



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

**Can We Contain Healthcare Costs Without Compromising
Quality?
Alliance for Health Reform and Commonwealth Fund
January 28, 2008**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

ED HOWARD, J.D.: I'm Ed Howard with the Alliance for Health Reform, thanks for being here. I want to welcome you on behalf of our congressional leaderships, Senators' Collins and Rockefeller and our board. In this briefing exploring how best to tackle the task of restraining the growth of healthcare spending without compromising the quality of the healthcare that's getting paid for, maybe even enhancing it. Our partner today is the Commonwealth Fund. They're in their second century now based in New York City, philanthropy that has been focusing an awful lot of attention on the performance of the healthcare sector over the last few years. Karen Davis can't be with us, she's in some unnamed country we've determined where she's still sending emails asking about how this program is going, but we do have Cathy Schoen from the fund who will be speaking to you in a moment.

The fund has a commission on a high performance health system that's got a very distinguished membership, it's got a tireless staff in, Gothier and Stu Gutterman are here today. They've overseen a lot of the work that the Commonwealth has done on this, including the report that provides the jumping off point for today's discussion. It's the very patriotic looking ending the curb executive summary in your materials; there are some limited numbers of copies of the full report in the back if you would like to get one.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

There was a chart floating around Washington back in the '80s that took the then current trends for healthcare spending and projected them. And when you got to 2050 it showed that 105-percent of gross domestic product was going to be spent on healthcare. Herb Stein who was then a member of the President's Council of Economic Advisors took a look at that chart and he said things that are impossible tend not to happen, but we still worry about." And some of the trends that people are looking at in today's healthcare spending worry a lot of people. And today we're going to look closely not only at those trends but at some of the ideas for affecting them, ways to bend the curve, if you will in the words of the Commonwealth report, to get better value for what we do spend and allow room for spending on other worthwhile purposes, public and private.

Let me just do a couple of logistical chores here, probably by tomorrow morning you'll be able to view a webcast of this event on Kaisernetwork.org. In a few days you'll be able to read a transcript and on both Kaisernetwork.org and on the Alliance website you can find electronic copies of most of the materials that are in your packets today. So that's Kaisernetwork.org and Allhealth.org, you can even find a podcast there in a few days. We want to ask you to fill out your green question cards and or come to the floor mics at the appropriate time to keep this discussion going and before you

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

leave we ask you to fill out the blue evaluation form so that we can continue to improve these programs to meet your needs, because that's what we're in business to do.

So, we've got a very impressive list of speakers today to help us grapple with these tough questions. Economics they say is the dismal science but you wouldn't know it by our panel of economists today, they are all thoughtful and lively and engaging people so don't think dismal, think stimulating.

[Laughter] So turn your cell phones to vibrate and we turn to Cathy Schoen, Senior Vice President at the Commonwealth Fund for our initial presentation. Cathy?

CATHY SCHOEN: Thank you Ed. I'm delighted to join you today to present the report on behalf of my co-authors, Stu Gutterman, Tony Shean, Ann Gothier are all here today but also the Lewin Group that prepared all the estimates and on behalf of the commission and the Commonwealth Fund.

We titled the report, as Ed said, Bending the Curve but I want to stress that the report is looking at ways to achieve savings and improve value. We don't think we're doing well for the money we're now spending in terms of the quality and outcomes we get in return. We think we can both save money and get more for each dollar we spend.

This is a context of a U.S. national health expenditure that is expected to double over the next 10 years, going from two trillion to 4 trillion, and it will reach one out of every

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

\$5 out of all of our pockets with current trends and we're losing coverage, more numbers uninsured and underinsured. At the same time we see high variation in quality, low levels in performance and inefficient care.

The goal of our report was to focus on areas that we can achieve savings and improve value to illustrate it as possible to do that including while insuring the population, to stimulate and spur debate, and we hope action to start addressing these issues at a national level.

The contribution of the report, it's unique in many ways. It focuses on total national spending, not just federal costs. We are all in it together, the same market forces that are driving up costs for businesses, for households, for state governments, are driving up costs for the federal government. We focus on federal options, although some of these could be done on the state level, and we focus on options where we think there's an opportunity to have a win-win return. Both save money and improve value. And improve value I want to stress is access, quality, and health outcomes.

The report illustrates the potential in addition to individual targeted approaches of combining options for potential synergy along with expanding coverage to everyone. Overall, we find that it would be possible to achieve significant savings look at curbing the trend, reducing the trend. We estimate as much as \$1.5 trillion from a combination

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

approach. This approach would at the same time be buying more for those dollars; moreover the savings to the federal government could offset the costs of expending health insurance.

Bending the Curve illustrates it would be possible but as I'll discuss with a few illustrations, it also stresses the importance of starting now. Those savings accumulate, we need time for some of these to invest and learn as well as amass. Some of them accelerate over time when we invest, initially the returns come at first slowly and then faster. So that the sooner we start the faster we get returns.

We grouped the strategic options into four strategic areas. The first is getting better, and using better information to inform decisions, to guide and drive change, this includes information technology, a center on comparative effectiveness, patient decision aids, as well as transparency, posting information. We've included options that look at promoting health, population health approaches that include prevention, public health, and also disease management. Aligning incentives, changing the way we pay for care to stress value, quality, and efficiency. These options include strengthening our primary care base and paying doctors differently so they can coordinate care and provide medical homes with coordination for their patients. Also paying

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

differently, more in a bundled approach, episodes of care, and we have pay for performance options as well.

And finally the fourth category looks at correcting price signals so that markets are rewarded for lower costs not higher costs. These options include starting to address the large regional geographic differences we observe.

The report includes 15 separate options. The Luren Group did all the estimates for us and you both have the short summary, and as Ed mentioned, this longer report where the estimates show you the year by year national estimates and the cumulative effect, but also what happens to the federal budget, business budgets, state and local budgets and household budgets. We also estimated a combined approach that takes multiple options, paying differently, information systems, public health population, health examples, and combines it with insurance. In the case of insurance we looked at a scenario that uses a national insurance connector similar in concept to what Massachusetts sits on but we used the power of the federal government to include a Medicare like option that would compete with integrative private plans. We have enhanced benefits so there wouldn't be a need to supplement, and brings everyone in with premium assistance relative to income to make coverage affordable.

The 15 options this summarizes the results at the national level over a 10 year period, save anywhere from an

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

estimated nine billion to over 300 billion. Although these are, and often, either conservative or heroic estimates depending on how long you think each would take to implement and do well. Many include estimates that the value of what we're getting are much higher so you shouldn't judge the total spending savings based on the dollars. In the example of IT, we are getting a lot more than just IT when we invest in IT in terms of our ability to know what works, to report, to inform physician assistants decisions and to avoid errors.

When we look at a cumulative approach and you have this chart also blown up in one of the billboards, we estimate that you could get as much as 1.5 trillion over a period of 10 years. But it's important to note when you look at this, this is the affect of relatively modest changes. We have such a high base line that saving 1-percent initially or 6-percent by the end of 10 years adds up to 1.5 trillion. I also want to note that this combination approach of better information systems, public health paying differently in insurance, estimates each as a first order effect. We didn't look at the possible synergy and more dynamic changes. What would happen if everyone is covered, we don't have fragmented care, we could lower insurance overhead, we have better information systems, we have patient decision aids, and we're paying differently. If you do those together you get more transformative changes.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

The estimates together would bend the curve about halfway before, from where we are expecting to be with current law. So between the 20-percent where we're expected to be and the 16-percent we're paying now. So again, relatively modest change but significant savings. And as I mentioned at the offset, the savings that accrue to the federal government start to quickly offset the cost of expanding insurance to everyone so by the fifth year and the tenth year the net costs to federal government are negligible.

A few cost cutting thoughts that emerge from the report as I turn it over to the other speakers. One, it is possible to bend the curve to achieve savings and better value and cover everyone in the United States with affordable insurance to address access and equity issues. Addressing total health expenditures will be important, this needs to be the focus. As I said at the beginning, we are all in this together, we can't think about our, each of us our separate budgets or cost shifting games, we really need to have a collaborative and focused approach.

Even though we looked at separate options there are no magic bullets. No one approach alone gets us there and you get potential dynamic approaches as you start to combine different policy options. It will take this multifaceted approach to get us anywhere near the 1.5 trillion or beyond that. Value means much more than the dollars. We should be looking at getting

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

more for every dollar we spend, not just in savings. We know we can get more in terms of better outcomes and there are ways of providing incentives to do it. Achieving this will require national consensus and leadership to build this consensus.

