Public Plan Option: Fair Competition or a Recipe for Crowd-Out?
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Ed Howard: Good afternoon. My name is Ed Howard. I am with the Alliance for Health Reform. On behalf of Senator Rockefeller and Senator Collins, and our board of directors, I want to welcome you to this briefing to examine I guess you would call it the proposal to include in health reform legislation, a time bomb, a so-called public plan option.

[Unintelligible] aspect, I think, of the reform debate has generated as much heat as the public plan option. It is a deal breaker if it is included, or a deal breaker if it is not included. Either a tool for providing consumers affordable coverage by stimulating competition on the basis of quality and efficiency, or unfair competition for private insurers and in the extreme, a stalking horse for a single payer system.

Like so much in health care reform, disagreement stems from what sort of public plan you are talking about and what the other components of reform are. And in order to facilitate our conversation today, one assumption I would like to suggest that all of our panelists make, and that you in the audience keep in your head, is that whatever

the public option looks like, it is offered alongside private insurance choices in some sort of exchange or connector, or some entity that enforces a level of consistent rules in all the plans.

And beyond that, I suggest to everybody up here that they be as explicit as they can about what it is you are assuming in the plan that you are either defending or attacking.

If I can sort of diverge for a few seconds to do a commercial, you might want to mark your calendars for a Commonwealth Fund/Alliance briefing next Monday, specifically on the topic of exchanges. So if you can not get your questions asked about that aspect of this today, keep them and save them for next Monday.

And I guess that gets me to the fact that we are pleased to have as a partner and co-sponsor in this briefing, the Commonwealth Fund, which has commissioned or done, or both, some very good analysis of the impact of a public plan option in a reformed health care system.

A couple of logistical items; bear with me if you have heard this before. There is an awful lot of material in your packets that include speaker

biographies, more extensive materials, and you will also find all of the PowerPoint presentations, which are almost exactly like what you are going to see on the screen today.

There will be a webcast and podcast available tomorrow on Kaisernetwork.org. In a few days, you will also be able to get a transcript of today's discussion at allhealth.org, our website.

And at the appropriate time I would appreciate if you would use those green question cards and ask questions, or come to one of the microphones that are there for your use for those purposes. And fill out that little evaluation form before you go.

So we have a knowledgeable group of panelists today. And we will have three presentations from them, and then a lot of time for comments your questions and interaction among the panelists.

And we're going to start with Karen Davis, who is the President and CEO of Commonwealth. Karen is a health economist and one of the country's leading health policy experts. And public plan option has been a major item of investigation and

analysis of the Fund and the Commission on a High Performance Health System, that the Fund has established. And that has all been met with [inaudible 4:20.4] options and recommendations on the idea of the public plan. Karen, happy to have you with us.

Karen Davis: Thanks, Ed, for that lovely introduction, and for hosting today's forum. It is exciting to be at a time when health reform is getting serious consideration. And in a context of not just covering the uninsured, as important as that is, but doing so in a way that enhances value for what we spend on health care, slowing the growth in health care costs, achieving savings that are much needed by employers and by families. And doing so, through a transformed health insurance industry, and health care delivery system, that yields an affordable federal budget cost.

I'm particularly pleased to talk about the importance of a public health insurance plan in a health insurance exchange as a lever for pulling off these objectives. It builds on a report issued by the Commonwealth Fund called *The Path to a High*

Performance Health System, a 20/20 Vision, and the Policies to Pave the Way.

Briefly, the overall context of this, what we call Path Report, is that it builds on employer coverage and public programs, so it is a mixed public/private system that achieves health insurance for everyone. It does include a national health insurance exchange, and it offers choices through that exchange.

It does not require anyone to obtain their coverage that way, but permits employers, if they so choose, to purchase coverage for their employees through the national health insurance exchange. If they do so, it offers an option to workers of a public health insurance plan, as well as private plans, and does so in a way that pools risk and reduces administrative costs.

Everyone is required to have health insurance coverage. To do that requires making that coverage affordable. Low income programs are expanded. For example, Medicaid and CHIP cover adults and children up to 150-percent of the poverty level. And it provides income related premium assistance to make coverage affordable.

Employers are required to share the responsibility for financing coverage. There are insurance market reforms that apply to plans within the exchange, but also any sold outside the exchange, including things like covering everyone regardless of health status, and charging the same premium regardless of health status.

Very importantly, the plans offered, particularly Medicare, Medicaid, the public health insurance plan, would lead to a new system of provider payment that would reward primary care, would encourage people to enroll in patient-centered medical homes, would bundle hospital payment with care for 30 days following discharge. And in so doing, would slow the cost growth over time, sharing savings with providers.

Insurers would compete in an exchange on the basis of added value, not on risk selection. I won't spend time on the exchange since Ed mentioned the Alliance briefing. We will focus on that in next week's session. But the important point is that it would improve continuity and choice for regional health insurance plans, such as Group Health Cooperative in Seattle, Health Partners in

Minneapolis.

It would permit them to be offered to a wider market. Right now, employers may offer only one plan. They may not be the plan that is offered. So for those getting their coverage through the exchange, it expands the market for private, regional plans.

It is easy to enroll. You can enroll through the internet. It is easy to compare plans. It also reduces administrative costs by reducing the need for marketing, eliminating underwriting, and churning, so that when you change your job, if you have coverage through the exchange, you can go to work for an employer that also permits employees to obtain coverage through the exchange so that you can keep your policy with your employer. The employer to which you switch is responsible for the payment.

But how does a public health insurance plan offered through the exchange affect these dynamics? It broadens the foundation for rapid implementation of innovative payment and system reforms, which results in a slower growth in employer premiums. It provides a less expensive way to cover the uninsured, lower administrative costs, and therefore

lower the federal budget costs.

It expands coverage and choice and continuity. You can be sure there is always an option available. You don't have to worry about private plans pulling out of a geographic area. And it ensures that markets work in the public interest.

In many areas there are only two large insurers. In many areas there is only one hospital or one large health system. For example, in all but three states, two of the largest health plans control 50-percent or more of the enrollment.

The benefits in the public health insurance plan are modeled on the Blue Cross/Blue Shield standard option of federal employees.

Most importantly, creating the exchange would reduce administrative costs, particularly for individuals in small businesses. Right now, administrative costs for individuals in individual market are 41-percent of the premium; for small businesses anywhere from 20 to 35-percent of the premium.

