



**Ask the Experts About Reform: Where Are We Now and Where
Are We Headed?
Alliance for Health Reform
September 14, 2009**

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ED HOWARD: Welcome. My name's Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and Senator Collins, our Board of Directors, to this program that actually gives you a chance to ask the experts, as we say, about the current state of health reform. Let me get a little closer to this microphone.

Our partner in the program today is the Eli Lilly Company and its affiliated foundation. Lilly's the 10th largest pharmaceutical company in the world, consistently ranked in the polls as one of the best companies in the world to work for. If you want to verify that, you can talk to Kathy Miller and Shawn Donahue from Lilly, who are here. I want to thank them for their support for this program.

August and early September have been a lot more action-packed than usual around this town largely because of the debate over health care reform. There's been a lot of shouting around the country, even a little shouting right here in D.C., and now it's time to see if folks can maybe lower their voices a bit and hold a civil, productive

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conversation over how to fix what's broken in our health care system.

The purpose of today's program is to clear away some of the rhetorical underbrush and take a clear look at where we are, what direction we seem to be moving and whether that direction seems to be a good thing.

Quick logistical note: you have materials in your packets including biographical sketches of our speakers. The materials in your kits are also available on the Alliance website at allhealth.org. There'll be a webcast of the briefing available some time tomorrow, courtesy of the Kaiser Family Foundation, through both our website and the KFF.org Foundation's website. We'll have a transcript available within a week or so.

We have a slightly different arrangement from our usual one. You can see we have more than our usual complement of panelists. So we actually have assembled, I think, a spectacular collection of insight and intelligence on this issue, we're going to get an initial brief orientation on where we are by Julie Rovner. Then we're going to open the program up to questions from you immediately.

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We have some already received. We have microphones both in the front and in the back of the room. You have green question cards in your packets that you can write a question on and hold it up. We request that you keep your questions as brief as you possibly can.

Panelists, in turn, have agreed to keep their answers as brief as they can without the distorting their response and the purpose is to get to as many of your questions as possible in the hundred or so minutes that we have.

So let me simply list and identify our panelists rather than give them their properly deserved introductions and refer you to the biographical information in your packets for more.

Bob Berenson, at the far end of the table in this direction, at The Urban Institute, next to him is Dennis Smith who's now at The Heritage Foundation. On my immediate right is Julie Rovner from National Public Radio. Next we have the inimitable Joseph Antos from the American Enterprise Institute and next to him, Henry Aaron from the Brookings Institution. (Judy Feder of Georgetown University's Health Policy Institute joined the panel later.)

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HENRY AARON: That was too much of an introduction for me Ed.

ED HOWARD: We're going to see, Henry, whether you're as admirable as Joe or as estimable as Dennis in the course of the 100 minutes here. We've asked Julie, Julie Rovner from NPR, to kick off our discussion by grounding us in sort of the basics of what the debate's all about as a jumping off point for your questions and I will introduce Julie.

JULIE ROVNER: Having looked over the list of participants, I find it more than a bit presumptuous for me to be telling this audience anything about the current debate since I know some of you actually have had a hand in writing some of the bills under consideration, but these are my instructions.

I intend to follow them and I'm sure you won't hesitate to yell "You lie" if I make a mistake [laughter]. I will only ask, in that situation, that you apologize since I will not make any misstatements with malice of forethought or to gain any political advantage since I do not intend to run for any political office now or in the future.

I think I will begin with what seems to be the most misunderstood part of this entire debate. President Obama

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does not have a bill. In fact, until last week, he didn't even really have a plan. What he had was basically a page of guidelines laid out in the budget document issued way back last winter.

So all summer, whenever anyone complained that the President's plan would or wouldn't do this or that and I include members of the media, they were basically demonstrating they didn't really have a clue what they were talking about. Now that did change somewhat with the President's speech Wednesday night, sort of.

Here's pretty much what we now know about what Mr. Obama wants: He will veto a bill that adds to the deficit except we're pretty sure that the \$245 billion for the doc fee fix doesn't count. He's thinking that the package will cost around \$900 billion over the next 10 years. He wants to lower health care costs in the long run or bend the cost curve, to use Budget Director Orszag's favorite phrase, and he'll support a trigger to require further spending cuts if anticipated cuts don't happen as projected. That's what we call the soft trigger.

He really, really wants to ensure there's competition for the private insurance industry. He'd like there to be a

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public plan but he believes Max Baucus when Max Baucus says there aren't the votes for that in the Senate and is he, the President, is willing to settle for co-ops or a trigger or something that someone hasn't thought of yet. But he dearly hopes someone will pretty soon [laughter].

He wants, back to the President, an individual mandate and this is a major change from Candidate Obama, if you remember back to the primaries with Hillary Clinton, and he would like to require big businesses to either cover their workers or pay a fee. Most small businesses would be exempt.

He wants, in exchange, for individuals in small business to be able to buy coverage and subsidies and tax credits to help those who couldn't otherwise afford it. He wants a whole series of insurance market reforms, no limits on pre-existing conditions, no rescissions after people buy coverage. No more lifetime or annual caps and catastrophic out-of-pocket limits on all policies so basically an end to the problem of underinsurance.

Now, how these proposals are going to get into the existing legislation is a really interesting question I will leave for my esteemed, inimitable, whatever you would like to call them, colleagues.

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Meanwhile, we actually do have several bills in various stages of legislative process. You have a side-by-side in your packets so I won't go into a lot of detail, but here's a very quick review for those of you who've been napping for the past few months.

H.R. 3200 is currently not one but three different bills. The versions, as marked up by the Ways and Means, Education and Labor, and Energy and Commerce Committees -- I should caution you in particular that the Energy and Commerce Committee made major changes.

First, in order to satisfy enough of those fiscal conservative Blue Dog Democrats to vote for the bill and then in order to resatisfy some of the more progressive members of the committee -- because by the time they got those Blue Dog votes, they had lost some of the progressive votes and didn't have enough votes to get it through the committee. So they had to go back and change it again.

Basically the bill's outlines are pretty much as President Obama described. Remember that laugh line when he said details are to be worked out. There's an exchange, an individual and a business mandate, insurance reforms, reductions in Medicare and Medicaid spending - oh, and H.R.

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3200 has this tax on people with high incomes to help finance it. If I might add, the exercise the House Democratic leadership now faces is pretty much the exercise that the Energy and Commerce Committee had to go through.

They have to basically come up with a bill that can get 218 votes by walking that tightrope between progressives and conservatives in their caucus.

This isn't just about the public plan, even though that's what everybody's been yelling about. It's about things like the size of tax credits and subsidies and closing the donut hole in Medicare's prescription drug benefit and how big the deficit or nondeficit, what we're going to have to pay for, is going to be.

Over to the Senate side, all the focus has been on the Finance Committee, but we actually have a bill reported out of the Health Education, Labor, and Pensions Committee. We still haven't seen bill text -- at least I haven't the last time I looked -- nor a full CBO estimate but we were treated to weeks and weeks and weeks of mark-up for those of us who had nothing better to do with our June and July.

The general outlines of the HELP bill look a lot like H.R. 3200 although it calls its exchanges "gateways" instead.

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It has relatively more generous subsidies. It doesn't have any financing mechanisms because that, after all, is up to the Finance Committee and the Senate, which brings us finally to the Finance Committee.

That's where we have the notorious Gang of Six -- Chairman Max Baucus, Ranking Republican Chuck Grassley, along with Democrats Ken Conrad and Jeff Bingaman and Republicans Mike Enzi and Olympia Snowe working behind closed doors for the past four months or so in an effort to get a package that can pass the Committee and the Senate. I got to tell you, I'm really, really, really tired of sitting outside of Max Baucus' door [laughter].

Senator Baucus, as I'm sure you all know, said last week he's going ahead with his own mark later this week and a committee mark-up next week. Somehow, that got transfigured -- I heard a news report last week that it's going to the Senate floor this week. Not sure how a mark became "going to the Senate floor" but welcome to the wonderful echo chamber of Washington.

But the proposal he put before the group of six leaked last week and, by the magic of Xerox machines, you have that in your package too.

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That mark is generally less expensive and less generous but a little bit more controlling of cost, at least so we're told, than the House or the HELP bills. Its financing also relies more on dunning providers who aren't particularly happy about it. They have been clogging my email box the last week telling me that.

