



**Health Care Costs: What You Need to Know
The Kaiser Family Foundation
Alliance for Health Reform
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MARILYN SERAFINI: Good afternoon. I am Marilyn Serafini with the Alliance for Health Reform. On behalf of our honorary co-chairman Senators Cardin and Blunt, I would like to welcome you to today's briefing on the subject of health care costs. I would also thank your partner in this briefing, the Kaiser Family Foundation. We have with us today as my co-moderator, Drew Altman who is the founder of the Kaiser Family Foundation.

Our mission today is to try to take some of the mystery out of health care costs. Our experts are going to explain the trends, the prospects moving forward, what is driving health care costs, and what policy makers in the health care community are already doing to try and help keep costs down. A couple of housekeeping matters: First, we are covered live on CSPAN today. If you are watching on C-SPAN, you are welcome to also follow us on Twitter. We will be live tweeting with the hashtag #hccosts. If you are watching on C-SPAN, we invite you to submit questions via Twitter, again using that hashtag #hccosts.

I would also like to note that you have a blue evaluation form in your packet. Before the end of the briefing today if you could kindly fill that out. If you are a congressional staffer, you also received on the way in a yellow survey. We would be extremely grateful if you could fill that out and give it to one of our staff members on your way out. That will help us to know what your interests are and to help us do a better job in putting on these briefings.

I'd like to introduce our panelists today. First to my far right, we have Gary Claxton. He's the Vice President of the Kaiser Family Foundation and the Director of its Health Care Marketplace Project. Gary today is going to explain the health care cost trend and what we can expect moving forward.

To my left is Joe Antos. He's the Wilson H. Taylor scholar in Health Care and Retirement Policy at the American Enterprise Institute. Joe is going to help us understand what factors are driving health care costs.

To my far left is Jeff Selberg. He's the Executive Director of the Peterson Center on Health Care. Jeff is going to address the various programs and approaches that are already underway and the strategies to keeping health care costs at a manageable level.

And to my right, I have already introduced somewhat my co-moderator, the founder of the Kaiser Family Foundation. He is a member of the Institute of Medicine and was Commissioner of the Department of Human Services for New Jersey. He was Director Health and Human Services at Pew Charitable Trusts, and also Vice President of the Robert Wood Johnson Foundation. Drew also served in the Carter Administration. Drew is going to start us off by giving us some perspective on the issue of health care costs. By coincidence, he has a column in today's Wall Street Journal on the subject. You also received a copy of that on your way in. I'm going to turn it over to Drew.

DREW ALTMAN: Some of you remember the Carter administration, right? It's great to see so many of you here. I just have to say a word about Marilyn. I started working with Marilyn when she was at the National Journal asking me hard questions a lot of the time. Then she worked with us at Kaiser Health News and I got to ask her some hard questions sometimes. Now we're working

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together at the alliance. It's great to be working with you again. And, it's amazing to see so many of you here. Thank you for being so interested in this topic.

I actually started studying the problem of health care costs a long time ago when I was at MIT sometime between the passage of Medicare and Medicaid and when you were all born—just looking at the audience. It's kind of tempting for me to say I feel a little bit like a football coach who has seen all the plays and all the formations and even the trick formations from my New England Patriots before, and there's nothing new. But actually, that's not true. We're at kind of a different point where there's a lot that's new about the problem of health care costs. There are some pretty big questions about where health spending is headed. So, I actually think it's a very timely briefing. The alliance always gets it exactly right.

In 2002, I published...let's see if this works. I published this chart in Health Affairs. It was a one page article and the title was "The Sad History of Health Care Costs As Told In One Chart." It documented what, since the beginning of time, had been the basic dynamic for the problem of health care costs—they moderate and then they bounce back with peaks and valleys which are driven by both changing economic conditions and changes in health policy and changes in the health care marketplace, and also just the threat of changes in health policy or impending changes in the marketplace.

Now, we're coming off of several years of unusual moderation in the rate of increase in health spending. It's really historic, let's call it extreme moderation. It's really historic moderation in the rate of increase in health care costs. Gary is going to show you the data. I'm not going to do that. But, just a couple of big picture points for you to keep in mind. One of them is that there is widespread agreement that the slowdown is due both to the sluggish economy and to changes in the health care system, by which we mean changes both in health insurance and in the health delivery system with the economy being the biggest factor. But there is...how should I put it? I guess I would describe it as modest, but not profound disagreement about the relative contribution of each of those factors. I'm sure Joe and the rest of us will be talking about that today. Since I'm sure you're going to ask, this far and less agreement about the role of the ACA, about the role of the Affordable Care Act, or frankly whether it has played any role at all—and we will all have views on that. The big question really is: Has the sad history, these peaks and valleys that you see here in the chart, been repealed? Have we somehow boldly gone on health care costs where we have never ever gone before? Is that even plausible to anybody?

We're beginning to see now, just very recently, and uptick again in the rate of increase in spending, which was predicted by most of the models—including our own models at Kaiser. I think the question really to keep in mind is not whether health spending grows more rapidly again, but when and by how much? Is it a lot or is it a little? Here's one thing to keep in mind, and that is that this is a business where small increments really do matter. So, think about this rule of thumb: A 1% difference in the rate of increase—so 1% up or down in the rate of increase in health spending—that's \$2 trillion dollars over a 10 year period. So, a lot of what you do, a lot of what we do in health policy when we work on the problem about health care costs, it's not the effort to see if we can totally change the health care system or cut health spending in half. It's really more the effort to see

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if through 100 little ways or 50 little ways we can shave 1% or half a percent, or a quarter percent off of what that rate of increase in health spending would otherwise be.

Just one other big picture introductory point I wanted to give you: Keep in mind also that this is a multifaceted problem that you need to deal with in your jobs from several different angles. You also focused a lot of Medicare and Medicaid because they're such a big part of the Federal budget and spending on those problems are affected by a whole bunch of factors, which can be different from the factors that drive national health spending. Lastly, you also need to deal with health care costs from the perspective right of constituents and voters. So, it's worth pointing out that experts and people and you know in my experience experts are also people but maybe not always—view the issue very differently. That's what that Wall Street Journal column you have in your packets I wrote today is about. And it just...this may be obvious, but it's worth saying. It would not be a great idea to tell the average constituent in a town meeting that they should be grateful because they live in this wonderful period of great moderation in health care costs because they might look at you like you're a little crazy. That's because, from their perspective, their premiums are going up, their deductibles especially are going up, at a time when their wages are flat.