In fact, overall administrative expenses are much higher for those in the small group and individual market. But even with large companies,

the top five companies, 17-percent of the premium goes for administrative overhead and profits; much higher than the rates we experienced with public programs such as Medicare and Medicaid.

What is the effect of those advantages on premiums offered through the exchange? The public health insurance plan that offers coverage that pays providers at Medicare rates would provide family coverage at roughly $9,000 a year, according to estimates prepared for the Commonwealth Fund by the Lewin Group. Without that advantage, for the current small firms with average enrollees, the benefits in Blue Cross/Blue Shield standard option would be $10,800.

There are intermediate options. If a public plan were to pay at the same rates as commercial insurers, the premium would still drop by $1,000 per family, from $10,800 to $9,800, as a result of the administrative savings. And it would fall further by another $900 if it were built on Medicare's payment rates.

What difference does that make for total health spending? With the public health insurance plan offered through the exchange, the cumulative

savings in total health spending over the period from 2010 to 2020 would be $3 trillion.

If this public health insurance plan were offered only to small businesses, there would be savings, but 1.5 trillion. But without a public health insurance plan, the savings to the health system from the various payment and system reforms included in this overall proposal would be about three quarters of a trillion dollars, substantially less relief.

Not surprisingly as a result, the effect on major payers, on employers, on federal government would be quite different between an exchange with the public health insurance plan and without such an option; not only to total health system spending. Savings decline, and without a public health insurance plan, the cost to the federal budget goes up from about 600 billion over that period of time to 1.1 trillion. The savings to employers of 230 billion with a public health insurance plan, in fact turn into a net cost of about $900 billion.

So it sketches out at least one practical, pragmatic way of achieving the goals of health reform; coverage for everyone, savings to the health

system, slowing the rate of increase in health care costs from 6.7-percent a year to 5.5-percent a year, easing the financial burdens on households by about $2 trillion--in fact about $2,300 per family in the year 2020, significant savings to employers and substantially lowers the federal budget costs. Thank you.

Ed Howard: Thanks very much, Karen. Next we will hear from Karen Ignagni, who is President and CEO of America's Health Insurance Plans, AHIP, whose members are the private health insurance plans that would have to compete with this new public option, whatever it looks like. Karen has been at AHIP, and one of its predecessors since 1993. I didn't realize that.

Karen Ignagni: Do you have to sound so shocked when you say that?

Ed Howard: She was very young when she did that. And when she was even younger, she directed the AFL CIO's Department of Employee Benefits. She was a professional staff member of what is now the Senate

Health Committee. She worked at the Committee for National Health Insurance, which a lot of us had forgotten. And we are very glad to have you here with us today.

Karen Ignagni: Thank you, Ed. Good afternoon, everyone. For those of you who are either current or former Hill staff, I am in the latter category, as Ed just said. Sitting on this side of the desk is just simply weird. I will just not be stopped by that. But I want to thank Ed and the Alliance for the opportunity to participate on this very distinguished panel.

I think the Alliance does fantastic work, and always adds to the body of information that all of you need on Capitol Hill, and for those of you who are off the Hill need to wade through these difficult policy questions.

I think the central policy question that underlies this discussion is what should be the role of government. And in wrestling with that, what we have tried to do, and I have gotten a great deal of help from my colleagues--some of them are here--I want to thank them for that. We tried to look at

this question of role of government through the prism of, if we were in your shoes, what would we like to know? And just as Karen did in her excellent presentation, I would like to make just some level-setting remarks.

We have a hundred years of trying to enact health care reform in this country, so for our community we hope this is the year that after a century, we are actually going to achieve health care reform. And it's with that commitment and that hope that we have worked very hard in our industry to put on the table a series of bold recommendations that would fundamentally change the way the market works today. And I'm going to talk about that.

And I think that the reason we need to do it this year is not only for social reform purposes-- which history is replete with all sorts of articles about the importance of getting everybody covered--but also for economic reasons. And I suspect we will talk a great deal about that.

So what are we trying to achieve? We are trying to get everybody in, and we are trying to improve quality, safety, affordability, and effectiveness.

And what have we done so far? This is where I would like to begin. No one in our community is advocating the status quo. I hope you have heard that. I hope you have seen that. And I hope that you have had an opportunity to look at the specific proposals. They are basically in five buckets. From bending the cost curve all the way through changing the market, covering everyone, and improving quality and value.

And with the last bin of improving quality and value, the policy question that all of you are wrestling with is how do you get to, and how do we as a country best get to this 21st century health care system that we want? Is it through what we have now in the traditional Medicare program? Is it through what we have now in the private sector systems? Or is it through a combination?

And I am going to talk a little bit about how we answer that question. I want to also, though, beat the dead horse about fundamentally changing the way the market works, in terms of the proposals we have offered. I will talk about them very specifically in a moment.

But to go back, there is a reason that the

market works the way it does. With the exception of Massachusetts, we did not as a nation pass a policy where there was personal responsibility for everyone to be in. So health insurance grew up the way auto insurance and life insurance and other kinds of insurance products did.

So many of you have queried, why do we have pre-existing conditions? Why do we have health status rating? To simply answer that question, we have a system where if you are not in the employer sector, being offered insurance, if you are purchasing on your own, then what happens basically is you have every incentive to stay out of the system until you need it. That pushes up the cost for everyone else.

So as we have laid out our recommendations, this issue of personal responsibility is fundamental to addressing those issues that everyone in this room, I believe, wants to be addressed.

Now, the next policy question is what is the architecture that best meets these objectives? And the first point really captures it all. What is the best blend and where do you put the fulcrum between public and private? I think that it is very

useful--and I suspect we will talk about this in questions--to talk about the FEHBP as a model, which is not a public sector plan. It is a very aggressive regulation with private sector competition. Or look at a number of the European systems, which work exactly that way.

Okay. So how do we compare design choices? I want to just say a couple of things about this slide. First, what is the best way to get to cost containment? Clearly, a policy choice, as Karen very effectively laid out, is to work on a public program. More and more people would be driven there. I think the Commonwealth Fund has done an excellent report which demonstrates that. I think that there would be very little left of a private market if that were the case, because of the amount of cost shifting now in the system.

And if you doubt the amount of cost shifting, for any of you who are interested in the policy issues, just take a look. You do not have to take a look at any of the speculative studies. Go on the OSHPD data site in the state of California, has the best data system in the country. You can actually look by category of payer, and what the

payers are paying.

And so Medicare is paying on average 80-percent. Private sector is paying anywhere from 130 to 150-percent. If we drive to Medicare payment system, whatever you think about efficiency of what is going on inside hospitals, now you have to, I think, recognize that would be a tremendous shock to the system that we have now.

