made to wear spectacles, therefore we have spectacles. (Laughter.) Legs were clearly devised to wear breeches and we have breeches, and since pigs were made to be eaten, we have pork all year round. Therefore, those have been maintained that all is for the best have been talking nonsense. They should have maintained that all is well, then talking nonsense.” They should have maintained that all is for the best. And this, to me, encapsulates revealed preference in modern economics.

The two most famous articles written in my field, written about 40 years ago in the AER by Kenneth Arrow, and then a response by Mark Pauley, one of the things that Arrow said is that if there’s not a market for insurance, government should start one to increase utility, but Pauley said that this isn’t necessarily the case because of moral hazard.



And many of you’ve seen this argument and it goes like this: the prices are on the right here. So assume that there’s no insurance, price is P_1 and people demand, Q_1 at Point A, and now assume we give people full insurance, price goes down to zero, they demand Q_2 at Point C. So what we see is that there’s an increase from Q_1 to Q_2 and the total cost of providing that if marginal costs are flat at P_1 is the big rectangle ABCD. But if demand curve shows utility, then the benefits they’re getting is the area under the demand curve, which is the bottom triangle ABC and ACD, the upper triangle, is the welfare loss. And the interesting here is society may best off when there’s no insurance. That’s the way to decrease welfare loss.

Now, I’m very aware that part of the theory people do get utility from begin insured, but when people have done empirical studies of this using the RAND Health Insurance Experiment, they found that this is trivial empirically. So what’s my problem with all these? It’s basically that people don’t have the information to weigh the cost and benefits of the information, and if they can’t, the demand curve doesn’t represent utility, it represents something else.

“We are skeptical that the observed demand can be interpreted as reflecting ‘socially efficient’ consumption, [so] we interpret the demand curve in a more limited way, as an empirical relationship between the degree of cost sharing and the quantity of use demanded by the patient.”

-- Ellis & McGuire, 1993

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It’s basically what people are buying and two health economists way more mainstream than me, Tom McGuire and Randy Ellis actually agree with this and they put it this way: “We’re skeptical that the deserved demand can be interpreted as reflecting socially efficient consumption, so we interpreted the demand curve in a more limited way as an empirical relationship between the degree of cost-sharing and the quantity of the use demanded by the patient.” And in fact the most important experiment we’ve done on the RAND Health Insurance Experiment found that when people paid more, they used less, but they used less of everything. It wasn’t less of the things that we thought made them better off. It was what we called meat-axe approach to policy.

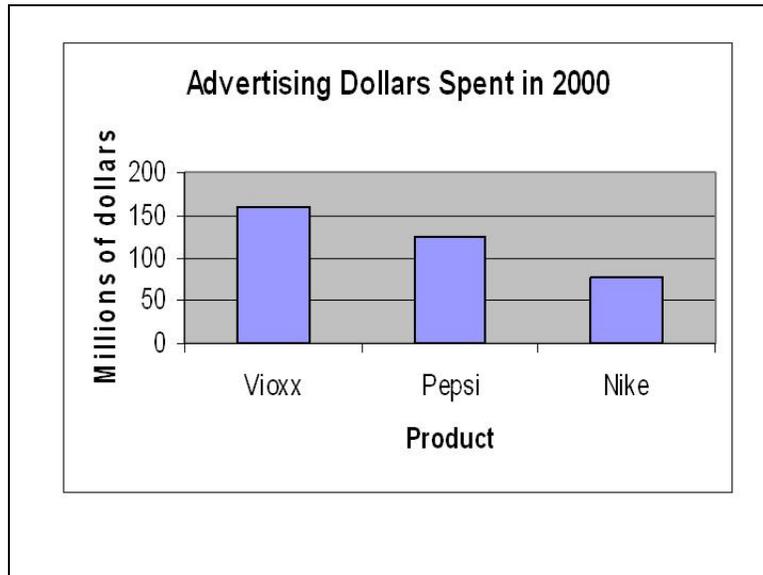
Consumer Sovereignty Implies...

- People would be better off having less health insurance, or none at all
- Copayments should be higher for price-sensitive services like prevention and mental health care
- The U.S. health care system is, by definition, more efficient than in other countries simply because we charge people more, minimizing welfare loss
- Direct-to-Consumer advertising of prescription drugs is better for society

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So but if you really believe that consumer sovereignty is the way to go, you should also believe these things. People would be better off having less health insurance or no health insurance at all, that co-payment should be higher for more price sensitive

services like prevention in mental healthcare if you do the geometry you'll see that that reduces the welfare loss triangle.



The U.S. healthcare system – you should be proud – is the most efficient in the world by definition because we have the highest co-payments, and the directed consumer advertising is better for society. Here's one of my favorite slides. I know it's true because I found it on the internet. (Laughter.)

“addictions, even strong ones, are usually rational in the sense of involving forward-looking maximization with stable preferences” [and that even though unhappy people often become addicted] “they would be even more unhappy if they were prevented from consuming the addictive goods.”

-- Becker and Murphy, 1988

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So, I'm skeptical. Now, here's my favorite quote by Gary Becker. I'd only mention this one. “Addictions, even strong ones are usually rational in the sense of involving forward-looking maximization with stable preferences, and that even though unhappy people often become addicted, they would be even more unhappy if they were prevented from consuming the addictive goods.” This is just simple micro – I don't

know what your problem would be with it. (Laughter.) Now, my problem is that I have doubts about consumers' ability to make decisions in healthcare that are on their own best interest given what we're throwing at them.

What's so difficult about the information that we have in healthcare, I think that the problem is the counterfactual. What would have been different? How would you have acted if, you know, if history were different? It's hard to learn from other people's experience in healthcare. It's hard to learn from your own experiences, too. Should you have not treated a problem, gone to a specialist rather than a generalist, chosen a cheaper health insurance plan? These are the things you never really know that you've got right. Now, there've been efforts for decades now to make consumers more aware of healthcare prices and quality, and it seems to be actually working with regard to price. People are very price-sensitive with regard to purchasing health insurance. I don't think it's working very well with regard to quality. Consumers still don't seem to be choosing plans based on the quality information that we're giving despite of the massive efforts we've put into putting together as good healthcare report card probably as can be put together.

“An economy can be [Pareto] optimal ... even when some people are rolling in luxury and others are near starvation as long as the starvers cannot be made better off without cutting into the pleasures of the rich. If preventing the burning of Rome would have made Emperor Nero feel worse off, then letting him burn Rome would have been Pareto-optimal. In short, a society or an economy can be Pareto-optimal and still be perfectly disgusting.”

-- Sen, 1970

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Now, up to now I've been focusing on efficiency and I would feel remiss in a group like this if I didn't mention equity at least briefly. Now, just a reminder – probably some of you don't need – from a Nobel Laureate I actually agree with, Amartya Sen. “An economy can be pareto-optimal even when some people are rolling in luxury and others are near starvation as long as the starvers cannot be made better off without cutting into the pleasures of the rich. If preventing the burning of Rome would have made Emperor Nero feel worse off, then letting him burn Rome would have been pareto-optimal. In short, a society or an economy that can be pareto-optimal and still be perfectly disgusting.” (Laughter.)

Now, one of the things that worries me about the movement towards consumer-directed healthcare, whatever its promise or pitfalls, is they'll make things worst off from

an equity standpoint, and this is true because the poor people who happen to be sicker will pay more of the resources. It's very regressive.

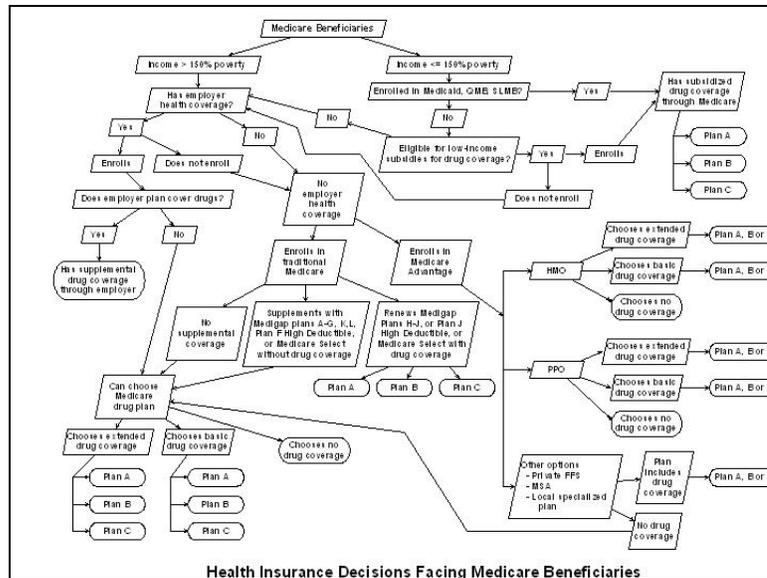
“People pay taxes in rough proportion to their incomes, and use health care in rough proportion to their health status or need for care. The relationships are not exact, but in general sicker people use more health care, and richer people pay more taxes. It follows that when health care is paid for from taxes, people with higher incomes pay a larger share of the total cost; when it is paid for by the users, sick people pay a larger share... Whether one is a gainer or loser, then, depends upon where one is located in the distribution of both income ... and health.... In general, a shift to more user fee financing redistributes net income ... from lower to higher income people, and from sicker to healthier people. The wealthy and healthy gain, the poor and sick lose.”

-- Robert Evans

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And the last quote I have is the longest one. I apologize for that, but it's the most important one so I did want to read you this one. It's from Canadian health economist Robert Evans: “People pay taxes in rough proportion to their incomes and use healthcare in rough proportion of their health status are need for care. The relationships aren't exact, but in general sicker people use more healthcare and richer people pay more taxes. It follows then when healthcare is paid for from taxes, people of higher incomes pay a larger share of the total cost; when it's paid for by users, sicker people pay a larger share. Whether one's a gainer or loser then depends upon where one's located in the distribution of both income and health. In general, a shift to more user-free financing redistributes net income from lower to higher income people and from sicker to healthier people. The wealthy and healthy gain and the poor and sick lose and that's just where we've been going in healthcare policy.”

Let me just end with a few words about the new Medicare drug benefit and then some lessons for healthcare reform. Joe Antos, one of our panelists, wrote a couple of really very nice pieces about this in – one in AEI and one to Healthcare Finance Review – which basically said, let's give the program a chance. He wrote that the long-term performance of the drug benefit will depend on whether competing – (audio break, tape change) – are younger people who have employer based coverage.



In an article that Yaniv Hanoch and I recently wrote for the Milbank Quarterly, we illustrated what seniors are going through for the Medicare coverage now under part D and also their choice of Medigap and other supplemental insurance. Hey, it came out pretty well. (Laughter.) And now this is really quite a simplification, because – (laughter) – I’m only showing you three plans, A, B and C and in Los Angeles County where I live, there were 85 plans last year, more this year. And it’s also a simplification, because this acts like the benefits are standardized, it just shows basic and extended benefits, but because of the actuary equivalence in the legislation, there is actually a range of the benefits.

And so it’s way more complicated. This is what we’re putting our seniors through. It’s not like private insurance where the employee benefit manager does the winnowing down for the employee. And what I’d like to see Medicare consider is offering a few of these many plans that it thinks the best, just as employee benefit managers do that for their employees. And I’m not alone in this. In November, the Kaiser Family Foundation asked a question like this – and my great thanks to Molly for helping tailor this question and get on the survey. It found that 60 percent of seniors felt the same way. They would like to see Medicare winnow down the choices and only 30 percent felt that seniors like themselves should have available all the comers who want to enter the marketplace.



