ALLIANCE FOR HEALTH REFORM

Show Me the Money: Options for Financing Health Reform

Alliance for Health Reform
July 31, 2009

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

[START RECORDING]

ED HOWARD: Thanks very much for coming, I want to welcome you, my name is Ed Howard with the Alliance for Health Reform. I welcome you to this program on how to cover the costs of reforming our health care system. For Senator Rockefeller and Senator Collins and the Board of Directors, we welcome you to what we obviously know is a very popular topic to discuss in this town and one of supreme importance.

Our partner in this enterprise today is the Commonwealth Fund, a New York-based philanthropy that's been promoting the common good, the common wheel for almost 100 years, they know a bit about health policy too, as many of you know whose bosses have asked for briefings from Karen Davison the fund staff and you're going to hear from Rachel Nuzum in just a moment.

There are a lot of major proposals under consideration in many committees in both houses of Congress and a lot of them involve new federal expenditures of about $1 trillion over ten years. I suppose if Everett Dirksen were around today he would say a trillion here and a trillion there and pretty soon you're talking about real money. It's important to note, thought, that over that same decade our country is going to spend on healthcare $35 to $40 trillion.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So while Senator Dirksen would be right about a trillion being real money, it needs to be kept in perspective, if you will, with respect to the total size, both of the healthcare spending and of the economy in this period. Now Congress decides to pass some version of reform, how is it going to pay the bill?

President Obama, leaders in Congress in both parties say any reform bill has to avoid increasing the federal deficit and that is obviously is our topic for today. Two main ways, to finance added government costs, either you've saved money in other government programs, or you add additional revenues. And there are two distinct financing questions that policy makers are faced with.

First, how you cover the $1 trillion needed in the first ten years, and second, how do you bend the cost curve over the longer term for both the public and the private sectors so that we don't end up all working for some hospital chain in McAllen, Texas [Laughter].

Now to address these and related questions we have with us as formidable a mixture of economic and political acumen as you have seen gathered under one roof in a long time in this town. And before we do that I want to call on Rachel Nuzum, who's a Senior Policy Director for the Commonwealth Fund, she's a former Winston Fellow, she's helped policy staff to two

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

senators over the course of her career and she'll be co-moderating today's briefing and we've asked her in addition to that, to give some background, some framing if you will to this very wide ranging and controversial topic. Rachel?

RACHEL NUZUM: Thanks so much, thanks to all of you for coming. We're really pleased to be hosting this briefing with the Alliance for Health Reform, so thanks to Ed and his staff for coordinating something that is very timely and very relevant as evidenced by the crowd here today.

We're also pleased to be joined by such an esteemed panel, we know that all of you have many demands on your time and we're very appreciative that you've taken the time to join us for this conversation. As we know, and really the biggest topic in Washington, D.C. right now is how to slow the rate of cost growth and how to find a way to pay for reform and we really think that the two go hand and hand as Ed just talked about.

I think one thing everything can agree on is that we are on an unsustainable trajectory of healthcare spending, and simply extending coverage to Americans without reforming the way healthcare is delivered is not an option. So the Commonwealth Fund and its commission on a high performance health system has been looking at this issue for the last couple of years, and through a series of reports we released,

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

we found that it is possible, in fact, to provide access to affordable, high-quality coverage and efficient care for all while also bending the cost curve.

The bad news is that there's no silver bullet, there's no magic wand, and that the only way to do this is going to take an integrated set of policy delivery system and payment reforms. We're never going to be able to find enough new revenue sources; we're never going to be able to cut enough to actually keep pace with the rising growth of healthcare costs.

Right now, we spend 2.5 trillion in total health expenditures on healthcare annually and we're on track to be spending an additional 5 trillion annually if we don't alter our course.

The second line here shows the impact of implementing the set of policy and policy reforms and system reforms that I've just outlined. It includes a new national insurance exchange with a choice of a public option, alongside public plans, and it turns market reforms and individual mandate for coverage, shared responsibility for financing and provider payment and delivery system reforms through working high value care.

That's all said, I say all of that to illustrate all of the things that have to be done to bend to the curve just a little bit. This slide illustrates the savings associated with

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

the policy options in the path report. There's a lot of numbers on this slide, but direct your attention to the bottom.

We can realize almost $3 trillion in total health systems savings. And we think it's critical that when policies are considered, that the impact on total health spending is considered in not just the impact on the federal budget.

Total health spending includes the impact on state and local governments, on individuals, on employers, on households, and in order to ensure that the policies we're talking about are actually reducing costs, we need to look at total health systems savings to ensure that we're not simply redistributing who is paying for healthcare.

As you can see here, the payment and system reforms, which I've talked about, which include things like enhancing payment for primary care, encouraging the adoption of the medical home model, bundling payments for episodes of care and producing and using better health information is what actually holds down the cost, the federal cost of expanding insurance coverage.

And finally a mixed public private approach with the features that modeled in the path report does have benefits that accrue to all state holder groups. And that's why it's extremely important to consider the impact—the financial impact

on, not just the federal budget costs, but the total health system spending.

So although much of the focus right now is getting the price tag of a final bill down and the impact the reform options would have on the federal budget, we shouldn't lose sight of policy options that will slow the healthcare cost curve, while also expanding access to affordable high-quality efficient care.

The impact of the policy decision upon total health spending must also be examined to ensure we're not simply shifting costs. The only viable option for bending the curve and finding enough resources to extend meaningful coverage is by reforming the delivery system and the way we pay for care, and by ensuring that incentives for providers and patients are lined in way that rewards high value care.

Finally, we must ensure that there's a mechanism to track our progress on revenue raised, on savings accrued, on coverage extended, so that we know if it's time to correct our course, our path mid-course and make those corrections if necessary. Thanks.

ED HOWARD: Thank you very much Rachel. A couple of quick logistical items, you have all the materials in your packets, if, excuse me, if you find that a particular set of slides is not there it's because we didn't get them in time and

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

you will find them on our website when you get back to your office or shortly after you get back to your office.

That's www.allhealth.org. The web cast will be available no later than Tuesday, perhaps Monday, through the good offices of the Kaiser Family Foundation and the Kaiser News Service. There will be a podcast available as well and we at allhealth.org will have a transcript in a few days that you can take a look at. There are also green question cards that you can use at the appropriate time to ask questions of the panelists, along with microphones that you can use to voice them, and a blue evaluation form that we hope you'll take the time to fill out before you leave.

Now, let's get the program, we have a terrific group of folks today, brief presentations and then your questions, and I know that we're going to get a lot out of this. Leading off we have Bill Hoagland, whom I got to know when he was the Director of Budget and Appropriations for then Senate Majority Leader Bill Frist. He also served for more than 20 years on the staff of the Senate Budget Committee, and as seven years of that as Republican Staff Director under Pete DiMenici, now, he's the Vice President for Public Policy for CIGNA, a major health insurer, and coincidentally enough the CEO of CIGNA, Ed Hamway is on the board of the Alliance for Health Reform.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Bill can't get away from us. We've asked him today to give us some insight into the congressional budgeting world into the relationship among healthcare, the federal budget and the economy. Bill, thanks for being with us.

BILL HOAGLAND: Thank you Howard. Let me start by saying I'm here wearing my former Congressional budget hat, and I'm not here representing the immoral villains out there [Laughter]. This is going to be… I'm not entirely sure if this covered the Economist at the beginning of July, was a harbinger what was to come this concluding month, but it also could apply to the topic I was asked to address, the Congressional scorekeeping process.

Howard asked me to demystify this scoring process with the additional caveat that to the extent possible, the real healthcare experts here on the panel will tell you where the money is to be found, I only have to tell you how it will be accounted for if it is found.

Let me begin, however, by putting my biases on the table. I began my career in this town when the new Congressional Budget Office was established in 1976 under Hallis Rivlin. My responsibilities were cost estimates for the food nutrition programs, federal nutrition programs broadening out later for income security programs including Medicare and Medicaid.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So, as a CBO alumni, I have to be—I am a very strong supporter of the work they are required to do under the Budget Act, and I would only ask you to try to imagine Congress wrestling with the major fiscal issues confronting with the country today without an objected CBO scoring.

Maybe legislation would fly through the Congress a lot faster without them, but I am not sure that would be in the best interest of the country's long-term fiscal interest.