As I close I want to start, go back to where I started. There are tremendous stakes, human and economic stakes here if we don't come together and start to act now. We're losing the base of coverage for the nation. We're putting stress on business, household and public sector budgets. It's important to start acting now. Thank you.

ED HOWARD, J.D.: Thanks very much Cathy. Great wealth of information and I commend that full report to you. Next we're going to hear from Katherine Baicker who teaches health economics at the Harvard School of Public Health. She's a research associate also at the National Bureau of Economic Research. Kate migrated north only last year after serving three years as a member of the President's Council of Economic Advisors. And since I'm married to a Harvard trained economist I know that is a big deal and it's a big deal to have you on our panel, Kate. Welcome back and we're pleased to have you with us.

KATHERINE BAICKER, PH.D.: Thank you. It's really an honor to be on the panel and to be able to discuss this very interesting and important report. I think it highlights a lot

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

of the things that we might need to do. Can you hear me? No. How about now? All right, everybody's awake now. Excellent.

So I think this is a fabulous report. It highlights a lot of the things that we could do to help improve the value that we're getting out of the healthcare system. And in fact even though rising costs seem to be the primary motivator for political reform, both because people are worried about the rising ranks of the uninsured and because they're worried about what these rising health expenditures will do both to private budgets and to the federal budget, I think the emphasis on cost is along the lines of what Cathy said, somewhat misplaced. Really the goal should be to have higher value for our healthcare spending.

I don't have a strong prior belief about the right amount of GDP to spend on healthcare. It could be 16-percent, could be 20-percent, could be 30-percent, healthcare is a wonderful thing, it buys us lots of good stuff. So I don't have a strong belief that we should be spending less. I have a strong belief that we should be getting more for what we're spending. We should be getting higher quality, higher value care and this report points out a lot of the ways that we might go to try to achieve that higher quality care.

That's what our healthcare system looks like on drugs. [Laughter] Well I have my notes so I'm just going to keep going.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ED HOWARD, J.D.: And you have copies, you have hard copies of all of Kate's slides in your materials to follow along with. And we're working on that.

KATHERINE BAICKER, PH.D.: But please try not to have a seizure, okay. So the appeal of these cost saving value improving propositions is enormous. Of course I think we're all in favor of any healthcare reform that at the same time reduces what we're spending and improves our outcomes. That's great and we should absolutely seize all of those opportunities.

My concern is that a lot of really valuable improvements that would get us a lot more money for our healthcare dollars, a lot more value for our healthcare dollars, may not save money. They may in fact cost a little bit more and improve quality a lot. So I don't think we want our only metric of success to be saving money, or saving money while improving quality. Those are great but I think they're probably also some reforms that just improve value without necessarily lowering spending and I wouldn't want those to be of the table.

An analogy might be thinking about plans to cover the uninsured. Some people hold up proposals to cover the ranks of the uninsured with some health insurance policy and say that that will be revenue neutral or cost savings and it will cover everyone. Well, I'm a little skeptical of getting a policy in

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

place that will cover everyone and not spend anymore money and I don't think that should be our goal. I think our goal should be to get a more value out of the system, whether that spends a little bit more money or a little bit less money is up in the air.

So, there's ample evidence that we're not getting high value for our healthcare dollars. And I won't spend really more than 30 seconds saying that we spend a lot more of our GDP, even than our trading partners, on healthcare and our outcomes are not commensurately better. On some dimensions we look like we're doing a little bit better than our trading partners, on lots of dimensions we look like we're doing a little bit worse. Our healthcare spending is rising just as rapidly as theirs. So there's very little evidence that we've just gotten there first. It looks like we're spending a lot more money than we maybe need to to achieve those same health outcomes and that also suggests that if we spent the money more wisely we could achieve much better health outcomes for the same amount of money that we're spending.

There's also domestic evidence, and Cathy talked a little bit about geographic variation and I'm going to spend a few minutes on that as well. If you look in the U.S., in the Medicare program where everybody's covered by the same insurance products, so it should be some people have more generous coverage, some people have less generous coverage,

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

everybody's got roughly the same coverage yet if you look at different areas of the country people get dramatically different quality healthcare. What this graph shows is the likelihood of having to be hospitalized for what you might think of as an avoidable hospitalization, or an ambulatory care sensitive condition. Hospitalizations that probably could have been averted if people had gotten care earlier, something like being hospitalized for pneumonia or diabetics having to have an amputation where if their blood levels had been monitored more closely they could have avoided that amputation. So these are bad hospitalizations and there's a huge amount of variation across the country even within the Medicare program.

Now, there's also a huge amount of variation in spending within the Medicare program. In some parts of the country we're spending more than twice as much per beneficiary in Medicare than we're spending in other parts of the country. And these beneficiaries are not starting out sicker, they're not ending up healthier, they're not even ending up happier with their healthcare. We're just spending more on them because of variations in the way that care is practiced within those geographic areas. So you think okay, in some areas we spend more, in some areas people get higher quality care, connect the dots. No. In the areas where we spend more people get lower quality care. So in the parts of the country where we spend the most on Medicare where beneficiaries are least

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

likely to get high quality, low cost interventions. So there's clearly something awry, even within this uniform healthcare system of Medicare.

Now there are a lot of different causes, potential causes of inefficiency. On the public side within Medicare that I was just talking about, we reimburse for the quantity of care, not the quality of care. And there's some experiments under way now to try to change that a little bit but pay for performance is still in its mason stages, paying hospitals who provide higher quality care a bonus, there's some experiments there as well that I think are promising. We also know that we spend a lot of our public resources on the uninsured in ineffective ways. We spend a lot for hospitalizations that could have been avoided but there also, if you insure uninsured people they consume more care but they get much better health.

On the private side, there's been a lot of discussion about reforming the tax code and about the barriers to well functioning non-group insurance markets. I won't get into the details there but there's clearly room for improvement on that side as well.

So, what I would have us do is focus on changes that have, as you can see, [laughter] system wide effects. Changes that are likely to have spillover effects to neighboring hospitals, or neighboring jurisdictions or other people treated by the same set of providers. I think that's where we're going

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to get the most bang for our buck is in adjusting the system so that everybody participating in it gets higher quality, higher value care.

So, what kind of interventions are those that I have in mind? Back one, you don't get the graph yet. So we've seen in private markets that when there's more competition among insurers that lowers the premiums paid by everybody in the market, not just the people who are in those particular insurance plans, or when managed care comes in there. We've also seen better compliance with best practices, when there's more completion among providers.

So for example, you see in the Medicare program when there's an increased penetration of planned competition, everybody is more likely to get beta blockers post heart attack, not just the people who are in those new plans themselves. If you see, in my own research I've looked at an expansion of the dish payments through the Medicaid program and a lot of those payments go astray and don't go to the low income hospitals for which they are intended but the payments that do go to the low income hospitals for which they are intended actually improve the outcomes not just of the Medicaid patients but of all the patients served in those hospitals. There's also a strain of literature showing that physicians treat their patients as a panel differently when their insurance is different. So if a bunch of my patients get

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

insurance that has better incentives for high quality care, all of my patients benefit from that higher quality care. So a lot of these interventions can have system wide effects.

And then there's this beautiful graph [laughter] that's on the next slide that is the case of hospital quality. And what I've graphed there is hospital compliance with best practices. Hospital Quality Alliance has put out a set of measures that has things like time to intervention post heart attack, use of beta blockers, use of aspirin, use of the appropriate antibiotic, the appropriate antibiotic being administered before a surgery, basic high value care that is not expense but that makes a huge difference in outcomes. And there's again huge variation between hospital areas in the rate at which these best practices are implemented. But if you look at the likelihood of me improving my practice, as a hospital, the chance that I provide higher quality care this year relative to last year dramatically increases if there are neighboring hospitals that are doing best practices.

So even controlling for what I did last year, I improve more when I have an example of good hospitals to look at. And we've seen studies that support this from the Northern New England Cooperative Study where they looked at heart attack treatment spending and mortality after heart attacks and they found that when hospitals got together and discussed what was working for them, just that discussion, the safe harbor of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

being able to trade that information, both reduced costs and improved mortality.

So I started off by saying we shouldn't focus just on things that reduce costs and improve outcomes but those things are great and they set the stage for all sorts of improvements that might change the value that we're getting out of the healthcare system. So I think this is a wonderful report that highlights some directions we might go in but if it turns out that some of these suggestions don't save as much money as initially we might think, that's okay. I think we want to focus on improving value, whether it saves X dollars or costs X dollars, as long as it's worth the improvement in health that we get. And we may get the biggest bang for the buck from reforms that are likely to move system wide care, not reforms that are targeted at particular providers. Thank you.