Let me just end with a few comments on healthcare reform. I'm not satisfied with any healthcare reform proposal and I haven't come with any myself, so I'm not criticizing, but I'm not exactly sure where we should go. But proposals focusing on market forces have been invoked for a while and I want to stress that, like James Thurber before me, I do see a place for competition. If you don't see, it's the aggressive homeless talking to the sheepish man, as in most Thurber cartoons.

Tentative "Lessons" for Health Care Reform

- Coverage should be universal, and financed primarily from public sources or government-ensured social insurance using progressive revenue sources
- Delivery of services can be carried out privately under the oversight of government, which acts as a purchaser of services
- Emphasis should be placed on containing costs through supply-side rather than demand-side methods

19

Just a few lessons for healthcare reform that I've written elsewhere: coverage should be universal, financed primarily from public sources or government insured social insurance through progressive revenues, delivery can be carried out privately under the oversight of government which acts as a purchaser of services, so there your competition falls in. I think we should place emphasis on containing cost through supply side rather than demand side methods like most of the countries do.

“Lessons” Continued

- Patient cost-sharing requirements should be reasonably low
- Payments to providers should be coordinated among payers
- Government should proceed with caution in providing consumers a choice of insurer
- Fee-for-service payment should be re-evaluated

20

The patient cost sharing requirement should be reasonably low, that payments to providers should be coordinated among payers – as many countries do – and the government should proceed with caution in providing the consumers a choice of insurers; something we do, but very few other countries do. And finally, I happen to think that fee for service payment should be reevaluated, but I’ve been in HMOs all my life and one year I was in a fee for service – I was miserably unhappy.

Anyway, happy to talk about these issue, but I don’t want these lessons to be the main thing that you take away. I did want to show you, though, if I’m going to criticize markets, some of the tenants I would think in terms of the healthcare system I’d like to see.

Thanks very much. (Applause.)

Realistic Health Reform: Spanning the Ideological Divide

Joseph Antos, Wilson H. Taylor Scholar in Health Care and Retirement Policy, American Enterprise Institute



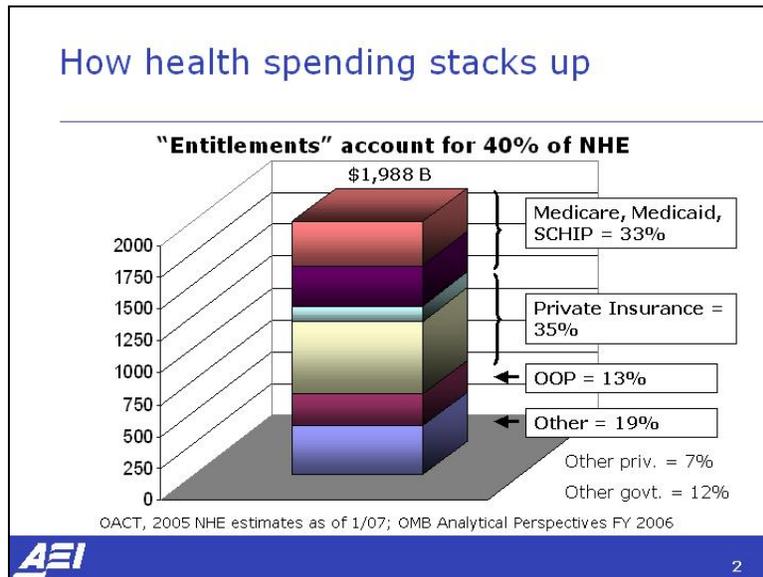
JOSEPH ANTOS: Thank you very much. Well, Henry’s presentation started this session off very well laying out what I think everyone in this room believes which is we need real health system reform. And I have to hand it to either Henry or Bill Gates in subtly suggesting that health system reform might be a religious experience – (laughter) – and probably will take a miracle. I’m going to try to convey maybe three main thoughts.

First of all – oh, actually four main thoughts. In fact, this is the most important main thought, which is something of a shameless promotion for a book that Alice Rivlin and I are editing, which is coming out from Brookings Institution Press. You may wonder why am I promoting it, because after all, we don’t get any money for this, but it’s called “Restoring Fiscal Sanity: The Health Spending Challenge,” and out in March at your local book seller.

Anyway, three other less important points. First of all, there’s a lot of debate about health reform, and bluntly, it is not useful for people to remain stuck at one of the ideological poles. That’s where we have been, that’s why we haven’t done it.

Second, health system reform is needed, but the argument that we can’t do anything with Medicare, I think it’s just flat out wrong. Medicare in particular, but also government in general can and must take the lead on many initiatives, but cannot take the lead – has to be the follower – on other things. We have to be careful about this. And third, health system reform, whether we like it or not – and one of Henry’s last slides conveys this – inevitably means lower spending than currently projected. You have to be careful how you do that.

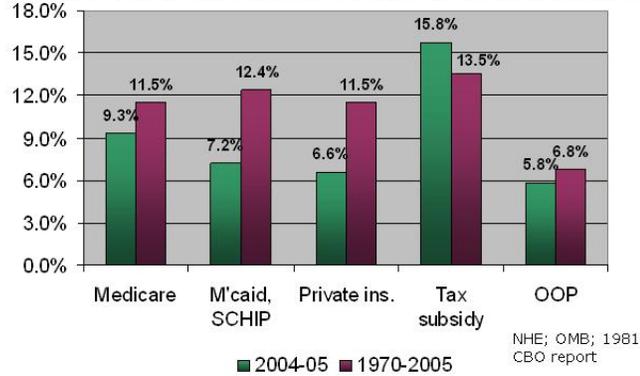
This is a budget session, so savings are related to baselines. Lower spending than currently projected is necessary. Whatever you think of the projections in terms of numbers, they tell us in general is that we can't continue in this fashion indefinitely. So one way or the other, we're going to have to work on the spending side. Certainly, we're going to raise more money in terms of taxes. We're going to collect more revenue, but slowing spending is absolutely critical.



The point in slide 2 is to observe how widely government entitlements affect the health system. It's not just Medicare and Medicaid and SCHIP. It's also \$122 billion of federal income tax subsidies for the purchase of employer-sponsored insurance for 2005 according to the Office of Management Budget. So virtually everybody but the uninsured gets a federal subsidy and the nature of that subsidy, including the tax subsidy, is an entitlement. In the past there has been no great debate over how much should we put into subsidizing the middle class and the rich. It just automatically increases.

Rapid growth of insurance, subsidies

Similar long-term growth of insurance, entitlements



AEI

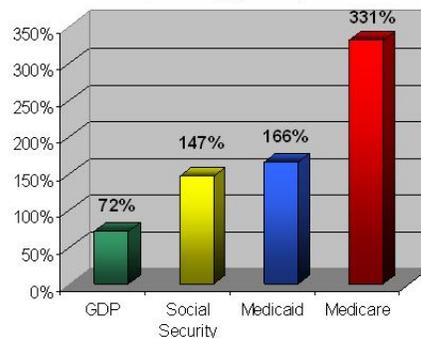
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An interesting set of numbers just came out in “Health Affairs” from the CMS actuaries’ annual report on recent spending trends. You’ll see (in slide 3) that basically the three major sources of health insurance - Medicare, Medicaid and private insurance – have all been growing for the last 30 years at about the same rate: very rapidly, much faster than the economy. The tax subsidy that I mentioned has been growing much faster than any source of insurance. Out-of-pocket spending – that’s what’s left - actually has been growing much slower than those items.

The argument that Medicare can do better at controlling cost than private insurance is not realistic. They’re all part of the same system. That’s why they tend to grow at the same rate. They enjoy both the advantages and the disadvantages of the somewhat flawed health system that we have today. It’s not just a financing problem.

“Unsustainable”

Real spending growth, 2005-2030



If it can’t happen, it won’t...but we may not like the consequences.

Insufficient revenue is not the problem—it is the mismatch of spending and value.

Innovation is driven by 3rd party payment.

Innovation outpaces knowledge, judgment.

Source: David Walker, *Saving Our Future Requires Tough Choices Today*, GAO, August 24, 2006

AEI

4

I share Henry's concern about some of the more flagrant numbers, but remember, this is sort of a cry for help from analysts who really like numbers, not necessarily something that you can go to the bank on 50 years from now. The fact is that those scary projections that you see, which are probably not that well represented by this graph, clearly indicate that the current course is impossible. So it won't happen. Absolutely right – it won't happen. The issue is, what are the consequences of this spending trend not happening, and do we want to shape those consequences so that they are more to our liking? I think that's the issue of health reform.

Clearly, insufficient revenue is not the major problem here. With \$2 trillion in the health system, surely we can solve these problems. It can't be the case that we must increase the revenue by leaps and bounds. There's got to be another way. And I think that sentiment is fundamentally right.

Opposing strategies

Market reform
Reduce moral hazard
Consumerism, choice, and competition yield efficiency, promote expanded coverage and quality care
"Money follows the patient"

Government expansion
Avoid market failure
Large government programs can drive efficiency and ensure universal coverage, consumer protection, and quality care
"Patient follows the money"

AEI 5

Let me say a few things about the opposing ideological poles of the reform debate and make some observations about how confusing all of this is. Those who support market reform, it's often said, want to reduce moral hazard. What is moral hazard? People use that term – usually they misuse it. And usually they get confused about moral hazard versus downward sloping demand curves.

Moral hazard involves changing the risk structure and then having adverse consequences. A good example is mandatory seatbelt laws that change the risk of serious injury in an auto accident, so we drive faster to make up for that, whereas subsidizing gasoline purchase doesn't change the risk. We drive further, but it doesn't change the risk. Moral hazard involves changing the risk. So Tom's picture is the right picture, but it's a very confusing picture. There are elements of moral hazard in there, but there are elements of downward sloping demand. Yes, people who care about market reform care about moral hazard, but they also care about downward sloping demand. Note that moral hazard is a market failure.

Then there is the hope that consumerism, choice, and competition will yield efficiency. What's efficiency? Most people think it just means to produce whatever we produce with fewer resources, and that's part of the definition. But another part of the definition is you have to produce what you want. To produce what you don't want with lower resources isn't efficient. Ultimately the question is, who decides what we want? Those people who think that the government is the answer want to avoid market failure, but you can't avoid market failure. It's always present in one form or another.

Opposing fears

Supporters of a government solution fear

- The sick lose coverage
- People can't make good decisions
- Lack of direct controls means excessive profits, no effective cost control for the 10% who spend most of the money
- Quality will suffer as competition drives down premiums

Supporters of a market solution fear

- Coverage is in name only
- One size does not fit all
- Regulatory capture drives up spending, heavy-handed limits on the use of services
- Control limits ability, desire to innovate

AEI 6

Another assertion by those favoring a government solution: large government programs can drive efficiency. The question is, if consumers can't drive this, can experts know, identify it and make efficient health care happen? Many observers hope that this can be the case, but it remains to be seen. Remember, we've got a big program in Medicare that attempts to promote efficiency, but we haven't been very successful. There are opposing fears outlined in slide 6. All those fears are correct. I'm not going to go through all those. They're all familiar to you. Every one of those fears is absolutely correct. Those are things we don't want. The point is that we can't avoid those things by simply saying, let's go in one direction or another.

Blended strategy for a blended system

U.S. health system a hodgepodge of market and regulatory elements

- Government finances more than half of health spending
- Private payers adapt to Medicare's policies
- Regulatory and research agencies influence private markets

Specific proposals often a blend of market and regulatory elements

Federal and state programs can lead the way in key areas


7

We have a blended system, and because of that, we need to have a blended solution.