So four quick points I want to make here this afternoon. There is, number one, there is a budget scorekeeping process and while it may not be perfect, none ever could be. It is essential to the Congressional decision making process.

Number two, this year's adopted budget resolution allows for flexibility in reforming the healthcare system so long as it does not worsen an already difficult fiscal situation.

And number three, some will see this as a shortcoming as do I, but the process and the various points of order for enforcement are by design addressing only federal expenditures of healthcare, not the total national healthcare expenditures as Rachel was talking about.

And finally, as much as we can say today about the money shown thus far in the various bills, not only do they not

meet the current budget resolutions requirements this year, but qualitatively, they also do not meet the President's objective of reducing national healthcare expenditures in the future.

The budget resolution as reflected here was adopted on the 100th day of the President's time in office; the adopted resolution establishes the parameters for the debate on healthcare and all other legislation going forth on this Congress. The numbers in the resolution just shown on that slide represent the aggregate level of spending and revenues permitted annually over the next five years through 2014.

As an example, as you can see there, the total spending for the current fiscal year is about 3.9 trillion and revenue is 2.2 for a deficit of 1.7. In the interest of time, I'm only going to focus on the mandatory spending components of these aggregate numbers, not the discretionary appropriated levels.

In bed within those aggregate numbers up there set by Congress is an assumption that starts out with the fact that Medicare and Medicaid mandatory spending remains unchanged from current law with one exception. And the one exception is the resolution that Congress adopted added $38 billion through 2011 for keeping the current doctor's Medicare payments frozen at their 2009 level, not the 21-percent reduction that would take place under the SGR in January if it continued.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So except for this one adjustment, total Medicare spending and Medicaid, total about $720 billion for this year, or 18-percent of total spending. So how then—how then if you assume that everything is current policy, how then can you accommodate healthcare reform with additional spending or additional revenues if these are the numbers that are simply current policy?

Well you create a reserve fund in the resolution, extraordinary powers given to the Budget Committee Chairman to make changes in those aggregate numbers under certain conditions.

And what are those conditions, the Chairman may revise as those are exact words within the budget resolution, that can revise the aggregate levels of spending and revenues to accommodate healthcare reform legislation being considered on the House and Senate floor so long as when he makes those adjustments and revisions, he does not change the aggregate level of deficit spending over the next five years. That just happens to be about $5.6 trillion.

Well, why make these changes if you're reporting legislation as deficit neutral if you do not revise those numbers on the floor, what would happen is the legislation, even if it deficit, it would come to the floor would violate the aggregate levels and there would be, at least in the United

States Senate a 60 vote point of order that would lie against that particular legislation.

Now at least the revisions that the Chairman makes will avoid that budget act, I want to be clear that does not get around non-budget filibuster procedures as an example and there still could be other problems. But at least that major point of order is taken care of.

Now, just as Rachel was talking about—by just offsetting the federal cost of healthcare reform, while maybe moving legislation through the congress does not address the more fundamental problem of how do you—how do the reforms impact aggregate national health expenditures.

Obvious to this audience, I'm sure, but not always so to the general public, the focus of paying for healthcare reform is really targeted on paying for the federal expenditure changes, which is the line depicted in the middle of the chart here, showing the cumulative federal cost to Medicare and Medicaid.

What Congress does not have to address in its own scorekeeping rules, but is increasingly becoming more cognizant of, is how will reform change total national healthcare expenditures, the top line. I have said sarcastically that balancing the federal budget is easier than reforming healthcare.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

The budget process accommodates scoring of that middle line, not the top line. In 1997 Congress enacted changes to Medicare in the infamous Balanced Budget Act of that year, that helped put us on a path toward a balanced budget, but it did not necessarily change total healthcare expenditures equivalently, as Medicare costs savings to the federal government were offset by Medicare providers increasing charges to the private sector healthcare recipients.

In the CBO estimates during the 1993 healthcare debate, estimates of the impact of reform proposals would have on the national health expenditures that were provided often overlooked in Reichard's '94 cost estimate of the Clinton Healthcare Reform Bill was a statement that by 2004, if the bill had been enacted, national healthcare expenditures would have been reduced by 7-percent in 2004.

The current director, Elmendorf, has addressed this issue just recently on one of his CBO blogs stating that CBO does not analyze national health expenditures, but does analyze—primarily it focuses, of course, on the federal budget. But he also did say they were working to enhance their capabilities in this area.

He went on to say that while they cannot provide quantitative estimates of the effects of national health expenditures, they can and have provided qualitative

indications of whether proposals would be more or less likely to raise national expenditures over the next couple of decades. Unfortunately, the budget resolution horizon is five years, one decade at best, and certainly not two decades and qualitative indications are not enforceable under the budget act.

So, that brings me to the final quantitative scorekeeping slide which I—after I put it all together and after the agreement two days ago and I guess another agreement this morning, with the house Blue Dogs, and nothing to fill in under the Senate to finance column there, and only half to fill in under the HELP committee bill, I concluded this was not very informative [Laughter]. I apologize.

But here it is anyway, and showing you at least the aggregates that neither of the two bills today, if you look at, hard to see for the back of the room, I think you have charts in your packet, that either of the bills today meet the first budget scorekeeping requirement requiring balance over the next 10 years, and both would have deficits increasing in the 10th year, leading CBO's qualitative conclusion a couple of weeks ago before the budget committee that national health expenditures would be increasing.

Now one really green eye shade budget score keeping point here, very hard to see on the chart back in the back, somebody call it SGR reform, adding 228 billion. Notice that

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

the Tri Committee Bill assumes relative to the budget resolution assumptions, the bill does away completely with that doc fix and adds, as I say, $228 billion over the next 10 years.

But remember the reserve fund I talked about earlier? The House Budget Committee Reserve Fund has language which says that you do not have to have to offset the SGR fix if the house passes a new statutory pay law, which they did last week. So, one could conclude if we used house scorekeeping rules the preliminary estimates of the Tri Bill adds 11 billion to the deficit not the $280 some billion shown there.

Isn't scorekeeping wonderful? [Laughter]. It depends on who is keeping score, and at least, for those of you who cannot see it at the bottom, at least we can all take solace paraphrasing the great sportswriter Grantland Rice, that when the one great scorer comes to ride against our name, he will not use CBO scorekeeping and with all due respect, Rachel, we will not use Commonwealth fund either [Laughter].

ED HOWARD: Thank you very much Bill. You're not supposed to use Lewin [misspelled?] [Laughter]. Now we're going to turn to Uwe Reinhardt, whom many of you already know, he's the James Madison Professor of Economics and Public Affairs at Princeton.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

He's a member of the Institute of Medicine, he's served nine years on what's now Med Pak and he recently presided over the Governor's Health Reform Commission in New Jersey. He's headed most of the important health policy organizations in the United States and serves on the editorial board of every important health journal you can imagine, so who better to give us a broad view of what's at stake in financing reform. Professor Reinhardt.

UWE REINHARDT: Thank you. I'm not as bright as Bill who can remember all his numbers, so I'll stand up so I can see what I'm talking about. First of all, what is to be financed.

If you look at Hadley AL, they estimated that had we had full insurance coverage, last in 2008, it would have cost 122 billion, additional health spending. 5-percent increase. Bring that forward to 2010, that's about 140 billion, growing at 6-percent is 1.85 trillion at 5-percent, 1.8, so, somewhere between close to $2 trillion additional national health spending if we cover the uninsured.

Now before you fall off your chairs, let me remind you, I think it's something like $44 trillion for national health spending. So it's a 5-percent increase in national health spending, and before that makes you fall off your chairs, remember you always sat quietly as it grew at 6.7 or 8-percent per year.

So this is nothing, actually [Laughter]. So, now this additional health spending has to come from three sources. You could, ask the people, of course you will extract some of it from the newly insured by a mandate, by saying you must be insured, and whether they like it or not a lot of the young people who like to go hang gliding and use what they would have paid for insurance for their parachute or whatever they wear, they will now have to have insurance.

How much can be offloaded onto the states, of course, and how generous the package is that needs to be subsidized, and then also this wonderful trick, the longer you phase it in, the cheaper everything gets, in America only [Laughter].