So what happens next? Well it's up to the House leadership to merge 3200 from its current three-bill iteration back into one bill for a floor vote that can get 218 votes. Not totally clear exactly when that will happen and we will wait to see what emerges first, from the group of six and then from the Finance Committee. I'm going to leave it back to Ed.

ED HOWARD: Well, that was simple [laughter]. Anybody care to do the conference committee and the bill's signing ceremony for us and we can end a little early? I'm absolutely serious. We are depending, not only we encourage you, but we find it essential that you participate in this process with questions.

Let me just carry out, while you're either walking up to the microphones or filling out your green cards, for anybody who would like to give us a little civics 101

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lecture, how do we get from three bills to one bill? You made a reference, Julie, to the House leadership, how do you get from HELP and Finance -- assuming that the Finance Committee can get its act together and get a bill through -- to a single bill on the floor?

I know enough from my 30-years-ago days on the Hill what happens once they get the conference, at least in the how-our-laws-are-made diagram, but how do you get to a single bill on the floor in the House and the Senate respectively? Mechanics anybody? Anybody from CRS who would like to describe that? Dennis, did you have to deal with this when you were running Medicaid?

DENNIS SMITH: We did and when I worked on Senate Finance previously, basically the way you get there is after -- in the Senate you'll have the two different committee bills and there will be a big manager's amendment presented on the floor and suddenly that's what everybody will be in, and at this point, we don't know what that is. In the House, the same way, it'll be written. There'll be a rule written in the Rules Committee and that amendment will be in order and probably virtually nothing else. That's what will go to the House floor.

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JULIE ROVNER: Yes. My understanding is that there's a big difference between this and budget reconciliation when you're doing a bill and you have Energy and Commerce and Ways and Means doing Medicare, for instance, you get things that conflict, which often happens. Those things go to the floor conflicting and it gets worked out in conference.

In a situation like this, I think they resolve them beforehand so they will not go. If you're going to do regular order, they will not go to the floor conflicting. They will be worked out.

That's a big difference if they end up having to go the reconciliation route -- that (with)reconciliation, indeed, you will have different versions because those are put together by the Budget Committee. And because of the way reconciliation were to actually end up passing things that are in conflict and they get worked out later, that will not be the case this time.

I think there will be one bill and it will be up to the leadership to determine if things can get to 118 votes and there will be one bill that will be worked out as Dennis says at the Rules Committee.

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ED HOWARD: Okay. We have folks at the microphones. Let me just reiterate please identify yourself, please keep your questions short, and go ahead.

TONY HELSNER: Okay. Tony Helsner. First I just want to encourage people to sign up for Organizing for America to help push at the grassroots level reform. I'd like to ask each of the panel members to comment on what they think the chances are of a reform bill that will pass and that the bill would cover a reasonable percentage of the uninsured.

ED HOWARD: I was busy kicking over my water glass so I didn't hear Tony's question [laughter]. I hope somebody on the panel did and can respond. We now are joined by Judy Feder from Georgetown.

TONY HELSNER: Ed, my question was to each of the panel members, what do they think the chances of reform passing and covering a reasonable percentage of the uninsured.

ED HOWARD: That's fairly straightforward.

JUDY FEDER: Tony, I'd say pretty damn good and it's actually -- I apologize for not having been here earlier. I was at another similar conversation. You all know that we've

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never gotten quite so far. That's not getting all the way there. But I think that the short story on why it is that we're going to take action is that this is simply too big to fail.

There is too much riding on it in terms of both the expectations of the American people and of the President and members of Congress in terms of delivering for people, I think. I won't go into whether the times are different but I think that a delivery, a significant impact bill is expected.

ED HOWARD: Since somebody asked for responses from others, anyone who feels moved to make a prediction should feel free to do that.

HENRY AARON: I was going to say that I agree with Judy but I would refer back to President Bill Clinton who said and I'm paraphrasing, it all depends on what the meaning of the word "it" is [laughter]. I think it's quite likely that a bill will be passed and signed by the President and whatever its character, I think the President -- and with some justification -- will be able to claim that this was a great year for health reform.

That said, it's by no means obvious to me that the bill is going to be as large as any of those currently, that

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have currently emerged from committee, either the HELP bill or the H.R. 3200. The Senate Finance, we've seen general descriptions of but not detailed cost estimates. In your package, you have an article that was in *The New England Journal* that I wrote on financing and I think there is some key numbers to keep in mind here.

The hard nut here is that you're going to end up spending about 20 percent of the 10-year costs in the 10th year alone. If, as the President has pledged and I do believe he means what he is saying, the bill has to be balanced in the 10th year, that means a trillion-dollar bill costs \$200 billion in the 10th year.

The HELP bill's a little larger than that and costs still more. The Baucus bill will probably be smaller and cost a bit less. But that's still a great deal of money. Finding a combination of spending cuts and tax increases to cover that is the really tough nut to crack.

Public option is going to go away. It's been grossly exaggerated in importance, in my view, by both proponents and opponents and it seems to be receding, but paying for the bill can't go away. That's here and finding the money is, in

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the end, going to be a constraint on how much Congress will find itself able to do.

ED HOWARD: Yes? Oh I'm sorry. Go ahead Joe.

JOE ANTOS: Thank you. Let me just add to Henry's comments. I completely agree, just to say that the government's favorite way of financing anything in health care is, of course, to take Medicare cuts. This would be particularly challenging this year. Not that the cuts are, that people are talking about, are all that unusual, at least at the talking stage, but thanks to all the hype, senior citizens are, we've awakened the sleeping beasts, so to speak, I don't-

ED HOWARD: I think I resent that remark.

JOE ANTOS: I don't really mean to say that about my mother [laughter], but-

MALE SPEAKER: The sleeping geezer.

JOE ANTOS: The sleeping geezer, exactly but they are awake. So it'll be more difficult than ever before to take the kinds of reductions in provider payments in Medicare that we've actually grown to expect.

ED HOWARD: Yes? Go ahead Dennis.

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DENNIS SMITH: Going on down the line here. I agree something will pass; whether that something is really reform is a different question. I think that there are so many difficult inconsistencies in competing values that are presented. That's going to be very hard to reconcile them.

I think the financing, the Medicare cuts, there are again -- I think still what the economy is doing within the next couple of months, so it's going to be very important. I think that there is a big, big push to show that there is huge momentum. I think that momentum is not as folks would like us to believe. I think members of Congress, at the end of the day, will act like members of Congress, which is what is in their own best self-interests.

ED HOWARD: Bob?

BOB BERENSON: I'll make a different kind of a point. I think it's likely that the way you pose your question, which had to do with coverage expansion mostly and maybe insurance reform, I think it's likely we'll pass a bill. I'm with Judy on that one.

There has been a view that -- and in fact, some language -- that this is health insurance reform not health reform that has -- and David Brooks and others have sort of

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commented about the lack of systematic health reform that is emerging. I am partly persuaded that that's right but it's a sort of a glass half full or half empty thing.

There's a lot of good stuff in the House on demonstrations and pilots to test lots of delivery system reform ideas. So on the one hand, you can say it will be disappointing for those of us who think we need a major overhaul of how care is delivered.

On the other hand, I don't think that we're actually we're ready to put all of these new payment systems into place tomorrow. It would have made the politics much more complicated. So I think it's likely that we will have a health insurance coverage expansion bill.

It will not be any broader than what's being talked about now and it'll probably be cut back even more but it won't get us on the road. I actually think there's some promising things down the road if what emerges includes some of the elements that I've seen in the House language.

ED HOWARD: Thank you all. Let me just remind you that you don't need to ask every panelist to respond to every question. We want to be able to cover as much ground as we can. I sense a certain level of disagreement among members

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of the panel. So we may be hearing from multiple people in any event but go ahead.

STEPHEN SPITZ: Hi. I'm Stephen Spitz. My question relates to Medicare Advantage. Just before President Obama was inaugurated, in *This Week With George Stephanopoulos* he was asked what programs would he eliminate in health. And he said the Medicare Advantage (program) because the government shouldn't be in the business of subsidizing private insurance companies. Whoever cares to answer this question, what do you think is going to happen to Medicare Advantage in the legislation that will be passed?

JOE ANTOS: I have a view.

ED HOWARD: Joe, go ahead.