No easy answers

Develop information

- What works: data on costs, outcomes, provider performance
- Effectiveness, comparative effectiveness, cost effectiveness

Improve delivery

- Guidelines, care management, health promotion

Improve payment strategies

- P4P, bidding, negotiation

Promote effective consumerism, competition

- Premium support, decision support, financial incentives
- Streamline regulatory process, malpractice reform

Limit unnecessary spending

- Modify entitlement status, cap tax exclusion




8

There are no easy answers. Everybody's seen this list (on slide 8). I think an important point is that while people want to argue about the big political issues that will not be resolved readily, short of a real crisis, there are lots of things we can do, and for many of those things, government is uniquely in a position to do them. Especially, gathering information and making it available in ways that could be useful at least to researchers. Ultimately, it's up to experts who really understand how people think to turn data into information, but collecting the data in the first place is something that the government is in the best position to do.

Reform is not just a demand side solution. Demand side is important. Remember that if you work on the demand side, you're affecting the supply side, but you also have to work on the supply side. Medicare must become a smarter purchaser, which not all conservatives agree with. If we expect individuals to be smart purchasers, then surely Medicare ought to be a better purchaser. We are at the beginning stages of most these initiatives, and there is a great deal of work that needs to be done.

Policy logjam

Scary numbers won't force good policy.

Non-negotiable demands prevent progress.

Incentives matter...but so does institutional setting.

We do not know how to slow the rate of growth of health spending.

There are many possibilities for one-off savings.

Enhance value—but do not centralize decisions.



AEI 9

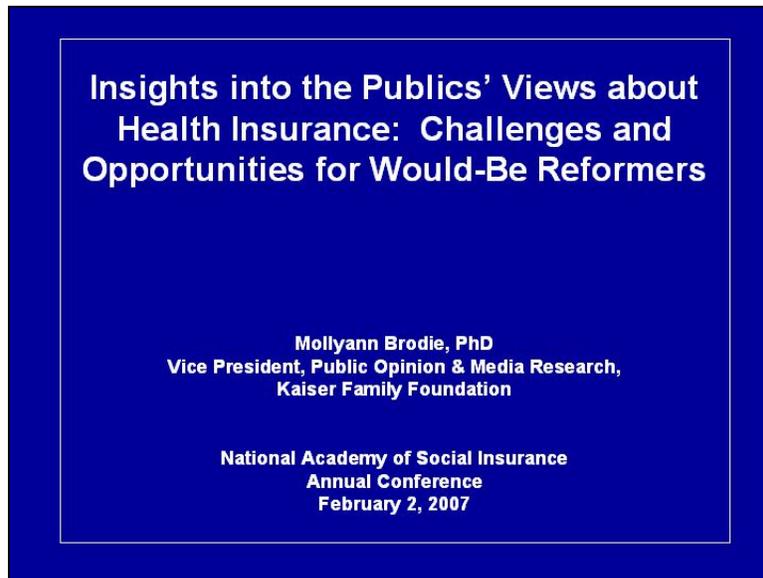
Finally, the policy logjam. As Henry I think implied in his paper, scary numbers are not going to force good policy. You can't scare politicians into doing the right thing, at least not with numbers. You can scare them by having a crisis, a real crisis that affects many people, but you can't scare them with numbers and projections. On the other hand, non-negotiable demands, which we often hear from one side or another, simply prevent sensible discussion and ultimately frustrate progress on health reform. I think the market people are right: incentives matter, but there's a tendency to forget that the institutional setting matters too. Wherever we might go, we're starting from where we are right now. We have to think about how we get to our preferred goal, based on where we are now.

Bluntly, we don't know how to slow the rate of growth of health spending. We simply don't, but there are a lot of experiments we can perform and policies we can try to slow spending in sensible ways. This is not just a Medicare entitlement problem, it's a nation-wide problem and there are things we should start doing—and probably should have started ten years ago.

Thanks. (Applause.)

Insights into the Public's Views About Health Insurance: Challenges and Opportunities for Would-Be Reformers

Mollyann Brodie, Vice President and Director of Public Opinion and Media Research, Henry J. Kaiser Family Foundation



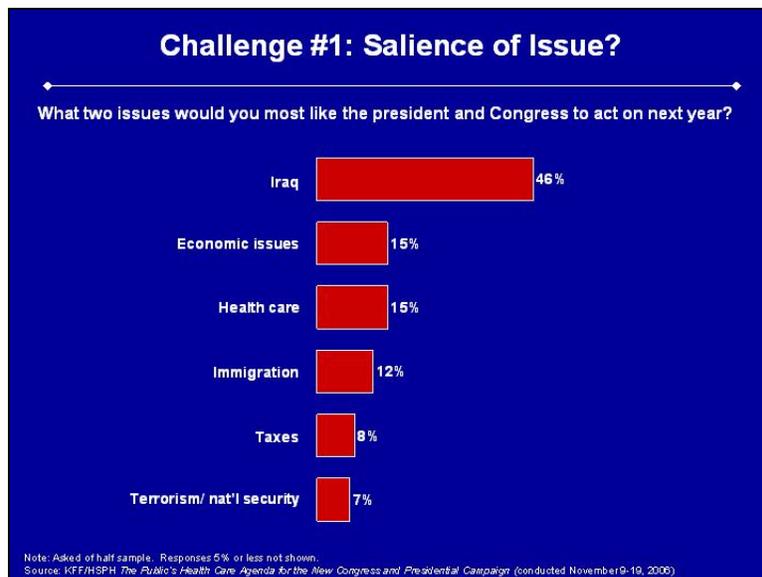
MOLLYANN BRODIE: Thank you. I know we've been talking a lot about the need for health insurance reform and I know there's lots of interest for that in this room. And I think I've identified what the primary problem is with that and, unfortunately, there are 301 million of them, more being born every single day, and they are the people of the nation who don't have the training and expertise of those of us in this room!

So I do think that including the public in these kinds of discussions and understanding where their positions are is a really important part in understanding what challenges we face as we want to do any of these kinds of insurance reforms. So this is also what I'm going to be talking about. And I'm taking a very broad look. I'm going to look as often as possible at the long-term trends on this, as opposed to reactions to very specific policy proposals. And my real goal is to lay out the challenges and the opportunities that we need to think about when we include the public in our thoughts about the ways we can reform the health insurance system.

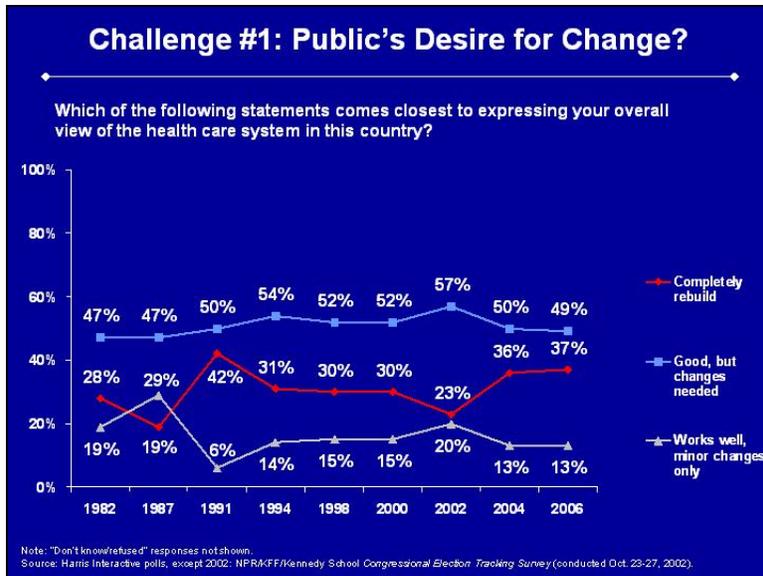
Challenges

1. Salience?
2. Goals easy, solutions hard
3. Willingness to pay or bear risk
4. Evaluate based on how it affects them (and don't think of themselves as at risk)
5. Worry more about rising costs
6. Debates and messages matter

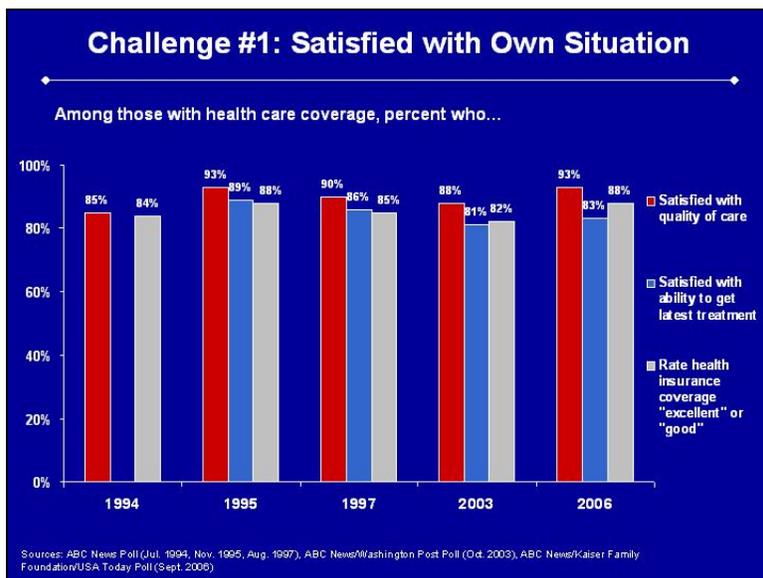
So I'm going to start by running through these six challenges. I'm going to go through them kind of quickly. The first one is just the salience of the issue.



Right now, healthcare ranks about third in the public's priority list. It's very far behind Iraq and it's behind dealing with the economy. Here you see it's kind of tied with the economy. In a variety of questions you'll see it sort of tied around second, third or fourth. It's a place where it's stayed pretty constant for the past decade. Healthcare is clearly an issue that people care about, but it's only one issue among many that garners their attention, so policies aimed at reforming the healthcare system will continually be competing for public attention with other topics. And certainly, until the situation with Iraq is resolved, it's going to be tough for anything to break through in a very major way.

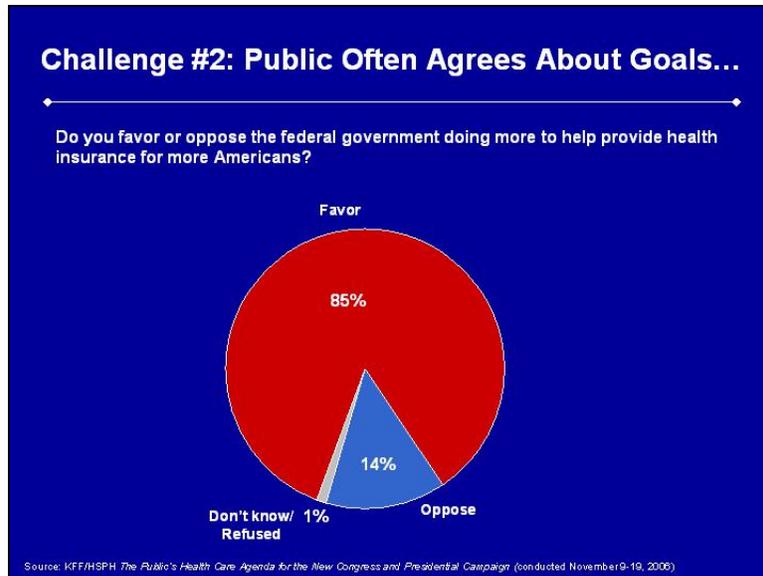


So healthcare ranks on the public's agenda, but what kind of change do they mean when they say it's an important problem for the country to address? Well, you see here a long-term trend back to 1982, that basically the middle response to do something, but don't completely rebuild, it is the longstanding winner so to speak. That's that blue line across the top. Few over time say the system is completely broken and needs to be completely rebuilt. Well, why don't we get the overwhelming response to just throw the system out and start over, which is certainly what you might expect if the public understood everything that all of you in the room understand?