So the current preference on the hill seems to be that $1 trillion is a good number, again, remember that. So where would you get this money, there are three sources, when you think of it. You could ask the descendants of Mao Tse Tung [Laughter]. They financed our tax cut for the well to do.

They financed our wars, why should they not finance being our brother's keeper? But apparently that's been ruled out, it's a shame, but there it is. Increasing various kinds of taxes on Americans, which of course, what we don't like, that's why we ask the descendants of Mao Tse Tung to pay for what we like [Laughter].

Or, cutting health spending on the already insured, to help finance the newly insured, another way to put this is to say to the delivery system, we're going to give you more stuff to do, and we're not going to give more money, and yet another way to say that, we'd like you to increase your productivity, which is, of course, anathema to that sector [laughter], but other sectors have done it [laughter].

The menu is far and wide, you could raise income tax on high income Americans, that's obviously been discussed, you can Picovian spill over taxes, that's like the pollution tax, when you pollute there are these effluent taxes. And here you would be taxing activities or substances that cause ill health, sugar or fat or riding motorcycles, in general, there should be a big motorcycle tax, even if you do wear a helmet.

And if you don't, there would be a bigger tax. And a modest broad-based earmarked healthcare tax, even half a percent would yield 500 billion a year, so if you make even less then that and just earmark it and say healthcare tax, and what does the tax do for you if people ask members, what's in it for me, never was good for the country, but that's the theme now.

What you could say is number one, it's be your brothers and sisters keeper tax, but it's also if you're in trouble, we have the money that essentially you are insured and you won't

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

lose your home and so on. I would remind you, I just downloaded that this morning, and so you can believe it [laughter].

In 2007, we were the second least taxed nation in the OCD. Right? And yet we're a nation that likes to be the policeman of the world, we have a legacy of slavery and the aftermath, so it's a complicated society we run, and to think you can do that for such a low overhead rate, forget about it. I tell my students you'll be doing 33-percent whether you like it or not. We're still struggling with this, but at some point we need to raise taxes.

And then we have bending the costs curves, during the past four decades, health spending has doubled every 10 years. And the supply side of the sector seems to assume that the continuation of that trend is a firm social contract between them and the rest of society; that we have signed a piece of paper that says from here to kingdom come, we will double your revenue every 10 years. And they firmly believe that. And that is why you get this strange language, any downward deviation of that trend, and you saw that in the Commonwealth Fund, is viewed as a give back. They never had it, it's a give back, or a contribution to health reform. Now I want to tell you, I just gave, contributed a couple of thousand dollars to Princeton University.

How did I do this? The provost recommended to the trustees to freeze the salary of the full professors, right, and if I didn't get what I wanted, it's a contribution, right? [Laughter] That would not sell in New Jersey, somehow this sells even in the White House, that President Obama goes along with this game, just amazes me, it's not a give back, they never had it to begin with, in a sort of New Jersey thing. [Laughter]

So here we have, just as an illustration, I just want to pick on hospitals, I love hospitals, but they're nice big numbers. So if you look at the CMS forecast, total hospital spending will be $11 trillion for the next 10 years. A total federal spending on hospitals, 5.2, and total Medicare spending 3.3.

The blue is, the red is, if we didn't increase anything, just multiply by 10 the 2010 number, but the blue is additional money. And then it had been proposed to have $155 billion to finance healthcare, and all hell broke loose.

This is 1.4-percent of total health spending, and I sort of ask myself, I sit on boards, I know business, I teach business, think of a business, any business, that faces a revenue stream of $11 trillion coming down the pike.

And you tell those managers, you know what, we're going to cut that revenue stream by 1.4-percent and that industry

jumps off a bridge and dies and say there's no way we could manage, that is what we are facing, ladies and gentleman, and of course, the inability, the professed inability that they cannot manage such a cut will guarantee us, that Peter Orszag's slide, he was off by two-percent, my slide says it's 40-percent by 2050.

What the social contract seems to be, is that the supply side of the health sector expects to get 40-percent of the GDP by 2050 and any time you want to deviate downward from that trend, all hell breaks loose. And the question really, I just come from China, where people have a sense of purpose, it makes me worry about America, frankly, that our supply side of the health sector couldn't manage the kind of cuts we're talking about, that this, be the expectation they have.

So what are we to make of an industry that faces revenue, I just said that, and cannot manage that. What are we to make of that? And I could say that about other sectors of the health industry. I believe that one should not accept these statements with such equanimity, there is a certain degree of despair about our country in my soul, if they cannot manage better than giving us this curve, God help America. Thank you very much.

ED HOWARD: Thank you Uwe. It's a good thing he's still tired from having flown in on the red eye or he would

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

have been really fiery. [Laughter] I'm going to introduce our next two speakers together; nobody wants to follow Uwe themselves, so they'll do it as a team. But also because together, they direct the staff of the Leader's Project on the state of American healthcare at the Bipartisan Policy Center.

And they've just guided former Senate Majority leaders, Baker, Daschle, Dole and Mitchell in their in their efforts to create a bipartisan plan to transform the healthcare system in this country, they are obviously Mark McClellan and Chris Jennings.

Mark McClellan at my far right directs the Engleberg Center for Healthcare Reform at the Brookings Institution, he's a physician, he's an economist, he's held most of the significant executive branch healthcare jobs in Washington and several significant jobs only partly connected to healthcare. He has headed Medicare, he has headed Medicaid, he has headed the Food and Drug Administration and served on the President's Counsel of Economic Advisors.

Chris Jennings, is President of Jennings Policy Strategies, a policy and advocacy consulting firm in DC. Under those sleeves on that nice suit, Chris bears many of the scars from the last health reform battle, having viewed them from his post as Health Policy Advisor to President Clinton. He also served, for those of you who were on Congressional staffs, on a

Senate staff, the Senate Aging Committee for the better part of 10 years, dealing with health and aging issues.

And we would ask Mark and Chris to examine the policy and political potholes one has to avoid to get to a workable bipartisan reform plan, using the leader's plan as kind of a case study, so Mark, if you'd like to start off.

MARK MCCLELLAN: Great, thanks Ed, it's great to be here with all of you and it's always entertaining to follow Uwe, this is the first time though I've seen you do your remarks as sort of a standup comic routine that ending with God Help America. [Laughter] The Lenny Bruce of healthcare reform. [Laughter]

So this is going to be a little bit different tone, I'm going to try this sitting down and am going to focus on a possible path forward, the work that we've done with Bipartisan Policy Center, to bend that curve and to get towards coverage for everyone, but along the way, I want to highlight a couple of the areas where we're having some real difficulty doing this actual policy process right now.

For those of you who aren't familiar with it, the Bipartisan Policy Center is a group made up of most of the Majority Leaders in the U.S. Senate. We started out working with Senator Daschle, Senator Baker, Senator Dole, and Senator Mitchell.

Senator Daschle left us for a little while but now is very fully engaged in healthcare reform fortunately. Senator Mitchell was working with us for a while and got tapped by President Obama to go do Middle East peace, and we keep asking him which one is easier, I'm not sure he's got the answer yet. And Senators Dole and Baker have been very helpful throughout the process.

We released a specific reform framework back in mid-June and this is not level principals; it is a level of specific policy reforms that are scoreable and that we did our best to score in order to meet that goal of a budge neutral approach to healthcare reform.

And, it's been out there, recently it's gotten another round of attention as people have and come and gone through every other alternative I think, to bipartisan reform and finding that a bipartisan approach may be the best one.

So I've heard it recently described as aging better than fish, or it's like that person who you thought about dating, be he was, he or she was kind of bland and you tried all the other ones who were flashier and better and then finally decided to settle down with this one.

I don't know, I've heard it described a lot of ways, but I'll try to take these as compliments, but this approach is I think definitely still on the table and I have a lot of

respect for those on the Senate Finance Committee, who are struggling through trying to come up with a politically viable one, which was exactly what our goal was in this process.

Now, not that this should be taken as any indication of the potential for bipartisan reform, but my slides don't seem to be working, right? Okay, so, that's okay, that's okay, I can—we'll still get there, we'll still get there.

But I wanted to highlight a few key issues. That reform package that we developed had four key pillars, one was promoting high quality, high value care, something that everybody agrees we need to do to bend the curve and the question is just how to do it.