JOE ANTOS: I think Medicare Advantage is plagued by a variety of problems, one of which is a bidding system that guarantees payments, according to MedPAC, upwards of 14 percent higher than the cost of, equivalent cost of Medicare services in the fee-for-service program, so obviously (it) is an interesting budget target.

However, the big challenge with that target is that, especially in the Senate, there are health plans now in rural parts of the country that never would have existed without

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the, let's call them overpayments. And what they actually buy for people out there -- and not just in rural areas but also in urban areas -- what that buys for people are some extra benefits. In essence, it's a kind of government-paid wrap-around plan for people who didn't necessarily have access to such a thing paid for by an employer.

So bottom line is that there are a lot of Senators from mostly Western and rural parts of the country who have really stood up for Medicare Advantage and I think what that means inevitably is that there will be some policy that will pare back the payments. But I don't think it's going to go all the way to the policy in the President's budget, which would essentially level them up with fee-for-service over the course of three years.

HENRY AARON: Could I just have, by way of extending what I said previously -- the budget document presented in February claimed \$177 billion, over 10 years, in savings from leveling down Medicare Advantage payments.

That's included in the something north of \$900 billion of tax increases in spending cuts that the administration has put forward, first, as a reserve in the budget for health reform and subsequently through additional

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proposed cuts in Medicare and Medicaid. Subtract 177 from 900, you're down to a little over 700. I think that drives home the tension between the scope of the plan and the methods of financing.

BOB BERENSON: And allow me just to jump in also. I agree with Joe's analysis of the difficulty in Senate finance of just taking the 14 percent away. I mean, I think the President actually has missed the point that it will not be painless to reduce overpayments to plans.

I was at HCFA at the time that the BBA passed and was there, I mean within a month of my arrival, I got the first call about "what is this we're hearing about plans pulling out." And the next three years that I was there (that)was -- I guess the number one item on my agenda -- was trying to manage some of the dislocation that took place. I think, as policies, the overpayments are unjustified and need to be cut back.

It happens that the House and the Senate have two different approaches so far. It looks like the House would just phase out, over three years, the overpayments and get to payment neutrality, the original MedPac notion of payment neutrality. Which is at the local area level, paying the

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plans the same risk-adjusted amount that is in the traditional Medicare program -- essentially go back to the pre-BBA payment neutrality days.

And they would do that over a couple of years. They do have a pay-for-performance add-on to give some money back to some plans.

The Senate, from what I've seen in the framework that has leaked that Julie talked about, is adopting apparently, at least the Gang of Six, the President's proposal for competitive bidding amongst the plans.

They would actually phase that in over about a four-year period, first taking 3 percent away from the plans and then phasing in a combination of administered pricing and competitive bidding. And ultimately by 2014, having a competitive bidding but only amongst the plans, not premium support notions that have been around, which would include traditional Medicare. So how this all plays out I'm not sure.

A dynamic that still exists is the fact that some of these Democratic Senators from Washington and Oregon and some places where they have strong, very good plans are being protective. At the same time, it's an obvious place where

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savings are to be found and I would argue on programmatic grounds, it's hard to justify these overpayments.

ED HOWARD: If I can just do a slight follow-up here, both Dennis and Joe referred to either mothers or moderators who might be nervous about cuts in Medicare. It's clear in the opinion polls that the support for reforms is less robust among people my age and over than it is in younger ages.

I wonder whether panelists might have an opinion about whether older people ought to be nervous about either of the Medicare Advantage provisions or the overall impact on their health care of the proposals as they're floating around. Judy?

JUDY FEDER: I think that the nervousness and the poll data that we're seeing reflects, in large part, a lot of the misinformation that I don't know whether we need to go into anymore. I'm prepared to let it die, shall we say. So a major effort to scare seniors -- and when we actually look at the legislation, I think that they should not be nervous.

There may not be as much in the bill as they would like. But I would say that, as Joe Antos said, when we look at the payment reductions that are in Medicare that are part of the financing, those are tiny. With respect to the overall

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future costs of Medicare, they are significantly lower than reductions that have been made in the past.

Hospitals, for example, have not had a reduction in their update. We used to see them on a regular basis and a slowdown in their legislated increase -- haven't seen one in years. There's evidence that hospitals, the only hospitals for whom Medicare payments are not sufficient, are the hospitals who are not facing competitive pressure from the private insurance market for the under-65 population.

So we've got lots of evidence that these payments are adequate and the reductions in payment that are being proposed are expected to extend the life of the trust fund. The reality is that we know that we have a Medicare financing program into the future and that changes of this kind are necessary for Medicare sustainability and in the context of health reform for providers will be offset by substantially more patients as we expand coverage.

So in terms of the discussion we've been having, I don't think they should be nervous. I think we should also look to the payment reforms that are aimed at improving, over time, it is a challenge, the availability of primary care, enabling more providers to spend more time with patients, the

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combination of the pharmaceutical industry pledge and other provisions to close the donut hole and major improvements in preventive benefits and benefits for low-income people.

So I think there's a lot that seniors should welcome in health reform and be afraid of a failure to begin to put the nation on a track that actually does create affordable health care for everybody because that endangers Medicare along with everything else.

ED HOWARD: Dennis?

DENNIS SMITH: Yes. I think in having done a few town halls, seniors are nervous about a number of different things, health care is one of them but they're also nervous about the deficit. They're nervous about the implications for their grandchildren, et cetera. So you hear them express a lot of different concerns not just about health care.

Part of the problem is that they've been conditioned, over the years, from different provider groups and advocacy groups in the past whenever Congress, of whatever party or of whatever administration, touches Medicare, they are immediately blasted the X number of alerts saying Congressman so-and-so wants to end your Medicare.

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So it's a little hard for them to shift gears now and say \$500 billion isn't going to impact you. So again, I think a lot of it is people are hearing so many inconsistent messages and they are using their own common sense to say look, something just isn't right here. I think that's really what's making them nervous.

ED HOWARD: Bob do you want to add something?

BOB BERENSON: Yes, just very quickly. Part of what's going on, on the Hill now is something like a food fight over geographic variations and this comes out of the Dartmouth data, there is some disagreement over the magnitude of the geographic variations emerging but there's no disagreement amongst anything that I've seen that there is still significant geographic variations with higher spending areas not producing higher value.

Whether it's 15-percent or 30-percent, we're trying to bend the cost curve one-and-a-half-percent, I think that there's plenty of opportunities. Judy mentioned to do that and given the sort of both the providers and the beneficiaries' voice on the Hill, I don't think it'll be done precipitously.

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I think we can enjoy these kinds of cuts [laughter] over 10 years. So there is nervousness. I agree with Dennis that that's out there but I actually think we can have a reformed Medicare program and that can contribute to help, well I mean it can become financially sustainable. It'll be difficult to get there.

ED HOWARD: Yes? Go ahead.

TERRY GARDNER: Terry Gardner with Small Business Majority. My question is about the health insurance exchange specifically the proposed by the Senate, 50-state exchanges, and how do the panelists think this would work in our small states, the 20 states that are under two million in population, have already a lot of insurance concentration and provider concentration, will a state-based exchange really change anything as proposed?

ED HOWARD: And while you're contemplating the policy aspect of it, let me just throw in a factual question that someone has asked on a card, which has a political component as well. Which of the cooperatives, I'm sorry, different question, never mind [laughter]. So I have given the panelists time to think about their answers.

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HENRY AARON: You wouldn't have done that when you were younger. I say that as older than you. Let me take a crack at it. I think the idea of having exchanges in relatively small, thinly populated or lightly populated geographic units would not realize the full advantages that exchanges hold as a potential.

My own view is that if one started with state units and included language authorizing collaboration across state lines between different groups of states that an essentially state-based system could be a sensible beginning but the key would be to let Delaware or Wyoming or other small states join with neighboring states in order to achieve a little bit, a larger marketing unit.

JOE ANTOS: I would argue that the geography doesn't have too much to do with it. They don't have to be necessarily next to each other but I mean that's something that people often imagine has to be the case. We're talking about a financial product. If you have a computer, you have a market essentially.

I think the problem here is that we're starting from an institutional base that is kind of hard for people to get over especially state insurance commissioners.

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JULIE ROVNER: But what about provider networks?