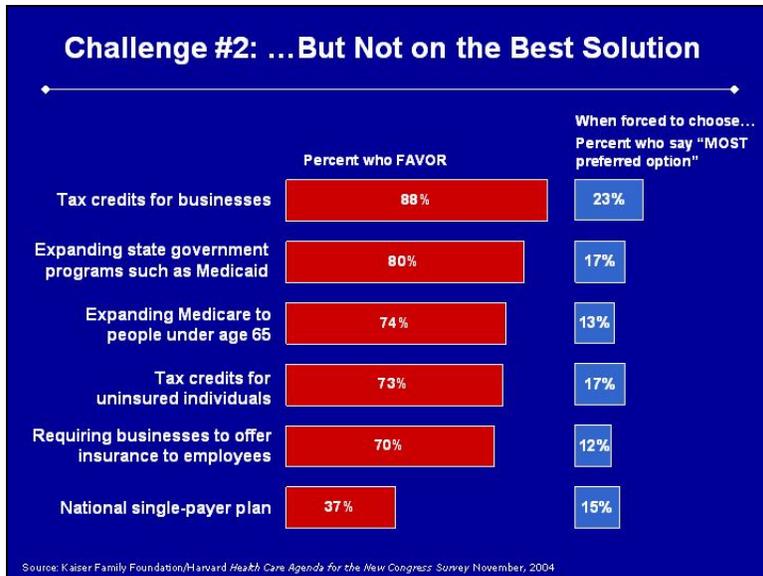


Well, the bottom line and what you may know from your own conversations is that for the most part, the vast majority of the public is satisfied with their own current healthcare arrangements. They're dissatisfied with the system, but they're satisfied with what's happening in their own lives. There's a huge caveat here and that's that this is

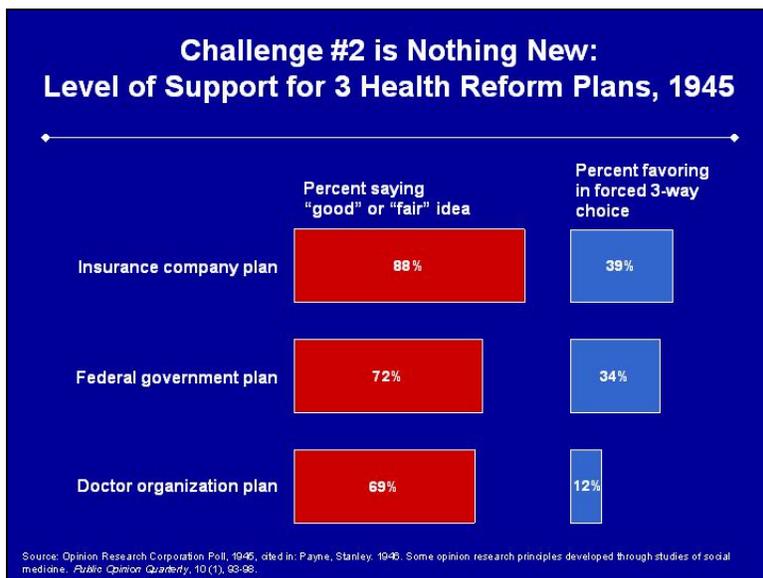
true if you have health insurance. So if you have health insurance, you mostly think you're doing okay. You're satisfied with your quality of care, your access, your health insurance coverage, and the status quo for you isn't that bad. Now, again you can see this is pretty constant in the last decade or more. Okay.



So we don't see an overwhelming vocal demand from the public to fundamentally change the system, but what about when we ask specifically about helping to solve our health insurance coverage problem? Well, goals are easy, and you know what -- Americans are pretty nice people. They want to help kids, they want to help the elderly, they definitely want to protect the environment and they fundamentally believe that everybody should have access to health insurance. You see here that the vast majority believes that the government should do more to help in this arena. And this includes large majorities of self-identified Democrats, independents and Republicans. Goals are very simple to get agreement on.

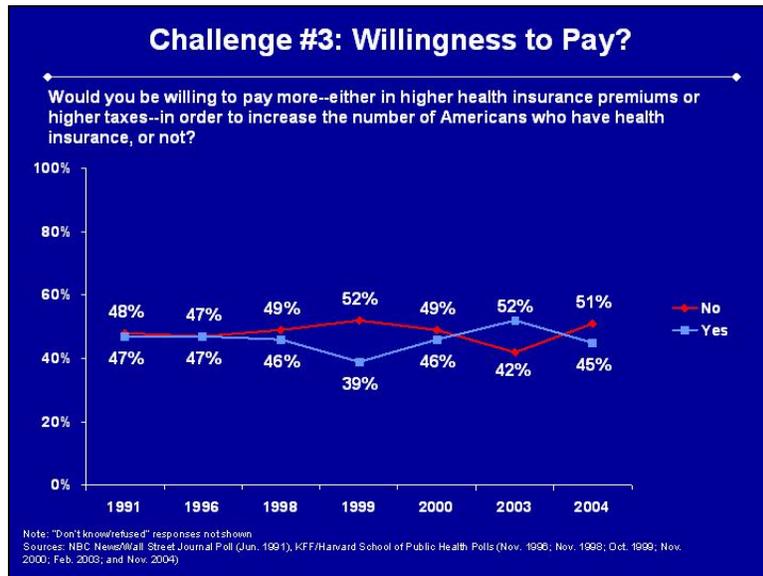


The challenge comes when we start talking about what the potential solutions are. So when we ask about things by themselves, virtually every approach to expanding coverage with the exception of single-payer, is popular with the majority of the public. You see that on the left in the red. No mistake of how popular expanding Medicare is. (Laughs.) However though, when people are forced to choose among these options, you see that none of the proposals get even close to majority support. So here I offered six options. I got a six way tie. If I had offered four options, it would have been about a four way tie, if I'd just given them two options, it would have been split about evenly.

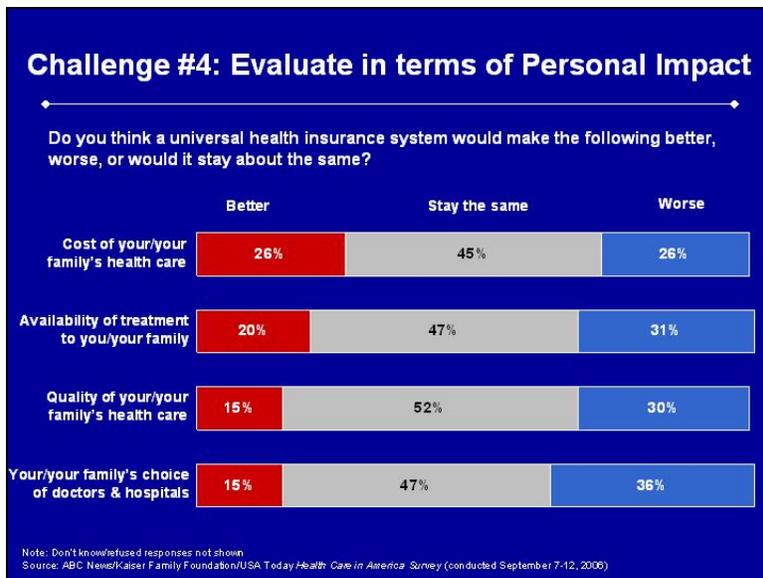


And just to note, this isn't new. This is the same thing we see back during the Truman debate. There were three options at the time and you get sort of a three-way split.

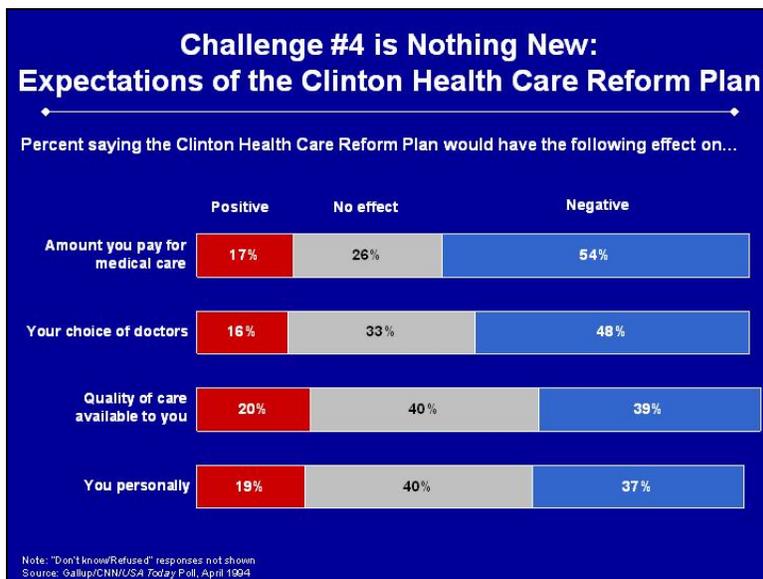
Well, what does this mean? What it means is that no matter which solution a policymaker chooses to put on the table, there's many people who think that they could have picked a better option. That makes it very easy for the opposition to convince people that the offered policy is on the wrong track. So when leaders talk about goals, there's no doubt in my mind we can get agreement about what direction people want the nation to move in, but when the conversation shifts to how to achieve those goals, there's no doubt in my mind that we're entering a very difficult public debate.



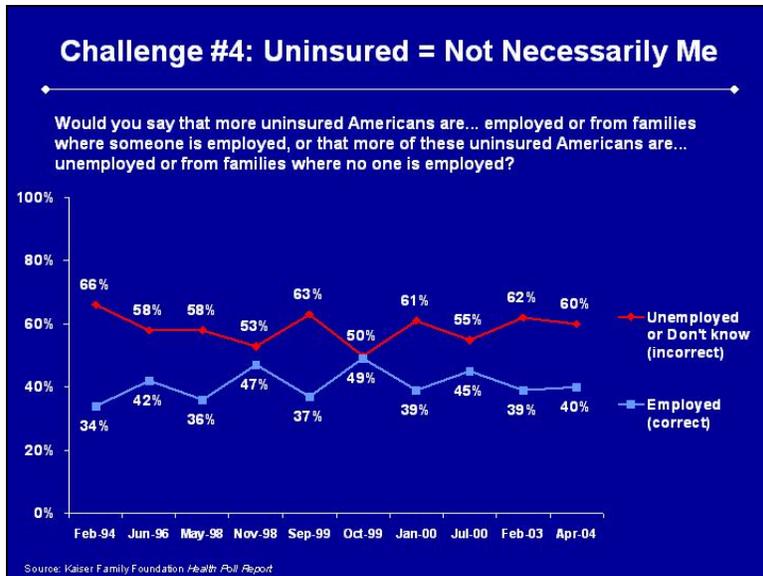
Now, the third challenge is the willingness to pay. We're talking about some degree of redistribution of wealth. Somebody needs to pay for those who can't, and willingness to pay is always tough. You'll notice that in the chart I showed you earlier, when we were talking about the goals, eight in 10 said, yes, this is something the government should be involved in. However here, when instead it's framed in terms of willingness to pay to expand coverage we see pretty consistent, sort of lukewarm results hovering around 50 percent since 1991. Now, this doesn't mean that they don't want to see more people covered. It just means that they're already feeling financially stretched and aren't thrilled about being asked to pay for something they don't necessarily see benefiting themselves personally.