The second pillar related to making health insurance available and meaningful and affordable, that's really making sure that people that don't have good coverage options through their jobs can get it without too much disruption in the existing coverage through Medicaid, Medicare, private employer provided insurance that people generally like or that least are concern might be disrupted in the healthcare reform process.

Third, an emphasis on personal responsibility and health, health and wellness, staying well, not just paying for the problems after they happen, and finally, making sure we have a real workable, sustainable, explicit approach to

financing all of this, not just over 10 years, but year by year in those 2019 numbers that Bill put up earlier.

I wanted to focus most of my time, remaining time, on the provider payment reforms in pillar one and the other steps to improve high quality care. We emphasize in the report that this is not going to be easy to do.

It's easy to talk about how much waste there might be in our system, a 30-percent numbers, things like that, but actually finding ways to remove that, the American public and providers would be comfortable in implementing, or at least willing to implement, giving those, funding streams and people jumping off the bridge that Uwe was talking about earlier, that's not so easy to do.

We emphasized, number one, that we need a much better infrastructure for developing evidence on what works that includes a much better capacity to develop measures of quality and performance throughout our healthcare system on the public and private side.

We described a framework for moving forward; we want to move forward on comparative effectiveness research, not just comparing one treatment to another, but also practices, medical practice styles and alternative policies. And we described a way to do that.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Those steps by themselves are not going to save money, so we need to move to a payment system and benefit choice system that's focused on accountability, not for more and more intensive services, but for quality and efficiency, or value. To do that, we proposed a set of reforms along the lines of accountable care organizations. These proposals are largely reflected in current legislation that's moving through congress.

We also emphasize that other payment reforms that have been part of recent legislation and the reform debate, like payments for health IT, or bundling of payments, or payments for care coordination or medical home. Those are important steps to help us get there, but by themselves, unless they're explicitly tied to this goal of demonstratively better results at a lower overall cost, it's probably not going to be enough.

And CBO has scored these reforms accordingly. We also emphasize the importance of a much better piloting and evaluation capacity for Medicare, there's been some concern about giving CMS or some new independent board more flexibility and authority to determine changes in Medicare payments and other aspects of the program to get better value.

We think that by linking that to a much more developed evaluation capacity, you can see whether these reforms are

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

actually working or not, much more clearly, could be a way forward on that issue as well.

We emphasized the importance of care coordination for dual eligible Medicare beneficiaries, that's something else that's been largely missing from the Congressional debate now, that's where a lot of the money goes, if you really want to coordinate care, that's the population you need to focus on, that's where the opportunities are.

And we emphasize the importance of wellness through a community wellness fund, which would provide a bridge from moving beyond this focus just on healthcare and medical services, to how you actually get population health better, these funds would be tied to performance measures, related to the same kinds of improvements and health outcomes that we want to see a much bigger part of payment systems as well.

On the consumer side, we also emphasize changes in incentives to encourage purchasing less costly coverage. And less costly care as a result, so, we have a system of insurance exchanges with flat credits, refundable tax credits, that would be a flat amount.

We have a tap on the tax exclusion from employer-provided health insurance, we have reforms in Medicare supplemental coverage that would actually make the elderly better off financially, lower net costs of their supplemental

policies with better protection against high costs, but some requirement to pay for up-front costs and proposals for centers for excellence.

So if people choose better systems for getting their care, bypass surgery from organizations that can get better outcomes and lower costs. Oh great, great, let's see if I can get to the right places, maybe, let me just keep talking because I think I be quite out of synch with the slides at this point, but thank you for the effort.

But I was talking about the incentives for consumers to choose less costly care, so if you go to a surgeon or an institution that's getting better outcomes at a lower cost, for bypass surgery, or for your diabetes care, you ought to be able to save money, it shouldn't be the case that just because you have to go to the hospital or you've got a serious chronic disease, that you need to pay $5,000 or $10,000 a year for your healthcare.

There are too many opportunities, too many things that people can do to help get lower costs, to avoid that situation. So a lot of steps to reform provider payments, reform consumer incentives, and we're not there yet on the healthcare reform packages, but again, a lot of effort to try to move in that direction, and of that the Senate Finance Committee is working to do that as well.

I emphasize the importance of making affordable, reliable health insurance options available to everyone without disrupting coverage that people depend on now, or minimizing those disruptions, making available insurance options at with guaranteed issue and community rating means that you need to also include a requirement for people to participate in coverage.

It's really pretty simple, otherwise the insurance markets don't work, we've seen that happen around the country already, and if you're going to do that, you also need to provide subsidies for people who otherwise would not be able to afford that coverage requirement.

And that leads to the other core issue, that people in the healthcare reform debate are struggling with right now, which is how generous can you make the coverage on the one hand versus where can you get the financing to pay for it on the other. More generous coverage requires more financing, it's pretty straightforward.

We made a choice as many of the committees seem to be moving in the direction of as well, that we can't provide, really anything like a first dollar or very generous subsidized coverage to everyone. I think the estimates, other people may have better numbers, Bill you might, of doing something like FEHD level subsidies for every American, would probably be up

in the $2 trillion range, which is out of the realm of feasibility right now.

We actually have a proposal that would be closer to the 1.1 trillion or so range, which has a basic coverage requirement, at the level of a high deductible health plan, plus coverage for preventive care and drugs up front, so that again, with this emphasis on wellness, but, progressively higher subsidies at lower income levels, so that people at the lowest income levels would be eligible for comprehensive Medicaid benefits and then subsidies to the level of an FEHB standard plan and than more intermediate levels of subsidies or systems, sounds kind of what they did in Massachusetts.

This was a trade off, having, this is more generous subsidies than I think many conservatives would like to see, but we are paying for it and this is coming along with those reforms in choosing healthcare coverage to try to encourage efficient, more efficient choices as well.

So that's the trade off that we face, and in terms of paying for all of this, we, it does take some hard decisions, this the hard part right now. It's one thing to make some tough choices to lower down the overall costs of the subsidy, but then the really hard part, is you know, where do you find that the pay for is the financing to offset that.

We manage to do a lot of ours through changes in Medicare and other federal programs, and I've briefly alluded to some of those, but there are further steps that would probably be needed. Such as, some additional tightening up of payments, where there is evidence of overpayment. Such as some possible budget triggers, perhaps hitting in high growth rate areas more than elsewhere, such as, possibly a health counsel or an advisory counsel that has some real binding authority to reduce spending growth if other steps are not working. And we also proposed a cap on the tax exclusion. As I emphasized earlier, I don't really see any other way to get there, even though there are obviously some political concerns.

In terms of capping the employer tax exclusion, I do want to emphasize a couple of things about criticisms of this policy. Some of the criticisms are focused on the fact that people who live in high cost areas would be hit harder.

That is true, if you use the same cap nationally, you don't have to do it that way, the cap can be geographically adjusted to address that problem, same for existing plans that have unfavorable demographics. And in terms of who gets hit from a fairness standpoint, I really can't think of a better policy, under the proposal that we developed, which starts out at a pretty high level and affects more people over time.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Only about one-percent of the costs would be borne by households with incomes under $50,000. In contrast, most of the new subsidies that were providing are going to those groups, remember I said it's an income related subsidy.

So, its a really, it's a big benefit for low to moderate income households, it gets rid of a very regressive tax subsidy that's worth over 250 billion a year, it does so only in a limited way, and because it means that all of our financing for this healthcare reform package comes from within healthcare, it means that we're keeping up with financing over time.

You don't get that problem that Bill showed on his earlier chart, where if you're using tax revenues from other sources, high income people, you sugar taxes, whatever, those tend to grow at most at something like the rate of GDP growth. Healthcare costs are going to grow, even if we have these steps improve efficiency, at a significantly higher rate than that, so you're going to be building in a deficit over time, unless you find a financing source that keeps up with that growth, like the ones that we identified.

So, it's not clear that these issues are all going to get resolved in the political process, but I'm actually fairly encouraged by the fact that people are sticking with it and, as time has gone by, there is continued to be some real attention

to bipartisan approaches like the ones we developed, so hopefully I can end these comments on a somewhat different note than Uwe's God help America. Thank you all very much.

[Applause]

UWE REINHARDT: Maybe God doesn't have to, because you just did.

ED HOWARD: And he's going to get some more help from Chris Jennings, and let me say upfront, Chris accommodated us on this panel despite the fact that he has another commitment he couldn't get out of, so you may see him duck out before the end, like 30 seconds.