JOE ANTOS: That's an issue. There's a difference between insurance and the provision of services. That was a point I was about to get to. It does make sense to try to promote more competition and choice in all geographic areas where that's possible but, in the end when you think about where you're going to find savings, in the end, as we know most of the money we spend in health care is for services.

So all the talk about administrative costs and insurance and so on, that's the small part of it. If you can't organize a provider network, if you can't encourage your provider network to be efficient, in other words, if you don't change anything about the delivery system then this is a relatively small part of the answer.

ED HOWARD: Yes, go ahead.

DOUG TRAPP: Doug Trapp, American Medical News. What are the issues and this is for anybody on the panel with an opinion, what are the issues that the Democrats are not dealing with in the legislation that you think are going to have to be dealt with at some point in the health system?

ED HOWARD: Wow. That assumes that we know what's going to be in the legislation I guess. Dennis go ahead.

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DENNIS SMITH: Well I'll start since everybody else is going to be shy. Well I think one of the biggest is you're adding more to the Medicaid program. Medicaid's already in big trouble. The states are already pushing back and to put another 11 to 15 million people into Medicaid is not realistic. A year ago, the GAO said Medicaid was unsustainable. That's before any of this additional responsibilities were going to be piled on to it.

So I think the Medicaid expansion is a huge issue that they don't seem to really be dealing with the reality of what is facing Medicaid.

JUDY FEDER: Where did you go sir? Oh there. Okay. I would take issue with that Dennis because the issue of Medicaid capacity has a great deal to do with the resources that go in and although there are issues about future state obligations that legislative expansions of Medicaid are coming with substantial increases and federal resources. I don't think that counts as something that isn't in the bill because for God's sakes, it is in the bill. There are lots of future issues to be dealt with.

I'm more equipped to see what, I think that the view of legislation, as it's going forward, is that it is not

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even, if extremely successful as I hope it will be, it's not putting any of us out of business. There will be plenty of work to be done in the future.

So I think its scope, and I'm not one who's going to broaden its scope at the moment but I think it's putting in place, whether it's coverage or as we were talking about earlier, the mechanisms to slow cost growth, things that we will be continuing to work on and refine and just if I were going to stretch and think about something that wasn't there, even it is there and that is, relates to Medicaid too are provisions related to long-term supports and services.

Medicaid being our primary financier and it is quite interesting to note that in both the House, the Energy and Commerce legislation, along with the HELP bill, there is a proposal for or there is a provision establishing the class act for creating a new insurance program for long-term supports and services. So even that's in there. So I'm not an advocate of expanded scope although I think there's going to be plenty left to do.

DENNIS SMITH: If I may respond though, again what I was alluding to, maybe I didn't say it very well, in terms of Medicaid simply saying go get us more money for Medicaid is

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not really a solution. I mean that's not really reform, it doesn't take a lot of imagination simply to expand Medicaid eligibility and say well let's just go get more money for it. That's what I meant was, I don't think they're really dealing with the reality.

ED HOWARD: Henry, you didn't think there should be very much in it in the first place?

HENRY AARON: Well on the contrary, that's not the case. I was going for absolutely as much as you could get. The question was how much you could get and things are looking a little better than they did a while ago. I think there is a very important issue that has not been addressed.

Conservatives and liberals alike look at the health care delivery system and bewail the fact that it is fragmented as it is that there's too little coordination in the delivery of care through most of the U.S. health care system.

There are islands within that system that are exceptional, Mayo, Geisinger, and so on, the ones that President Obama mentioned. We all agree that we would be better off if there were more such organizations delivering health care in the United States but at this point, a lot of

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the discussion moves in the direction of the old economist joke, how do you open the can? You assume a can opener.

Well in this case, we assume, in effect, more such organizations. They're not going to spring up all by themselves. They're going to require entrepreneurs with financial incentives to pull them together, get doctors to participate, wrap hospitals in, and have the administrative know how to run these coordinated systems. That is going to take a massive effort. I don't see it in the legislation.

I'm not sure it can be in the legislation at this point but in terms of what the nation needs in order to achieve the transformation that we all agree would be desirable, that is the single most important thing that we need to do.

ED HOWARD: Yes, go ahead Bob.

BOB BERENSON: Let me pick up on that. I agree with Henry that we need to transform delivery into those kinds of organizations but that brings up an issue that is my number one issue that hasn't been really talked about, which is the development in many markets over the last five to 10 years of provider market power, hospitals in particular, certain single specialty physicians who are able to ask for and get

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significant multiples of Medicare reimbursement rates from health plans because they are what's called must have entities.

There's a number of strategies that providers have engaged in, legal ones. I don't frankly think antitrust policy is going to touch most of what is going on. To me, it's actually a reason to have a public plan.

I agree with Henry that I wouldn't die on my sword over the absence of a public plan but a public plan, which had some, not just a weak one but one that actually could set rates, would be viewed by providers as a moderating influence on their demands for rate increases from health plans.

If we don't have a public plan, I think we're going to be somewhere, in the next five years, talking about rate regulation or some kind of regulation on private sector prices. I think it's an issue that's going to boil over one of these years.

So to Henry's point, once we had the kinds of organizations, if we were able to get there, the question I would have is what is to prevent those organizations now able to manage costs, able to hold down costs, turning around and demanding significant price increases or prices from health

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plans for, in other words, not passing through the savings from their cost containment to ultimately to consumers. So I think the two issues are related.

HENRY AARON: Do you want to go on or, I'd like to answer that directly.

ED HOWARD: Go ahead.

HENRY AARON: I think Bob has raised an essential question, which is what is the counter power, the countervailing power, to use Galbraith's old term, against organizations that would be very large and very powerful.

The answer is being played out, even as we speak, in the state of Massachusetts. The key is that the state of Massachusetts made a bipartisan commitment to cover essential, everybody. Along with that commitment came the requirement of providing subsidies, which impose very significant budget costs.

As overall health care spending rose, more than was initially assumed in the draft legislation and a recession came along as well, the state confronted very severe budget pressures and now is talking about very far reaching, they haven't yet done it, but they're talking about very far reaching payment reforms.

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In other words, by making a commitment to universal coverage and the attendant subsidies, a demand is placed on public budgets that pits the revenue and the expenditure side of the budgets against one another in a way they have not been almost anywhere in the U.S. health care system.

So I think the key to building up the backbone to deal with these organizations is the public commitment to universal or close to universal coverage and the subsidies necessary to make that a reality.

ED HOWARD: Joe, before you go, Dennis, do you want to stay on that point?

DENNIS SMITH: Well now you gave me something else to talk about [laughter].

JOE ANTOS: Let Dennis go.

ED HOWARD: Go ahead. Then we'll go to Joe.

DENNIS SMITH: Well a couple different things. Again, the public plan and the media and the effect of it it's going to have, we have no idea what it's going to be. Some people insist that it's going to be lots of people are going to be in the public plan. Some people insist it's going to, very few people are going to be in the public plan.

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When you look at the provision in the House bill on the public plan, we don't even know what the public plan is. The public plan conscripts every Medicare provider automatically into its network. You have to actually opt out to get out of it. We don't know how much it's going to get paid.

There's short-term payment instructions in there but, over time, we don't know if that's really going to materialize or not. The secretary, once they have them all in, can cut all of the payments.

So we don't really know the impact of what the public plan's going to have on the market. Massachusetts, again I apologize for probably too much time at the microphone, I can't resist Massachusetts because I helped negotiate the Massachusetts waiver.

The problem with the cost in Massachusetts's waiver wasn't what they created within the exchange. It's all the other additional expenses the politician insists to be in there.

They gave \$300 million rate increases to the providers. They expanded Medicaid to 300-percent of poverty. If they actually would have stuck with the market-based

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reforms, they probably wouldn't be facing the budget problems that they're now having.

ED HOWARD: Joe?

JOE ANTOS: Well, the idea of digging a deeper hole so that it'll be easier to climb out doesn't make any sense to me. We're already in that deep hole and, Henry, I guess that's true that we, in the sense that Congress has yet to face up to the whole [inaudible]. So you're right that we have not confronted this issue but I really have serious doubts that Congress is going to be anymore equipped to face a 20-foot hole than the 10-foot hole that we're in now.

Medicare, we've been blithely going along without really making any real changes in the Medicare program for a long, long time now. The news hasn't gotten better year after year. I'm fearful that we will follow the Massachusetts example, which was as David Cutler said, well the first thing we've got to do is we've got to get everybody in there and then we'll think about what we do about costs.