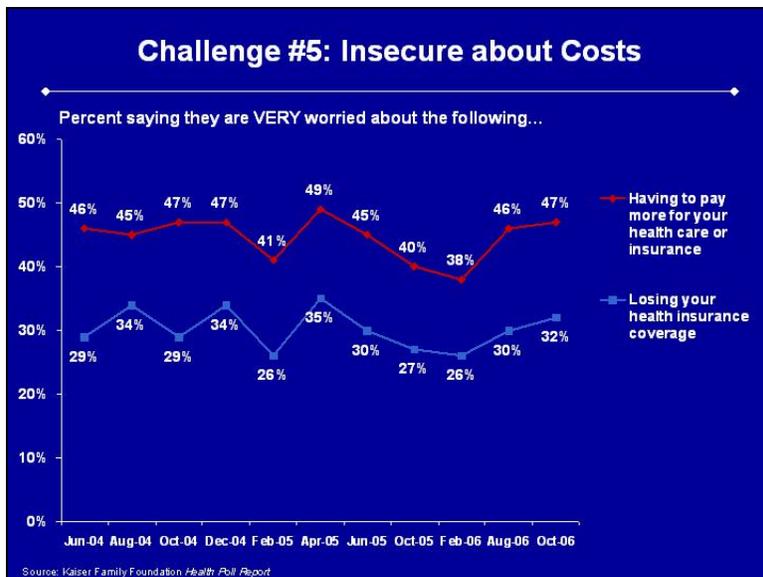
And this is really a key component and it's our fourth challenge. When people think about proposals that would lead to universal coverage, they don't generally see much upside for themselves personally. Note here how few believe their cost, their access, their quality or their choices would be better under universal insurance system. That's the red in each of those bars.



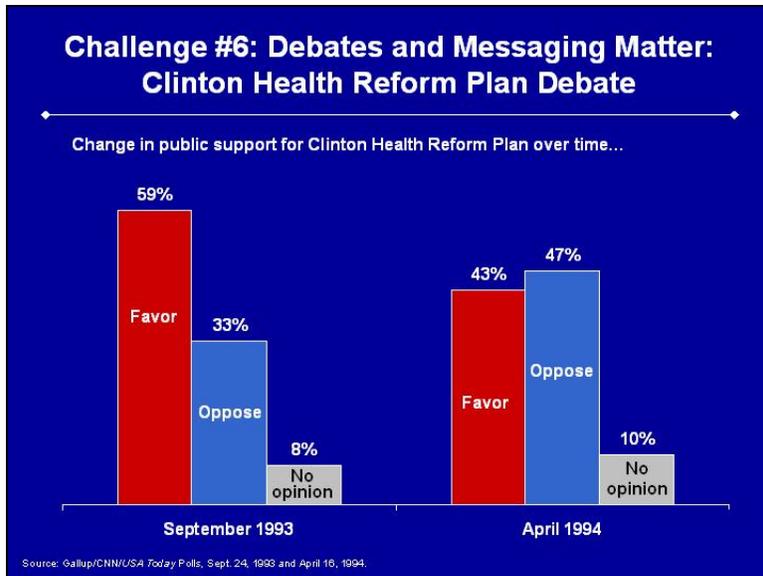
And once again, this is nothing new. We basically saw the same thing in people's evaluations of how the Clinton healthcare reform plan would impact them. It's pretty hard to convince people to pay more or to be excited about a policy change that they don't believe will have positive impacts on their own healthcare. It's especially true when we noticed before that they're pretty satisfied with their own current arrangements.



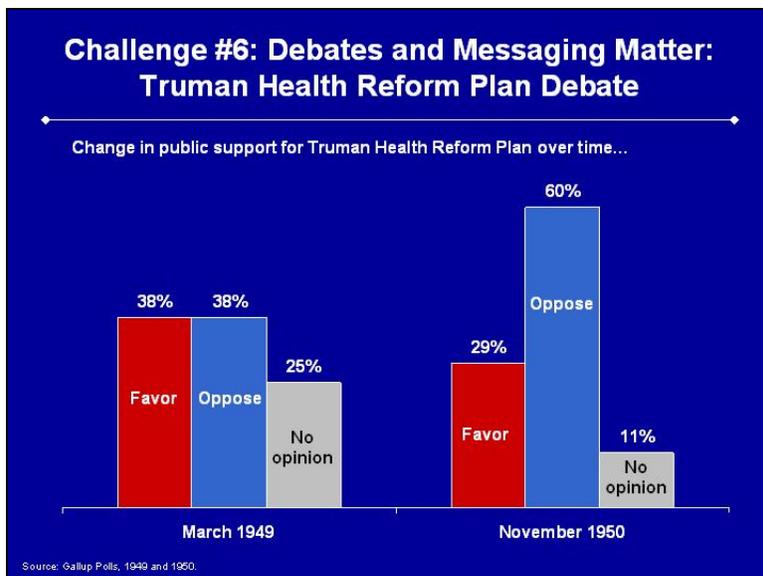
Now the corollary to this challenge is that people don't necessarily see themselves as the uninsured. You see here that despite many notable efforts over time and a very good deal of media attention, there's been virtually no change in the percent of the public who have the basic understanding of who the uninsured are. Today, as has been the case since we first started asking this back in February of 1994, about six in 10 mistakenly think that most of the uninsured are unemployed or say they don't know.



Now, in addition to this, not only do they not see themselves as the uninsured, they don't worry much about their risk of losing their own coverage. What they are worried about and what they are dissatisfied about is the cost of care. That's the red line across the top. This is the underline concern that's driving people to say that the most important problem to address in the nation is healthcare.



Now, lastly in terms of challenges, and certainly without time for an indepth discussion on this, but I do need to put on the list is that how a policy debate occurs in the public arena matters a great deal to how the public will ultimately come down on the proposal. So attitudes could be influenced by the messages, the language and the terms that are used to describe it. This doesn't mean that strongly held values could be changed, and yes certainly, the public generally holds stable policy positions over long periods of time, but in short spans of political debate, we see much more volatility. Messaging can tap into concerns, fears and Americans' fundamental desire to avoid risk and it can make opinion on any proposal seem weaker and much more malleable than perhaps it truly is. So here, just remember what happened in the massive public debate between September '93 and April '94 on the healthcare reform plan.

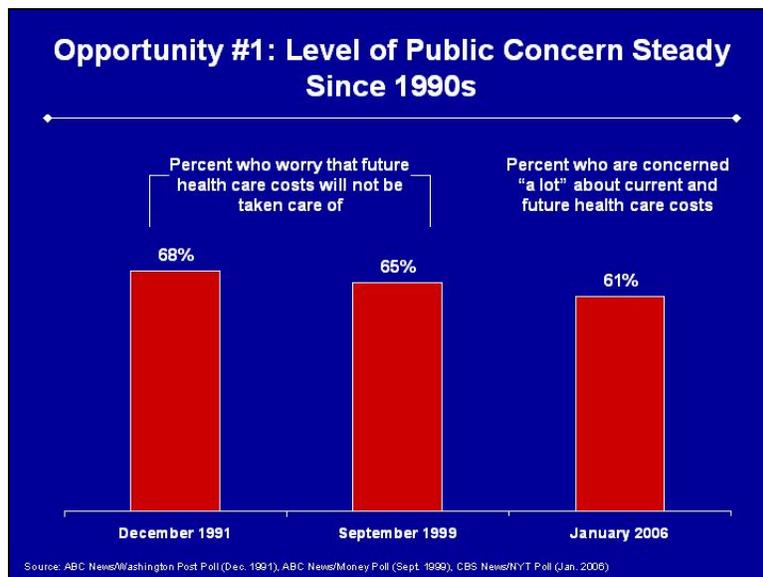


And again, you see the same thing in the public debate over Truman's plan. It caused the same trend in public opinion to move away from support.

Opportunities

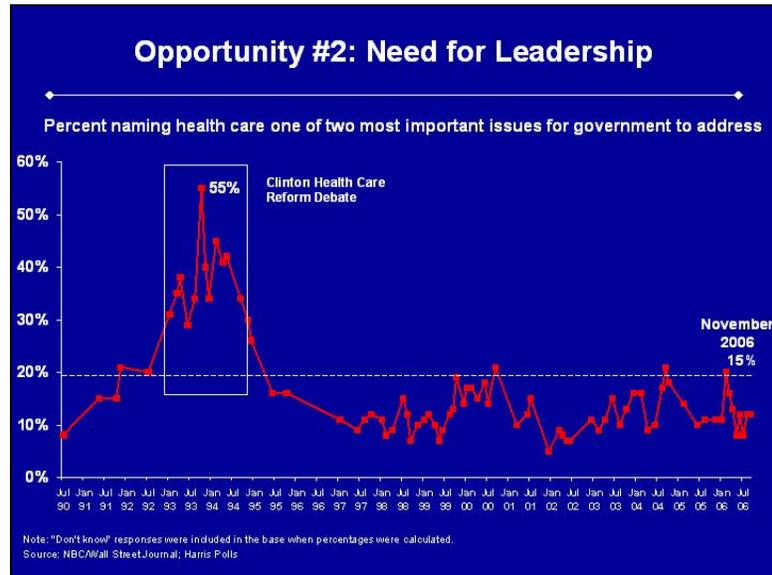
1. Recognize needed public concern already present
2. Leadership needed – Top Down
3. Frame in terms of dealing with health care costs
4. Combine approaches; Build on what people know and like

So given all these challenges where are the bright spots? Where are the opportunities to engage the public in this topic?



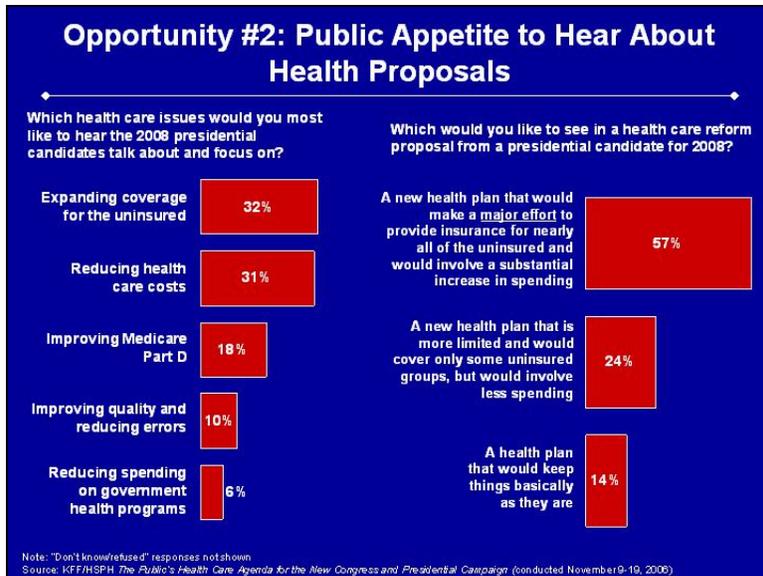
Well, I think the first thing we need to recognize is that the needed underlining level of concern is already present. In fact, it never, ever went away. People are worried about paying for and getting their medical care. And I think leaders can tap into that to discuss needed policy changes. Did you notice that on virtually every trend I showed you, it's been basically flat over the last decade? The absolute indicators, the real life situations may have gotten better, and in fact worse as most of the economists have told us – (laughs) – but public perceptions have remained remarkably stable. What was

available for the leaders to tap into in the early '90s, is still available today. And what this means, is that this is an issue that is really ripe for leadership.