The last chart I just wanted to get into your heads shows that...I don't think it could show it anymore clearly. This was in 2013, which was a record year increases in health spending and health care premiums. Just 3% of the American people told us that they thought health care costs were going up slower than usual.

I will end with this—kind of my framing for the discussion: The national health spending problem, the health and the Federal budget problem, the health costs as a consumer issue problem; these are all related but different dimensions of the overall health costs problem, which in your jobs you all need to deal with. As you listen to the briefing this morning, listen for not just one problem but at least those three problems. With that, I'll turn it over to Gary.

GARY CLAXTON: Good afternoon everyone. I just have a couple minutes to try to talk to about health care costs, what they are and how they've been changing over time. I'll try and do it kind of quickly so that we have plenty of time for questions. This first slide shows information on per person spending on health care over the last 50 years or so—a little bit longer than that. This information comes from the National Health Accounts, which is sort of the nation's way of keeping track of how much we spend on health care. The total, from what you can see from this slide, the total expenditures on health care in the US in 2013, which is the last year with final numbers, was \$2.9 trillion. This translates into about \$9300 per person. The little numbers on the bottom show it represents a little over 17% of the gross domestic product or sort of national income.

Health care costs have risen steadily over time from about \$1100 per person in 1980 to almost \$4900 in 2000 to the \$9300 in 2013. They also have risen faster than other goods and services in the economy. Health care represented about 7% of GDP in 1970, 12% in 1990, and as I said 17% in 2013. While things have slowed recently, as Drew pointed out, the rapid growth in health care costs in the previous decades is what really raised policymaker's concerns about the ability to afford and sustain our health care spending over time. Obviously why we care about health care costs, just to

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say the obvious, is it costs money obviously for people to consumer health care costs and for governments to support health care programs. But also, the more money we spend on health care the less money we have to spend on other things we care about, like education at the state level.

This next chart shows how the US health care spending compares to that of other nations. Some of it didn't come out very well, but generally the US spends about \$2600 more per person than the next closest country, which is Switzerland, and about twice the amount per person as sort of the average of other nations, which are...which have large populations and high incomes.

MARILYN SERAFINI: If I could just stop you for just one second Gary. You have the full graphic, even though it's not showing properly here, you have it in your packets. I wanted to also mention, if you're following this briefing at home on CSPAN, you can look at all of these presentations and other supporting materials at our website, which is www.allhealth.org. Sorry Gary.

GARY CLAXTON: No problem. When you look at this spending in terms of GDP, as I said, the US spends about 17% of our GDP on health care. These other countries spend between 9-12%, so much, much less.

Sort of another dimension of the issue of health care is that different programs, different payers, diff...there's different ways to look at it and they all have their different political and economic dimensions. I have one example here which shows Medicare spending per enrollee verses private health insurance spending per enrollee over a couple different decades. What you can see from it is that although the growth has been very similar until recently where Medicare growth has been much slower, Medicare continues to be a much hotter political topic than private health insurance spending. There's a couple reasons probably for this. One is that Medicare is a public program which is on budget. Private health insurance, while it has a big effect indirectly on the budget, those effects are indirect through the tax system. So, they're not as visible.

Another is that Medicare has a demographic issue where the population is aging and many more people are going onto the program. Even if Medicare spending per enrollee goes up at the same rate as spending in private health insurance or for just the rest of us, the costs of the program are going to grow because there are more people in the program. There is also some issues around the trust fund and the payments for Part A.

I didn't want to so much point out the Medicare issues, although they are important to what you all do, but to point out that each program and each sort of perspective has its own important factors that you need to consider when you look at the health care costs issue. We're not even mentioning today the effects of health care costs on individuals and their out-of-pocket expenses and their ability to afford their out-of-pocket expenses. We could do a whole briefing on that.

As Drew mentioned, health care spending has slowed dramatically recently. This slide shows that the average growth rate of health spending compared to the economy as a whole has been faster for the last...the previous four decades, and sometimes considerably faster—a couple percentage points. Until recently, when health care spending has actually gone up slower in the last couple of

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years than the economy. This recent slow down in health care spending which began, I think as Drew said, in the mid-2000's, but has really accelerated recently into record low spending, has raised the question as to why—what's going on?

Some people, including a paper that we wrote at Kaiser with some others, attribute most of the slowdown to the economic downturn that we experienced recently and the slow recovery. That paper shows that the lag growth of GDP is correlated with health spending and is highly predictive and accounted for a substantial share we think of this slowdown. Others acknowledged that the economic slowdown had an effect, but they would say that structural changes in the health system—primarily higher cost sharing in insurance policies, but also things like better data systems and payment reforms—played a larger role in slowing the health care spending.

Why does this matter? As Drew said, the answer to the debate about why spending has slowed down suggests something about what health care costs will be in the future. If the slowdown was primarily caused by the slow economy, then health care spending should begin to slow again as the economy recovers and we may see something that looks more like the traditional pattern of health care spending greatly, you know going up much faster. If the structural reforms dominate, we may see a longer period of slow growth.

This chart shows the both historic but then the projected spending from the actuaries at the Centers for Medicare/Medicaid Studies. Their take on going forward is that health care costs will rebound as the economy rebounds but will not go up at the levels that they have gone up in the past. In general, they're projecting health care costs to go up at the rate of growth of the economy, plus about 1.1 percentage points, which is slower than it has gone up historically. As Drew pointed out, the amount there matters a great deal. If they're wrong by half a percentage point you're talking about half a trillion to a trillion dollars. So, it's meaningful.

If I could just make one final point: You may notice that—they're hard to see on the slides—a number of the slides that I showed today are attributed to the Peterson Kaiser Health Care Tracker, which is a new program that we have with Jeff and the Peterson Center on Health Care. The Tracker is place where you can find a lot of this type of cost information but also information on performance measures in health care. Just today, we introduced an interactive tool which will allow you use information from the National Health Accounts and to draw your own charts and look at health care spending for different payers and different periods of time and different programs and set your own parameters and look at them in nominal terms and real terms and things like that. We hope you'll go check it out.

MARILYN SERAFINI: Fantastic. Can you pass the clicker down? Okay, we're going to turn now to Joe Antos who is going to talk to us about what is causing...what is driving health care costs.

JOSEPH ANTOS: Thank you Marilyn and Drew. It's a pleasure to be here to talk about this topic. It's always good for people to begin to come to grips with reality about health care spending in this country, which is as Drew said, it's bouncing back up—which is good news and bad news of course, depending on who you are and how you look at it.