We need to think about what we're doing about costs. We need to do that at the same time that we're thinking about how to solve the budget problem. When people say how are we going to pay for it, all they're really talking about is

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rearranging the deck chairs on the Titanic right now because, as Bob said earlier, a lot of the promising ideas just aren't ready yet. That, to me, is an argument by itself for some reasonable transitional policy rather than trying to bite off the whole thing right at the start.

ED HOWARD: Go ahead Judy.

JUDY FEDER: Joe, when you're talking about holes here, I think that we are talking about and the President has made an even stronger commitment that what he's going to sign is going to be fully funded, that I don't think any of us think that's not a challenge but that is his commitment.

So I think talking about holes here is a bit inappropriate challenge that I'll take, mountains maybe but not holes. Then I think that in terms of what we're discussing about changing payment mechanisms to promote changes in delivery reform and you get the health cost growth slowed, there's an enormous consensus on the directions in which we need to move, albeit recognition of the challenges, as Henry was putting out, in actually moving the system forward.

I think that it is a mistake not to recognize that what the legislation that we're seeing is doing in this

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regard is moving in that direction that, Bob you've talked about essentially getting rid of overpriced services and physician payment mechanisms so that we stop rewarding for so much for low value, high tech services and start providing incentives through new kinds of arrangements and shared savings, for delivering more coordinated, as Henry was talking about, more efficiently delivered care.

Everybody recognizes that that's a huge task but everybody also thinks that we've got to move in that direction and the path is very much there.

Finally I would say, in terms of supporting what Henry's saying is, that we are talking a lot of the problems that people are mentioning here go well beyond the technical to the political among the system when everyone's got a stake in the system.

The commitment to moving forward to actually delivering on better quality care and lower cost growth, everyone becomes responsible for that as an elected official. It changes the political dynamic.

ED HOWARD: Okay. I have a hunch we'll come back to that. Let me just get a quick question here as you're making

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your way to the microphone. It's addressed to either Julie or Judy. Try Julie first.

Was the President really referring the Senate Finance draft on Wednesday night when he said my bill, surely he was not referring to either the House bill or the Senate HELP bill. I won't read the number of exclamation points and question marks after [laughter].

JULIE ROVNER: As I think I made clear in my opening statement, I think this was a rhetorical flourish by the President. This is now his plan. Of course as reporters have tried to flesh this out in subsequent briefings with Robert Gibbs and talks with other administration officials, we haven't seen anything on paper since the speech. So my plan is now what's in the speech, which is more than we had in the budget but now we have the speech. So take that as you will.

ED HOWARD: Very good. Yes?

ROLAND BESIL: Hi, I am Roland Besil with the NCQA. I detect a bit of disagreement in the panel about whether or not the proposals we've seen really do constitute an expansion in coverage or a fundamental restructuring of the health care delivery system.

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Since there is so much consensus, part of the 80-percent that Republicans and Democrats seem to agree with is contained within the Baucus white paper that dealt with quality. Isn't this the opportunity where we need to really aggressively start restructuring and realigning incentives to pay for quality instead of sort of leaving that to the next phase?

ED HOWARD: And let me just relate to the earlier part of the discussion. Bob you were talking particularly about how many of the devices for bending the curve are hard to deal with now and are now in demonstration form in one or another of the pieces of legislation. There are certainly many of them are related directly to quality improvement.

JULIE ROVNER: Actually can I piggyback a question on to that before the panel answers, which is how ready were the DRGs when we started phasing them in? I mean I know New Jersey had done it but I mean we've done a lot of pretty big changes to the payment system before things were quote/unquote ready.

BOB BERENSON: Let me jump in a little bit and distinguish between what's now becoming sort of the mantra.

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We should stop paying for volume. We should start paying for quality. That is going to take some time.

I don't know that we have a robust set of quality measures to start paying for quality but we do have a number of specific ideas, which have married around patient-centered medical homes, different versions of accountable care organizations with one.

The House has two models, a shared savings model and one that would go back towards part, not the full capitation that ran into trouble some of the 90s but a partial capitation model, developing organizations who would be cost conscious and be rewarded for quality.

We do have enough quality measures now that I think some of the concerns we had in the 90s about capitation, about stinting of service, we'd be able actually to detect but the point I'm making here is with some exceptions, this is not in the health system today. I think we need to work it through.

Judy reminds me that we still have plenty of opportunity to improve the current payment systems that we've got, continued refinement to DRGs, which in fact has happened

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the last two years to get better severity of illness adjustments into DRGs. I think we have a real opportunity.

It's easy to say we should just abandon fee-for-service but fee-for-service is how we're paying doctors in Medicare and we could improve the RBRVS payment system dramatically by going after mispriced services.

I think one of the more successful things that Congress has done in recent years, whether it knew it was doing it at the time, was to reduce the payments for advanced imaging services and at least, in the first year, this was in the DRA legislation at the end of 2005 when they needed to find some money to pay for that year's SGR fix.

And what the result was is that in 2007, according to a GAO study, imaging services decreased, the payments for advanced imaging services decreased 13-percent. The volume of imaging services continued to go up but not at the same previous prior rate. The prices came down. It was an instance of and good policy, not transforming in the health care system by any means but getting the prices better.

So I think if we had the will to do it, we could be doing this in a lot of areas. So I don't want to say that,

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there's a lot of opportunities that I've seen in this legislation to actually make some significant improvements.

I think it would improve the situation for Medicare beneficiaries rather than threaten them if we actually did some of that while we are doing the more difficult things, which is trying to figure out how to pay for quality, which is what we all want to do but I think there we need to do more testing.

ED HOWARD: This is another aspect that's connected to that that's probably the subject of an entire seminar but you may want to bite off a piece of it and discuss it. It's related to what Bob was just talking about.

The questioner wants to know how health reform will affect how physicians and nurses and other health care providers are compensated for their services. That would be either in direct changes now or in some of the devices that you're talking about over time.

As I say, this is something that you could probably pick up 100 different aspects of but maybe what the most important ones are in the immediate and in the long-term.

BOB BERENSON: Well let me jump in. Initially, ideally we would go to the kinds of organizations that Henry

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was talking about and that they wouldn't just be the same ones we've talked about for 30 years, Geisinger and Intermountain and Group Health of Puget Sound but that we would.

There are actually many more out there that don't have the same, I guess, PR engines that are doing the same, that are actually organized, doing very good work, and providers, I mean professionals, I don't like to use the term providers for health professionals, would be paid according to how that organization pays them.

In many cases, it would be on salary, salary with bonuses. In some cases, they might pass through the incentives that the insurers provided to the organization, whether that's capitation or fee-for-service. So basically I would think we'd be in a much better situation when the decision making about how to actually compensate professionals was being made by organizations in which those professionals had a role in governance and some control over their own fate.

Where we still have sort of small solos, onesies, and twosie docs getting paid directly by the third parties, private insurers, and Medicare, it would be nice to move off

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of fee-for-service but I don't think that's going to be so easy.

JUDY FEDER: But Bob, I think you've written about even those, the onesies and twosies essentially being able to take advantage of shared savings arrangements that we are talking about promoting into the future.

BOB BERENSON: Well I think with more, shared savings perhaps the patient-centered medical home payment model, which is a hybrid payment model, which is both fee-for-service and a monthly payment to do care coordination and a better job being primary care docs outside of office visits I think is a very promising hybrid model, payment model.

So you could add some pay-for-performance on top of that. I think that's why I'm encouraged about what's in the House legislation. They would greatly expand the patient-centered medical home demo. Interestingly, in that area, they would add a model in the patient-centered medical home sort of a community-based component where you'd still have small practices and in the community.

There would be a care coordination disease management capability to work in conjunction with the practices. That's

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what Vermont has put in. It's the North Carolina Medicaid model. We need to be testing this stuff.

One of the things that is getting a lot of attention is to change the way CMS demos have occurred, which is it takes about eight years from the beginning to when you get an evaluation report, and then who knows what happens next. You need to be able to do real learning and adjustment in real time and that needs to be in the legislation and it is in the legislation.

CMS needs to be more flexible and one thing we haven't talked about yet is to do any of this right. CMS needs to be adequately resourced. It is a very thin agency right now.