We have actually now gone beyond and looked at what would happen if most of the hospitals in California [drove toward a Medicare payment system]. Again, that's the best place to get data. If we do nothing in health care reform, we should have a data system like California in every state, so we can see what is going on. It would be a complete shock to the hospitals. And the major flagship hospitals would be losing a very significant amount of money. And there is a great deal of doubt about whether they survive. That is an issue I think we need to talk about.

Also, if we are able to make the market changes through health care reform that we have proposed, the question is do we need a public program, and is the presence of a public program

going to make it difficult to actually have that level playing field for competition?

In terms of keeping the plan you like, I think it is going to be very hard to sustain employer coverage. I think that goes on to the federal budget, and somehow begins to get accounted for in the budget. The administrative savings I am going to talk about in a moment.

What I would like to say about this slide is, in the interest of time, just a couple of things. I talked about the provider effect, which I think is something worth considering. And is there another course? I believe there is. And I will talk about that in a moment.

But in terms of the federal budget, if we were to have a public program that worked on Medicare rates, and if the benefit package were significantly above what most employers are providing, there are two things that would have to happen.

There would have to be a very aggressive maintenance of effort provision on private employers, which I think in this economy, is going to be very difficult. And two, there would have to

be a significant increase in the amount of subsidies to employers that are now providing benefits. So we have to walk through that as well.

In terms of individuals and families, I think that there is a way to provide more competition than less with respect to health care reform, and have a portal that exists in each state through which individuals can find out all the coverage options that are available to them. That does not exist today. The only place it does is Massachusetts, and it is working very well. They have paved the way for a very effective, competitive level playing field.

The next slide is, and you can read it in your package, the things that are going on in the private sector, where we are in the public sector, and how do we get from A to B? Could we do better in column 1? Yes. But it is very difficult to get through the politics of doing the kinds of things that we are doing now in the private sector in terms of disease management, care coordination, dealing with re-admission rates and things that are important to folks.

And we have provided some data. These are

looking at discharges, apples to apples, AHRQ data, in California. We are going to be looking at other states that show the efficiency of the private sector there in terms of particularly what we are doing on disease management, reduction in days and re-admissions.

This is a comparison of more specific kinds of achievements. I will say more about that. These are still unpublished data, but Jeff Lemieux, the Chair of our Policy Center, was comfortable enough with our using this. And he is hoping to publish these data very soon. These are new data with respect to the effectiveness of private sector strategies.

Finally, administrative costs; if we look at apples to apples, if the government were to take on the kinds of strategies that we are now implementing, and if we had to do an apples to apples comparison, all of these issues would be included in administrative costs.

What we've seen now are very thoughtful pieces that zero in on only one part of the administrative load, which is the paying of claims. On the pure paying of claims, our payment of claims

percent is equivalent to Medicare. We do all these other things. And so that would be a policy issue that I know we will talk about in questions.

Finally, to end, cost containment; it is the most important thing that the nation needs to take on. President Obama is right that the nation is being choked by health care costs.

We think there is a better way than moving to a public system or program that moves a massive amount of people in, and actually pays Medicare rates. We think it could be better for the system, better for providers, better for consumers, and I'm looking forward to questions to talk more about that. Thank you.

Ed Howard: Great. Thank you, Karen. Now, we turn to John Holahan. He is the Director of the Health Policy Research Center at the Urban Institute. He has developed lots of proposals over the years for broad health system reform, most recently in Massachusetts as an example. And he co-authored a very thoughtful paper on the public plan option that is in your packets.

I am pleased to say that John is not a

first-time panelist either for our seminars. And we are glad to have you back, John.

John Holahan: Thank you, Ed. A public plan, a necessary part of health reform? And I think the answer is yes. But I do not think it is part of a secret plot to destroy the insurance industry and bring about a single payer system. So I apologize to anyone who was hoping that was what this is all about.

I think the argument is that we really do need to reduce the rate of growth in health care spending. And a lot of those problems I think are caused by the increased concentration in insurance and hospital markets that we have seen in recent years.

Obviously, cost containment is necessary to make health reform affordable, particularly in making low income subsidies affordable. And if you look at the two huge volumes that CBO put together recently, it is pretty hard to be optimistic about most of the other alternative strategies for containing costs. So to me it's hard to see the alternative to a strong public buyer.

A public plan would also help assure access for those with serious health issues. But that is not the focus of what I want to talk about today.

They said something about the evidence on market concentration. There is a growing literature here in insurance markets. Three or fewer insurers account for 65-percent of the commercial market in 2003. Thirty-four states are considered highly concentrated by the standards of the FTC or the Department of Justice.

Hospital markets, 88-percent. I recently saw a number, 93-percent. Our large metropolitan areas are highly concentrated, from a 2006 study. And then there is a bunch of studies that show the concentration has contributed to higher hospital cost and increased profitability, and that those rates are higher the more concentrated these markets are. And it goes up from anywhere from five to 40-percent above.

And the dynamic here is that competition really is just not working in the large number of markets. And markets are different all over the country for hospitals and specialists. So there is no one argument that one could make that would apply

everywhere.

But we all know that effective competition requires many competitors on both sides of the market. And that just simply is fading away.

For one, when there is little concentration among insurers, but there is a dominant hospital system, there is little ability for those insurers to negotiate. When there is a dominant insurer, they do better with discounts. But they really still do not have much leverage over the dominant systems, and often those systems are led by teaching hospitals.

And in some markets, some insurers have no real incentive to be tough negotiators, because they themselves don't have tough real competitors. And the smaller insurers are content to shadow price and go after good risk.

The final thing is there is no real competition in many hospital markets, because the smaller hospital simply can't compete with the dominant hospital systems. Insurers are even limited here because if they really go after and really use the market power that they do have with respect to the smaller insurers, they end up putting

all of the competitors of the dominant systems out of business.

So we are really in a bind here. Without effective competition and strong inside power, we just have growing health care costs, medical arms race, and growth and cost of GDP plus 2-percent that we all know we can't sustain.

So I think the problem is that there is a lack of counter billing power. Maybe there are other ways to get there, but I think one way for sure is a public plan.

Let me say what I think this looks like, and I'll go fast because I think this has been said already by Karen Davis. I see [the public option] as a national plan that would compete in local or regional exchanges, that would have the same insurance market rules faced by private plans, and the same required benefits. Government subsidies would be tied to a mix of the lowest-cost plans in the market, not necessarily the public plan.