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Everybody has their favorite slide. Let's see...how do you do it? Oh, good. Here's one of my favorite slides. This shows health spending growing as a percentage of GDP. It's a lot smoother than Drew's slide, but it basically tells the same story. I will try to describe some of the many factors that people have suggested that have contributed to what really is pretty much a relentless steady growth in health care spending over the past 55 years, which is as far back as the data really takes us.

[MISC]

JOSEPH ANTOS: Here's Gary's slide if you wanted to see it. I want to thank Gary for producing that slide. Since he already talked about it, we can move on. It's always good to know what we're buying with your health care dollars. This is just a straight forward kind of slide. One of the things that people often say is that health spending has changed or the nature of health spending has changed. We've moved away from hospitals and we've moved toward outpatients services of all sorts. Turns out, that isn't what the data shows.

If you go back to 1960, hospital spending as a percentage of national health expenditures was 33%. Now it's 32%. Physician and clinical expenditures basically stayed about 20%. The one interesting part of this chart that really moved around in the last 50 years or so is prescription drugs. If you look at the end points all you see is pretty much the same story. It started at 9.8% of national health spending in 1960 and is now about 9.3%. But unlike the other major categories of health spending, this is the one category that has really moved around substantially. Prescription drugs dropped as a share of national health spending to about 4.5% by 1981. It really didn't begin to grow substantially until the mid-90's. That is consistent with the technology story in this country, with regards to prescription drugs at least.

We saw an explosion of medical innovation that led to tremendous new drugs—Staten's [PH] for example being maybe the biggest driver of that. Similarly, in recent years we've seen that percentage drop off precisely because of Staten's mainly, the big Staten's dropping off of patent protection and frankly a little bit less innovation although we're beginning to see some change there.

The other thing I wanted to say about this chart is, I'm mostly going to be talking about the kind of health spending that's covered by health insurance. You'll note that there's a small but substantial portion of this chart that we're spending on what is essentially long-term care. That's the nursing care facilities and the continuing care retirement communities. That doesn't even include the costs that people incur that don't show up in the national health accounts. That's a major factor. I'm not going to try to explain that directly.

Who is paying? It's also good to know who is paying. You can see that about a third of the spending comes from private health insurance. Medicare and Medicaid account for another third or so. Out-of-pocket and other sources account for the rest. Let's move on to health spending growth.

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Of course it's virtually inevitable that we're going to see health spending grow over time. The factors you all know. It's an aging society. It's an economy that ...we're fortunate enough to live in a country that continues to grow. Despite the big recession recently, nonetheless the economic news here I would argue is better than maybe any other country in the world. We're living with more chronic disease. That's partly because we're living better, we're eating more, and maybe not exercising enough. We're living longer, which is one of the reasons why chronic disease is a bigger factor. The longer you live, the more likely you are to have a chronic disease.

Financing of course is a big, big factor. This drives a lot of this spending. The fact that we have health insurance makes it less expensive for people to buy health services. Health insurance prepayment is a combination of prepayment for routine expenses and coverage for unexpected, totally unaffordable costs. But it's that prepayment that's really driving us. And, the fact that hospitals, doctors, and other providers are assured that the cost will not get in the way of treatment means essentially they are more free to do the right thing in terms of recommending what could be very expensive care.

Obviously there are very large subsidies. The Medicare/Medicaid programs are heavily subsidized. Tax subsidies...essentially, it's hard to find anybody in this country who doesn't have some part of their health care costs subsidized by the taxpayer.

The way we run the system also drives spending. Fee for service payment is a big factor. Fee for service promotes the use of more and more expensive services. If you're a physician in the fee for service world, if you provide more services you get more pay. It's very simple. Financial incentives promote innovation as well. There's a yin and yang in all of those. We're spending more money but we're getting more innovation and that often adds to spending.

Fragmented delivery system—here's a bit of a puzzle. On the one hand we all say—and I believe this myself—that because we deliver health care in a fragmented way, especially because it's mostly fee for service and we're not having this kind of coordinated care that health policy people talk about all the time, that leads to inefficiency, suboptimal care, unnecessary services. We're spending more money and getting less out of it. On the other hand, I wouldn't be an economist if I didn't say well you know, consolidation in the local markets must be driving up prices and that must be adding to our costs. I'll let you ponder my schizophrenic stance on this.

Lack of transparency—we've been talking about this a lot lately. We really don't know what it costs, if we're consumers. We really don't know whether the service is good for us. We don't know whether the providers have a good track record. And this also contributes, I think, to the cost. The question ultimately is, is there a cure? And, I think the real question here is: Is the growth in health care spending too rapid? I think that's a philosophical question. It's also a financial question. It's very difficult to say that we need to cure something...again, it depends on your perspective. If you're looking at it from a Federal budget perspective, there's a big issue, especially when you realize that a very large contribution to our national debt is in fact caused by health spending. But, from a personal standpoint, what I spend...I spend what I think I should spend. At least, that's what

I think. But, I'm not fully informed. So, this is a really difficult question. It's a difficult policy question. It's a difficult question for people and their families.

Will eliminating waste inefficiency put us on a sustainable path? We talk about this all the time. I would argue no. If you cut out all the waste in the system you would still have a substantial amount of spending that would still grow. So, it's really a question of how much growth do we want? As I said, this is a difficult question to answer and I will not plunge into competition regulation consumerism, but that certainly relates to my schizophrenic view on that other slide.

MARILYN SERAFINI: Fantastic. Thank you. Before we turn the mic over to Jeff, I just wanted to remind you that if you would like to follow the conversation on Twitter, the hashtag is #hccosts. And, if you would like to submit a question via Twitter, please use that hashtag and we'll pick that up here.

After we hear from Jeff we're going to turn to a question and answer period. While we have two mics in the room where you may ask your questions, we also have cards in your packets that you can write a question on, hold it up, and a member of our staff will come by and get that. Let's turn it over to Jeff who is going to talk to us about what is happening and what can happen to keep costs down.

JEFFREY SELBERG: Thank you Marilyn. I'm going to take just a little different tact. But, before I do that, I just want to reinforce Gary's comments about the Peterson Kaiser Health System Performance Tracker. Our intent in our partnership with the Kaiser Family Foundation is to try to show whether or not this most vital of economic sectors, health care is improving in terms of its value proposition. In other words, are we creating value over time? Are we getting more for the spend, less, or are we in neutral? It's more challenging than you might imagine. While tracking the spend and the components of the spend is challenging enough, identifying the measures to determine what we get for that spend is proving challenging. But, we believe over time we'll be able to demonstrate just what this most vital economic sectors in the US is doing with regard to performance.