ED HOWARD, J.D.: Thank you very much Kate. I'm sorry about the technical difficulties. That's right, as things go flashing by. [Laughter]

Well we're going to hear now from Peter Orszag who's just starting his second year, as a matter of fact, as Director of the Congressional Budget Office. He came to CBO from the Brookings Institution where he was, among several other hats he wore, director of the respected Hamilton Project. And in case you missed it, the first item listed in the additional resources page in your materials is the budget and economic

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

outlook issued by CBO just this past Wednesday. So Peter we're very pleased to have you with us at what is an extremely busy time for you and we're looking forward to your contribution.

PETER ORSZAG: Thank you very much. Is this on? You can hear me? Okay. It's actually quite liberating not to have slides and also to be on this side of the podium, so I think I'm going to have a little bit of fun now.

Let me just, in the absence of going through the slides, pick up on a few themes and make a few other points that haven't come up quite as much. First, although I agree that we need to be concerned about both cost and quality, I do need to, just in case we have a technical resurgence, I do need to highlight that in terms of the federal budget, the rate at which healthcare costs grow will be the primary determinant of our fiscal future.

And so for those who are concerned about the path that the federal government is on, the rate at which healthcare costs grow is the key to whether we wind up with huge budget deficits or in a somewhat better fiscal position. And you can see that, you might be able to see that, from the first slide which shows you the path under our long term budget projections of Medicare and Medicaid, the light blue area, Social Security, the dark blue area and the rest of the government the white area. And I think it's pretty obvious from that chart that the light blue area is what drives the long term budget picture.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And in particular there's a lot of attention that is often paid to Social Security in demographics but that plays a much smaller role in where we actually wind up than the rate at which healthcare costs grow, which you can kind of pick up from the fact that the light blue area is rising so much more than the dark blue area, even though they're both affected by the same demographic forces. I won't belabor the point but if you combine that spending path with any reasonable projections on the revenue side you wind up with these exploding debt scenarios that won't actually happen but they highlight that something has to change.

One way of measuring the nation's long term fiscal imbalance, I just want to sort of underscore the point about demographics is to compare the projected spending and projected revenue and collapse those into a single number and present value. And on the far right side of that graph, that gives you under what we call the alternative fiscal scenario and I can go through the assumptions but I think a lot of people would recognize that as the sort of current thrust of federal policy, a fiscal gap that amounts to 7-percent of GDP over the next 75 years. What that means is that in order to avoid an explosion of debt, one would have to reduce spending or increase revenue by 7-percent of the economy and to put that in context, you'd have to do it immediately and hold it there for the next 75 years. And to put that in context realize that both spending

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and revenue are about a fifth, or 20-percent or so of the economy. So in other words, to avoid an explosion of government debt, we have to cut spending by a third roughly or raise revenue by a third, roughly, or some combination there of.

And the political economy of doing so immediately and holding it there for a long time should underscore the long term fiscal challenge that we're facing. Furthermore, you can isolate the pure effect of demographics on that long term fiscal gap and that is the dark blue area in the graph. And there's a little bit of an interaction between ongoing healthcare costs growth and an aging population that is if you have more beneficiaries in the future the impact of ongoing healthcare cost growth is magnified, that's the light blue area. Even if you include that part you're still talking about only a small fraction in the nations long term fiscal gap coming from demographics, and I will say here as I've said before, I think relative to that graph we, as an analytical community are woefully misallocating our resources in terms of studying the impact of demographics and not devoting enough attention outside of gatherings like this one to the lighter area which has to do with the rate at which healthcare costs are growing.

We have done long term projections of healthcare costs, I'm going to sort of skip over those and get to a couple other

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

points about what we can do to change the path. The only value added I have here relative to the graph you've already seen is that we updated the graph, it's 2003 instead of the mid-1990s. But again you have very substantial variation in cost per beneficiary in Medicare that has already been noted. Don't correspond to higher quality in the higher spending areas. I think it's interesting to then try to dig underneath that a little bit and there's a lot of cross country comparisons that are done. I think it is noteworthy that if you go back to that graph there are large areas, at least geographically, of the United States that are delivering healthcare at lower costs and better quality than other nations. So the difficulty of undertaking cross-country comparisons might suggest wouldn't it be worthwhile to get under the hood even more of this very substantial variation we see within the United States within a single payment framework that might be more amenable to analysis than cross-country comparisons.

And when you do that I think, I will first say CBO, among other papers, is going to be coming out in the near future with an extensive analytical study about regional variation, but one of the things it seems to be driving the regional variation is that it occurs more in areas where we don't know what to do, or where there's more ambiguity about what to do. So if you look at things where it's very clear what should happen, and the simple example is administering an

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

aspirin upon admission to a hospital for someone who suffered a heart attack, the highest regions and the lowest spending regions are all doing that. The variation tends to be, by the way if you're on the vertical line that means that graph would all be one color and if your away from the vertical line then it would be multicolored, the variation seems to be coming more in those areas where it's more ambiguous what should happen. Think of an MRI for example, which on average has improved diagnoses but often gets applied in lots of settings where it has a very low probability of affecting the diagnosis which drives up costs without improving quality. And in fact if you interview physicians and other medical professionals in the high cost areas for the same medical conditions they are more likely to indicate an MRI is warranted than in the low cost areas. And you see in imaging and in diagnostic tests a lot of variation.

I also like to put up this chart because people often note that the darker areas are leading academic medical centers, and it is true that we had at our leading academic medical centers we have the best healthcare delivered in the world however when you look across those medical centers there doesn't seem to be a lot of difference in the quality, they all rank relatively high, and there's huge differences in the cost per beneficiary even for those beneficiaries in the last six months of life. As you can see here, at one of our nations

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

leading medical centers, cost per beneficiary twice as high at another, and it leads LA Fisher to ask how can the best medical care in the world cost twice as much as the best medical care in the world, which I think is an excellent question.

It's one that I want to talk a little bit about how we could possibly capture this opportunity that people are talking about to reduce costs at no or perhaps little harm to quality, which I think will be difficult to do but let me talk about some of the sort of buckets and also talk briefly about what CBO is doing to play its role in this effort.

Seems like there are at least four categories of things that could be done, the first has to do with information. I think many people do not know, it's ironic, economists often talk about the tradeoff in terms of higher healthcare costs leading to lower wages and that offset does occur, but I think on both sides of that transaction there are misperceptions. Firm executives feel like they are paying the costs, even though the economic analysis suggests they're not, and I think most workers have no idea how much after tax wages they're giving up for the health insurance that the firms are providing. And that kind of lack of information accommodates and facilitates an inefficient healthcare system.

We also do not have enough information about what specifically works and what doesn't. When that MRI is warranted and when it's not, how many times you should go back

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and see your physician after surgery, what have you. So that's the first bucket and the second bucket is incentives, we pay, we have a financial system that pays for more care rather than better care and unless you tie that improvement information to different incentives it's very unlikely that you're going to get major changes in behavior. There are also questions about the deliver system that I would put that in the third bucket, questions about coordinated care, profit versus non-for-profit hospitals, physician group practices, what have you. One thing I would note is that while CMS is to its credit undertaking a variety of demo projects that will allow us to learn something more about these various delivery systems and related activities, the demo projects are not designed very well to actually teach us anything. And I think we could do a lot better in terms of designing those demo projects to teach lessons about what works and what doesn't.

And then in a final area, or bucket, involves health behavior, I think we have woefully under tapped behavioral economics as a field in terms of figuring out why people make decisions that they do in healthcare. Whether it's framing of co-insurance rates, or where you put the fruit on a cafeteria line, or what have you, there's a whole area of activities that we haven't tapped.

Let me just briefly add, and I know I'm a little bit over my time by saying what CBO is doing. As many of you know

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

we are significantly expanding our activities in this area, we have a new Deputy Assistant Director for healthcare in our budget analysis division, which is the part of CBO that does scoring. We have a new, RWJ Fellow who's actually here in the room with us this afternoon, we're bulking up our staff in healthcare very significantly. There are a whole variety of reports that are going to be coming out in the near future involving one on historical cost drivers, one on regional variation, one on health information technology and throughout 2008 we are undertaking a massive effort on two volumes.

The first of which is called critical topics and health reform and has to do with the major things that are under discussion that may not be amenable to specific point estimates but where we will try to provide ranges, if you do this kind of thing you could wind up with effects of between and 10 and, I'm making up the numbers, \$50 billion, and if you do it this way it's more likely to be 10, do it that way it's more likely to be 50.