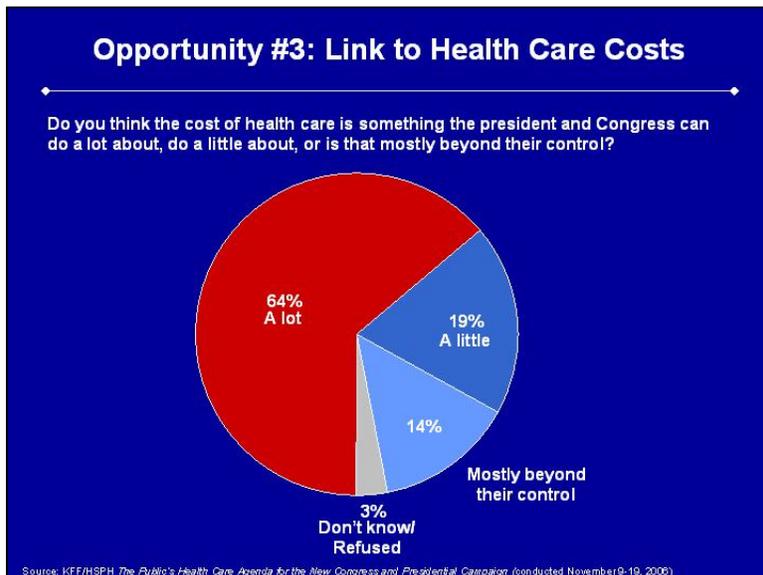
Here's a long-term trend on the percent of the public who names healthcare as a top issue for government. Notice that in the early '90's and over the past decade, we see this consistent sort of 10 or 20 percent naming healthcare as the most important issue. But what about the massive amount of interest we see in the '93 and '93 measures? In fact, I would argue it's the result of the nation's leaders talking about the issue. These numbers in the 30 and 50 percentage points reflected what people were hearing about all the time in the media as a result of the intense policy debate that was occurring. There were measures taken during the debate, not prior to it.

Now, this is what we've begun to see recently in Massachusetts with Governor Romney and in California with Governor Schwarzenegger, with the proposals from the strange bedfellows coalition and with the president in the State of the Union. We are seeing public leaders taking on the topic seriously and focusing the public discussion. And I would say that this a really good time for that kind of leadership and that discussion.

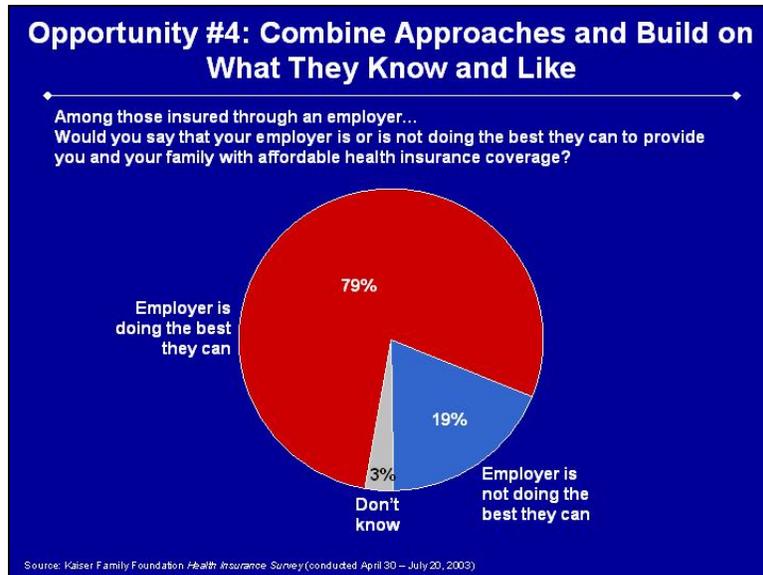


There is public appetite for discussions about health insurance coverage. In fact, when we ask people what they wanted to hear about from the presidential candidates, on the left you'll see that coverage and cost topped their list. When we asked what kind of proposals they're interested in, you see on the right that we found some appetite for a bigger proposal, even if it required more spending.

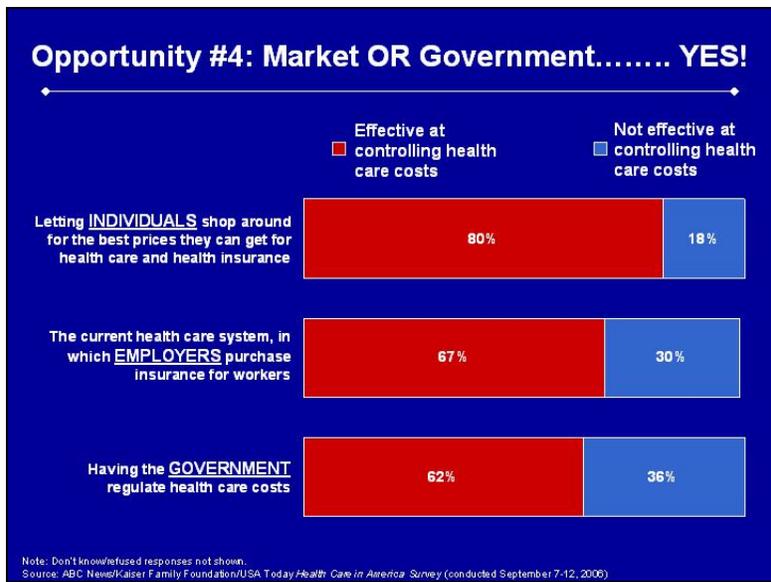
Now, this was certainly more the case for Democrats and independents than it was for Republicans, but still there is some public interest in these discussions. And this is why what happens in this congressional term and what happens in this presidential campaign is all-important to the current fate of this issue. If our leaders and candidates can talk about this, we may see an impact on public. If not, I think it's going to remain one of the issues that the public cares about, says they worry about, but will have less of a chance of getting traction.



The third opportunity I see is to frame it in terms of addressing people's health care cost concerns. Health care costs are certainly something that people believe the government can and should do something about. So proposals that address this will help to get the public engaged and committed. Now, I need to be clear, people are worried about their own personal healthcare costs. When we talk about the nation as whole, they actually tell us that we spend too little on health. Now, I say that just to remind you that the average American is not the same the same as the average economist in evaluating costs. (Laughter.)



Now, I think there's also a big opportunity to build on the current system which is seen as less threatening to people and to combine approaches like what we've seen in the California and Massachusetts proposals. Now, some say that it's time to start removing the employers from the business of providing health insurance, but I think it's important to note that the public is not there yet. They have empathy for their employers, and when we ask them about getting their insurance through their employers or getting it on their own, they tell us the employers can do it better. When we ask them about trade-offs between getting higher wages or maintaining their benefit, they tell us they want to maintain their benefits.



Now, just to remind you once again, that the public doesn't think about like an economist. The public doesn't make the stark distinctions between the market oriented and the government oriented solutions the way some of us in this room do. They just want something that makes sense and works. That's the issue with the Medicare prescription drug negotiation issue. It just doesn't make sense to people that the government shouldn't be allowed to do it. Same thing with lots of the hairs we split on government versus market. The public says, yes to both, yes to all, just fix the problem. Price regulation, government negotiation, better and more informed cost conscious shopping in the marketplace are all things that sound good to them.

- ### Biggest Hurdles
- Bridging ideological divides
 - Figuring out how to pay
 - Leaders willing to take this on
 - Be prepared with messages that resonate

So what are our biggest hurdles? Well, first I think it's really going to take a skilled policy entrepreneur to overcome the deep ideological divides that exist in terms of establishing a potentially successful policy proposal to take to the nation. And alongside

that, it's going to take a bright and creative economist to figure out how to pay for whatever proposal they bring forward in the face of the ideological divides that are inherent.

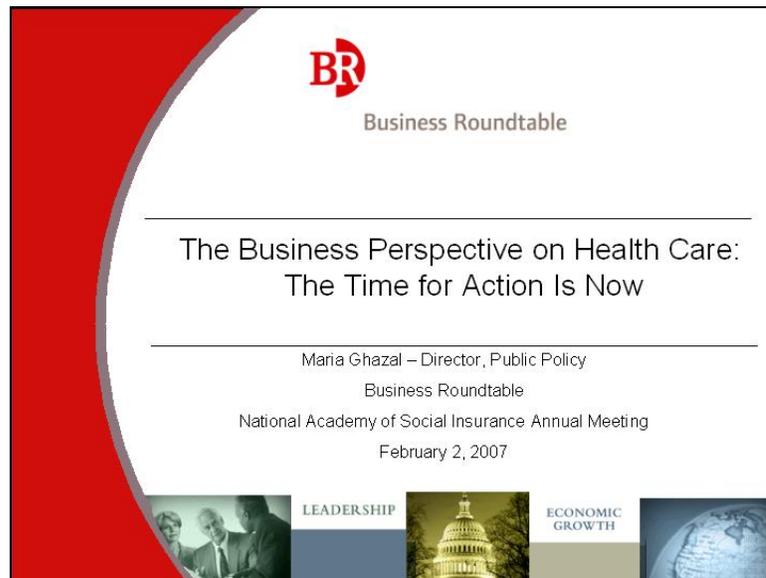
Third, I think public opinion tells us where the public is, but it certainly doesn't tell us what the right things is to do and getting insurance reforms through the public debate, must come from the top down. We can't expect it to percolate from the bottom up. This means is going to take skilled leadership to communicate with the public and someone who can show an understanding of the concerns and interests, but lead them towards a successful policy option. So what happens in the current presidential campaign is going to be all important to determining whether a window is going to emerge, and if that window does emerge, we are going to have to be prepared with messages and explanations that resonate in the face any of the public's beliefs that might be coming under attack in a contentious public debate about the merits or drawbacks under the current proposal.

With that, thank you.

MS. BUTO: Thank you. (Applause.)

The Business Perspective on Health Care: The Time for Action is Now

Maria Ghazal, Director of Public Policy, Business Roundtable



MARIA GHAZAL: Good morning. Thank you for this opportunity to join this very distinguished panel.

About Business Roundtable

- An association of chief executive officers of leading U.S. companies working to advocate for policies that will ensure a strong economy
- Roundtable companies represent more than 10 million employees and provide health care for more than 34 million Americans
- Roundtable companies have \$4.5 trillion in annual revenues, comprise nearly a third of the total value of the U.S. stock market and collectively returned more than \$112 billion in dividends to shareholders and the economy in 2005



Just a few words about the Business Roundtable. The Business Roundtable is an association of 160 chief executive officers of leading U.S. companies, and our CEOs represent companies that have more than 10 million employees and I think an important thing for this discussion is that healthcare coverage is provided to approximately 34 million Americans. The Roundtable has 10 taskforces, one of which is the Health and Retirement Taskforce that I work for and that is right now chaired by Mike McAllister who is the CEO of Humana.

The System Is Broken



- As we increase access, we must not bring more people into a broken system
- In 2006, for the fourth year in a row CEOs cited health care costs as their greatest cost pressure
- Staggering health care costs are sapping American businesses, slowing economic growth and burdening American households
- We must find a way to make the system more efficient and get more value from our health care dollars



The charge of the taskforce is to develop and advocate public policy that is aimed at improving the quality, efficiency, and accessibility of our healthcare system and driving down costs. This is a picture of an ad that we took out last year in one of the Healthcare Weeks that Congress had. The title of this slide is “The System Is Broken.” Every year we survey our CEOs, and in 2006, for the fourth year in a row, the CEOs cited healthcare costs as their number one cost pressure. The interesting thing for this year is not just that it was the fourth year, but for the first time it was cited by over 50 percent of the CEOs and it was three times more than the next highest cost pressure, which was energy cost.