Different tact: The Institutes of Medicine I think has shown that about 30% of all health care expenditures do not add to the value of the outcomes intended. Some would classify that as waste. Let's talk about what that means. A 30% waste in a \$3 trillion dollar sector is something on the order of \$800 billion. What is \$800 billion? It's equivalent to what we spend in K-12th education, all in. It is double what we spend in all of research and development in this country. So, it's a very, very, very big number.

One of the ways that the Institutes of Medicine came up with this number is it studied variation in health care—variation in quality outcomes and variation in cost. It found a very high level of variation not only across the country, but within communities. It also found that cost and quality frankly are mutually inclusive. In other words, lower the cost, higher the quality in the outstanding programs that they identify. Now, most of us would lament this variation, this high degree of variation. We see it as a wonderful opportunity to improve because there are the positive variants

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out there—the exemplars, the less than 5%—that are generating the highest quality outcomes at the lowest cost. Our intent at the Peterson Center on Health Care is to identify those positive variants, those exemplars, validate the work that they're doing by identifying what the active ingredients are that generate that exemplary performance, and then replicate. Replicate on a really controlled basis to really understand if there's causation there in terms of those identified features or ingredients, and then move to replicate on a controlled basis, limited basis, and then a mass basis. I'll give an example of that in just a moment.

Now, I know I'm in the land of policy here, which is foreign territory for me. My background is being out in the field of practice. I will say that policy is extremely important in this effort to face the issue of improvement in health care. Policy, in my mind, creates the conditions under which the field is willing to engage in change, engage in improvement. I found, however, that sometimes you can get so enamored with policy that it's all you...you come to the belief that it's all you need. Somehow the payment incentives will be aligned, somehow regulations will be aligned, and then the miracle will happen out in the field. We don't believe that. We believe that practice is as important as policy and that's where we're choosing to focus. Practice, in terms of what I just described—identifying the exemplars and then replicating the key features that they have that generate that exemplary performance.

I'll tell you a third element that's critical in this, and that is patients. We found that in integrating patients into the design of these new models is critical if we're going to have that exemplary performance. It isn't just being...designing with the patient in mind. It's designing with the patient involved. Those are the three P's—policy, practice, and patients.

Let me give you an example of the work that we're doing which hopefully will give you just a little bit more of a granular idea of what I'm talking about. We funded research with the Stanford Center for Clinical Excellence Research led by Arnie Milstein. What Arnie and his team did was identify the exemplars in primary care. The metrics he used were the HEDIS measures, the top quintile, top 20%, and all-in per capita costs, the lower 25%. He found a little less than 5% of the practices surveyed did both—high quality, low cost. He went out and site visited 11 of those practices and came up with 10 features, 10 features that we believe correlate to that exemplary performance.

Now, we're in the process of what we call limited market tests with five practices to determine if in fact these features are the cause of that performance. Replicate those features in those practices, have a control group to determine in fact it is causation, and then really understand what of those features have leverage in terms of improvement. Then, go to 30-50 practices replicate and then go to a mass replication. Now, we don't claim to know how to mass replicate—if that's even a phrase. But, that's what we are determined to learn, that approach.

We think there is a lot of different approaches in adult education that we can use, whether it's the Khan Academy or language like Rosetta Stone or Pimsleur. You might think boy, he's getting pretty far field here. But there are, I think non-health care approaches that we're going to have to adopt to get to a point where the 5%...the 5% exemplary performance becomes the 95% standard in the community.

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I have been challenged on this in the sense that the question has been asked, aren't those five percenters really exemplary in terms of people? Aren't they the geniuses? Aren't they like the great teachers? You can't make a good teacher a great teacher. We would strongly disagree. What we're finding in these practices is yes, there are great people in those practices but they've surrounded themselves with systems and processes and other great people that can be replicated.

So, we have great optimism in moving this sector by engaging in identifying, validating, and replicating those exemplary practices, whether they be in primary care, high cost/high need patients, and also advanced illness management. Thank you.

MARILYN SERAFINI: So, we're going to start out Q & A session. If you have a question please step to the mid or write your question on the card and we'll have our staff pick it up. In the meantime, I'd like to ask a first question. We've heard a lot of discussion about moving, moving away from fee for service to coordinated care. The health care industry, the sector, is moving quite a bit toward value. How long is this going to take? What is the time frame here? When... are we already seeing some results? When will we see some significant results? When do we actually turn the major corner here?

JOSEPH ANTOS: I'll go ahead and plunge in. It takes a while before you really know you have results. So, I think to the extent that the Affordable Care Act may have opened some doors, it's way too early to know. It is certainly the case that there is a lot of talk about changing the way that health care is delivered. But, we do go back to some of our favorite examples, Geisinger for example, the Marshfield Clinic. These are organizations that are very successful and they didn't get that way over night. It really has taken them decades and they're continuing to work on improvement. I think that's the key here. Don't expect a miracle any time soon, but let's not stop working at trying to resolve the problems that we know we have so that we can move onto the problems that we don't know we have.

DREW ALTMAN: I have a perspective on that. As long as I've been in the field, there were always two schools, basically two schools about how to approach health care costs. One came mostly from conservatives who believed in market competition—more skin in the game, insurance, prudent purchasing. The other came mostly from liberals who believed in government regulation. Now we're in a slightly different phase where through delivery reform, payment reform—some of the things Jeff was talking about—we're actually trying to get inside of the black box of medical practice and change it. There's reason to be very hopeful about that and Jeff outlined some of those reasons. There's also reasons to be skeptical about some of that. Joe talked about consolidation and being schizophrenic about consolidation. Joe also talked about it takes time and can we get beyond the big integrated health care systems to the mainstream health care system with some of these reforms?

My view of it is let's not be religious about it. We need evidence. One of the nice things about the Medicare demonstrations is they're all tied to independent, rigorous, scientific evaluations, which will give us some actual data about what the results of some of these changes are. But, it is a new

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approach. It is a new approach to...if you look broadly at how we've taken on the problem of health care costs over 30 or even 40 years to how we tackle this.

JEFFREY SELBERG: Marilyn, if I could. I know you've got a stack of questions there, but I think this is a great demonstration of how this is a two-step process. Value based payment is, in my estimation, a very good thing. It does provide an incentive I think for greater efficiency and effectiveness. Where, I think as Joe said, fee for service is volume based—greater the volume, greater the revenue, greater the incentive. The fact is though, that you have to follow-up with more effective delivery, more effective practice or you're not going to get higher quality and lower costs. All it does is create a condition under which improvement can be incentivized.