So there is something of a disconnect between the expectations for all of these new payment models and organizational developments that will occur and a staffing level that is actually no greater than it was in 1980 at CMS. So CMS would need to be adequately resourced to be able to pull this off.

ED HOWARD: Dennis?

DENNIS SMITH: If I may just add though again on the payment side and again there's been lots of things for lots

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of years on the payment side on the provider side, I think though we also need to be thinking about how you get the beneficiary involved and in many respects, part of our problem is we keep pushing the beneficiary further and further away from participating in their own decision making.

We keep saying go ahead and make any decision that you want but you aren't going to have to pay for it. So I think the providers, I think provider reform is important but I think the beneficiary reform is important as well as for people to understand and participate in the cost of the decisions that they are making as well.

ED HOWARD: Go ahead Sonny.

SONNY: I'm interested in knowing what you all think about the coop proposal that Senator Conrad has and is featured in the Baucus plan and if you think it's a reasonable idea. Are there some provisions that need to be included to ensure that they would be successful?

ED HOWARD: At the risk of embarrassing myself again, I'll go back to the part that I tried to read before, which suggested that they wanted to know which version of the cooperative model was gaining traction, the state-based

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coops, regional coops, or as they put it, the Schumerized national coops. Anybody? Joe?

JOE ANTOS: Well, so one of the features of the Baucus outline, which is really pretty puzzling, is his specification about who can't start up or participate in a coop that he has in mind and turns out that if you've ever had anything to do with health insurance, you know anything about the business, you're not allowed to go in there.

So I guess if he really wants them, he'd better hope they're too big to fail because they certainly will fail if you don't actually have competent people trying to start these things up and trying to run these programs.

This is, the word coop sounds like a nice soft word and I'm sure it sounds probably better to people who get their electricity from rural electrical coops, so out West, this is probably a very resonant kind of a term but there's no particular indication that health coops actually operate very differently from other kinds of health systems.

The illusion of participatory democracy in these things disguised as the fact that they're businesses and they operate under the same exact incentives that all the rest of them do. So it's hard for me to see that unless you change

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the rules that they will have any substantial impact on anything.

SONNY: What kind of rules might you want to include in them?

JOE ANTOS: I'm not real eager to perfect the imperfectable [laughter].

ED HOWARD: I will repeat something that Uwe Reinhardt said a few weeks ago on a panel here, which was that the description, to him, sounded an awful lot like what we used to call BlueCross BlueShield nonprofit mutual plans that he predicted that within 10 years, they would be back arguing that they couldn't compete in the capital markets unless they converted to proprietary status [laughter].
Forgive me Senator Conrad or Senator Schumer.

JULIE ROVNER: A quick little add, if you go to the NPR.org website, Joanne Silberner has done several good stories on several of the coops including Health Partners in the Twin Cities. I think we did another piece on Group Health in Puget Sound. They've been operating for years and years and it's true, they look just like any other nonprofit regular HMO.

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I mean I think the question goes back to what we were looking at with Part D, which is the fundamental ideas to create more competition and will coops create competition where there wouldn't otherwise be competition. I mean that's the idea of a public plan. It's let's competition out there.

If you don't want a public plan, I remember going through all of this sturm und drang in 1997 about these PSOs, the provider-sponsored organizations, and we had the negotiated rule making and it went on and on and on. We were going to have doctors in hospitals banding together to create these the, again the idea was to create competition. I think in the end, we got, if I remember correctly, two, right two.

JOE ANTOS: It was a wild success.

JULIE ROVNER: Yes. It was a huge success. So you can go through all of this trouble to create this enormous mechanism in Washington but in the end, if the market out there doesn't want there to be these entities, they're not going to happen.

BOB BERENSON: If I could just correct the record, I believe there were three but I would also mention, as we talk about Accountable Care Organizations and think of the model

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that is somewhat risk-bearing, issues around PSOs that came up are going to be back. This stuff ain't easy.

So I think it's exactly the right stuff to be working on but these new organizations that we want to promote, I think there's been some facile thinking about the challenges here. We need to work through them but we may be back talking about PSOs again.

ED HOWARD: By the way, let me just ask, as we move well into the second half of this program, as we go forward, I'd appreciate it if you help us to improve these programs by filling out the blue evaluation forms you have in your materials. With that, the lady in the back of the room.

HANNAH NEPRASH: Yes, hi. Hannah Neprash from MedPAC. This is a question on the media coverage of the current debate. I've been both a little bit horrified by the attention paid to death panels but also pretty impressed with efforts to explain complicated concepts like the rec process or today's *New York Times* article on immunosuppressive coverage after you get a kidney transplant in Medicare. So I'm wondering for you, what has surprised you about the coverage of this debate and how do you think that will affect the coverage of the next health care debate?

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JULIE ROVNER: I'd like to hear from the rest of the panel [laughter]. I'd like to hear from the rest of the panel.

ED HOWARD: She thinks the coverage has been terrific [laughter] but only in certain outlets. What's that website again? Judy?

JUDY FEDER: It's hard to be surprised by coverage. I think that you have, rightly, identified that there's been a range. I think coverage of this kind of issue, it's true today as it was true in the past, is not always as educational as we would like it to be. I'm too old to be disappointed in that but I think it is the truth and that there's not as much educating goes on as we would wish, the media's picking up what hot stuff.

So I think that that's problematic. It is my sense and you know what side of this issue I'm on is getting it done, so it is my sense that in the post-August, we've only had two weeks into September but that I have been more impressed with the discussion and the media since August than I was for much of August.

JULIE ROVNER: It couldn't get much worst.

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JUDY FEDER: Well there's that, as Julie said, it couldn't get much worse but I think that we are seeing a fair amount of pretty objective, informative discussion. I'm obviously talking about only the part of the media that I listen to, which is, I still read the paper and watch public television and listen to NPR. So I'm not speaking for the non-mainstream media, which I think does its thing. That's what it's there for.

JOE ANTOS: I'll just make a quick comment that on this point, you were asking how would we expect to change in the future and how one might look back at the Clinton reform and realize that Judy's point about reading the newspaper probably everybody in this room reads the newspaper, that everybody in the country read the newspaper in 1994.

Today, outside of this room, nobody reads the newspaper. They all get their information from television, which is inevitably distorting in the sense that you can't possibly explain anything even simple in the 10 seconds that typically happens. So my prediction for the future is that you will have the thoughts immediately beamed into our heads eliminating all the cognitive functions that we may still be exercising there.

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ED HOWARD: *In the year 2525*, I believe it was the name of that song. Yes, go ahead.

TOM LALINBERG: I'm Todd Leeuwenburgh [misspelled?] with Thompson Publishing Group. I noticed in the discussion there still remains uncertainty about the exchanges, which obviously don't exist but we even had some discussion that we weren't certain that people wouldn't show up and sign up and significantly also, I think that as far as funding, through savings and eliminating inefficiencies that he'd also have somewhat of an uncertainty in terms of are the savings going to materialize when you rationalize a system and so forth.

With that as a backdrop, there's been a lot of statements from the administration so far that they do not want to harm what works and what is working in the health care finance system. Most working people get their coverage through their employer. So my question's about the employer-based system and get my little piece of paper out here.

Yes, I mean there's been a lot of speculation that this plan would result in an erosion of the employer base, removal of the stability under which the employer-based market has worked and that you'd have incentives for people to leave employer-based plans that would erode the either in

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the case of insured plans that would raise their premiums and lead them to send their workers to the public option.

On the other hand, you'd have an exodus from self-insured plans, which would also lead to more risk and again, possible erosion of those plans. So I think that would qualify as harming what works right now. If I can get to the question, how do you answer the fear that it would erode both insured and self-insured plans? Yes, you got the point? What do you think those plans would look like in 10 years or five years, whether or not there's the erosion that I described?

ED HOWARD: Can I just add an element to that question, which is based on the latest current population survey reports, we're already seeing a continuing erosion in the coverage being offered by private employers. So in the context of erosion, how much erosion are we talking about?

JUDY FEDER: Do you want to go first?

ED HOWARD: Henry?

HENRY AARON: We are talking about 16-percent or 17-percent of the U.S. economy, two-and-a-half trillion dollars, tens of millions of employees, delivering service, insurance products, and so on. It's pretty clear there's some gross

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flaws with the current system. Stepping in to correct those flaws with 100-percent certainty will produce unanticipated consequences [laughter].