CHRIS JENNINGS: Well, first, it's always a pleasure to be with this elegist group, many of us have been doing this for quite a long time and I'm now into my 26th year, and, I was telling Ed and Rachel earlier that my father recently said that, you know, you've been doing this for almost a quarter of a century and not much has improved [laughter] have you thought of a new profession? [Laughter]

Then Ed called and said you've had such great experience in the Clinton Administration, you can certainly advise us about what we should be doing. So with that record in mind, please take with any grain of salt you wish to what I'm about to say. I would just, I think I'm just going to step back for a moment and say that you know, this opportunity to

talk about meaningful reform just happens maybe once every 15-20 years.

And it's a very, very rare opportunity to really make a constructive contribution to something we know we must do. And I think that too often we evaluate any discussion about health reform, either through the context of budget, or nirvana, or whatever, but I must say, that's not what we have, we have it in the context of failure to act the status quo.

And what that means is, more cost, more cost shifting, one insured, more inefficiencies, and what we always say, I'm willing to stand on the program. So the reason why I worked with Mark and the Senators worked with one another to try to create a policy that would maybe provide some constructive contribution to the cause, was that all those members and Mark and I had gone through that before and we wanted to get something done. And, I think, I'd just like to say, that if we don't get that done, if we fail to succeed this time, that we will rue the day when we don't think we understand our history or where we're headed.

Secondly, when Uwe talks about the context of the numbers, I'd like to further supplement him. You know, about two months ago, the health plans and the providers and the manufacturers went in to see the President and they said, oh yeah, we can save over $2 trillion over the next 10 years.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

This is them, right? Over $2 trillion. And if you do that application to the federal budget, that's over $500 billion.

UWE REINHARDT: [Inaudible] $20 billion.

CHRIS JENNINGS: No, no, no, I mean, not their pause, I'm saying that they asserted that they themselves as a sector could achieve over $2 trillion in savings. So, I'm not even asking for something that I want, it's something they said they could achieve. And yes, it will have to be supplemented by revenue, my goodness, look at all that we're talking about.

We're talking about a system that works for everyone in this country. And again, if we're serious about cost, we really can't do cost well without doing coverage. All we do is we shift costs in this country. Insurers spend all their time avoiding sick people. People wait until their sick to get insurance, it's this game amongst ourselves, I mean, is that how we want to spend our money?

Do we spend our money, how can we ask insurers to invest in prevention when, you know, people go in and out of coverage, or chronic care management, when people go in and out of coverage. You know, how can we expect insurance reforms to work unless everyone's covered, do you think we can require insurers to have a guaranty issue or any of these policies that we suggest that need and we must have, the elimination of preexisting conditions, and the rating reforms, and the

elimination of underwriting, that's not going to happen, unless we have everyone covered.

So, we can talk about all the barriers to reform, but these folks came together and they developed some recommendations. We do not have the hubris to suggest that we are relevant; we are only relevant if members of Congress think we are. They are the policy makers.

We are hopeful that there is bipartisan consensus to move ahead primarily because, frankly as a Democrat I'm worried that many conservative Democrats won't want to vote for a policy without Republicans, and I think, overall, the sustainability of a health reform package over a longer period of time will work much better with bipartisanship. Now that goes both ways, Republicans have to be constructive collaborators, and that's their choice to make.

One last point, just to put everything in a little bit of context here, as much as we need to do these deliver reforms that Mark has talked about, and they are a critical component, indeed it was our first and fundamental pillar of our health reform. We felt that if we don't change how we deliver healthcare through a combination of infrastructure and information and real incentives to move that, you know, so called, if this game changes or bends that curve anymore.

I think I'm going to vomit, but okay, whatever, we're for that, we're all for that. And indeed we have to put these things, we have to put these seeds in this health reform or we won't be able to afford even what we currently have committed ourselves to.

But, remember this, that's not what's being debated today, the debate is debating between four components, it's the insurance reforms we say we all want, it's the individual requirement that we say we must have in order to get those insurance reforms, it is the affordability through subsidies and benefits to make the healthcare meaningful and affordable because you can't require people to purchase healthcare without making it affordable and it is the financing.

Now, that's it, that's health reform. It's as complicated as it is simple, but it can be done, and I think I'm going to conclude with, I think we show that you can develop politically viable policy recommendations to get it done, and I have some confidence that this Congress can do so to.

And, I will predict to you, that in the heat of the day, where it's either up or down, that there are just too many people who remembered the last time we failed to blow this opportunity and get it done right, or at least to get it done. And I promise you, it will be not perfect, it will be ugly, but

it must get done. With that I'll conclude, thank you.

[Applause]

ED HOWARD: Thank you Chris. As Chris is putting his stuff away so that he can steal away from here, if you have a question that you want to direct specifically to him, you have about 30 seconds to get it verbalized at the microphone. And if you would, keep it short and identify yourself; that would be ideal.

BRETT FERGUSON: I'm Brett Ferguson at BNA News, Quickly for Chris or Bill Hoagland probably, I'm curious… everyone knows the gang of six, the finance committee is trying to hammer out some kind of compromise. What happens if they reach a compromise that just can't make it through the finance committee itself, and what are the procedures that the Senate has to allow them to move forward.

CHRIS JENNINGS: Well, you know, you can, there's a Rule 14, you can bypass the committee, there is the Senate Help Committee package, that leadership could send the legislation to the floor, I know that is not Senator Reid's desire, or expectation, I think those six members deserve a lot of credit, I think that it's important to recognize that there is a dynamic in any long standing meeting with six people, when other people aren't involved, that, over time, they may agree with everything in that package, but others may not.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

To me, though, the smart play is to work to improve it to the mark up process to the extent you can, recognizing that it will continue to evolve over a period of time, recognizing that Republicans won't want to evolve much. And, from the point that they supported in that committee, and that's all I have to say.

BILL HOAGLAND: Just real quickly, in terms, Chris is absolutely correct, there is a procedure, it's called Rule 14, and you do have the Help Committee Bill and all he has to do is Rule 14, that we can Rule 14 any bill that comes over from the house or a HR number bill and then stop the process on the floor by amending it with the help bill or whatever was close to having come out of the finance committee if they had not filed it or reported it out. So there's a process, they can move it along.

ED HOWARD: And I should, let me just reiterate, you have a green question card in your packets if you have a question you want to write on it, hold it up, as this gentleman is doing and someone will come by and pick it up and we will go forward from there.

MALE SPEAKER: I'm going to ask a question of the whole panel, I suppose, my name is Henry Dove, and my company is called Case Mix Consulting from New Haven, Connecticut.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

And I want to go on record as saying, I'm a real fan of Med Pack, and the way that they do their work, and I'll also say I am a fan of CMS, because I like their payment systems that they have developed and refined over the years and I'm critical that not more managed care organizations have adopted those payment systems.

However, year after year, Med Pack, we pay too much for indirect medical education, and I think that the only way that we can really make these tough decisions is through the IMAC, the Independent Medicare Advisory Counsel, which would mean that Congress is going to have to give up some power, and my question is to the panel, how likely do you think that is going to get enacted or passed, the IMACs?

CHRIS JENNINGS: Can I take that and that will be my last question? I'm going to take that because this will be my last question but it's a great question. It's a tough balance. The members of Congress and particularly the committees of jurisdiction have worked, for years, to get that jurisdiction. They have become experts in those areas. They value the role that they play.

I think it's also true, as Senator Daschle indicated in our work, for months and months and months that he felt that it was also clear that there were many times that he felt, as he sat in front of those committees, why am I sitting here talking

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

about England’s payment rates or wheelchair reimbursement or anything along those lines? I have no expertise whatsoever to be able to make that judgments based on people I’ve talked to.

That’s why he had become a big advocate of something similar to IMAC as well. I think it’s getting increasing attention. It may happen if for another reason because the members of Congress may not wish to put on the table specific policies to achieve all the savings that they’ve been talking about. They may have a trigger mechanism. That trigger mechanism may be pulled by something like an independent IMAC or whatever the design is.

Frankly, I see it, if it’s constructed right with the appropriate representation, there’s a very real argument to do that for me personally. I know that Senator Daschle feels strongly about that too. In the end of the day, I think it’s about 50/50.