MARILYN SERAFINI: Okay great. If you can please identify yourself.

MIKE MILLER: Thanks Marilyn. I'm Mike Miller. I'm a health policy communications physician consultant. I've been doing that for about 25, 6, 7 years. Parallel to the change from volume to value, there's also sort of new initiatives in terms of how health care is delivered and what's considered important, particularly more of an emphasis on population health, community based care, getting care out into the community. I'm wondering if any of you are familiar with Elizabeth Bradley's work where she looked at international comparison of health care spending as a percentage of GDP and also looked at what country spend on social services as a percentage of GDP and found that when you add the two together, social services and health care services, the US came out not way up at the top, but sort of in the middle, consistent with our health care outcomes. I'm wondering if any of you can talk about those social services as an aspect of how we can improve the quality in reduced cost for health care and how social services might be considered as something that health care payers can start incorporating into their schema of what they will reward?

JEFFREY SELBERG: I'll start very quickly. There's a lot there in your question. Yes, I am aware of Elizabeth Bradley's work. Some have chose to respond to it and say see, if you combine those two we're not the highest spender, as if that's a response to the question of cost. If you look at her work, you'll find that we spend disproportionately on the clinical medial side and much less so on the social service side. I think what we're finding, especially with high cost/high need patients, that the most effective models there...high quality in terms of responsiveness to the patient, living conditions, clinical outcomes at lower costs, effectively integrate social services and the medical model together.

So, how does policy then follow that practice to create the conditions under which that can happen vexing issues in terms of insurance models including social services? There have been models that have worked on a per member, more month based reimbursement or per capita that say it's still worth our while to provide those social services because they lead to such a reduction of the medical services. So, I think we're right on the frontier of trying to understand how to integrate these different services.

MARILYN SERAFINI: I'm going to direct this first question to Gary, although others are welcome to chime in. While health spending is at record lows, premiums while growing more slowly aren't showing the same historic growth slowdown. Why not?

GARY CLAXTON: At least in our employer survey, premiums have been growing fairly slowly—not quite as slowly as health care spending overall. Part of the reason that overall health care spending takes into account some of the reductions in public programs that have occurred recently, private health insurance doesn't have quite the same effects.

Also, when you look at changes in overall health spending, when people lose health insurance they actually spend less. That goes into the health accounts. That means there is less health care spending overall. But, the average premium for people who have insurance doesn't necessarily go down because some people lose health insurance. That's a couple of reasons. I don't know. Joe may have some others.

UNIDENTIFIED MALE: But it has been low?

GARY CLAXTON: Yeah, it has been low. The way we do our survey, we can't say it's the lowest we've ever seen, but it's really low.

JOSEPH ANTOS: Also, there's a lag in all of this. You can't have the premiums go down until the insurer has actually experienced actual slowdown in spending. So, that's going to take some period of time. I don't want to speculate about how long that would be. But, as Drew pointed out in his opening remarks, we seem to be heading back to a more traditional higher rate of growth in spending. So, this may be a very temporary phenomenon.

MARILYN SERAFINI: We have one question from Twitter. By the way, again, as a reminder, if you want to tweet a question the hashtag is #hccosts. Should we change the way medical schools educate doctors to perform well in the new delivery models and how? I would add to that nurses and advanced practice nurses in particular are playing a very large role in the new models of care delivery. So, should we also change the way that we are educating them?

JEFFREY SELBERG: In a word, yes. I think in Italian you would say assolutamente, just to conform that. What do they need to change? I would say design is a key issue. Flow of care; integrated, coordinated, team-based care. Integrating some of the things we talked about in terms of social services with the medical model, empathy, orientation to the community, population based are all elements that I think need to be fully integrated into a medical school curriculum.

MARILYN SERAFINI: Okay, let's talk a little bit about prevention and whether prevention should be at the forefront. If not, why? Also, what is the data behind prevention and whether it saves? Consumer education of course is a part of that.

JOSEPH ANTOS: I'll plunge in here. Prevention, you know it's a nice word. The most effective prevention that anybody can follow is to change their own behavior, to take the advice that we

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ought to get off our chairs and start moving around, we ought to get a full night's sleep, and we ought to be nice to our neighbors—absolutely. The kind of prevention that people usually talk about when they talk about health spending is preventive health services. That's a whole different kettle of fish. Emphasis on services, not necessarily on prevention.

In deed Louise Russell, about 25 years ago, maybe 30 years ago by now, has the classic paper that pointed out the obvious, which is that a lot of preventive health services have to do with screening. Fortunately, most of the disease we screen for, most people don't have them. If you have a national program to screen everybody for some rare disease you'll spend a lot of money potentially on screening to pick up a very few people. There will be of course false positives. There will be false negatives. There will be follow-ups. It's a complicated and difficult subject. We need to be smart about this. What we need is a health system that thinks sensibly about what prevention is. The slogan is not where it's at. It is, as Jeff has said, it's where the delivery system meets the patient that really matters. But as I said, the principle culprit in this is you and me.

JEFFREY SELBERG: I would like to see us maybe shift our nomenclature slightly from prevention to engagement and activation regardless of where the person is in their health process. I think it's been shown and I think the research is there that says activated and engaged patients result in higher quality outcomes at lower costs. So, regardless of where you are in your aging or disease process, by being engaged and activated you're going to be better off.

MARILYN SERAFINI: So, we have already waded into this a little bit, but what about reimbursement for wellness verses other kinds of care? Should we be doing this? Are we doing this? Is anybody doing this?

GARY CLAXTON: Certainly we seen in our employer survey that quite a few employer based programs have some sort of incentives for people to both assess their own health and their own behaviors and then have some sort of incentives to improve those behaviors. They vary from small incentives to take a health risk assessment and then to maybe enroll in a program to address your way to your eating or smoking or some other things to much...to somewhat more aggressive programs where employers collect biometric markers—they get your blood, they get your cholesterol, they get stuff—and in some of those programs they actually have incentives or even penalties for not having certain health benchmarks that are within norms or within target amounts. You may or may not get incentives to try to improve.

We have a range of things out there. Whether or not it's a good idea, clearly we have population health problems and employers are in a position to help influence those. At the same time, you can use these programs to impose much higher individual costs on people who have medical conditions, some of which may not be readily amenable to change. This can be about employers saving money or insurers saving money or it could be about trying to improve population health or some combination of those two things and sort of how they're implemented really will say a lot about probably their future.

JOSEPH ANTOS: Just a footnote on that. There are some court cases now on this exactly point.