You would kind of use the Medicare administrative structure, the public rule making, Medicare's advances in payment systems. But it would be different benefits, and clearly a different risk

pool.

You would have MedPAC oversight, which I think is essential to this. And hopefully, you would have more effective care management than we have seen.

A new administrative cost issue; I think I agree with Karen Ignagni that this is often overstated. I think there are differences, but not as much. They are not going to be huge. Some of the studies have not adjusted the fact, for example, that Medicare has larger claims, and oftentimes all of the government costs don't show up in these studies. But those that have controlled for them, one particular done by CBO finds differences of six to 11-percent in administrative costs.

But that's not the end of it. The public plan, unlike Medicare, would have a lot more roles to play within an exchange. Private plans will probably have fewer. And if you have true insurance market reform, there would be no need for underwriting, which is expensive for private plans.

So I think that these gaps were closed. But I think they would still be there. Would the plan use Medicare payment rates? I don't think they

would. I mean, I think it would be way too disruptive to drop rates for doctors and hospitals by 30-percent overall. It just would not happen. No responsible body would let that happen. But they can drop a lot and still have a major impact on health care costs that we see today.

I am going to say something about the arguments against the public plan. One is that the public plan is always favored. I think you look at Medicare Advantage plans and where they are in terms of rates on a risk adjusted basis, and it is kind of hard to say that it is guaranteed that the public plan would be favored.

It is argued that the private plans have to maintain reserves, have to pay taxes. I think it should be built into the public plan rates, the money that would be required to build up a comparable level of reserves. Clearly FEHBP plan to my knowledge did not pay taxes. I think that could be arranged.

I think the issues that probably remain, and you worry about a level playing field, are ones that probably go against the public plan. They are probably going to get to higher risk. It is going

to be hard to adjust for that in rates. They are probably going to have to be in every market, whereas, private competitors would not have to be. So those are some comments there.

On the misuse of monopsony power, I think that is a real big concern. If the system does not pay well enough, it could lead to access in quality problems. And that is a big issue. But I think there are constraints on that.

First, MedPAC now monitors the effects of Medicare policies on hospitals and physicians, on access to care, on quality, access to capital markets, and so forth.

Second, providers do and will lobby the Congress if rates are unfairly reduced.

And third, if you have a competing set of private plans and public plans, people can go to private plans if they do not have the access that they want, so that there is a real constraint on the overuse of government power.

A point about the cost shifting issue; the idea here is the public plans will lower rates. That will force private plans to have to raise them. There is another alternative, and that is that

hospitals will simply have to reduce their costs.

MedPAC has a really interesting analysis of this recently. What they showed was that if where insurers have a lot of market power relative to hospitals, there is more financial pressure put on those hospitals, and hospital costs are lower.

When hospitals have strong market power, relative to the insurers, the opposite happens. Private payments are higher. Hospital costs go up. And I think the lesson here is that cost shifting occurs when there are weak payers and strong providers. And that, I think, if the market power shifts towards strong public buyer and fewer private insurers that have more market power because there are fewer of them, then whether hospitals can then at that point shift cost or lower cost to where we get health care costs under some control, I think is enhanced.

So let me argue the last thing. And that is that private insurance plans are not going to go away. They will survive. First, the public plan won't use all the potential market power that it has for reasons that I have already argued. It is MedPAC advising Congress, and studying the impact of

public rates on the system, provider lobbying, the impact to leave the public plan if you are an enrollee.

Second, private plans are probably more effective, as Karen Ignagni said. Managing utilization, they have really led in disease management programs. And she put up a lot of data that showed they really do well. I do not know that study well, but it is California. It could be a Kaiser effect. I do not know how they adjusted for risk, but the findings are stunning. So it is hard to imagine that private plans could not compete, given that management ability.

So I think the private plans are likely to provide maybe better service, or if they do, let's put it that way. If they provide better service and better access to the somewhat higher cost, I think a lot of people are going to want to be in them. They will not go away.

And then a lot of the data assumes that they do not respond. And these private insurers do not become more aggressive in the way they negotiate with providers, and in the way they manage care. I think there will be an insurer response. So this

30-percent differential between private and public is just not going to be there. It is not going to be that big of a difference. And access to private plans that will offer more, I think will be in the end attractive to people.

So to wrap it up in a few seconds here, number one, the public plan, for reasons that I have said, is not going to end the private insurance market. It will stay strong. It will be more effective than it is today. It will not get by by cherry-picking risks. It will do better at managing care and weigh it as providers.

The competition for private plans is important in the way it will affect public plans that will avoid or limit the excess use of market power by the public plan. People simply will go elsewhere if they want to.

And finally, the public plan is not a panacea. It is not all that we need to do. We need to worry about primary care doctors, medical homes, managing high cost patients, and so on. But I think if we are serious about cost containment, this has to be part of the deal. And I will end there.

Ed Howard: Great. Thank you, John. We will pass the clicker from far right to far left. I love that, from our point of view.

Our final speaker is Stuart Butler, who is the Vice President of Domestic and Economic Policy Studies at the Heritage Foundation, where he has been since 1979. How about that?

He has thought and written about the idea of a public plan, as you can see from the materials in your kits, and manages to speak English and economics on that topic at the same time. It is just amazing. Stuart, thanks for being with us.

Stuart Butler: Thank you very much. And indeed I have been working on this issue of health care for indeed 30 years, since the Carter administration.

Now I must say that I think this time around, compared with a lot of previous periods, particularly during the Clinton administration, this has been a remarkably positive and collegial process of actually trying to figure out how to do this with a strong commitment of people across the spectrum. But I think it is fair to say that two, what I call nuclear mine fields, have been encountered in recent

weeks.

One is the whole idea of a very strong, federal health board that would determine in some way precisely what services would be provided. Fortunately, that has been avoided for now, at least been reduced in its importance.

But the second is this idea of a government sponsored plan competing with the private plans in a government sponsored competition. And in my view, if that is part of the final package that goes to the hill, then I believe over time that government sponsored plan will be the coverage.

And if this persists in trying to argue this, to put forward this public plan as a central part of the final legislation, I really do believe it will break up the coalition that would otherwise achieve real change in this country. And it is not just me. If you actually look at the Washington Post this morning in its editorial, let me just quote from it. It said, "the fixation on a public plan is bizarre and counterproductive. It would be a huge mistake for the left to torpedo reform over this question." And I strongly agree with that.