BILL HOAGLAND: Can I just say that I’m going to take the Uwe line on this one that I’ve been very sad about getting to that particular point that you’re giving up on the legislative process. We have a BRAC Commission. This is a failure of legislation when you have to go to commissions, outside commissions, setting this. It may be the only solution but we elected these people to make decisions. They’re not making decisions.

I think that is a problem. I would also just now put my score keeping hat on. This is a problem because if you set up a commission, you cannot, Congress cannot score it at the action of setting up the commission. They could only score the actual legislation. These are fast track. So it's predicated upon a later action of Congress to enact the savings and therefore would not score.

ED HOWARD: Uwe?

UWE REINHARDT: Yes. This system of an outside board is actually operative in Germany. It was introduced in 2004, the Minister of Health Ulla Schmidt said I don't really know anything about medicine or running the hospital. We write the laws with the regulatory intent and then she turns it over to a body of stakeholders, hospitals, doctors, pharma, patients at the table. They have their own building, their own president, and they work out these rules. They are binding.

If, within a certain period, they cannot come up with a consensus on it, she makes the rules but she says they have six months. She seemed very happy with it. It worked quite well. Those rules are respected by the German people. So I think it is something to be explored. I could explain to you, as an economist, why the Congress is not willing to give up the right to make those kind of decisions because legislation has certain

commercial dimensions to it [laughter] but I'm too delicate to raise that here.

ED HOWARD: Yes?

MERRILL GUZNER: Hi. I'm Merrill Guzner. I'm a freelance writer and I also blog at Guz News on Healthcare Issues. Mark, you made a very interesting comment regarding the tax on benefits that it would grow with inflation. I think that's a strong case in favor of it but if you actually adjusted for differentials in regional variation and also for the risk adjustment for the older, sicker people have expensive plans, wouldn't this essential be a tax on half the population to fund subsidies for the lower part of the population and what's the political chances of that actually happening?

The second related question is if the, because this is [inaudible] for insurance, this really doesn't deal anything at all with the federal budget problems with Medicare funding down the road. Isn't that really an argument also for looking for possibly doing something with the Medicare payroll tax itself like, for instance, opening up to all forms of income as a way of possibly funding both Medicare and health care reform generally?

MARK MCCLELLAN: Merrill, let me do that second first. Health care reform debate seems to be focusing in on just trying to hold even, not to really solve the Medicare financing

problems along the way, the Medicaid financing along the way except to the extent that these reforms really do succeed in bending the curve or whatever you want to call it, slowing down overall growth.

I don't think there are any proposals that are being considered now that would improve Medicare's financial outlook significantly in the same time as paying for, on an ongoing basis, the health care expansions, the health insurance expansions that would be part of this move to coverage for everyone.

I think that'd be politically even more difficult to do but you're right. There are a set of further steps that could be considered to do that including additional revenue sources, including reductions in, further reductions in Medicare benefits, including other steps above and beyond what's being considered for health care reform even harder political with though.

With respect to the health insurance exclusion, I don't think the geographic adjustment is going to make the politics all that much worse. You're right that that would tend to make the bigger portion of the taxes fall or the affect of tax increase fall on people who tended to have more generous plans, separate and apart from where they happen to live and that tends to be wealthier firms, wealthier individuals, and that

would affect the incidence but this is not a reform that many Republicans, at least if you ask them kind of outside of the current political context.

It's not a reform that many Republicans are opposed to because it really does provide, at least in their view and the view of just about all of Congress, that incentives to use more health care and maybe to get into health plans that aren't as focused on delivering care efficiently as they should be.

So it does have more of an incidence on higher income people but I think the political odds, because of its impact on health care spending growth and the political odds are better than say tax on the wealthy, and it is more sustainable.

I should say too that because of the opposition around these issues like geographic differences in cost and current union plans, again all of which I think can be addressed, not completely eliminated but certainly can be addressed.

Most of the discussion recently is focused on alternatives that are intended to get to the same place, most recently this idea of an excised tax that would be imposed on insurers who have health insurance plans above a certain actuarial level as opposed to doing the tax exclusion effect directly on individuals. It's not exactly the same thing.

The excised tax would actually have different implications by income group than fixing the tax exclusion

mainly because people who are in lower income groups don't pay much in the way of income taxes.

So we're not being much affected by that income tax effects of making health insurance taxable above a certain level but there is a real effort even in despite the criticisms that have been raised with this proposal to keep it alive and so use it to help fill the financing gap. So I think it is, in some form, very much part of the ongoing debate and one of the more promising ways to get to financing for health reform.

ED HOWARD: Can I just follow up on one aspect of what you just said, Mark, that these reforms being considered aren't really addressing the trust fund status. Could either you or maybe Bill talk a little bit about how the money gets from being saved in the Medicare program to the subsidies that are going to be used to help buy insurance for folks who can't afford it?

MARK MCCLELLAN: Well I don't know if Bill wants to take this one but from an economist's standpoint, money is money and government revenues are government revenues. So they might look like, through a payroll tax or through their commitment to the Medicare Part A, Hospital Insurance Trust Fund that these are Medicare funds and it may look like the Hospital Insurance Trust Fund is getting better because we're lowering Medicare spending as part of these reforms.

It doesn't have any real economic effects, what matters overall is federal government outlays, federal government expenditures and the difference between the two is what contributes to things like government buying more debt and interest rates going up and potential implications for economic growth.

ED HOWARD: But in the budget world, as opposed to the real world?

BILL HOAGLAND: In the budget world, if you are actually going to reduce HI expenditures, you are going to extend the solvency of the trust fund. In fact, the estimate is that of the HI trust fund, Medicare HI savings that are currently in the House bill, will extend the solvency of that trust fund by two years from 2017 to 2019. So in the world of trust funds, those are real savings. Now people say those savings then get spent someplace else. They do but it does reduce the amount of the expenditures coming out of the HI trust fund. So in the real world, they do save.

ED HOWARD: Okay. Thank you. Yes sir?

BOB ROHR: I'm Bob Rohr [misspelled?] from BMJ, this is particularly for Uwe, I'd like to hear what would be the top three or four suggestions for squeezing out waste, inefficiencies, and things? What are the top three or four

reforms that you would suggest? Others would want to kick in, that's fine too.

ED HOWARD: I think you're being asked for your top suggestions for wringing waste out of the system.

UWE REINHARDT: Well first of all, that'll be a long-run proposition but there are these Dartmouth Wennberg variations, which we have never really looked at what drives them. We know from the Dartmouth Group, they seem not to be correlated with anything but I wouldn't be satisfied with just that research. What we could find out if we actually went to the individual level of the patient of what it is that drives these costs.

Then ultimately, I would budget the Medicare regionally and not as the nation as we now do. We proposed at the Physician Payment Review Commission that some of us were proposing it years ago but it never went anywhere. The other thing is one really should have some better grip on imaging. Today, I think yesterday or today's *New York Times* had an article about a group of physicians who bought CT scanners and then drove up the volume.

I think there ought to be some mechanism to try to figure out to have them justify that as other countries do. Then even sort of have a look on what should be paid for imaging. Basically you should assume a fixed use life for a

machine, assume a full utilization rate, and allow them a decent rate of return and work your reimbursement of that rather than what we now do. We seem to be sort of paying.

There are many things one could do. I don't think any of these are easy. The one proposal to bundle services is a good idea. However, I do believe that is a long-run proposition. First of all, there are many technical issues here. If you want to see these issues, just Google Prometheus Payment, Inc., and look at their manual, they're making good progress but it's hard to do but there are major political issues and they're the most important is to whom would you make the bundled payment?

My preference would be physicians and let them manage the bundle because if you gave it to anyone else and physicians get paid, I'm not sure how easy that would work in health care but those are issues, I think, that'll take probably a decade to do. It won't be overnight.

ED HOWARD: Mark?

MARK MCCLELLAN: I agree that there are some opportunities for long-term impacts here along the lines that Uwe was suggesting but also just add that there are some things that probably could be done in the short-term that would save some money but that I wouldn't expect to have these big increasing effects over time. Like if we are able to get to

health care reform that eliminates or substantially reduces underwriting and dealing with pre-existing conditions, that in itself is going to drive down administrative costs a lot but it's probably largely a one-time effect.