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GARY ANTOS: There are some privacy concerns and people obviously are concerned about some of the very intimate questions that are included on the health risk assessment or about some of the information that they're being asked to give their employer and when they're being asked to do it. It's been going on a few years, but as the programs evolve, we're going to have a lot more discussion about all of this.

MARILYN SERAFINI: Okay, we have a couple of questions for Jeff. We have lots of interest in the exemplary practices of the 5%. First, let's start with the first one. Could you give some very specific examples of what these practices are that we should be watching?

JEFFREY SELBERG: I tried to give the example of the Stanford research that the Peterson Center on Health Care is funding. Let me stay there. We also are working with them to identify exemplary practices in specialty care, hospital care. And, we're also working with another set of grantees on high need/high cost patients.

In the case of primary care, perhaps I could just very briefly go into the ten features—not all the ten—but the features that the Stanford group found. What they found basically was a practice organized around the patient. So, it wasn't just the physician. It was a nurse practitioner, physician assistant, nurses, coaches working as a team on behalf of the patient, knowing the patient's circumstances, life circumstances as well as their clinical condition. I'd like to depict that as not only knowing what was the matter with the clinically, but what mattered to them, which is different. Then, always being available, 24/7—having the systems to always be available to the patient—and having an attitude or a culture that said we will always be responsible for the patient regardless of where they are in the system. So, if they're in the emergency department we're still responsible for them. If they're in with a referral to a specialist, we'll still be responsible for them.

You could say, my goodness, how can they do this? My primary care physician can barely keep up with an eight minute visit with me, much less all the things you're talking about. Again, a system's approach, a team approach, good solid information in terms of medical record, good solid relationships with other components in the system. So, there's an example.

MARILYN SERAFINI: Let's take that one step further and talk about mass replication, because you said it's possible. Tell us how it is possible and what needs to happen to achieve success.

JEFFREY SELBERG: Well, that's what we're working on. Quite honestly, we're looking for help in this particular area. We know how to go into a limited market test to replicate, to really make sure that we're right about what these features can do. We believe we know how to replicate to practices of 30-50 practices at that level. The challenge that we have is when you go to the level of 200,000 primary care physicians across the country and is that going to be done in increments of 30-50 practices in what we call collaborative. Or, are there digital approaches in adult education approaches that I talked about that we can utilize? That's what we're going to test to find out. If there is anyone out there that would like to collaborate with us in the learning, we are very open to that.

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MARILYN SERAFINI: Okay. So, we had another question that has to do some...with nationalizing and approach. That has to do with accountable care organizations. The question is can you nationalize ACO's with all the variation that is going on? And, ACO's are held out as a means of leading toward value based care, coordinated care, with the hope that they will bring down cost and improve quality.

JOSEPH ANTOS: Well, there are a whole bunch of different types of ACO's. That's the first little issue. So, when you talk about...I don't want to use the word nationalize. When you talk about spreading them widely you have to be careful about what you're defining. It is certainly the case that there are things that are called ACO's that have nothing to do with the Medicare program. Why? Well, because it's a great phrase. We have to be with it in health policy. There are a whole bunch of organizations that follow a similar philosophy, but they're not doing it the way Medicare wants you to do it. To me, that's fine. Why not find a system that works for you as a local health system, rather than following especially the initial ideas that the CMS had? CMS has loosened up its rules, but nonetheless the results have been less than promising. I would say that's partly because they started off on the wrong foot, partly because it's too early to know, and partly because this whole idea for the Medicare program was a way of getting people into organized health plans without them knowing they're in an organized health plan. That strikes me as a very bizarre idea. We need to enlist the—I'm going to call patient to call him a patient, but he might also be a customer—we need to enlist that person in the struggle that we have in the health system to do a better job at a lower price.

MARILYN SERAFINI: Let's turn to the microphones.

JOYCE FREEDON: Joyce Freedom [PH] from MedPage Today. A few people have touched briefly on the effect or lack thereof of the Affordable Care Act. I just wanted to get back to that for a minute. Are people thinking it's too soon to tell whether the effect of the act or having more people have insurance is going to help mitigate health care costs and what evidence might we be looking for later that would tell us whether it's having an effect?

JOSEPH ANTOS: I am anxious to say that if you expand subsidies for health insurance you should expect to spend more for health care. So, that part of it isn't going to help the health spending issue. It really is, with everything that we've been talking about, changing the way health care is delivered. With regard to the ACA, I do think it is too early. I'm a little skeptical, skeptical a lot, about some of the initiatives that have been undertaken. But, nonetheless, let's see how they work out.

The other point though that I would make is that the ACA and politicians in general have studiously avoided really reforming the Medicare program. It seems to me that being the biggest payer in the country, that to really not take a fundamental look at fee for service Medicare and really ask ourselves isn't there a better way to do it and shouldn't we...instead of saying we solved the physician payment problem because we haven't changed anything about the way physicians are paid, we have just eliminated the political pressure on Congress to do anything on the update

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factors. That's not reform. We need to take a look at Medicare. I'm concerned that we're going to take the easy way out and say we'll, we solved that problem and not worry about it until the next crisis.

DREW ALTMAN: I would agree with absolutely everything Joe just said. I would also say that when you ask that question, I would look less at what's actually in the ACA and more at the effect it may be having and has had on accelerating changes already underway in the marketplace. So, if you're out there and you run a hospital or a group practice and you look at reductions coming down the line in future Medicare payments or you look at the Medicare delivery and payment reform demonstrations. You see the writing on the wall. It's part of the writing that is already on the wall—changes already underway in the marketplace. I think there's good reason to believe it has accelerated changes which were already underway in the marketplace, but don't ask me to prove it to you.

MARILYN SERAFINI: So Joe, I'm going to ask you to follow-up. You mentioned Medicare and of course other costs, the cost growth of Medicare has also been moderate over the last four or so years. At what point can we expect some return to this, to Medicare as part of the policy discussion because there has been less talk lately, potentially because of the more moderate growth rates? But yet, we have the aging of the population. We know that we have a lot more coming. So, what do you see there?

JOSEPH ANTOS: Another reason why there's been less talk about Medicare is the very legitimate reason that we have focused so much on the uninsured. By definitely, if you're in Medicare you're not uninsured. That was a legitimate focus. There's so much that people can really spend time actively trying to resolve.