And in addition to that we have historically done a budget options volume with specific point estimates doing this specific thing in our estimation will lead to \$14.4 billion budget effect in 2009. We're going to pull out the health part of that expanded and publish that as a health options volume. So you'll have both sort of a more conceptual thing with ranges and a more specific thing with point estimates so that folks

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

who are trying to put together both big and small health reform proposals have some idea as to what CBO sees the dials being and how much you have to turn them in order to achieve various different outcomes. Thank you very much.

ED HOWARD, J.D.: Great. Thank you Peter. Now's your chance to get in on this conversation. I remind you that there are green question cards that you can fill out. If you hold it up, as I can see someone doing in the back, someone will snatch it from your hand and bring it forward. There are also microphones, one here and there's some in the back? I didn't notice where you can come and ask your questions in person, and it looks like someone is actually not standing at that microphone. But I would commend that strategy for you because then you don't have to worry about me filtering what you want to ask, as long as you do it in a concise way and keep a civil tongue in you.

While we're waiting for those to come up, let me start us off, Peter, I wanted to follow up on something that you had talked about, that is the demonstrations that are ongoing in Medicare to test the number of delivery system changes. And I wonder if you could talk a little about what kind of design features you would build in to try to get the results that you think would be useful to people who are trying to reshape the policy and bend the curve.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

PETER ORSZAG: Sure. And let me actually broaden it beyond just demo projects and say I think there are a whole variety of things that the federal government is either subsidizing or involved in where we could be getting better information about what works and what doesn't. And I'd actually start with the Medicare Advantage program where the largest growing component of that program, private fee for service plans, have very light reporting requirements and even the other parts of the plans which are doing lots of innovative things so the HMO and PPO plans are doing lots of, I like to sometimes say, it's almost like they're conducting a variety of experiments in disease management, in various other things, and they are doing so with a public subsidy because as we estimate and MedTech estimates, the cost per beneficiary is higher in those plans than in traditional fee for service.

And so one might think, if you're adopting that perspective in exchange for this publically funded set of experiments we should be getting a set of rigorous data back on what works and what doesn't and that is unfortunately not as complete and rigorous as one would hope, even though I continue to beg for that data.

On the demonstration projects we need to separate them into a variety of categories. There's a bunch of demonstration projects that are actually not really demonstrating anything but rather are almost programmatic changes. The demo projects

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

that are designed to study particular interventions are often not randomized or they are, they lack comparison groups that would provide the kind of insight that you'd like to see. And in various other ways, as you go down the list, we've done, I had a briefing on this a couple of months ago and was frankly quite disappointed to see that in demo project after demo project the key elements that you would expect in a rigorously designed evaluation were lacking. And so we are picking up snippets of things that are kind of incomplete and partial but we could be doing a lot better in that area.

ED HOWARD, J.D.: Yes, we have someone at the microphone. If you'd like to identify yourself please.

JILL WEXLER: Sure, Jill Wexler with Pharmaceutical Executive Magazine. Peter, one of the proposals in the Commonwealth Report for saving money is to negotiate prescription drug prices and they map out a scenario for various things that could happen to achieve that. You have, your office has made comments about how some of the legislative proposals in that are don't offer great savings. And I'm just wondering if you could say if this is different or respond to that.

PETER ORSZAG: Yes, I think from my perspective the key part, and I'm reading from the summary here, is give the U.S. Secretary of Health and Human Services the authority and negotiate, and here's the key part, or set price limits. The

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ability to, simply providing the Secretary of HHS the ability or the authority to negotiate and in our opinion, or my opinion, doesn't do very much across a broad array of drugs. And I think I want to just pause for a second and compare the results for the Veterans Administration, which is often compared to the ability to negotiate, with what the Secretary of HHS himself or herself could achieve just with negotiating authority.

The VA has significant price discounts for two reasons. First, it's piggy backing off of other federal price setting, or other price limits or guidelines, and then secondly it has a formulary. So it has the ability to restrict the use of particular drugs in order to negotiate or obtain even larger price discounts. It's those two things that drive any price differential that the Veterans Administration is able to achieve relative to other purchasers in the market.

Providing the Secretary of HHS the ability to negotiate would only provide a bully pulpit and wouldn't provide either of those two steps. Now it may be that a very aggressive Secretary of HHS in an isolated examples could achieve some cost savings just by, again, the bully pulpit but the ability to do that without any real leverage behind it is quite limited which is why we've said there may be in selective examples some price effects but across a broad array of drugs it's not plausible to us that the Secretary of HHS could walk out and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

say I'm going to negotiate across the whole array of drugs and accomplish a significant price reduction without a tool that has a little bit more edge to it.

CATHY SCHOEN: And I might say the longer report gives you more details and it's around page 51 and 52. And what we did is focus particularly on drugs used by dual eligible's, very sick, some of which are unique pharmaceuticals. And Peter's absolutely right, it's a question of leverage not just negotiation and we can see entire countries that are using this approach that as in return for access to a market. You are not just negotiating but starting to limit particularly where there's monopoly. There's one unique drug, it's focused on very sick people trying to start to say is there another possible price as we've seen the AIDS price for drugs have come down.

PETER ORSZAG: If I could actually just come back in for a second because I think there's been some misunderstanding or I'd like to just clarify. CBO has never said that it's impossible that the Secretary of HHS could achieve significant price reductions, but rather that the proposals that have been put forward would not achieve that objective precisely because they lack the teeth or the tools that would accomplish those cost reductions. So I just wanted to make it clear, it's not an existence or possibility question it's rather a question of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the specific instruments that are being provided to this Secretary.

ED HOWARD, J.D.: Yes, go ahead.

BOB RORE: I'm Bob Rore with BMJ. You talk about changing some of the incentives in the system, yet so much of the healthcare system in the western healthcare system, not just financials but prestige, status, etcetera, is based upon cure at the cost often of prevention. How do you try and sort of level that playing field besides prevention more?

PETER ORSZAG: I'll jump in. I would say a couple of things. First, I include that within the incentives. I mean, I think to a first approximation if you want to think about what we get in healthcare, we get what we provide financial incentives for providers to provide. We have strong financial incentives for high end technology; we get a lot of that. We don't have strong financial incentives for preventative medicine; we don't get a lot of that.

So the first point is I didn't mean incentives only for the back end or the care part but also altering incentives for prevention if you want to pursue that. The second point I'd make is I think a lot more attention, as I tried to emphasize, needs to be paid to health behavior and not just healthcare. We are so missing the boat on what effects our health outcomes by just focusing on the delivery of the healthcare system instead of how we all behave, what we eat, how we exercise and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

all of that is so affected by our environment and by the choices that we're presented with.

Economists are trained as believing in hyper-rationality and that everyone's kind of maximizing all the choices, but I think in study after study on whether it's saving but also on healthcare and eating and exercise, the evidence is overwhelming that that is just that model is flawed and that what we wind up eating has to do with how things are presented to us and not how "hungry" we are. And whether we exercise has to do with how easy it is in other things and not perfectly rational calculations.

I know, I like to, I don't mean to belabor this but I, I like to think of myself as a fairly disciplined person but I know I'm tired right now, I know if you put a bunch of cookies in front of me I would eat those, if you put some fruit in front of me I'd eat those, and if you put both of them in front of me I'd probably eat both of them. And most of the choices that are made and most of the things that, most of the ways in which we behave are governed by default and the structure around us and we do not have a system in place in which people can easily do what everyone says they want to do, which is lead healthier lives. A lot of the defaults are backwards relative to what we would want it. It's really easy to get unhealthy food, it's harder to get healthy food. It's really easy to not exercise, it's harder to go out, the gym is less convenient.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

There are all sorts of settings in which we are not doing a good job on prevention and promoting healthy behavior because we're not insisting that we change the structure so that it's really easy to do the right thing.

ED HOWARD, J.D.: I want to turn to Kate, but I do want to note in passing that there are both pieces of fruit and salads available [laughter] on the lunch line, right across from the cookies as a matter of fact. Go ahead Kate.

KATHERINE BAICKER, PH.D.: Just to collaborate what Peter said, I absolutely agree that behavior economics has a lot to contribute and that we have a lot more work to do to figure out why it is that people don't engage in what we think are completely cost effective and health effective healthy behaviors. And I think the evidence that Peter cited suggests that in fact we could buy more health by spending money on improving people's health behaviors than if we covered those people with health insurance.

But the dollars go further in improving exercise and nutrition and risk avoidance, non-smoking, less drinking, etcetera. So if you're just trying to maximize health maybe that's where we should be focused and I think that's a great point. But then going, if you assume that people are not acting like the hyper-rational agents we would all like them to be based on our textbooks, then maybe there's a role for insurance companies in fostering better health behaviors if

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they have longer run relationships with people who are enrolled in them.