Let me just point out the basic problem

that the public plan is supposed to fix, and it is really sort of three issues in a way. One is only by having a public plan, may people argue, can you deal with the problem with high cost or lowering populations that have particular needs.

But of course we have been spending a lot of the time, a lot of effort, in joint discussions and so on, to deal with precisely that issue. And we made a lot of progress in terms of looking at risk adjustments, reinsurance, guaranteed issue, and so on, as ways of dealing with that.

The second argument is essentially that you have got to build up public confidence in some way to have competition, and that people are afraid of a public system of competitive plans, unless there is a public plan there. And I will talk about that in a moment a little bit more.

And then the idea that we have got a widened choice, and that a public plan is kind of crucial to this public choice, to the choice in the system, because only a lean, efficient, government plan can force and shake up these flabby AHIP members that Karen Ignagni represents. And that is what is really needed to sort of boost up the

system, as I put it.

Well, let us look at the different versions of this. I think there are two broad versions. The first is what you might call the aggressive Medicare like competitor, that by the use of lower payment rates by really aggressively getting costs under control, that this will really force other competitors to pay likewise. Now, you have heard the arguments against that in terms of the effect of cost shifting and what this really means.

There is also the argument that there are inherent lower administrative costs in a public plan, and that this is an inherent advantage that clearly is necessary as a choice. John Holahan discussed that. I will not spend much time talking about this right now.

But I must say that it seems to me that anybody can get overhead costs down if you run a plan and you do not actually have to advertise it, as is the case in Medicare, because you have the market. You do not do a whole lot about fraud, which Medicare does not really do. You do not have to build up networks of cost effective doctors, and you do not have to worry about reserves or $36

trillion unfunded obligation.

If you do not have to do any of that, you can actually keep your overhead down pretty well, I think.

So let us not be naïve that an idea of a public plan of this variety is to build up, to over time, become the larger and larger offering, and to essentially dominate the market. And if you look carefully at what Karen and others write, that is essentially what they foresee is what the Lewin Group shows in its analysis and so on.

Then there is another version which has just come up more recently by my good friend Len Nichols and John Bertko, what I call the good cop version. And this is really your sort of friendly public plan, sort of one of the guys, and really just the same as everything else, and really no different from a private plan.

It is a little bit like in my view sort of bringing a three week-old tiger cub to your apartment as a pet, and just saying, well, look how nice it is. Really over time, it is not going to be a problem for anybody. So get with the program.

In other words, the idea of keeping people

comfortable by having something really that is almost identical to a private plan. And under this arrangement, this version of the public plan, there would be no fixed payment rates, have the same rules, no special financial arrangements. Technically, only, it would be a government plan, really just for show, if you like, or to make people feel better.

Let me just look at this a little bit more. The common theme behind both of these versions is the idea that a public and private plan will compete on a true, level playing field. For you to believe that, you have got to believe, in my view, that people like Pete Stark and Henry Waxman and others in Congress, will do nothing to stack the deck in favor of this public plan. They will just sit back and let the chips sort of fall as they will. And they will do nothing to advantage the public plan, in my view.

If you take that view, if you believe that, you are probably the kind of person who believes professional wrestling is real. And I certainly do not.

Because the essential dilemma, really, in

all of these approaches to a public plan, is that if you have exactly the same rules, if it's operated in an identical version as the private plans, then why have it? Unless you just assume that government manages are inherently more efficient. But if you have different rules, then you really can not avoid the deck being stacked in some way.

Let me just look a little bit at this argument that you really do need a public plan to make people feel better about dealing with competition. And this is just actually, I have taken this slide literally from the CalPERS site, where it just sort of shows how in the case of the choices in California for state employees, like pretty much state employees anywhere, there really is not any mention of the fact that one of these plans is a self-insured plan through the state.

In other words, the public plan itself is not used to in any way to calm anybody down. It does not seem to be necessary for state employees. In the federal employee program, you do not have a public plan. In other words, federal employees do not seem to feel it necessary to have this public plan to feel comfortable about an exchange with

competing plans.

Uwe Reinhardt, in his piece in the package, points out that in the German system, in the Swiss system, in the Dutch system, in none of these where they have large exchanges do they actually have public plans. So I think there are a couple of lessons for this.

First of all people do not need a public plan to feel comfortable at competition. And the key is setting the rule, setting the over arching rules of competition for an exchange. That is what is important to focus on. That is what they do in the FEHBP. That is what they do in these foreign examples, and so on. That is the critical thing; not having a public plan in the competition itself.

And there are some very specific issues associated with this idea of a level playing field. It assumes a wall of separation between the government running the competition and the government running the public plan. And as Nichols points out, that would require some very specific things to be put into place for that to happen.

I made a mistake. He is on the penultimate one. There must be no systematic cost shifting.

And it really does take in my view a staggering leap of faith to assume that the congress and the United States government will somehow operate like a sort of benign umpire in the system, when it actually is also a team owner, and that will allow its team to basically just either win or lose, depending on how the situation turns out.

And there are various ways in which the level playing field can be very much altered. Indeed in Karen's piece on this, in terms of the way in Medicare extra system will operate. If you make that public plan a default option, which she does, and which Jacob Hacker does in his proposal, like an auto enrollment. If you don't decide, you are in the public plan.

Well, anyone who has looked at auto enrollment in the pension system, or knows anyone about Hagel economics, knows that gives a massive advantage to the public plan. We also see that if you give employers an option of simply just dropping people into a public plan, if it is cheaper for them, as the Lewin analysis shows you, you can very quickly rack up huge increases in the public plan.

So there are various ways of altering in

very subtle ways the rules to favor the public plan. And that is why I think that it is so critically important that this is the case.

And let me just end by just pointing out that if you look at other ways of trying to achieve the objectives that are purported to be for the public plan, there are many ways to do that. In particular, by looking at the FEHBP model and exchange, Mr. Obama said that is really what he wants to focus his proposal on. And that is good. And it is important to recognize some things about it, and how it could be a model, and how it could be improved.

There is no public plan, I repeat again, in the FEHBP. The government does, however, negotiate with certain private plans to provide coverage on a national basis. That could be improved by allowing the governments to negotiate on a state basis more refined versions of that national plan. But that is how they achieve the idea of some kind of safe harbor arrangement.

You can also look at changing the exchange system, again to look at ways of doing it on the state level to make it improve. So there are

various ways I think of achieving the objectives that are stated to be for a public plan, without all these dangers that are inherent in the fact you would not get a level playing field.