Now, healthcare costs, as everyone in the room knows well, are really sapping American businesses, they’re hurting the economy, which is what Business Roundtable was formed to focus on. Just as importantly, they’re burdening American families. And there’s definitely a feeling that as we spend more, we are probably getting less and that there are efficiencies that can be improved and that more value can be obtained from our healthcare system.

Urgent Action Needed

- “We believe Congress must act urgently on comprehensive reforms so all Americans have access to affordable health care. The issues of the uninsured must be tackled, and health care costs must be reduced for all Americans, for our economy and for our companies.”

- Business Roundtable Testimony before
U.S. Senate Committee on Health, Education,
Labor, and Pensions
January 10, 2007



This is a quote from testimony that we delivered at the first Senate Health Committee hearing a few weeks ago, and just to put in perspective, at the Business Roundtable we really do believe we're just about at the tipping point. We hear CEOs use words like unsustainable, the need for comprehensive reform. These are words that we're hearing increasingly frequently.

We absolutely believe that there is a need to pass a series of laws that will result in a transformation of our healthcare system and laws that will focus on improving quality and efficiency and bringing down costs. And the reason is that we need to find a system that is more affordable for business and for individuals. If we're going to maintain the employer based system, which we fully support, we really need to focus on improving it. So this was the message that we delivered at the health committee hearing. Frankly, it's only February 2nd, but since the beginning of the year we really have seen a change in attitude and enthusiasm, as I'm sure you've all seen through the media, for at least discussing the healthcare issues.

Divided We Fail

- New partnership of Business Roundtable, AARP & SEIU
- Our goal:
 - Place health care reform and long-term financial security on top of the domestic agenda
 - Foster political will to find common sense, centrist solutions to expand access to affordable health care and strengthen retirement systems

Business Roundtable

Divided We Fail. This is an announcement that we recently made and we would like to think that some of the positive momentum is due to this announcement. This is a new partnership. The Business Roundtable has joined with AARP and the Service Employees International Union, the SEIU, and we announced here at the Press Club on January 16th, a partnership to say that when it comes to healthcare and long-term financial security we're united on making sure that these are at the top of the domestic agenda. Mollyann's report was very interesting to me how much higher Iraq is and it just shows how we need to have this goal of Divided We Fail. So we've come together to raise expectations that solutions for these problems need to be found sooner rather than later.

We have a policy platform that we'd be happy to share with everyone, we have a website if you want to go on it: it's dividedwefail.org. The partnership is intended to continue right up until the presidential election, to continue the momentum to talk about these issues, to try to find solutions. We'll be placing more op-eds, doing joint speaking appearances, joint visits of members of Congress, and the administration. We've already started scheduling some of these for the three principals. And the goal is to make sure that policymakers know that we are three diverse groups: we have big business, we have consumers, we have organized labor, and if we can come together and say, you must act, then really we need to continue to seek solutions.

Finding Common Ground

- Divided We Fail is a call to action for our political leaders
- Discovered three immediate, common objectives:
 - Pass health IT legislation
 - Improve the transparency of our health care system
 - Reauthorize and expand State Children's Health Insurance Program

Divided we fail.



So this call to action is focused on the broad based goals of finding solutions, but along the way, we discovered that at least immediately we have three common objectives, and that those are to focus on passing something like health IT legislation, which was considered by Congress last year; improving the transparency of our healthcare system; and reauthorizing and expanding the State Children's Health Insurance Program, SCHIP. As we work together, the commitment is that we certainly we have to agree to disagree most likely on some things because we know at least from our past history on Social Security reform, there are things we won't be able to agree on in the specifics, but where there are things that we can work together, we think it's a tremendous opportunity to really accomplish something.

Business Roundtable's Health Policy Agenda



SCHIP/Covering the Uninsured

Wellness & Prevention Programs

Cost & Quality Transparency

Health Information Technology

Consumer Choice in Health Care

Medical Malpractice Reform

Tax Fairness



Now, just a few words about our own Business Roundtable health policy agenda. As I said, our agenda is focused on making healthcare more affordable, improving quality

and efficiency and increasing and expanding access to care. Our principles are based on the belief that the foundation of our healthcare system should definitely remain in the private marketplace and at the same there's certainly a critical need for maintaining safety net programs. And these are the key areas where we believe concrete steps should be taken – certainly, reauthorizing SCHIP and I'll speak more about covering the uninsured and expanding access in a moment. Wellness and prevention programs –as you would imagine, our companies do much to promote and sponsor programs for their own employees and their families and we take seriously our role of leading by example.

We're also examining if there are public policies that could really promote these initiatives. Cost and quality and transparency: as individuals are asked to make more decision about their healthcare, they certainly need information on the costs and the quality of services and providers. Health information technology: we're strong advocates for passing legislation that would set up standards for secure, uniform, interoperable health IT infrastructure. Consumer choice in healthcare: this priority is a recognition that a variety of options should exist for consumers, whether they are health savings accounts, or other consumer-centered plans. And it's also worth mentioning that we think that mandating certain benefit packages or design features is frankly ill-advised policy.

Medical malpractice or medical reliability reform: we're realists, we understand that this is somewhat of a difficult goal to achieve in the 110th Congress, but it would be irresponsible of us not to continue to pursue this objective. We do believe that lawsuits are only adding to healthcare costs and in some cases really jeopardizing access to care as certain doctors are leaving specialties or leaving geographic area. So we're looking at if there are things we could suggest and promote to Congress, alternatives such as medical courts.

And then tax fairness. This has been in the news a lot lately, certainly with the president's proposal. We've been examining the proposal to establish a standard deduction for health insurance. We think that it's an important step toward making healthcare coverage not only more affordable, but it would really increase fairness in our system. And just declaring it dead on arrival certainly doesn't help the debate.

Expanding Access

- We are already paying for uncompensated care
- The private health care marketplace offers the best opportunity to expand coverage
- We must start by focusing on populations
 - 2007 – SCHIP Reauthorization
- Tax fairness – making health insurance premiums tax deductible will expand coverage for individuals & working uninsured



So just another word about expanding access. As I noted earlier, healthcare costs are the number one cost pressure that CEOs cite and they recognize that those who pay for coverage, whether it's companies or others who obtain insurance on their own that everyone is already paying for the uninsured in the most inefficient of manners. So, we believe that the private marketplace is really the best place to look to expand coverage. And we use the words "universal coverage" and we've received some feedback within our membership that when the press reports on this, that some people when they use universal coverage they absolutely mean single-payer. That's not really what our CEOs mean by that. They more mean that we should definitely have the goal of universal coverage so that more individuals, employees, children, families, early retirees, everyone in the system has access to affordable, high quality coverage.

And we do believe that we should start by focusing on populations. We spent a good deal of time looking at who are the uninsured, something that everyone in this room is familiar with, but it's very helpful to the CEOs to hear that the fastest growing segment is early retirees, probably many from our companies, and we're agreeing with probably the rest of the town that starting with children and re-authorizing SCHIP is a good place to start. Then again, on tax fairness, we think that the president's proposal and others should be part of the debate.

Increasing Efficiency

- Health IT – major step in improving quality, efficiency and patient safety; will save up to \$165 billion/year [RAND]
- Transparency – give consumers access to information on cost and quality of health care services
- Wellness/prevention – *health* care, not “sick care”
- Pay for performance – benchmark provider performance



Increasing efficiency: this is an ad that we've taken out to pass health information technology legislation and that's one of the efficiencies that we are very supportive of. The RAND Corporation has estimated that up to \$165 billion could be saved from our healthcare system every year and this came very close. We've already met with Senator Kennedy to offer our support in making sure that this is something that is passed early in this Congress.

Transparency: we've spent a great deal of time on this issue. Almost two years ago, the Business Roundtable asked CMS to release the claims data in a patient-protected manner. It started quite a stir and we haven't gotten too far, although we have also joined with Secretary Leavitt in support of his value-driven healthcare purchasing initiative. Since it doesn't seem that the CMS claims data will be released, at least in the speedy manner that we're looking for, we are also working in a bipartisan fashion on legislation that would give CMS the clear authority that they feel they lack in order to release these information. Then, certain entities would be able to analyze it and then our companies would be able to purchase this analysis. And then, of course, wellness and prevention is another efficiency we're definitely supportive of.

The Time for Action is Now

- There is growing consensus that we must expand access and improve the quality of the system
- Everyone has a role to play – business, consumers, government
- We must begin a conversation
- Congress must come together in bipartisan approach
- Divided we fail



So just to sum up, we've given many interviews since the first of the year and we really do believe that something definitely feels different. Now, we like to think that Divided We Fail has something to do with it. Maybe it's other strange bedfellow groups that have been announced this month, perhaps it's just the feeling of newness since there's new leadership in Congress. Or maybe it's just something that we're more keenly aware at Business Roundtable, that with the healthcare cost we really are close to the tipping point. And maybe it's just a combination of all these factors and more, but it leads me to end this presentation with: The Time for Action is Now. I'm not so sure that we would have had this a few years ago. But we definitely believe everyone has a role to play.

We want to be part of the debate as business and we're grateful that at least we feel that an earnest conversation has begun. Some say that the window for action this year is very short and that real comprehensive reform will not be pushed until after the 2008 election. Maybe they're right; hopefully not. But we've already discussed here and at Business Roundtable there are some things that can be passed quickly, and whether it's health IT or some of the other reforms.

And I just wanted to end by saying that the very last thing that the CEOs at the Business Roundtable want is for more years to pass where we have announcements saying that for the eighth year in the row, for the ninth year in the row, CEOs have cited that health costs are out number cost pressure. It's not good for the economy, is not good for employees, and so we just want to make sure we are part of the debate.

Thanks. (Applause.)

Discussion

MS. BUTO: So we have I guess about 20 minutes for questions. Why don't you go ahead and please introduce yourself and say what your affiliation is.

Q: My name is Larry Seidman and I am a professor of economics at the University of Delaware. I would appreciate if any of the panelists comment on any of the four components of a plan that some people, including myself, are interested in for health insurance. The four elements are: requirement that each individual obtain insurance from employer or on their own, a refundable tax credit that scales to income and is large enough to enable every individual to afford to get that insurance, last resort government insurance for anyone who can't obtain private insurance at an affordable premium; and finally, government reinsurance of private insurers for enrollees who incur very high medical cost. So those are the four elements and if any of you would like to comment on any part of it – they really belong altogether as a package – I'd appreciate it.

MR. AARON: One comment as a question. How do you propose to pay for it?

Q: Taxes.

MS. BUTO: Anyone else on the panel? Tom?

MR. RICE: A few years ago I was very much against the individual mandate, but I'm not so much against it any longer because I don't see any movement towards ensuring that everyone's going to get it through another source. I think that the individual mandate is now being embraced by more people like me who wouldn't have embraced it several years ago, so I think it's something that needs to at least be front and center. I don't know how I feel about it, but I definitely think it ought to be discussed.

MS. BUTO: Go ahead, Joe.

MR. ANTOS: Let me just add that people like me also talk about individual mandates, and I think we're all a little unclear about how well they might actually work. The big question is what's the penalty if you don't do it and can you in fact convince people to even put \$15 a month into health insurance, if they previously were getting what they thought was acceptable care for nothing?

MS. BUTO: Any other thoughts?

MS. GHAZAL: I would say the Business Roundtable will look at all of this.

MS. BUTO: Okay? Yes.