And there are lots of reasons they don't now and some of the reform proposals on the table would move us towards longer term relationships and some would move us away from that. But imagine that an insurer is on the hook for your expenditures over a long period of time, maybe not only would they make preventive care not subject to a deductible, maybe they'd pay you to go get a flu shot. And that would be a rational way to structure insurance. Subsidize things that have really high payoffs in health over the long run, have higher co-payments for things that are of questionable value for treatment that we think has very little marginal benefit or even sometimes negative marginal benefit as some of the Dartmouth work might suggest, then you want to charge a really high co-payment for that.

You want to charge a lower co-payment for things that are less subject to moral hazard or less subject to choice about what might be a low value treatment. And then subsidize the heck out of preventive care and things that have long run payoffs.

PETER ORSZAG: Can I just add one other thing just as an example because you mentioned prevention. Again, just highlighting this point, the evidence, there actually was a study on this, the evidence suggests that if your doctor

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

recommends you go get a vaccine you're very unlikely to do it. If he then provides you with information about where you can go get it you're somewhat more likely to do it. If he or she circles on the map where you're supposed to go and there's a default appointment time, next Tuesday at 2:00pm, you're extremely likely to then go do it.

And again, you haven't changed anything in terms of the rationality of getting the vaccine or not, you just kind of created in someone's mind the default that yes, next Tuesday at 2:00pm I'm supposed to go get my vaccine at this place on the map.

ED HOWARD, J.D.: Cathy.

CATHY SCHOEN: I just wanted to come, that's a fantastic example and we have examples within the United States of where trying to pay differently. So, for example, North Carolina where there's low income population it has every primary care doctor participating, it's both paying the physician practices but also paying networks that are supportive networks with nurses and coordinating care. And they've gone after the high risk chronically ill so that if someone shows up in an emergency department you try to figure out why and what didn't happen.

They've gotten tremendous results both on asthma, diabetes, they're starting to look at the duals, and it's that allowing a physician and a team to start forming for more

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

systematic coordinated approach that can do things like make the appointment before you leave instead of just saying go get it and develop patient decision aids and educate patients.

Where Germany is doing a chronic care model across the entire country, and one of the things they found is that many of the chronically ill patients had never actually had a long conversation of what they could do. In a goal setting way this is the way I live, what can I do. And by engaging the patient and giving the physician protocols where the physician didn't know what to tell the patient they're starting to get reduced blindness, reduce amputations, and quite real results that are also on the hospital side saving money.

So I think this emphasis on just paying for the final result of the amputation is where we bend rather than paying for the system that could coordinate and focus more in the early end. But it's a systems approach, it's not just paying more, it's paying in a very different way.

ED HOWARD, J.D.: Yes, Gary?

GARY CHRISTOPHERSON: First I want to associate with Peter's comment there. I think your comment about behavior is key, but it's broader than just the person. It's also the rest of the players as well.

ED HOWARD, J.D.: You want to identify yourself.

GARY CHRISTOPHERSON: Oh, Gary Christopherson. What I want to go back a little bit is first place is now having lived

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

through these discussions and been part of them for 30 years at the local level, federal level, DODVA, and CMS and Medicare, it's sort of interesting to watch how this discussion continues to happen but doesn't continue to change, doesn't continue, other than get a little smarter every there.

And the question I think goes along the following lines. There's two questions. One is how do we avoid what's traditionally happens up and through about a year ago, at these major rooms where you sit down to have these cost quality discussions and the bottom line starts being quality but always ends up being cost, quality takes a second seat.

The second part of that, which goes back to Cathy, you're work in the, in terms of the Commonwealth Fund is we do it piece meal versus try to figure out how to put the whole package together. It doesn't mean you have to have the whole package enacted at one time, but you've got to know what your strategy is and you've got to know how you plan to get there. So how do we avoid the cost quality becoming a cost issue at that final moment and secondly how do we deal with the issue of comprehensive package of reform?

ED HOWARD, J.D.: You want to start?

CATHY SCHOEN: I think part of it is starting to have real conversations about it and analyze what is driving up costs. The types of reports Peter talked about coming out. We're going to see on my, I believe they're going to be

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

presenting it at the end of this week that will be out by next week, Minnesota has convened a transformation task force and they are going after both the behavioral health and we're thinking about more places for people to walk and the exercise kids get in schools and what they eat on the behavioral end. But they're talking about paying differently.

They brought all the payers to the table. So I think the federal government often thinks of just Medicare and there are real spillover effects when Medicare does something that's positive and innovative but trying to think of where those opportunities are that if Medicare was doing it and Medicaid was and private payers were, you start to get a synergy that providers can react to because they have more consistent price signals and incentives. It's very hard to run a panel in different ways so you'll respond to a dominate player or you'll respond to none of them.

And so I think that's important. And this notion of competition, I want to put another word in, it's collaboration. And throughout the Minnesota report they keep playing those two words because part of what you saw in the cardiac care group was real collaboration benchmarking cultural of quality where you want to be the best. Appealing to that professional pride, so it wasn't just I'm going to get your patients it's just we're all going to deliver better care.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So the federal government could be the convener this way. And thinking about what is going on in states with state experimentation but also learning from the states and giving the states tools would be a place to start.

PETER ORSZAG: Well I guess I will be forthright in not answering the question and instead answer a different one which is what I think will be different this time around, or what's different 20 or 30 years later, at least in terms of my organization.

I think that we have had an outstanding health staff but it has been very, very small. And the result has been that that staff has been put under enormous pressure to come up with estimates that means often that the focus from our end focuses just on cost because we don't have time to process the potential quality implications.

And one of my objectives in building up the staff is to be able to provide more information both about cost and about quality because the policy making process needs both. So I'm hoping that sort of it will be a little bit different in terms of interactions with CBO as we bulk up our staff and have greater capacity to analyze more options along both dimensions.

ED HOWARD, J.D.: Yes, go ahead.

CHARLIE SARAH: First off, thanks for hosting this. This is a good topic and I'm sure it will keep going over the next couple of years. I'm Charlie Sarah; I'm with the National

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Center for Policy Analysis. Over the next, I'm sorry, Aflac and Wendy's they're high providers of health savings accounts. And they seem to be having a very high uptick on the use of preliminary care and the preventative medicine on their HAS users. So I'm a little bit different on the behavioral side.

But I didn't see the user consumer of healthcare talked about it at all here. Is there a role for more funding, kind of like the rand study for more funding for healthcare dollars to come out of the consumers pocket?

ED HOWARD, J.D.: Let me just add to that that we have a couple of questions that have been submitted on cards wondering about the role of HSAs in this whole discussion of holding down costs and not harming quality. So it is a topic of concern. Yes, Peter you want to start?

PETER ORSZAG: I guess I can take a crack at that. Despite what you hear in the media, if you look over the last three decades or so the share of total healthcare expenditures or personal healthcare spending that comes out of pocket has actually declined dramatically.

And all of the evidence, whether it's from the rand experiment or from more recent work on the introduction of Medicare suggests that reductions in, especially in the margin cost sharing, does increase healthcare expenditures. So one can then sort of take that and say yes, it is true that more cost sharing for consumers as embodied in health savings

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

accounts could help to reduce expenditures. And we found actually in a report that was issued right before I took office, that a more universal type of health savings account approach would reduce expenditures by perhaps 5-percent or so.

There's a but though, and the but is, and the reason that number is not as big as you might think, healthcare expenditures are very concentrated, they're concentrated among Medicare beneficiaries, they're concentrated among private beneficiaries, they're concentrated among Medicaid.

The top few percent of healthcare beneficiaries ranked by cost account for a very large share of total costs, in Medicare the top 25-percent of beneficiaries account for 85-percent of cost. And that puts an inherent limit on how much traction you get from increased cost sharing on the consumers side because HSAs like any decent insurance package provide insurance against catastrophic costs.

I think as a society we're very likely to continue to provide generous insurance against catastrophic costs and because such a large share of overall costs come from those catastrophic cases, you kind of limit the traction you get from the cost sharing area in health savings accounts.

I think Kate and I in the past have disagreed on exactly the share but the point is there is some limit to how much traction you get. And the only other point I'd make, I actually have a health savings account. I think that there's

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

also a problem in the sense that, again, take the example of the MRI for, well, we don't even need to go through all the examples, but a particular intervention.