So just to end, I think it is very important that we get back to the collegial process that has been making such progress, and do not torpedo that potential progress and success by pushing this idea of a public plan option. Thank you.

Ed Howard: Well, I think we have unanimity here on the panel. [Laughter]. So there ought to be no problem in settling the policy dispute. Now you get a chance to enter into the dialogue.

There are, as I pointed out, green question cards. You can write a question there, hold it up, and hand it to whoever is holding up those green cards now. And they will get them up here. There are microphones up here for those of you in a position to squeeze through those narrow aisles and get to them.

There were some questions in advance. Let me just start as those are being collated and you

are finding your way to the front, with one or two of those.

Questioner asks, or says, Medicare costs are well below those of private insurance in most parts of the country, but isn't that because of Medicare being so big it can set prices but not negotiate them? And if that's true, won't the addition of the public plan, using Medicare rates, make government a thousand pound gorilla instead of an 800 pound gorilla?

I guess the first question is how you deal with the question of whether or not the public plan uses Medicare rates. Karen, you assume that it did. John, I heard you say something a little different.

Karen Davis: Well, just to clarify, I understand there are no 800 pound gorillas, that in fact, they only weigh about 300. [Laughter].

Obviously, one could have a variety of options, with both the process and the level for setting the rates. I think the first thing to understand is that this is in the context of paying providers to cover the uninsured. It is in the context of bringing Medicaid up to Medicare rates.

So those are huge infusions of no revenues to providers.

The particular proposal we have--which pays into the public health insurance plan at public rates--is phased in gradually over time. It starts with small business under a hundred employees and individuals. And as a result, while there is some shifting from small business private coverage to the public health insurance plan, in fact provider revenues go up because of this new infusion of money for the uninsured, and for bringing up Medicaid rates. It is really only in out rate years that provider revenues go up more slowly than they otherwise would have.

But over the period of 2010 to 2020, provider revenues go up by 73-percent. So there is not a 20-percent reduction in the level of provider payment. Now, obviously, there are various ways one could do that. Within that proposal, we assumed that the public health insurance plan would pay with a new innovative payment method, a bundle method, with the level approximately where Medicare is.

One could set it at the mid-point between commercial rates and public plan rates. In that

case, provider revenues always are higher than they otherwise would have been under the current system.

So it isn't implementing this in a way that leads to financial instability in the industry, as John Holahan said. You would want a process like the MedPAC process, looking every year at those levels and at the economic situation in the provider community, and making a judgment of what would ensure access to care and financially strong institutions, without overpayment.

The final compromise of course is that one could have everybody paying at the same rate. In other words, extend to private payers the payment rate of the public health insurance plan. And again, when you think about it over time, you could do that by slowing the rate of increase in private payer rates, so that they would then over time narrow the differentials that would exist between private provider payment rates and Medicare.

Ed Howard: Karen?

Karen Ignagni: Just to – oh, I am sorry, John, did you want to jump in? Go right ahead.

John Holahan: I just want to add I think what is complicated about this is that I do not think anybody can say where you set those rates. I think you can easily set them below the average of the private sector now.

People would worry, and it would have to be done with great care. But I think the ability to save money and to reduce the rate of growth over time, would clearly be present.

The other thing that is really important is that I really do believe that we would have a private insurer response that would bring down what they pay as well. I think you can get as much savings out of that as you are going to get out of the lower Medicare rates. So I think that is important to keep that in mind.

Karen Ignagni: I just want to make a comment on Ed's question. But listening, I hope you all have the same reaction. I think the panelists have really been – I've enjoyed listening to my colleague's presentations. With the exception of the session that Karen and I did with you up in

Baltimore, Ed; you rarely get an opportunity to have this kind of deep dive into the policy issues. So whatever your model is, you should model it. It is very, very important to have this kind of discussion.

I think the underlying question that we are wrestling with is how do you deal with bending the cost curve, and how do you best deal with the trend issue? And CBO has projected the trend. With the actuary's new numbers, it is a 6.2 on average rate of increase annually, on average over 10 years.

So how do you get that down? We agree with Karen's numbers in the Commonwealth report in terms of the impact that taking the slope of that curve down, you could free up $3 trillion. And then the question is how do you do it?

For us, as we look at the implications on the whole risk management side, the quality improvement, and the safety side, I think there are a couple of things that really stand out. How can we pay for episodes of care so that the anesthesiologist and the individual actually providing surgery are not billing separately. We have unbundled care now, so how do we deal with

episodes? We are beginning to make some real strides in the private sector there. I think that offers real promise.

How do we improve primary care? Part of it is medical homes, yes. We were doing it 10 years ago. It was called capitation. Nobody likes to use that term. But essentially that is what medical homes are, giving primary care physicians a real incentive.

We are doing that now in Medicare Advantage. We are paying more than traditional Medicare, and we are seeing real results. But there are other parts of improving primary care in terms of nurses and other health practitioners, in which we are seeing dramatic results.

So that would lead you to a scope-of-practice law discussion, because in some areas nurses and other practitioners cannot actually provide the kind of services that could be very integral here, particularly in very rural areas and areas that are underserved where we have particular disparities, etcetera.

How do we deal with readmissions? We now have some very – I'm not talking about just what we

have put on the screen here, NCQA is capturing these data as well - in terms of what we are doing on readmissions, working collaboratively with hospitals. Those are just a couple of things.

So the question is: will we bend the cost curve by exclusively dealing with an administered pricing system? How do we get that balance in terms of taking down unit costs, but at the same time really driving toward those 21st century models that I think we are all struggling for.

In the health plan community, we have learned a great deal in the sense that it is no longer clerk-to-physicians looking at these issues. In the management of radiology, for example, it's physician-to-physician, using specialty society guidelines.

So there have been a lot of advances over the last 10 years--or the last time we actually had this policy issue--which I think is very important to bring into this conversation of how you best get to this vision that we all have.

Stuart Butler: I have a quick comment. I think this issue of Medicare payment rates and its impact

on the private plan is very important. And as Karen said, one way you could envision theoretically a level playing field, as she said, is to extend the public payment rates to the private sector. That is precisely the problem; that when you set up this kind of situation, sometimes the only way to achieve the apparent fairness is in fact to extend the very rules and the same price controls into the private sector. That is precisely what I believe would eventually happen.

Ed Howard: All right. We have a couple of questioners at the microphones, and we will start here and then go to my right.

Russel Mokiber[Inaudible]: John Holahan said that –

Ed Howard: Do you mind identifying your self?