The idea that legislation and this area is going to be free of side effects, some of which we didn't want, necessitating further legislation in future years, the idea that that's not going to happen is beyond naïve innocence.

There are certain gross flaws that we are having a national debate on how best to deal with those. The effects are going to be, some of them predictable and some of them unpredictable. We're going to be back to fix the mistakes in future years. The idea that we shouldn't move ahead because we can't fully anticipate what the consequences will be is a big mistake.

What specifically is going to happen to employment-based coverage will depend on the details of the legislation, which as Julie's brilliant summary at the outset, made very clear is to put it mildly, still in play. Consequently, I think and I for one would not hazard an answer to specifically which direction, up or down, employment-based coverage is going to go.

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I'm going to mention one thing that exchanges will do, if they're done right, would have the potential of doing over time that would greatly strengthen the employment-based system, which is to say you'd end job lock, the idea that when you change jobs, you necessarily lose coverage.

If an increasing number of employers provide subsidies for individuals to buy, their employees to buy insurance through the exchange, the individual worker has the relationship to the plan. The employer subsidizes the worker. There's no need to change plans when you change jobs. That's one of the major wraps on the current system. If you could correct that, it would be almost worth the price of admission by itself.

ED HOWARD: Judy and then Julie.

JUDY FEDER: There are a tremendous number of uncertainties. Henry's absolutely correct. We also have a little bit of evidence in Massachusetts of experience of the kind that we are talking about in health reform. With the requirements on individuals to purchase coverage and the requirements on employers to provide coverage, the employer-sponsored coverage has gone up.

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It seems, to me, that the efforts being made because people, whatever one may argue about, about the merits of broader portability or greater choice, people are very concerned about being able to make those choices themselves and not have them made for them. So I think that what we've seen in the legislative process is a considerable effort to preserve the employer-sponsored health insurance and that's what I would expect will emerge in the legislation.

ED HOWARD: Julie?

JULIE ROVNER: If I could go back for a second to the previous question about how the media's handled this. One of the things I think the media has done fairly well this time are some of these fact check of some of the big myths that have been told but I think one of the myths that hasn't really been looked at is one of the things that the President's been saying that if you like what you have, you can keep it.

I think one of the things that's really been missed in a lot of this and I think the census numbers that came out last week really showed this, the reason that the number of uninsured didn't go up as a net last week is that a number of people, it was about a million and a half, lost private

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insurance. This is a longstanding trend. It's been going down since the 70s but that many more people, it was actually more than that because it picked up the population increase, got public insurance.

So this idea that if nothing, if the country doesn't do anything, if you like what you have, you can keep it, is a myth. We are already the frog in the pot of water and the heat is going up. So this idea that if Congress doesn't do anything, I mean the President is actually telling the truth when he says that if nothing happens at all, the idea that you can keep what you have is a myth.

So the chance and it's true, everyone says oh well he's probably lying when he says, as Henry says, when you do this if you pass some big bill, the chance is that you might not be able to keep what you have if you like it, that's entirely possible.

There may be all kinds of new incentives for your employer to stop offering insurance. You may end up somewhere else. You may end up with a plan you don't like but you're just as likely to end up without insurance or with a plan you don't like if nothing happens. I think that's the part that the public is really missing that employer-provided

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insurance is going down and it's going down rapidly because costs are going up.

It's just that it's going down, I shouldn't say really rapidly. It's going down gradually because costs are going up inexorably. It's just going down a million at a time when there's 160 million people who have employer-provider insurance. So people aren't feeling it because like that, the proverbial frog in the pot of water, it's just getting hotter a little bit at a time.

ED HOWARD: Dennis, how's the temperature over there?

DENNIS SMITH: Yes. I think when you look at the experience of, after SCHIP, State Children's Health Insurance Program was created and what happened to the coverage of children, I think the displacement or the shift between public and private is apparent. So if it happened for kids, it makes sense it'll happen for other populations as well.

ARC came out with a study near the end of August that basically said before SCHIP was created, there was 5.9 million uninsured kids. Ten years later, there was still 5.9 million uninsured kids but the shift, when you look at the percentage served by private sector and the percentage served by the public sector, those lines cross over a period of

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time. So I think it's realistic to expect the same thing to happen.

I think the question is if it's going to happen, do we care enough to try to prevent it? If we do then are there other policies that should be adopted going along with the existing policies? So again, part of the question in my mind is it's likely going to happen, do we care? Do we care enough to then also adopt other policies to try to prevent it?

JUDY FEDER: And Dennis, I think actually that there has been a fair amount of caring in the drafting of legislation so that the design of certainly what's in the House bill is really quite different from the design of SCHIP and the way you're talking about and employer-sponsored coverage goes up.

ED HOWARD: And correct me if I'm wrong, are there not some provisions in these bills that would buck up particularly small business?

DENNIS SMITH: Well I think the reality though in Judy's statement, people are then going to start being confronted with the reality, are we actually then increasing costs for low-income populations? Are we actually going to

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make them take something that, today, they think is unaffordable to them? Is that the right policy then to adopt?

JUDY FEDER: I don't think that that was what I was raising because there are affordability exceptions as I read the House bill that enables people to go from employer-sponsored coverage into exchanges but for the most part, the exchanges are for people who do not have employer-sponsored insurance and for very small business.

DENNIS SMITH: But in terms of the policies that do affect people who have currently access to employer-sponsored insurance, are you basically saying you have to take it? There are some exceptions for people who are on Medicaid.

There are some exceptions and then there are some hardship waivers, whatever that's going to be but I think the reality is people are going to start when they think through these entire policies, get people who have made decisions now that they can't afford it through their employer, you're going to make them basically start spending, making an expenditure for what they have determined they cannot afford.

JUDY FEDER: That's not the thing. The implications of the individual mandate will be noticed I think. I think

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that in terms of the affordability, it's important to note that the level of and benefits that are being required in this plan are far from even, I don't know what car we compare benefits to these days, but they are quite reasonable levels of benefits, some would say less than reasonable levels of benefits. There are affordability protections. I think those are important to remember. The question was about whether they're going to be an employer-sponsored coverage. I believe they will.

HENRY AARON: Just a factual point, I believe, in the Baucus principles, the individual mandate doesn't apply to the Medicaid eligible.

ED HOWARD: Right. Let me just follow up with another question based on exceptions. Also let me just observe that we have more green cards than you can hang on a Christmas tree and not all that much time to cover them. So if you absolutely, positively have to have your question asked, you better repair to a microphone.

This one, however, makes the cut and sketches a scenario for us. Congress passes an employer mandate with businesses with 50 or more employees. Let's say several dozen of these companies employ an Amish person who's opposed

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to insurance or a member of a health care sharing ministry who share their expenses without insurance. The Amish and the member pay their medical bills.

Should the employer be penalized if these people don't desire insurance? If an individual mandate is passed, should these people be exempt? I would call people's attention to the situation in Massachusetts, which I think presents some of these same questions.

HENRY AARON: Do you know what they did in Massachusetts?

ED HOWARD: Actually, I do.

HENRY AARON: Tell us.

ED HOWARD: Actually they did have a religious exemption in Massachusetts.

JULIE ROVNER: This is why you have a regulatory process.

ED HOWARD: Yes, go ahead.

JULIE ROVNER: This is why you have a regulatory process, I mean to determine questions like this. I mean I'm sure there will be exceptions for cases.

ED HOWARD: Right.

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JULIE ROVNER: Conscientious objection or special cases.

ED HOWARD: And I'm told there are a fair number of people who have suddenly discovered a religious aversion to insurance in Massachusetts [laughter].

JULIE ROVNER: I would think you would have to have some sort of verification there. There seems to be a lot of interest in verification these days.

ED HOWARD: Joe?

JOE ANTOS: It goes well beyond that. If you look at one of the versions of the House bill, you see that at every turn, there is a new body, a new person yet to be named who will decide on very fundamental questions, the benefit package and a whole host of other issues that you'd really like to know the answer to and you won't get that answer.

JULIE ROVNER: Well otherwise the bill would be 5,000 pages long.

JOE ANTOS: That's not the reason. Length is never a problem if you don't have to read the bill [laughter]. There are two problems. One is that a lot of these questions cannot really be answered in the course of a couple of months by a bunch of politicians and their staffs.