I don't know, as a consumer, whether it is worth doing for me, even if I were paying, to do X or Y because the information simply doesn't exist. So we are loading, I think it would be problematic to load too much responsibility on consumers, including through cost sharing without providing them with more information about what specifically works and what doesn't. And currently too much of that information is lacking.

ED HOWARD, J.D.: Kate?

KATHERINE BAICKER, PH.D.: And I think we actually agree on most of the fundamental, there's certainly a big confidence in, a whole lot of uncertainty around how much moving to allot more consumer directed care would do to spending. I think there is some evidence that there would be broader effects than just the individual incentives because of these system wide spillover effects that changing the mode for which some people consume care can have broader effects on other people, and a fair amount of spending is un-deductible.

But I think we agree that that's not the magic bullet to cut spending in half. That's outside the confidence interval for sure. But, that said, I think that there are a lot of different ways that insurers could work to deliver

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

higher value care. And raising the deductible is one way but I don't think we have a strong prior belief that that's the best way. There are lots of other ways as well. You can restrict the panel with in-network versus out-network differences, you can have tiered formularies.

There are all sort of different ways that insurers could work to provide higher value care to patients and you can imagine that people would then shop around and look for the insurer that has the best package knowing these things will be covered at this rate, those things will be covered at that rate. I really like seeing my doctor so I'm not willing to have a network, or I don't mind a deductible, etcetera. All of them require better information.

I had an HAS when I worked for the federal government and I went to the doctor for a sore elbow, true story, it's fine now, thank you. [Laughter] And they said, "Well maybe we should do an x-ray." and I said, "How much will that cost?" And they looked at me like I had just accused them of malpractice and said, "Well, we have no idea how much that would cost." Couldn't tell me at all and like the good consumer I was breed to be I said, "Okay." [Laughter] And had it anyway.

So, and then, an interesting comment, when I got the bill it was an enormous bill and I said, "Ah, I'm not uninsured; I'm covered by this high deductible health policy so

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I'm entitled to my insurers negotiated rates." And 18 bills later after I had moved two times trying very hard not to be in default on this bill they finally sent me a bill that was less than a quarter of the original price because they had finally figured out that I was entitled to the insurers negotiated rates.

So there, and I was an active, fairly aggressive consumer and it's still almost impossible to get the information you need. So we have a long way to go.

ED HOWARD, J.D.: All right. Great story. Yes, John?

JOHN GREEN: John Green with the National Association of Health Underwriters. So I think I'm encouraged by what I'm hearing you say Peter about sensitivity and analysis for legislative proposals. So for example, Senator Harkins Wellness Bill certainly is being considered by CVO for scoring right now. So when that score comes back we might see some analysis in terms of impact it may have in terms of reducing healthcare costs rather than just what is a pure cost to the government and to tax credit proposals.

PETER ORSZAG: Let me have the opportunity to clarify. With regard to the critical topics in health reform volume that we will be putting out later this year or early in 2009, there will be more qualitative information about ranges of costs and potential other effects. In the scoring process itself, first on the cost side, there is a requirement for a point estimate.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So our best guess and very little attention is paid to beings of uncertainty around that best guess.

A second question then is are there any kind of offsetting savings that can flow through? And a lot of settings those offsetting savings occur but they often occur over the medium or long term and I am often blamed for this but it's not my fault the congress picked it, the five and ten year budget window means that you're curtailing a lot of the potentially offsetting effects that you may expect of the medium to long term.

So preventions a good example where if you think there's some upfront costs and then it pays long term, long term can often mean a decade or more and it often takes a while until you see those effects coming or you can sort of quantify them. I am often put in the position of why didn't you score a savings out in year 15 or 20 when the congress is the one who picked the five and ten year budget window and we're implementing that choice.

So, we're doing a lot but you shouldn't expect miracles is what I guess the bottom line is.

ED HOWARD, J.D.: And let me just point out Cathy, if I'm correct, in the report a lot of the savings that were generated come late in that decade long measurement period. And presumably would go forward with larger savings beyond the 10 years.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

CATHY SCHOEN: That's right. Particularly about more transforming changes like an IT where it takes a while for the initial investment and you start to get the payback.

PETER ORSZAG: Can I also just comment on, there are a lot of things that in an ideal work if they were done today may start paying off in your eight or nine. When you actually look at specific real world legislative proposals are phased in very gradually in part because sponsors or policy makers don't want to deal so much with, or are sort of dialing down the upfront costs and so they're phased in very slowly. And so if you think that something will pay off after ten years after it's kind of reached steady state levels, you often don't reach that steady state for a significant period of time. And again we're kind of caught in that ten year window horizon.

ED HOWARD, J.D.: Before I call on this gentleman, I just want to point out that he is doing something very rational, which is coming to the microphone and asking the question in person. I have an incredible stack of cards here, green cards with questions on them some of which we're not going to get to. So if you have something that's burning in the back of your mind and you put it on a card you might want to come to a microphone as this gentleman did. Yes sir.

DIXON AWA: I am Dixon Awa, I am with the Men's Health Network. My understanding is that this problem of healthcare costs there are like three major areas which may be

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

responsible. The first has to do with, or maybe three major group, the first may be the uninsured. The second may be men and then the third is definitely people who are like in the last or six months or a year of their lives because there are different studies that show that.

And I want to talk about the uninsured in the first that they cost the situation by, because of the fact that they don't have health insurance and they are bound to go the hospital when they are really sick and there are all these different acts that maybe lead them to the emergency door and then they are very high cost because of their sicker conditions before coming.

And then the other one has to do with men who generally are not exposed to different things that may encourage them to seek preventive care. For instance, screening, a simple example may be the case of prostate cancer screening on men. There are, I think there are very few men who are aware that they are supposed to do things like that and they are a litany of other things which men just don't do which they are supposed to be doing.

Whereas women do things regularly, for instance maybe every year they have to do their mammograms and they have to do all these different things that they do. And men are usually caught in a situation where they're rushed to the hospital when

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

they are really very sick and they have slim chances of having that outcome for their condition.

And then when the elderly people usually some of them may not have done certain things that they were supposed to be doing when they were younger and so when they become old all these accumulated issues kind of come up and it's so difficult for them and they end up costing the system more in terms of healthcare costs.

So looking at all these I really want to think that this maybe a system problem and the approach to this has been us trying to, let me say the healthcare delivery system has been the type which is more acute disease oriented and so very often all the interventions we have talked about have been the ones trying to solve the problem of the people who are already sick. Whereas if we could suspend, or let me say while we are trying to solve the now problems, so people who are sick today, we could come up with a systematic approach of prevention for the system which may cost us less in the future.

And while the insurance companies are trying to do things like that, they try to give the incentives for people who do preventive and wellness behaviors but I think the CMS is like the biggest payer of healthcare in this country and if they can take the lead in trying to come up with some policy approach that can treat this thing differently, maybe in the short run the healthcare costs may be where it is but in the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

long run we are truly going to address or maybe do some significant impact on the healthcare costs that we are trying to fight. I don't know what the panel thinks.

ED HOWARD, J.D.: Prevention keeps coming up. Peter?

PETER ORSZAG: Well let me first say that as a well trained male that every large problem is men's fault. But let me, it actually and by the way on the behavioral economics Marilyn Moon told me about a study suggesting that if you, the best way of getting middle aged men to eat fruit is to put the fruit on the same shelf as beer in a supermarket. [Laughter] I think that, I'll just let that speak for itself.

ED HOWARD, J.D.: Works for me.

PETER ORSZAG: A couple of comments. First, I do want to be clear that although there are dramatic cases of very high costs associated with a small share of uninsured people, on average uninsured people cost less than insured people and covering the uninsured will on net cost money. So we're often held out this promise that even in the near term covering the uninsured will reduce costs because of the emergency room visit story that is told. But on average uninsured people, even at the same level of income, do spend less on healthcare than insured people and that's consistent with the point that we were making before about co-insurance rates and spending. When you're insured you tend to spend a little bit more in aggregate on healthcare.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

There were a lot of things in your question, end of life is clearly, the last six months of life account for about a quarter, or beneficiaries in the last six months of life count for about a quarter total of Medicare spending. A lot of the variation that we're seeing in cost per beneficiary has to do with those high costs near end of life beneficiaries. And the chart I put up for those academic medical centers where the average cost varied by a factor of two were all for beneficiaries in the last six months of life. So a lot of the variation we're seeing is occurring there.

More broadly on prevention, I'll just come back, I think that a big part of what we need to do has to do with changing defaults and structures and putting the beer on the same shelf as the fruit kind of steps even though I know that's kind of a fanciful example. Part has to do with changing the financial incentives for providing prevention as well.