Russell Mokiber[Inaudible]: Yes. Russell Mokiber[inaudible]. John Holahan said that he is not part of a secret plot to destroy the private insurance industry. There is actually a public plot to destroy the private insurance industry. It is

called HR676 single payer. And it has 76 members of the House who support it. I believe the Lewin Group did a side-by-side analysis of all the plans currently floating in Congress, and they found that it saves the most money. It is Medicare for all.

I think the idea is that the private health insurance industry deserves to be destroyed, because like in Canada and the UK it is unlawful to sell private health insurance for basic health needs. So that is the idea behind single payer. And my question to the panel is, other than the fact that it would give the death penalty to Ms. Ignagni's companies, why not do it?

Karen Davis: Well, let me leap to the defense of a mixed public/private system. I do think that offering both private plans and a public health insurance plan creates the opportunity for both to bring the strengths that they have to offer.

A private plan, as Stuart mentioned, can have flexibility about setting up networks of providers. It is very hard for a public health insurance plan to exclude certain hospitals, exclude certain physicians, even if they are not prudent

users of resources. They tend to be included, because of the political pressures.

Karen had a slide of the various kinds of utilization management techniques that private plans use; again it is very hard for public plans to do that. Public plans have the advantage of lower administrative costs. They have the advantage of economy of scale, land purchasing and leverage as a result of that.

In this we are talking about new methods of payment. And I think Karen and I are in agreement on that, of win-win solutions that bundle payment over a certain portion of care. I would not call it capitation, but you might call it partial capitation. It might be a global fee for primary care in the case of physician practices, [or it] might be a global fee for hospital episodes of care that cover all care for 30 days.

But the great advantage of that is that you give a reward to providers--whether those are physician practices or hospitals--that if they prevent hospital readmissions, they will share in those savings.

If it is a physician practice acting as a

medical home--if they control those chronic conditions and prevent hospital admissions, they can share in those savings. So I think to really have competition--a value-added competition about innovation in payment, [then] innovation in working with providers to have win-win for patients yields the best possible result.

I think when you do not have a choice, people get lazy and do not look for new ways of competing and adding value. I think in fact one of the problems with the private insurance industry today is because it is so concentrated that you do not have those kinds of incentives.

So I think the challenge of having a public plan will bring out the best in the private insurance industry. Having the choice of going to a private plan if you are dissatisfied with what is available from a public health insurance plan, in fact puts a check on any of those extremes.

Ed Howard: Stuart and then Karen.

Stuart Butler: Yes. Well, I have lived 30 years in the United States. But I have also lived 30

years under a public plan in the UK under the National Health Service. The fact I am here rather than in the UK may be some comment on this.

But the point is that there is an honest argument for a single payer system. If you know what you are getting, if you understand what is involved, if you understand the issues associated with it, and are prepared to make those choices, it may well be the right option. It may well be that another option is the right approach.

But the fact is that we are not having a debate here about one or the other. If we were, that would be fine. If the issue is if you set up this mixed system of a public and private system, together competing, with the government making the rules, is it a stable outcome or will it inevitably go down one direction? And that is the issue.

I do not believe that you can in fact set up a stable outcome of a public plan, just being sort of there, and not being favored by some who discriminated against in some other administrations possibly. I just do not believe it is a stable outcome.

And therefore I think we really ought to

just discuss whether we want a public system or a single payer system. Again, let me just quote from the Post editorial today, which talks about what happens when you start altering rules, favoring and so on.

It says, "such power," in other words the power to make these kinds of changes in rules, "if exercised in a public plan option, eventually would produce a single player system," which is why so many people support it. "If that's where the country wants to go, it should do it explicitly, not by default."

I could not agree more. The problem with what we have in this proposal is that it would get us to that position without actually honestly discussing it and saying, do we really want to go in that direction? That is what my problem is with it.

Ed Howard: Karen?

Karen Ignagni: I was going to go exactly where Stuart did with a bit of a detour.

First a number of our plans have actually been invited to Britain and to Canada to provide

disease management and care coordination, which the government plans there respectively have had difficulty constructing. And it is very exciting what we are seeing. I also think what is very exciting is the fact that you can have national health systems that operate with very aggressive--essentially the analog in our country would be federal regulations that prescribe the rules that Stuart is talking about that make everything very transparent--laying out the rules of the game so there is no inherent advantage of living in state A versus state B.

And that is going to be a challenge here in drafting legislation. But we need to have this regulatory uniformity. It can be executed at the state level, but unless we have that regulatory uniformity, I think that people, our citizens, will not feel that the system is inherently fair.

I think Karen very thoughtfully talked about the other side of the issues in terms of the progress that is being made. So the question is where do we put the fulcrum between public and private? What is the role of government?

And I think unfortunately the question of

public plan, yes or no--the bimodal kind of question--has really taken a little bit of the attention away from this question of how do we set up the rules, where should it be done, what are the intergovernmental relationship questions, which all of you who work on the Hill will struggle mightily with.

I think it is important for maybe the Alliance to have a session on that. I think that is very important, in terms of making sure that we get this right. But I am encouraged by looking at other countries [and by] the FEHBP, that there are models.

But without a doubt, the regulatory system at present here is not adequate. And we need to change it. We need to make it more robust. And that is precisely what we have proposed.

Ed Howard: John?

John Holahan: Just a couple of quick comments. The savings numbers that the person asked the question brought out are just not realistic. I have seen other people who do this kind of modeling make these assumptions about what kinds of savings you could

get from Medicare rates.

It would be such a dramatic impact on hospital and physician system that it would never occur to that degree. So often the savings and the advantage of single payers are so overstated that I would caution you to think about that some more.

Then you were going to what Stuart was saying. I do not think you can predict the outcome of the way this is going to go and how many people will really be in the public plan versus private, [or] that is inevitable that it is all going to be public.

I just do not see that. I think there are too many advantages of having private plans. But Stuart could be right. So I will just stop here. But I do not see how anybody could predict that.

Ed Howard: Yes, go ahead Peter.

Peter McMenamin: Hi, I'm Peter McMenamin, a health economist from Silver Spring and I have been in D.C. for almost 37 years, working on healthcare, at the bite level in some cases.

And I am not personally opposed to a public

plan, but I just do not know how you get there from here. I think the debate right now may be a little premature because they are talking about things that really need to be better articulated, particularly how do you staff it? How do you price it? And who would buy it?