Q: My name is Joe Coletti. I'm with the John Locke Foundation in North Carolina and one thing that we've seen in North Carolina, public opinion polls have found that the highest priority for people as a state issue is healthcare reform. And that

brings up the question of Henry Aaron's proposal with Stuart Butler that's been turned into a couple of pieces of legislation in Congress to allow more state attempts to experiment, whether it's market driven, whether it's government driven, or whether it's some combination of the two at the state level.

It seems that there might be more opportunity to act there especially because in many states we have governors who are taking the initiative. I think it was Mollyann who said that it has to be top down – and it seems like that's where we have more top-down willingness to do that.

MR. AARON: I think that idea is a good one. (Laughter.)

MS. BUTO: Whose idea was it anyway?

MR. AARON: Let me give a little background, which will be repetitious for those of you who were in the breakout session before. This idea of state initiatives, backed up by increased federal willingness and ability to facilitate those efforts, presumably through wavers and some additional money, is now embodied in two bills. The House bill is cosponsored by a Republican and a Democrat in the House. One of the most liberal members in the Congress, Tammy Baldwin, and one of the more conservative members of Congress, Tom Price from Georgia, have joined together. They have 45 cosponsors, 25 Democrats, 20 Republicans. That bill would set up a commission to review state plans for extending health insurance coverage in any of the very wide range of different ways.

The essence of the idea and the reason that two people as ideologically diverse as Tammy Baldwin and Tom Price can join together is that a wide range of options would be considered and approved for federal aid and support. Each of the co-sponsors is absolutely certain that the other person's ideas will fall flat on its face and their approach will be proven superior. In the Senate, Senators Bingaman and Voinovich have a similar bill. There are negotiations going on currently between Senator Feingold and Lindsey Graham over yet another version. You'll notice a pattern here, co-sponsorship by both parties as this is a studied effort to keep this bipartisan – a determination that both sides will get a fair shot in plans that would be approved and provided some federal support.

Each person involved in this – let me hasten to say – has their own favorite approaches that they would like to see applied nationally. I certainly am in that category and I know Stuart Butler is. We don't happen to agree on what that policy should be, but there's a widespread conviction that comes from 70 years of bipartisan failure to achieve national action on healthcare reform that maybe we ought to try something else and take advantage of the obvious interest of state governors and legislators in trying different approaches to extending health insurance coverage. The recession is over, money is flowing into state coffers, states are prepared to take some chances they weren't prepared to take a few years ago and with some encouragement from the federal government something might happen.

Prospects for large-scale, comprehensive legislation this year are about as close to zero as you can get. The prospects for even this health partnership strategy, which won't take much money, are not terrific. Quite apart from the politics of the matter, the budgetary climate is rough. There will be some money in the budget resolution for healthcare. Sustaining SCHIP at current service levels will take somewhere in the vicinity of an additional \$10 billion over five years. It will be the prime focus for all groups that are organized in supporting the extension of health insurance. They don't want to lose ground. They'll want to maintain SCHIP coverage. If current spending is simply extended, the number of children who could be served would decline drastically. So SCHIP reauthorization has first place in the queue and whether there's any second place this year is very much open to question.

MS. BUTO: Before I go to the next question, I have plug the Health Coverage Coalition on the Uninsured which embodies the proposal that Henry and Stuart Butler put together as part of the first phase. The group includes 16 fairly broad stakeholders ranging from the Families U.S.A. to the Chamber and everybody in between. We spent two and a half years meeting every month through one presidential election and one midterm congressional election. It was very tough to keep the group together, and I will say to Joe and Henry, the thing that we could not totally get to, but everybody recognizes as important, is the financing. But there is a lot of passion behind SCHIP in trying to make up that shortfall and I think a lot of energy is going to go into that, but anyway, let me turn to you.

Q: David Podoff, Georgetown University. I'd like to return to the issue of individual mandates. I'm delighted to see that Tom Rice wants to take another look at it and I certainly would agree with Henry that we need to put more revenue into the system along with other reforms as Henry suggested. But I want us to be reminded of that quote, and I don't remember who it's from, that those who don't learn from history are destined to repeat its mistakes.

In 1994, while working for the late Senator Moynihan, I recall in the Finance Committee there was lots of interest in the individual mandate with lots of bipartisan support, primarily pushed by the late Senator Chafee and Senator Dole amongst others. We didn't go that way because the Clinton administration wanted to go another with employer mandates. Perhaps we rue the day that we didn't try that because we are now 12 years later, and the number of uninsured is increasing. Perhaps we should learn a little bit from that experience. I wonder whether Tom or Henry might want to comment about whether that might be a possibility. Again, I'm open to all suggestions. I'm just ruing the fact that there was an opportunity out there, which we might have missed. I don't know, maybe not.

MR. AARON: I think the principal goal of achieving substantially universal coverage has to be breaking the current logjam. And consequently, anything that disturbs the rather unsatisfactory equilibrium that we're now in, has to have a sympathetic hearing. When I hear individual mandate together with reinsurance and last resort government insurance, I really wonder whether that can work in the long haul. The

fundamental starting fact is that the individual market is a catastrophe today not because anybody is venal or mean, but because if you are writing private insurance for individuals, you must charge a premium that roughly covers the cost.

Yes, reinsurance lops off the top of that distribution, but there's still a lot of variance below it, and you are buying into a system – at least if it's substantially unregulated – that is going to be administratively very costly to run. And is that what you want over the long haul? If one took steps aggressively to regulate an individual market to a degree that it seems to me would be as politically controversial as any of the other plans we're talking about, if you could get that consensus to really regulate an individual market, then yes, I think it could conceivably work, but I find it hard to see it emerging in the current environment.

MR. RICE: I couldn't really tell the last questioner whether I favor it or not. One big concern about individual mandate is that it is always coupled with a minimal insurance policy that has a huge deductible, and we've seen no evidence whatsoever that Americans are interested in buying insurance with deductibles like that, nor that they would feel protected with deductibles like that. Although as an economist, I like high deductible policies for myself, so I certainly understand on paper why it would work. So I really wonder if we're going to have a winnowing down on the extensiveness of our benefits when we do this. There just might be a movement towards these really high deductibles because that's what the individual mandate says is okay.

MS. BUTO: Oh, you wanted –

MS. BRODIE: I'm just going to add really quickly on the individual mandate. We asked in November the public how they felt about individual mandate – in our question we made a tie to like it is with automobile insurance, and their responses were much more lukewarm results than I actually expected. I expected people to be much more interested in it than they actually were. I can't exactly say; I think it's like 50-50 or so and there are big partisan splits. So I think that there's also an educational challenge of getting the public on board.

Q: Hi. Nancy Cauthen, National Center for Children in Poverty. Molly, I actually have a question for you on the public opinion piece. I'm always really surprised when I hear the results of these surveys that say that people who are insured are very satisfied with their own healthcare, but then when I look at the questions, I see questions about clearly the most important things: access, quality, cost. But does anyone ever ask about the administrative burden, how often they have to get on the phone to get their benefits either for public or private plans? I'm just sort of wondering how people feel about that.

MS. BRODIE: People certainly have had what we might call hassle problems and they don't like them and they can tell you all sorts of problems they've had with their health plan. In any given survey, about 50 percent will report that they've had some sort of trouble with their health plan. It's a much smaller percent who will say it is a very

serious problem. And then the other issue is that a quarter of people are now telling us they're having problems paying their bill. So, again, there are signs in a lot of the data of real angst and I, too, wonder when I see those 80 and 90 percents around satisfaction. It's not just a healthcare phenomenon.

We see this in all data. You like your congressman or your congresswoman, but Congress as a whole is horrible. You like your schools, but the nation's school systems are awful. The choices I'm making for my family's healthcare is fine; I'm doing the best I can, I'm getting through it, but we know that out there in the nation is awful. There is a book by David Whitman called "The I'm Ok-They're Not Syndrome," and it's pretty interesting – (laughter) – and it definitely plays into these debates and it suggests that people sort of don't have an accurate view of what's happening in their own situation and in some cases they overstate problems that are happening in the nation because of it, so it's a real issue.

MS. BUTO: We just have time for the last two questions at the mike. Why don't we start with you?

Q: Denny Vaughn. I used to work at Social Security and I worked a little bit at Census when I was working. The president has proposed a plan of tax cuts and deductions as an initial response to his concern with the healthcare crisis. As a person who was concerned with Social Security issues, I note that he's proposes that the first \$15,000 in wage income not be taxed. And I wonder if that proposal has hidden in it any implications for the benefit formula on Social Security and how it might affect low-income workers.

MR. AARON: Yes. I'm not so sure that it's all that hidden and there's a very nice paper by Len Berman and Jason Furman at the Urban Institute and Brookings on this topic – at least an initial look. And clearly for everyone who takes advantage of this will be paying less in payroll taxes, Social Security payroll taxes and of course, the benefit formula is tied to which you contribute, so it will knick people who have higher incomes, and it will be more significant factor for people who have lower incomes. I think that's fairly plain.

Q: Bob Rosenblatt, National Academy. I'd like to press all the panel members a little bit onto exactly how they would control costs. Let's say that our ever improving information systems enable us to identify the 20 percent of hospitals that are the least safe and the least efficient and the 20 percent of doctors who are the least safe and the least efficient. Should Medicare announce it will no longer deal with them? At the same time, should the Business Roundtable announce that its members will no longer include these doctors or these hospitals in their insurance networks?

MR. ANTOS: It might be a long drive if you live in certain states to the nearest acceptable doctor.

MR. RICE: Yes, that's an interesting point that Joe just made here. It's a very interesting question. I've always been a believer in regionalization. I think that basing regionalization on the quality of the care that's being provided is a good idea. The study down in Iowa that showed that regionalization wouldn't work at all, so it's something that we should consider. It's an example getting back to the other thing about state solutions where probably a national formula here won't work very well.

MR. AARON: The quality problem is a lot more pervasive than that and the right solution should be systemic rather than punitive. Probably the most cited recent study, at least that I know about, is the one in which Elizabeth McGlynn was the lead author that documents that on the average American patients get recommended care a bit, but only a tiny bit, more than half the time, when they have a contact with the medical system. What is needed to improve quality is much increased use of information technology, to improve communication among physicians, and a willingness by physicians to work as part of teams, not as individuals. One of the most challenging problems is how to end the go-it-alone attitude, the sort of individual cowboy mentality that many physicians still have about the provision of care.

There are some medical organizations that have actively defeated this mentality and introduced information technology. One of the leading examples is the Mayo Clinic, renowned both for very high quality care and relatively low per capita cost. Other organizations are trying to move in that direction. We spend more than \$2 trillion now on healthcare. Those who bewail that lack of quality overall I think are on target, and I think spending \$2.1 trillion well for 85 percent of the American population who are insured is actually as important as raising overall spending by, let's say, \$100 billion to cover the uninsured.

They're both important problems, but the quality problem requires a systemic reexamination of the whole organization of the healthcare delivery. This is all by way of leading into a plug for two issue briefs recently issued at Brookings, co-authored by James Mongan and Tom Lee of Partners Health in Boston and a second brief co-authored by them and David Mechanic as well. If you get on the Brookings website you can download it, or we actually have some hard copies left over if you want me to mail you one.

MS. BUTO: The only other thing I'd add to what Henry said, because I think he's absolutely right, is there's a whole translational issue, so that even if the evidence is there and Beth McGlynn knows what it is, whether physicians have access to that in a way that changes their practice is very unclear, and the responsibility for getting that information is yet to be sorted out. So I think, as you say, it's quite system that goes beyond whether there's a physician not following guidelines or not.

So join me in thanking the panel. (Applause.) And we're taking a very short break before lunch. Thank you.

(END)