Part of the issue here is that we do have the baby boom generation now coming into the Medicare program. By definition you're when you turn 65, you're younger than 20 years later. You're likely to be healthier, in general. The baby boom generation moving in is, on average, probably healthier than certainly the Medicare beneficiaries who are in their 70's and older. So, to some extent, this slowdown in Medicare spending, I think to a small extent, is related to actually having Medicare become a younger program for a few years. Certainly, in six, seven, eight years that's going to reverse. The youngest baby boomers will be in their 70's. They will have gotten to be very familiar with their physicians. They probably will have had diagnoses that require some active medical treatment. So, we're going to see a change there.

As far as why the slowdown occurred in Medicare, the numbers are quite startling—to have Medicare spending growth on a per capita basis slower than the rest of health spending for a few years. But, I don't think it's such a mystery. Seniors, contrary to CBO's working paper, seniors are affected by economy. They haven't gotten a raise in Social Security. Their pension or other retirement payments have been pretty slow because of the recession, not because of anything else. The slow recovery also affected them. In fact, I think part of this is that—speaking about some of my relatives—when they see something on TV they say well gee, this could affect me. So, I think we have seen a slowdown in spending driven partially by that. Also, a slowdown in spending

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because of Part D—especially the movement of the biggest Statin drugs to off patent basis. The cost of treating cholesterol in the Medicare program has plummeted. It is a very popular set of drugs to take. That obviously has had a big contribution.

Beyond that though, I think we're going to see Medicare spending return to its more traditional growth rates, if only because some of the payment cuts that the ACA enacted, which are beginning to take affect—cuts to hospitals and to other payment health care providers and Medicare—those can become very difficult cuts to take politically. They accumulate and can become quite large. A big factor here is what Congress does. If Congress decides that they need to slow down the cuts, then I think we're going to also see that's going to be another factor that will drive Medicare spending in the future.

MARILYN SERAFINI: Okay, so Joe, you have now opened the door to, but talking about prescription drugs, for us to prescription drugs—not just the ones that have gone down in price and cost for Medicare beneficiaries—but we've had several folks in the audience and via Twitter ask us about the cost of prescription drugs, both the increase in spending on generic medications and also specialty drugs. We have a very expensive drug on the market now for Hepatitis C. There are a number of questions in this area, including: price verses cost, how do you address the cost of specialty drugs such as for MS or Hepatitis C without creating barriers to access, and how much do the prescription drugs play into the costs and what do we need to see happen in this area? There are a lot of questions there. I think we could have another briefing on this.

GARY CLAXTON: Just to do part of it, clearly the specialty drugs are one of the big concerns from payers, private and public payers. We have seen in employer programs, but also in some of the individual market plans, tiered formularies which put all of the specialty drugs into high cost tiers. People who use those drugs will end up at their out-of-pocket maximum very quickly. Public programs have some of the same problems, depending on how they're delivered. It comes back a little bit to private payers in particular have no leverage whatsoever over drugs that are necessary, have no true competitors or substitutes which are on patent. So, those drugs are necessarily for those patients and there aren't alternatives in some of these cases and they can charge what they want.

The way that some insurers have chose to deal with it is to make the cost sharing as high as possible, which to some extent shares the cost but also shames the pharmaceutical manufacturer to some extent. Then you get other programs going the other way, where the pharmaceutical manufacturers will subsidize people who can't afford it and it all becomes very silly in some ways. But everyone is doing what meets their economic interest.

Whether or not we're able to come in and say we want to do more in terms of regulating the prices, that's never been a place where we have been as a country. Whether we want to try to push insurers to not put high cost drugs on...that are necessary and have no substitutes, on high cost sharing tiers might sound like it's helping the patient and it probably is, but those insurers really don't have any way to ameliorate those costs either. That will just end up in premiums, which may or may not be more fair. But, the way this works out is not easy to deal with if you're not willing to go in and say

something about what you think manufacturers should be able to charge for some of those drugs. Generic issues are completely different.

JEFFREY SELBERG: I agree with everything Gary said. I was involved in a meeting with various pharmaceutical manufacturers and the question was asked, why aren't you oriented to those chronic diseases that generate what's called the highest disability adjusted live years, or DALYs, because that's where the biggest impact can be in terms of the health of the population? And the response was there's too much risk. The price point is more competitive. The level of distribution to the population is much more challenging. The level of differentiation in terms of what we can manufacture in the drug is perhaps marginal where with orphan drugs you have a much different set of circumstances that Gary just described.

My hope is that there can be a convening of well-meaning experts to determine what type of regulations can be put together that will create a greater interest on the part of pharma to align their priorities to these diseases that generate the highest level of disability adjusted life year.

JOSEPH ANTOS: As an expert, chills run down my spine when anybody says let's convene a group of experts. The pharmaceutical market is extremely complicated. It's very hard to make generalizations that are actually correct. I really appreciated Marilyn's distinction of price versus cost. The price of—we don't need to name the names, but the price of the Hepatitis C drug is very, very high. Now, the question is, is it really \$1,000 a pill? Has any insurance company actually paid \$1,000 a pill? We don't know the answer to that question. We do know that's the list price. Second question, and this is the critical one, which is the cost: What is the cost of actually treating the patient as opposed to delivering one form of treatment or one aspect of treatment? The older methodology, which apparently doesn't work very well... I don't know enough about the medicine here to be credible. But, what I've read is that the older method of treating Hepatitis C does not work very well. The percentages that I vaguely remember are not very good for cures. It's painful treatment. It's very difficult for the patient, and it's also very expensive. Where did \$100,000 come from, if that was the list price? It was related to a judgment by the pharmaceutical company about the efficacy of their treatment versus the alternatives, the cost and the overall cost of the system. Which gets to the real point—it's the overall cost of the system that we should be focusing on. This again, goes back to the fragmentation of the health care system.

That said, we're treading here on very dangerous ground for the future. It's not just Hepatitis C. It's that cure that I want for me 15-20 years from now. I don't think we have the answer to that. It is certainly the case that if...in pharmaceutical investment in research is a major factor. It is certainly the case that pharmaceutical investment by NIH is very important as well. It is also the case that you have to have a market in order to encourage that kind of investment, unless you nationalize it. If you nationalize it, then you run into questions about whether you are at the same time reducing the scope of research.

So, I think there are really difficult questions here. It's easy to say there are some bad guys here. It is certainly the case that some insurance companies are putting specialty drugs in the highest tiers. By the way, what's the reason? I think the main reason is to discourage people with those diseases

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from signing up for their coverage in the exchanges. When you limit what an insurance company can do to control costs, then you're going to get that kind of behavior. That's what the ACA has done for the exchanges. So, we need to look more broadly at this problem. It's difficult.