BOB GRIS: Bob Gris with the Institute of Social Medicine and Community Health. My question is really a follow up to the last one, when, Peter, you say that the uninsured cost less, I guess you mean they're not getting a lot of needed care and consequently there's no market value for that care that they're not getting. But if they were provided appropriate care over what period of time would there be a net savings to the healthcare delivery system if they're getting

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

appropriate care and consequently not getting the medical complications that were preventable.

That to me is the critical question, not are they using less healthcare right now but if they got appropriate care both, and the disparities were removed, would there be cost savings to the system and how long would that take?

PETER ORSZAG: That's a very good question and, well, okay, I thought it was directed at me but go ahead. I'll go last, that's fine. I can be patient.

CATHY SCHOEN: Okay, I just want to jump in to broaden it a little bit and not cut off the conversation. I think when you're looking at the uninsured we need to look at the insured as well. Kate mentioned the phenomenal churning we have. If you talked Humana and United some of them will tell you the people they have today three years from now they're all going to be gone, even their own employees.

We in Medicaid have a hard time looking at a full year of HEDIS measures because the Medicaid beneficiary isn't in for a full year. So they're in and out of coverage. If we could get to more continuous coverage long term, I think you can do a population health approach that will work for both the uninsured and the insured. We have transaction costs that are huge with just moving in and out of the plans all the time, every time that happens a new account is set up.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So when you take that into effect I don't think you get anyone who will say you necessarily that person is a long term cheaper person but we get much better health for the way we're covering. Right now the use of an ED is not the right place for an asthma attack so if we can prevent the asthma attack but we have to spend money on caring for the asthma. So if you look narrowly at the uninsured they're a diverse group moving in and out and if you look a little bit more broader there are real life opportunities to achieve efficiencies on the insurance side that start to help you pay for the expansions.

KATHERINE BAICKER, PH.D.: I'll go next so that Peter can correct anything that I say that's wrong. My perception is that the answer is never. That you don't save money by covering the uninsured, you spend more money but you get a lot more health. They are under-consuming care, they're going to consume more, the full cost of that additional consumption is dampened by the fact that you're getting more efficient use of the resources because you're avoiding the emergency rooms, because the uncompensated care costs isn't being spread to other people and driving up insurance premiums, and all of those things dampen the increase spending but you're spending more.

That doesn't mean it's not worth it, it probably is worth it, you're getting a lot more health for it but it's not self-financing.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ED HOWARD, J.D.: Let me just ask you ask we get into the last 10, 15 minutes of questions that you help us improve these sessions by pulling out those blue evaluation forms and filling them. Let me just combine a couple of questions that are concerned about comparative effectiveness. Several of you have been sighting that as one element of how one might bring about positive change. The questioner asks did Commonwealth tie comparative effectiveness research to reimbursement changes and how do you implement this without a huge backlash since people are often unwilling to forgo an expensive procedure with little chance, even if it has little chance of working.

And the second questioner was asking who ought to do the comparative effectiveness, which is sort of the question du jour as we consider proposals along those lines.

CATHY SCHOEN: I'll give a quick answer and then I noticed that in Peters longer report he talks a little about this. We both, the answer is quickly yes, we tied it. We looked at new freestanding entity that would be conducting research and as we knew more about what works well for which patients it could influence the way it's covered. So you could have differential co-payments, it wasn't don't cover it at all versus cover it and marginal instances.

I think if you don't do something to then make coverage and payment decisions you're relying on just information flows, which we know have an effect, giving people better decision

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

aids on here are four choices not just go get an x-ray or not, but invasive back surgery versus not, not by the one who wants to cut you but a more robust set, that people often pick the less invasive, less risky when they have that information. But that alone won't get you to the savings so starting to tie what works well when.

Again, other countries on reference pricings for medications has used this approach that they price a new product, they bring it in, they cover it, but if it's not doing any better than any existing covered product they cover it at the price of the existing product and you can pay the difference to get it if you and your doctor decide you want that new one which costs more. So I think coupling it with a payment policy and a coverage policy is where you get teeth.

ED HOWARD, J.D.: Anybody else? Okay. A couple of Medicare Advantage questions, one of them directed to Kate, question wants to explore whether, you sited the fact that everybody in Medicare gets roughly the same coverage and the question is how do you square that given the growth of private Medicare Advantage plans which may have different benefits and features.

And then secondly Medicare Advantage has been sited as receiving, in recent Alliance meetings in recent research, up to 112-percent of the traditional Medicare payments, how do you reconcile that this study did not evaluate quality or

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

appropriateness of care assuming of the chronic care features mentioned today may partially contribute to this overspending.

So, Medicare Advantage, Kate, you want to start?

KATHERIN BAICKER, PH.D.: I'll start and then hand it over. First of all let me clarify, I'm glad you've given me the opportunity to clarify, I like that. That the graphs I put up were just for traditional Medicare, so that was taking Medicare Advantage beneficiaries out of it. Now part of the reason for that is to make the beneficiaries in comparably insured plans, another reason is that we do have a terrible lack of data on what goes on within Medicare Advantage plans. The Medicare grasps that the Dartmouth Atlas people have put together are based on detailed claims data when you go to get a mammogram that has a Part D charge that goes to Medicare that's available in a research file, what you do within a MA plan is not available. So it's very hard to do some of these comparisons without some better data.

That said, clearly Medicare Advantage plans are delivering different types of care than traditional Medicare plans and I'm very interested in, I focus today on spillovers, I'm very interested in the spillover effects of enrollment in Medicare Advantage on the treatment received not just by those patients but by all the patients treated by the same providers in the same area. And there's some indirect evidence on that by Lauren Baker and others, I'm working a little bit in this

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

area now but I think that's a big open question, can we gain any system wide advantage by increasing Medicare enrollment Advantage. I think people hope that we can but I think the evidence on that is a little bit thin right now.

PETER ORSZAG: If I could just add, again, the most rapidly growing component of Medicare Advantage is private fee for service where a lot of the theory behind HMO penetration rates affecting the practice of medicine don't really apply because it's not, it's got a much lower level of care utilization management and other management techniques built into it.

With regard to the 12-percent differential, I guess I would say two things, one is that there are some questions about the way in which the risk adjustment is done because of a potentially greater incentive for up-coding of risk within Medicare Advantage relative to traditional fee for service. But that having been said, is not the case that you see outside a special needs plans which are different category, substantially sicker patients going into Medicare Advantage plans relative to traditional fee for service.

And then secondly on the quality of care delivered, there's only very limited evidence but again I don't think it's the case that we can rigorously say that the quality of care delivered is better under Medicare Advantage than under traditional fee for service despite that payment differential.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And then that leads me to the third point which is, again, Medicare Advantage plans are doing lots of things on disease management and other steps but we have very little idea in terms of what they are actually accomplishing because of reporting inadequacies. So it's easy to get reports of, and I've been exposed to many of these, of this plan accomplishing this on a narrow measure but on a comprehensive measure like even in terms of cost let alone quality, in terms of the all inclusive impact on total costs per beneficiary much of that information is still lacking. We have been working with AHIP and other organizations to try to get the information that would provide policy makers with better insight into what's working, what's not but I would say currently we simply don't know.

CATHY SCHOEN: I'll just put one end note on what we also don't know is they would have to get a huge return on quality and improvements to offset the higher administrative costs. We know they share a premium that both for the market and enrollment and running the plan is much higher than traditional Medicare. So they have to do a lot more to earn back that 12-percent.

And it's one of those if you're paying above what the traditional plan would have cost or you're paying higher than what the provider network is already providing you, you're giving a pricing signal that says higher costs are better than

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

lower costs. So potentially resetting the benchmarks would intensify the pressure on a quality value tradeoff.

ED HOWARD, J.D.: We're, I am reminded that we are technically scheduled to go to 2:15 today, we may not go all that distance. We have a bunch of questions to get to but they're a lot of them that have already been covered in one level or other.

Here are a couple that haven't however, they're both related to obesity. First, I guess primarily directed to Kate, what would the geographical distribution look like if we factored obesity and or chronic disease into the picture? And more broadly, someone is worried about the role of addressing obesity from a healthcare system perspective, improving quality and reducing costs. That is, there's evidence for example that there's widespread physician prejudice against the obese and how do you deal with that in the context of trying to come to grips with the challenges that obesity presents to the system?