There's a lot of evidence that Medicare and Medicaid spend too little money on policing the programs, on fraud, prevention, and things like that. Spending more money there would probably have some beneficial net effects but again, these are one-time savings, not really bending the curves as it were.

Then there's this whole set of proposals around tweaking the fee-for-service payment systems here or there, reducing rates for home health or imaging or it even put, even bundle payments. These things can help but in one way or another, you're still squeezing on the balloon in one particular place.

We had a meeting last week here, co-sponsored with Elliot Fisher and his group at Dartmouth and Don Berwick from IHI and Tua Duand [misspelled?], who wrote the article that everybody read now with some of the physicians and others, the business that are paying them, some consumer groups, from 10 of the regions around the country that seemed to be doing really well according to the Dartmouth atlas and they did seem to have some important differences in practice, more coordination of

care, more reliance on primary care, but it wasn't something that had arisen because of squeezing payments here or there.

In fact their view was that, to the extent that we keep trying to solve the spending growth problem by reducing payment rates for some services, that that was going to make it harder and harder for them to sustain what they are doing.

They could force them to play the volume game more since, after all, the only way you get paid and the main way you get paid in Medicare now is you go through more services or more admissions or if we go to the Prometheus Payments, maybe more bundles over time. You're not really dealing with the core problem. That's why I think a good part of the solution is to pay providers for what we really want. That's better overall outcomes for a population of patients at a lower overall cost.

There are good ways, I think promising ways to transition to that. That gets at those subtle differences in medical practices that are really driving a lot of these cost variations and the cost growth. How often do you go to see your primary care physician? How often are you referred to the specialist? How many imaging procedures and lab tests get done? How many elective admissions do you have; things like that that you're just never going to solve by focusing on one piece or another piece of the fee-for-service financing system.

ED HOWARD: Uwe and then Bill has a comment.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

UWE REINHARDT: I had one more idea. If you step outside just the government and look at the whole health system, particularly private insurers, they now negotiate with every hospital and with every doctor over these thousands of little items, their fees, and so you have it that a given hospital gets completely different fees depending on who the payer is.

And if you ask an insurer "what do you pay for a colonoscopy" they'll tell you "oh we have 40 different prices." My question is, first of all, what benefit does actually accrue to American society for having this huge armada of price negotiators whose ultimate product is a pretty ugly price discriminatory system in which big insurers get low rates, small insurers pay higher rates, and the uninsured pay the highest.

So some of us are thinking maybe we ought to move towards all-payer systems and that can be done in different ways. Maryland has it but as an intermediary step until bundling becomes more prevalent if ever, I have proposed, in *Health Affairs*, there is a blog where I said why don't we make a law that every provider, every hospital has to use the DRGs as a relative values scale and the hospital, for the private sector, can set its own monetary conversion factor, right? They can compete that way.

Then you have to negotiate only one number with a hospital. You could do that by phone. You would have competition that everyone in America always talks about. Then you have it and you could do the same for physicians as well.

Well let's see what happens with that blog when people shoot at it, but there are things in the meantime that you could do that does away with the incredible waste of negotiating this scheme of price discrimination. I wonder how many labor hours a year go into just that and that feeds into the 10-percent of the premium that goes for administration. You could save that.

ED HOWARD: Bill?

BILL HOAGLAND: Uwe, from one of the moral [inaudible] down here, I agree with you on that but I was just going to address the inefficiencies. I say this facetiously, take away the most expensive piece of equipment in the doctor's office, then take away their pen for overutilization.

RACHEL NUZUM: We've got another question that came in and this one goes to the trigger. So maybe the whole panel could address this but Mark, maybe you could start out since you talked about moving the trigger and part of the compromise of the Peter's project came up but given the SGR experience, is it wise to set procedures for cuts if you don't hit the triggers for a specified savings? How viable are these triggers

and does Congress have a follow-through to actually makes these cuts if the triggers are hit.

MARK MCCLELLAN: Well yes, the SGR trigger has worked so well [laughter]. I think this time around, people are considering a different kind of approach, one that would tie the impact of the trigger more directly to provider actions and the one issue with the current physician trigger is that it's a national number.

It really has no relationship at all to what any individual physician or group does. It has to do with overall spending trends. It's just related to physician services, which they do hold the pen but that's not the biggest part of health care costs that they influence their own services. It's the hospital services and everything else. So some of the more recent proposals would change the trigger in several ways.

One is that they would relate to overall spending trends not just physician services. Second is that to make it more tied directly to physicians and other health care providers whose behavior is involved, it could be done at a geographic level or even at the level of a group of providers.

So for example, one proposal that Earl Palmeroyne [misspelled], some of the other blue dogs have been considering lately would have an SGR-related trigger based on the growth in local regions but give providers the option to get out of that

trigger having its effect on reducing the payment rates across the board.

This is not just for physicians but hospitals and so on. They could get out of it if they formed an accountable care group or something like that that could document that they themselves are slowing down the spending growth rate.

So that would only really apply to providers who were in areas with high growth and who aren't taking steps to slow spending. So the point being that you would have to be more tied to the goal of overall spending reduction and more tied to the particular providers whose action that you want to influence.

ED HOWARD: Yes, go ahead.

GEORGE HACKER: I'm George Hacker from Center for Science in the Public Interest where we've been promoting those Pagovian taxes to both raise substantial revenues and reduce health care costs and are specifically promoting alcohol, increases in alcohol excise taxes, which have not raised since 1991 and has lost much of the value to inflation but in addition, we've been promoting a tax on sugar-sweetened beverages, which are the only known food or beverage product that has been associated with increases in levels of obesity, which are incredibly costly to our health care system.

So I wonder whether anyone on the panel could comment on the variety of economic, political, and other obstacles that lay in the way of these tax increases that could help provide some revenue for health care reform.

ED HOWARD: Bill, do you want to start on that?

BILL HOAGLAND: Very quickly, a $0.03, as I understand, increase in sugar excise tax on a 12-ounce bottle of sugary substances only, I wouldn't say only, but it raises you $50 billion in terms of the revenues. So I'm all for it. I think it's great just on the politics. Remember where Chairman Baucus comes from, sugar bee country and where the ranking member, Mr. Grassley comes from, Iowa and corn. So seem to be a little bit of a political hurdle [laughter].

ED HOWARD: Let me use a question from the card. It's initially directed to Uwe Reinhart but other panelists should feel free to weigh in. Why are employers seen as a source of financing for health reform when they are already spending so much on providing health care to their employees?

UWE REINHARDT: Well I don't know why this happened in general that when we talk about shared responsibilities, that employer should be in the game at all but this is an extremely narrow economist's view. My view is employers should make widgets and sell them and be as efficient as they can and beat

our foreign competitors in the global market and not be saddled with social security systems.

Those systems shouldn't be an arrangement, in my view, either between the individual and a private pension system or between the individual and the government. Employers shouldn't be in there. We saw what happened. It destroyed General Motors and it's hurting a lot of other industry. So my view is generally known on that.

I think most of us would probably wish if you had to do it all over again, I don't know what you think Mark, very few health economists or policy wonks, in general, would say if you had to do it over again, we wouldn't have the employer in the game. We would have had a different arrangement but not made employers the guardians of people's health. At some point, where does that stop?

I mean it can lead even to their intervening in your decisions about your personal life, Nurse Ratchet saw you in a restaurant eating meringue pie and that somehow enters a database. So I wish [laughter] they'd just get out of it and that is why some of us are hoping that there will be a market, an efficient market for individually purchased policy as a parallel to the employer-based system, which I don't think has been all that helpful in America.

ED HOWARD: Mark, do you want to comment?

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

MARK MCCLELLAN: Yes. Well that's as far as health care reform, major health care reform, is going to go is to perhaps create, hopefully create a viable individual insurance market where people can get the same kind of quality choices they need to depend on their employers now to receive. The current individual market isn't doing that particularly for people with chronic illnesses and pre-existing conditions. I do think that there are some arguments in favor of employer coverage.

There are a number of employers who are sort of getting more into the game, Safeway, Pitney Bowes, others that feel like they've got a better handle on what their employees need than some state-based or federal exchange would. There's some advantages to integrating health benefits with other things that the employers are trying to do to promote greater productivity, wellness, and the like so that, done right, helps get their worker's comp and other costs down but that may lead to too many of these, what was it, the Nurse Ratchet problems.