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Worst yet, it probably can't be answered by a bunch of experts in years of study but if you're going to lay out outlines, you're going to have to leave holes. So this is one of the easier holes because you can imagine an exceptions process but what about the things that you actually have to decide on before you put the plan in place?

ED HOWARD: By the way, this reminds me of one statement that I think everybody on the panel would agree that President Obama misstated in his speech on Wednesday night, which was that he intended to be the last President [laughter] to work on this problem. I got a question that's addressed, at least initially, to Joe and Dennis. Your organizations had supported the idea of limiting the deductibility of health insurance for tax purposes.

Now for political reasons, that isn't going anywhere but Chairman Baucus has a 35-percent tax on insurance companies who offer policies valued at over \$8,000 for individuals and \$21,000 for families. Do you think this achieves the same results and are you supportive of that and what do you think happens in the market if it's passed? I'll take that for a no.

HENRY AARON: Could I actually add something to that?

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ED HOWARD: Sure.

HENRY AARON: The estimates are that the revenue raised directly from that tax will be zero. It increases overall tax revenues substantially because to the extent of the taxes effective in discouraging such policies, workers will receive a larger proportion of their compensations in the form of taxable wages rather than untaxed health insurance. So that's where the revenue gain comes from.

Secondly and this is a point that Peter Orszag stresses because he understands compound interest very well, everything in that proposal depends on the indexing provision. The indexing provision in the Senate version is to the consumer price index. Given the more rapid growth of health care spending, that limit becomes increasingly severe and possibly, over time, too severe in limiting the amount of health insurance that people would receive.

Built within that implicitly, over the long haul, are big increases in cost sharing. It's the corollary of insurance that bites decreasingly into the total health care bill.

So that provision is, in my view, a bit of a meat axe but it shouldn't be criticized for being too small or timid.

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JOE ANTOS: So let me add to that. I agree with what Henry just said. This particular idea is kind of a gimmick because it allows politicians to say we're not taxing you.

We're taxing some company that you don't actually like anyway but, of course as Henry indicated, the real economic effect does affect you directly and in the sense that it is more dishonest policy making, that's not a good thing because people actually ought to come to understand what they're doing with respect to their compensation and what deal is it that they're actually making with their employer about how they get paid.

I'm concerned that this particular dodge might actually not lead to the adjustment in wages that all economists think ultimately making these kinds of benefits more taxable. Then it might slow down the transition to higher wage income and lower contributions for health insurance.

The initial reaction from many employers who, I think, themselves don't necessarily understand their own compensation arrangements and responding to pressure from employees might be to say well we've got to do something here

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but it's really hard to talk to the insurance agent. So instead of doing that, we'll kick in a little bit more.

We'll slow down the wage increases even more than they have been and we'll ask the employees to also pay a little bit more in dollar terms for their insurance. So that would actually delay the transition that everybody who supports limiting the tax exclusion really would like to see.

In the end, what both of these policies, the indirect deceitful policy and the direct policy that may not ever be passed, drive that is that people ought to have more of a say in how they spend their money because although it is true that the employer contribution is part of their compensation, it's also being spent for them. Not everybody wants to spend the money that way.

ED HOWARD: We've got a question addressed to you Julie. What is your assessment of the so-called mark-up II in Energy and Commerce now? I would be interested in knowing whether mark-up II is mark-up after the blue dog conversation or mark-up after the progressive conversation after the blue dog conversation.

JULIE ROVNER: Well this is actually really none of the above. At the very end for those of you who were really

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paying attention to the Energy and Commerce mark-up, I think it was Friday night, actually the way the mark-up was concluded was that there was an opportunity to come back and reopen the bill and this is an ability actually if the leadership would like to have to make some changes via the Energy and Commerce Committee. This is a way that they can do it.

So it is a possibility that Energy and Commerce could reopen the bill and come back and do it. I am not counting on that as a likely venue. It is still a live possibility that that bill could be reopened even though it's technically been reported by the Energy and Commerce Committee.

I haven't spoken with staff since they did that, remember this was the night before they left for recess. So I am not speaking from knowledge here. I am speaking from lengthy speculation spent from watching an awful lot of committee mark-ups. I'm not thinking that they're anxious to reopen it but it is the way they left it, it is a live possibility.

ED HOWARD: Okay. Yes.

DAVID CONNELLY: David Connelly from Capital Associates. I have a question for Julie. It's kind of an

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end of the session question. It hasn't really been touched upon. It's an ERISA question and it really is a pension question. It's this.

In referencing the fact that we all read the newspaper in this room, but probably most of America don't. If we all read the newspaper in this room, we're probably all covered by pension plans. So my question is why hasn't the media focused on who really owns the insurance companies in this country. Who really are the health insurance companies?

It's not AHIP and it's not the face of AHIP, with all due respect to Karen, it's the shareholders of the insurance companies who are whom, Julie, in this country and why hasn't that story been told?

JULIE ROVNER: That's a very good point. Yes, it's big pension funds. Yes, I see where you're going with this. That's a very good story. I think there have been a lot of stories. There's a big bifurcation in the health insurance industry between the for-profits and the nonprofits. I think that's actually been lost.

I think in the President's eagerness to kind of recast this debate as health insurance reform instead of health reform and kind of beat up on the health insurance

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industry's indiscretions, if you will, and talk about rescissions and talk about all the insecurity that health insurance has, it's been a little bit lost in the mix.

I think there's been a fair bit of investigative reporting certainly, about campaign contributions and who's getting what and the idea that this gang of six represents the population of two-percent of the country making all these big decisions but I think that is a line that hasn't really been looked at.

On the other hand, I don't think that the health insurance industry is having the kind of influence on the debate this time that they had the last time. That may be one reason why that hasn't been as interesting a line of pursuit as others. It's been a different kind of debate this time. It's been a debate where the loudest voices are getting heard.

Maybe that's the 24-hour cable news cycle. I have to say I cover the debate the last time around. In some ways, this has been a harder debate to follow because there's been less there, there. We've had this kind of, we've got plans here and there. It's hard to explain in three sentences what it is.

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We've got some coverage. We've got some costs but it's pretty amorphous. So no wonder the public is confused and I must say quoted out of context in a story saying well if she's confused, why doesn't she stop covering this [laughter]. I feel bad.

ED HOWARD: That's the first free publication disclaimer I've ever heard.

JULIE ROVNER: I would like to say now I am not confused but it is difficult to explain this I admit this time around. It is more difficult to explain it this time around than it was last time around. I think last time around, we didn't do a great job either.

JUDY FEDER: But that's because you've had so much practice.

JULIE ROVNER: Yes thank you. Thank you Judy. Notwithstanding, there's lots of good stories around out there and actually maybe to wrap up, I think we're going to have plenty of time to lots more good stories because I don't think this is ending any time real soon.

ED HOWARD: Okay. We actually are near the end of our time. What I'd like to do is give each of our panelists one minute to answer the question that they really wanted to

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answer and didn't get a chance because it wasn't asked. How about that for an opportunity?

You must have come prepared with the notes that said I'm glad you asked that question. Now here's what I want to say. What do you think? Dennis? I have a question actually directed to Bob Berenson but I would rather, I can always fill in with and it's really tough.

BOB BERENSON: Go for it.

ED HOWARD: Okay. This is actually from a member of the Congressional staff. So they're looking for help Bob. Please describe what the health care market will look like in terms of the cost of premiums, the uninsured rate, the share of GDP [laughter] in five, 10, 15 years, if the elements of reform being proposed are either incremental or not in one minute [laughter].

BOB BERENSON: I'm not doing that one [laughter] Ed.

ED HOWARD: Go ahead. Henry could do it.

HENRY AARON: Bernard Baruch who was an early 20th century financier was once asked, since he knew everything, what the stock market was going to do. I think his answer is the right answer for Ed's question. He said it will fluctuate [laughter].

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ED HOWARD: And as it turns out, people who quote Bernard Baruch are the 10th wonder of the world. I think that's, unless somebody wants to interject in that, we're going to end on that note. Let me remind you to fill out your blue evaluation forms if you would. I want to thank the folks at Lilly for their participation and support.

I want to thank you for your wealth of questions and apologize to those of you who asked them and we couldn't get to them and ask you to join me in thanking our "Ask the Experts" panel [applause]. You were terrific.

[END RECORDING]

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