KATHERINE BAICKER, PH.D.: Those are interesting questions and we clearly know that obesity and related disease account for a large and growing share of healthcare expenditures, especially going out into the future. But the question was actually asking about the role of obesity in variance of healthcare spending and I don't have the answer off the top of my head, it's a good question and I'll try to find out. But the indirect fact that I can tell you is that those

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

graphs again are adjusted for overall illness burden so you're comparing a roughly comparably ill group of people in different areas and seeing how much is spent on them so it's not driven by differences in obesity rates across areas but that really doesn't answer the question of holding obesity constant how much of the variation in treatment is because of variation in obesity treatment or related diseases, and I don't know.

PETER ORSZAG: If I could just come in, the increase in obesity and especially the very upper tail of the BMI distribution or this sort of very obese that has occurred largely since 1980 has increased costs and does impose quality, does pose significant questions about healthcare outcomes or quality. But I think that a lot of the discussion, at least backward looking in terms of the role of obesity in explaining the cost increases that we've observed has exaggerated that impact.

We're going to have more to say on that topic in the near future but just a quick note that I think a lot of the estimates that are floating around with regard to the share of the increase of healthcare costs historically as opposed to prospectively that can be attributed purely to obesity seem much higher than CBO analysis is going to suggest.

ED HOWARD, J.D.: Okay. Let me just use one card, if I can, that asks a broad question as a way of bringing this discussion perhaps to a reasonable conclusion. And I will

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

amend it if the author will allow me the privilege to narrow the focus a little bit.

Asking our panelists opinion about what perhaps the, the questions asks three things, I would say what's the one thing that we might be able to focus on as a way of trying to promote the idea of being able to bend the curve and improving quality and restraining costs over the next ten years, say, in America. And what's the likelihood of your one thing actually happening, that political part I'm not sure you need to worry about but if you had a very short agenda what would it look like? Cathy do you have one of the 15 that you want to single out?

CATHY SCHOEN: I won't give the answer that the person who asked the question would like. I don't think it is one thing and that my slide on magic bullet. I think it's critical that we have better information systems, they are tools and they can guide and drive change but you have to be able to take that information system and use it to inform your payment policy. We can't continue to pay the way we are now we need to be thinking of different ways of paying primary care, paying for coordination and more integrated care systems. Both of those will drive system changes the way we organize, better information on what works and doesn't, better information at the physician level.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I think insurance is critical piece as well. If we continue with a fragmented insurance we have, not just the high rates of uninsured, it's very difficult to do the kind of coherent payment policy you need to get to a collaborative approach around paying differently or IT systems. So we need to be, we can do it, we just need to be thinking on a population wide basis even if we remain in a Medicare program and a Medicaid program.

So I think those are all critical elements. When you see other countries make dramatic improvements you see all of those at work. Denmark's IT system is remarkable but they've immediately coupled it with a payment system because they can know more and they're getting system efficiencies that I don't think we can even imagine because we don't have these in place yet in terms of the way doctors time is spent, the way nurses time is spent, the way pharmacists time is spent.

ED HOWARD, J.D.: So you did have three items. You ought to be satisfied questioner. Yes, Peter?

PETER ORSZAG: I guess I'll answer the question in terms of what could be usefully done while great policy forces are battling over huge structural issues, which ultimately will be very important. But it seems to me regardless of where one resides on that policy spectrum, whether you're in favor of consumer directed health or a single payer, more information about specifically what works and what doesn't is necessary.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

If you believe in consumer directed healthcare so the consumers need to know it, believe in a single payer it's the single payer entity knows it, if you believe in some mixed system it's insurance firms, employers, households, state governments, what have you, some mixture needs it. Everyone should agree that we need a lot more of that and so I would think that we could get going on building the infrastructure and conducting the steps that are necessary in order to build out that information base.

It's often said that what we need to do to fix our long term fiscal problem is just lock policy makers in a room and not let them out until they've solved it. And unfortunately since excess cost growth is the key to our fiscal future, that approach just doesn't work, I don't know what people would talk about. I have not seen a single long term plan that restores in a credible way solvency to Medicare and Medicaid in part because we're lacking the information that would be necessary to make that kind of determination.

And the second thing I think that could be done in the meanwhile is a lot of this kind of behavioral economic stuff could be substantially flushed out. We have examples now in retirement savings where both sides of the political aisle agreed and enacted changes to the structure of 401K plans that allowed firms to make it a lot easier for households to save. There could be a lot done in that kind of sphere so building

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

out the information base and then on making it easier for people to lead healthy lives that I don't think would be as controversial as many of the broader structural changes that will require a different set of political economy dynamics.

ED HOWARD, J.D.: Kate?

KATHERIN BAICKER, PH.D.: I agree. The thing that I was going to highlight was information availability and I think we focus on information to patients about price and quality but we clearly need to invest a lot more in information for providers about what best practices are. And we've seen lots of evidence that providers getting together and trying to hash it out can make some headway in improving outcomes and implementing best practices but there are a lots of procedures for which providers think they're doing the right thing and in fact we later learn that they're not or we could have learned that they're not by looking at neighboring providers.

So investing in that kind of provider level information is a necessary first step to getting consumers the information that they need and to getting that built in to the reimbursement system. In Medicare it's all well and good to do pay for performance but you need to measure performance accurately. You need to know what performance is and you need to measure it well enough to not punish providers who have sicker patient pools, etcetera. So there's a lot of investment there that would really be worthwhile.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Maybe in the short run though the financial pressures that Peter has been talking about especially on the federal and state budgets will provide an impetus to doing some shorter run things to try to get higher value from the system but these investments in information are bound to pay out over a much longer horizon.

ED HOWARD, J.D.: Excellent. Okay, you're going to get the last word if it's a quick one.

ERIC WEADER: It's pretty quick but it's very speculative. I'm Eric Weader, I'm with GAO. I'm wondering if the panelists would care to speculate if we continue to bumble along as we have been for the last 10 years and you look out 10 or 20 years, and as we start approaching the 105-percent of GDP, which I would say is actually pretty scary giving that Peter's graph flat lines other spending and it doesn't include growing debt service.

So what's going to happen if we continue this way? Will something break? What will break? If something slowly declines, what will it be? Will it be massive cuts to providers, will it be 70-percent of the population uninsured and insurers rushing in with cheap catastrophic packages to fill the gaps sort of through Wal-Mart? Engage, speculate a little bit about what the grim future could be.

PETER ORSZAG: I thought we weren't supposed to be dismal? [Laughter]

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ED HOWARD, J.D.: That's right.

PETER ORSZAG: Let me just briefly say I think one of the difficulties that we face is that there are many long term but gradual problems that the nation faces, ongoing increases in healthcare costs, climate change, etcetera, which ultimately become catastrophic if left unaddressed but it is difficult to say failing to address it tomorrow relative to today or failing to address it today relative to tomorrow will end the world.

And it leads to the sort of M&M problem which is each single M&M is only like whatever it is, three or four calories, so you can eat one of them and it's only three or four calories and then you keep doing it and then all of a sudden you've eaten the whole bag and you've consumed 300 or 400.

Each individual day that goes by or each month that goes by it is difficult to argue that it is essential that we address the problem now as opposed to waiting another month and frankly I think our political system does not deal with gradual long term problems. It deals well with urgent problems and it deals, well, it doesn't necessarily even deal well with them but it deals with them, [laughter] and gradual problems are a lot harder to motivate action about. And I think there's been some attempts sometimes to create an artificial sense of crisis as if that will spur policy activity and I don't think that works.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So the things that could work involve broader changes in our political economy and that's a much broader discussion. I think a big deal would involved having workers be more aware of how much their forgoing in after tax wages which some people have pointed out may cause them to actually consume more healthcare, "Hey, if I'm paying \$4,000 for that I want to get more for it." But likely over time we'll put pressure on the system to get higher value out of what we're putting in.

Changes like that I think are auspicious or may ultimately yield some change. I don't think it's realistic for us to think though that in absence of a crisis and in the absence of changes like that that all of a sudden we're going to wake up and start saying oh if I eat all of those M&Ms it's going to add up to 400 calories. I think the same logic of low cost of delay unfortunately is a very powerful one.

ED HOWARD, J.D.: That's get right on the edge of dismal, yes. [Laughter]

PETER ORSZAG: But I don't want to fall into that dismal trap.

ED HOWARD, J.D.: Well, that's probably enough dismality for one afternoon. Let me just say that this has been and in fact it was, as I predicted it would be, a very energizing discussion and wide ranging. Really quickly, make sure you fill out your blue evaluation forms if you would.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I want to thank the Commonwealth Fund for sponsoring and having such a rich participation in this very interesting program and for producing the document that kicked it off. I want to thank you for hanging in there and I want to ask you to join me in thanking our panelist for an incredibly useful discussion. [Applause]

[END RECORDING]