That's got some disadvantages too but in any case, in practical terms, we're not, nobody's talking about getting rid of employer coverage and hopefully, what will come out of this reform process is a more vibrant and dependable individual insurance market.

UWE REINHARDT: I've always thought of employee benefit managers as social workers dressed up to look like Republicans

[laughter] with the intense love of their employees but the minute you get fired, they don't give a tinker's damn about you anymore. I'd like to have a more loving, longer relationship and I just don't think you can get that from an employer unless you are like me, a tenured professor at a good university [laughter].

ED HOWARD: We have several questions on cards that relate to the area that curiously we've come this far without really mentioning and that is the public option as a way of saving money and we have, if I may use a phrase that my wife, the economist, might use, a bimodal distribution here.

Some are asking "why is a public option or co-op so important to include in this package" and others are worried that whatever loans or other payments might go to this public option will never get paid back or otherwise there will be an unlevel playing field for that public option to compete against private insurers.

Comments from any of the panelists? Or I might even ask Rachel, you've done a lot of work at Commonwealth on the public option.

RACHEL NUZUM: Right. I think there's been a lot of conversation, a lot of controversy over, first of all, whether or not to have a public option and what the role of it might be and then if so, how to structure it and most importantly,

lately anyway, is what rates you would potentially pay providers under this public option.

I think all of those are valid questions to be hashing out but I think one thing to keep in mind and regardless of the rates that you've set, the provider payment levels that one of the big values of having a public option is it serves as a tool or a mechanism to really move some of these system reforms and these payment system reforms that we've talked about, that Mark and Chris have talked about, that Uwe's alluded to, and that even that Bill has mentioned that has potential of actually producing some saving and applying those to the under 65 population.

Right now, we don't have a tool to really be able to do that and it's one of the reasons why when we look at estimates for delivery system reforms and payment system reforms, savings are larger when we tend to do these estimates because we're applying them not just to Medicare, not to Medicaid but also to the public plan. So in the absence of a public plan, I think one thing to keep in mind is what lever are we going to be including to give us the opportunity to be able to take some of these delivery system reforms and these payment system reforms and apply it to a broad based population.

ED HOWARD: Uwe? Mark?

UWE REINHARDT: Well from the fundamental level, I think the attraction of a public plan is actually not so much that it could be cheaper to the American people but that it would be permanent, something permanent that they can trust and that will always, like the post office. People always say if you like the post office, you love government health insurance but Humphrey Taylor always tells you in every survey, the post office is one of the most revered institutions because it's always there.

So I think that is the big attraction and then the question then comes by what rights would one deprive a people what that wanted it from that choice. I mean that's a question I think, in a democracy you could ask. Now there is the other issue, of course, of the level playing field but I think one could solve this the way the House apparently now says they have to negotiate rights just like any other insurance company and then the *Wall Street Journal* said well if that's the case then why bother.

They say well it has this permanence to it, which people may like and if they don't like it, they will not choose it. I said that's, in some way, I come out, now you could say the problem though is if you did this for every industry say take airlines and you just say there should be a government airline as an option. I just don't think people would choose it

because if the other airlines are there, they wouldn't choose it. It's just how reliable, I would put it to the insurance industry.

Can you, as an industry, develop an insurance policy that's permanent that you can carry through life, that's lifecycle in a way that most other nations think of health insurance as a lifecycle proposition? When I was an apprentice in Germany, I picked the sickness front and I expected to be in it for life. So can the private insurance industry develop something for the American people that is permanent, that you always belong to? Then I think the whole issue of the public plan would go away.

MARK MCCLELLAN: It is kind of interesting that the other industries that are having trouble, the automatic solution isn't well let's have a public version of this. Airlines goes bankrupt. The auto industry, and we're not seeing this kind of outcry for "gosh let's have the government come in and do it instead competing alongside the private plans." I think that, Uwe, your point is right about just a kind of a sign of how many people are not satisfied with the way that the private industry is working.

I think that the best solution to that is to try to get to a system for market competition, insurance market reforms that would lead to the kinds of insurance options that you're

talking about where you can count reliably on a plan. If you're enrolled, you're going to be able to continue to afford coverage and have a reasonable range of choices. I think that's why a lot of the attention ought to be focused on getting that right.

In the BPC effort, this was our last issue. This was the last one that kept everybody up, I think fairly late, even the night before the announcement. We ended up dealing with it by leaving it to a state option where states could set up state level plans to do this to provide that kind of permanence if they wanted with some technical support but not a federal level plan.

There are other ideas out there, the finance Committee seems to be focusing on this and the Senate more generally on this public co-op idea to sort of like the same goal, don't know if it will, you look skeptical already. I can understand that too but I don't think, in the end, this was the way it was for us, if all of these other hard issues get addressed, how are you going to reform insurance markets to make these exchanges work? How are you going to do subsidies? How are you going to pay for it?

If people worked out those kinds of issues, I don't think this is going to be the issue that prevents an agreement from coming together and at least I certainly hope it doesn't.

I really hope that we deal with the underlying problems that cause that level of public dissatisfaction with insurance today.

UWE REINHARDT: I must say though the idea of the public co-op really, I can't keep a straight face when I hear it and I'm a little jet lagged so I dream when I woke up at three and I had this dream, the co-op was passed. Great, hoorah.

These people were running these co-ops and in the third year, they went to a big convention in Bermuda and all the co-op guys were in hushpuppies and the other guys landed with their jets and so on. The co-op guys went before the public and said you know what? We can't compete unless we have access to the capital market and we need to convert to for-profit.

Why would I have such a weird dream? Well you are all too young but I'm old enough to remember there were such co-ops once. They were called Blue Cross. They were owned by the members and so on and so forth. Most of them went for-profit. So I think that's what would happen with the co-ops.

ED HOWARD: Okay [laughter] but this may have been, by design, but no one did talk about any difficulties in making a level playing field. That is to say, a playing field that didn't tip toward government because, as I have heard it

described, you have George Steinbrenner hiring the umpires or some such metaphor. Is that really a difficult problem?

BILL HOAGLAND: No, no. Yes, it's a very difficult problem, a huge problem. Let me approach this slightly differently. I'm going to build off of what Chris said. The opportunity is here now to get an agreement on a bipartisan basis across the board. I'm going to use talking points. The government-run plan, as opposed to the public option, is a divisive issue, huge dividing line.

If you do all the things that these evil people, the insurance industry, have agreed to six months ago, no pre-existing conditions, guaranteed issuance, no caps on lifetime limits, an exchange to open up the market, subsidy affordability purpose, if you do all of these things, why do you need another government-run program?

We already have a Medicare program, as we've already talked about here, that's going to run out of, it's going to be default here in a few years. I think, I thought Mark, I thought where you guys were headed was the right way.

Get the deal now. Set this off to the side. If the goals are not achieved then I thought you were talking about triggers, I'm talking about triggering in a government-run plan in the future but we've got the opportunity now to actually

have a bipartisan agreement and this issue, I think, is too divisive.

I want to make one last point. I'm an agricultural economist by training. I know something about co-ops. I agree with you Uwe, a nongovernment, nonprofit run by the consumers. The worst thing I can imagine for health care is for the consumers to be determining what their health care should be in a co-op.

UWE REINHARDT: Actually I should add, I mean I agree with Bill. If this is so divisive and you could get most of health reform done without the plan, I think one should go ahead that way because you're quite right.

This could be revisited later. It's become too big an issue that we could do a lot of good for the American people by not solving this problem this year. So I totally agree. If the private sector solves the problem then okay, don't worry about it. If it doesn't, we'll be around tomorrow.

ED HOWARD: And I feel, unfortunately as if we're going to be around tomorrow [laughter] discussing health policy problems for longer than I was expecting to be around before I claimed my 403B proceedings. I think we've come to a convenient stopping place here.

Let me just reiterate our thanks to the Commonwealth Fund not just for its support and co-sponsorship but for the

excellent participation of my co-moderator, Rachel Nuzum. Thank you for showing up and struggling with not having a place to write on a Friday afternoon and ask you to join me, two things, one is fill out your blue evaluation form before you go but after you join me in thanking the panelists for this discussion.

[END RECORDING]

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.