MARILYN SERAFINI: Okay. We have a question at the mic. Could you identify yourself please?

GARY PHILERMAN: Yes, Gary Philerman [PH]. I'm on the board of AACME—the accrediting council on continuing medical education. It's through that lens I'm listening to hear what you have to say about changing provider behavior. They're not sitting in the Marshfield clinic and at Geisinger. They are three guys sitting upstairs at a drugstore writing their prescriptions on paper blanks. They don't have an EHR. CME is the only tether we have to them because the hospital medical staffs aren't functioning as we assume they are or should or would. They've changed. So, the only way we have of engaging this backbone of practice in the community is through the CME structure. I don't hear anybody addressing the question of improving its efficacy, it's reach, and bringing the physicians into more active engagement and participation in order to bring them along in everything you're talking about.

MARILYN SERAFINI: Any response?

JEFFREY SELBERG: Gary, you and I have talked about this. I would say it's just got to be made more meaningful, more relevant. You and I have talked about just kind of studying for the test—in other words, get your credits, licensure, or board eligibility and the like. I would certainly agree that it is a channel, a distribution channel that we should more effectively utilize.

DREW ALTMAN: I have a question for, I think for Joe, mostly for Joe and Gary. From my perspective, we've been so focused on the ACA. There's been almost a revolution in health insurance, from more to less comprehensive, especially with the tremendous and steady, and in the end tremendous growth in deductibles. The average deductible now is \$1400 for a single policy, \$2800 for a family. The most commonly silver plan in the exchange, it's \$2500 for a single policy. Those are high deductibles—higher cost sharing. It brings to the point, you know we talk a lot about national health spending and health care costs in the budget. For me, it is also a people issue or you could think of that as your constituents.

For Joe, and I'd also like to get Gary's comment on this, do you view this as a good thing, a bad thing, a little bit of both? And then, I'd also like to see what Gary thinks.

JOSEPH ANTOS: Well, if you're a relative low income person with a heavily subsidized premium on the exchange, but you're facing a \$5,000 deductible, that's as good as being uninsured as far as most people are concerned. Now, it is true that there is that sort of end of the line safety net that we have. If you put everything off and something really bad happens, you end up in the emergency room and the hospital will have to take care of you. You will end up either qualifying for Medicaid or something will happen. You might just be in bad debt. That's not exactly the image that we have for organized health insurance. That's not what we want.

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We need to make some changes there. The enthusiasm that a lot of conservatives have, which I share, for high deductible health plans with health savings accounts is really an enthusiasm for those of us who ought to be in them—that's basically everybody in this room. The people who have the money, the middle class people, and they need the...they need a little nudge to remind them that everything isn't free and they ought to be sensible about what they're buying. But for low income people, we've got to recognize their circumstances. And, we haven't solved that.

GARY CLAXTON: I wouldn't disagree with Joe. For the most part, cost sharing has gone up. It does, unfortunately, look like people with lower incomes often have higher cost sharing than people with higher incomes, except by choice—if they go into an HSA qualified plan or such. So, we have some serious issues with people who have insurance being able to really effectively use it. We did a paper, which you can find on our website which shows that substantial shares of people don't have savings or liquid assets to actually pay the deductibles, much less the out-of-pocket maxes in their policies, including families where everyone had private health insurance. So, this is an issue that we have to keep paying attention to over time.

One of the ways that the ACA addressed it, but to a minor extent is that people who are lower income also can get cost sharing subsidies. That's certainly not everybody and that's certainly not people who are lower income in employer plans who may be facing high cost sharing.

MARILYN SERAFINI: Great. Before we take our last question or two, I want to remind you that you have a blue evaluation sheet in your packet, if you would kindly fill that out. Those of you who are congressional staffers, you were also handed a yellow survey that we would be happy to have back from you at the end of the briefing.

We have a question about how affective all payers claim databases are in effecting prices and consumer behavior? What is the potential of these databases? I think before anyone on the panel answers that question particularly, it would be good to have an explanation as to what that is.

Gary, can you handle that?

GARY CLAXTON: At the state level, there are a couple states trying to collect information from payers about transaction costs for at least hospitals and maybe some other types care. There are some national things as well. Some of those are charges, which means that the information you get is almost useless in terms of price. It tells you something about the number of services. Whether or not...there are a couple small states that have tried to pull together some actual price information—maybe Jeff can say more about this. I have downloaded it from one of the states and it was daunting. So, I haven't explored it as much.

Getting more information about price certainly let's people know where they stand, let's us understand more about what things actually cost, which is a good thing. It's not clear we know how to affect it giving...any of it other than by publicizing it, given the way we pay for health services. It's certainly a move forward to better understanding what's going on.

JEFFREY SELBERG: I'm certainly no expert in this, which I think gives me credibility with you, Joe. Is that right?

JOSEPH ANTOS: Absolutely. I think we need to form a committee.

JEFFREY SELBERG: But, I just take what Gary has said. This is very, very complex. I think there was a time where we thought if we could just mask these private sector payers with the public sector payers into one database and then we'd have what we need. Clearly, it's only a step among many steps. As we look at the need for information, it's high need performance, comparative performance on quality and cost. It's opaque in health care. It needs to be transparent. It's going to take a lot more work than just having access to data to make usable so that providers can understand their relative performance to other providers as an incentive to improve. Payers can see provider performance per condition or procedure. A lot of that needs to be bundled in terms of hospital and multiple physicians involved in that care. And, patients also need to know, especially now that they're incentivized with high deductibles and copays, what the comparative cost is. I would submit, very important to also know comparative quality.

So, I would say it's a step in the right direction, but there are many more steps that have to be undertaken.

MARILYN SERAFINI: Okay, so this will be our last question. We talked a little earlier about the high cost of waste in the system. Of course fraud is a big part of that. The question is what role health care fraud and Medicare fraud have in influencing cost and how can we reduce fraud? I think that's probably easier said than done.

GARY CLAXTON: I guess I would probably disagree with one of the things you said which was if we were talking about waste being as multiple percentage points of health spending, I'm not sure fraud is a big part of that. It's millions of dollars whenever you do a report or tens of millions of dollars, which is important and it sends bad signals and it reduces people's confidence in programs—public programs, private programs. It often can result in people being poorly treated as well. But compared to \$2.9 trillion, it's not a big part of that.

MARILYN SERAFINI: Okay, so we're going to wrap up here. Please join me in thanking our panelists for a discussion that I think will continue throughout...for a long time to come.

[MISC]

01:27:23 END OF TAPE