[Regarding] the administrative costs, I agree with many of the commentators--Medicare pays big bills. Twenty percent of the beneficiaries are hospitalized in any one year, less than 10-percent are on the private side. Medicare enrollment typically is one time only; this enrollment, one time only, all the plans are individual plans. For the most part there are no births. They do not have to worry about out-of-state benefits. They cover the country.

There are administrative savings, but they are not going to be as big as many people expect. On the physician side, how do you staff it? The Times, just a couple of weeks ago, had an article about how people are worrying about doctors participating in Medicare.

My research done from HCFA data and private data was that there are an awful lot of doctors who

have a minimal attachment to the program. They may do a couple of thousand dollars in business. And they have a handful of patients, either because of their specialty or because the patients have aged in.

If they are having trouble right now, they could walk away, unless they are given the opportunity of taking a 25-percent across-the-board cut in their private patients who had shifted to a public plan for the same services at lower rates. As John said, I do not think it is going to happen.

The actual premiums might be a little lower, but you are still going to have a family policy about $9,000. Now, if we look at COBRA, where people pay 100-percent plus 2-percent, only 27-percent of the people eligible actually enroll in that.

So unless there was an additional subsidy program on top of this public plan, it is not going to help the uninsured.

Ed Howard: Peter, I know there is a question in there somewhere.

Peter McManaman: Well, I am getting to it.

Ed Howard: That would be good.

Peter McMenamin: The major one, I guess, is that right now, according to Kaiser, 85-percent of the employers who offer employee-based insurance offer one and only one plan. How are you going to deliver it in a setting where there is not a choice right now? And if the only way to do it is in a public forum, won't you have to cash out the benefits, and then all of the presumed savings are going to be taken up in payroll and income taxes?

That is my question. How do you get there without resolving those issues beforehand?

Ed Howard: Karen, do you want to take a crack at that?

Karen Davis: Well, obviously one does have to build some administrative structures, the most important one being a national health insurance exchange. So come back next week for that.

But we have seen in Massachusetts that it

is possible to set up a choice among plans, and it does give people more opportunities than at least half of the working population that now only has a single plan offered to them. But I think we have to do it in a way that is economical. We just, given our current economic situation, can not tolerate waste anywhere in our system. We really have to put a premium on value added.

So [we have] to look at the administrative overhead that is now 14 to 17-percent, and say we can not live with that. We have to get down to under 10-percent. In other countries, that Stuart touted, in Switzerland and the Netherlands, administrative overhead is 5-percent. We simply should not accept it. We could do as well as the best countries in administrative costs, we could save $100 billion a year. And that would be enough to provide the kinds of income-related premium assistance that is going to be required to make a $9,000 premium affordable to a family that only makes $20,000 [or] $30,000 a year.

So overall [we need] framework, choices for everyone, shared financial responsibility, employers contributing to health insurance premiums, income-

related premium assistance, but buying a high value product; one that has little waste, little going for overhead, and that has innovative payment methods that rewards hospitals and physicians for working with patients to manage those conditions. That is the win-win over time.

Karen Ignagni: I just wanted to say a little bit about administrative costs. You made me think about a number of issues that I didn't talk about in the presentation. And so thank you for that. And just a couple of things quickly.

One is that with respect to the overall level of administrative costs, CMS does a very good job in the national health expenditure estimates of tracking this very, very carefully. And it is on average, for the last 25 to 30 years, 12 to 13-percent overall.

In the area of the individual market and the small market it is higher, because the sales and administrative expenses are higher because you are actually going out, trying to find individuals. Brokers play a very important role, not just selling the product. If you talk to the broker community,

particularly, one of their most important features is explaining what various features work for an individual family: the kitchen table test.

As we think about health reform to the extent that we are going to move to a system where each state would have a portal, we should not have them reinventing this in every state. We should have at the federal level a template that gets presented to states, so that they do not have to spend money and a great deal of time doing it, whatever we think is the best way to do it. And Massachusetts I think has done a great deal of work that should be modeled. And I know they have some thoughts on how we even improve that very good system.

But that would allow people what they don't have, particularly the individual in small group market right now. They do not have benefit managers working on their behalf. They would have more information in real time about what is being offered. That is precisely what is going on in Massachusetts.

We think brokers would still play a very important role in this kitchen table test. But we

think costs could come down. We also think--and we have been working with and listening very closely to the provider communities, both doctors as well as hospitals, [about how] there are things that we can all do, starting with our community, to simplify the administrative processes. We are working very diligently. You will be hearing more on that.

But in the European systems, they do not have this very complicated, regulatory system. I was thinking about bringing this slide, and I did not because I did not give it to our colleagues beforehand. But as I was prepping this weekend, we have a slide which shows exactly how we are regulated. And I will give it to Ed. It looks at how each individual product is regulated, and how all of the different products are regulated.

Suffice to say there is no white space on this chart. We are doing things both at the federal government and the state, time and time. There are multiple functions being carried out in multiple places. That is just to encapsulate the problem.

So as we go to health reform, we think, yes, there are things we can definitely do. But I was struck by the point, the thoughtful one that

Karen made. It is an opportunity, not only to challenge our community and others to do better on the issue of administrative simplification. It is also an opportunity to really look at, are we getting value from the current regulatory structure?

And I could make an argument that now it has become so complex, we are not, it is not transparent to anyone. We will have a number of recommendations, but if you want to bring the cost down, those are very, very important issues to look at as well.

Ed Howard: Thank you. A couple of points before we go on; one is I commend the two gentlemen standing at the microphones, because they are certain that their questions are going to get asked. I am not certain that those of you who filled out green cards are going to get your question asked.

So depending on the degree of urgency with which you wrote that card, you may want to shuffle up an aisle and get to a microphone.

And secondly, before you shuffle in, afterwards I would urge you to pull out the blue evaluation form and offer us some feedback on how we

can make these programs better for you.

Yes, go ahead, the gentleman in the suspenders.

Male Speaker: Yes, thank you, Ed. The [inaudible] Kristofferson wrote at both a national single payer approach plan in 1986, and a mixed public/private sector plan in '86. The idea being both approaches can work. We just have to make some decisions, going back to a number of the commentaries.

The second part is I have been a senior scholar for a while at IOM, and decided to sit down and figure out how many different approaches could actually accomplish [covering] everybody and have the access, [constrained] cost, [improved] quality. And after I got to about 17 or 18 different approaches that all would do that, I decided that was probably as many as I needed to do.

So I have been at this for a few years, as a number of my colleagues have as well. My concern here in the discussion is we are now getting very late in the game, not just in terms of decades but in terms of June, July, August, September, and October.

And while I think it is true [that] we are far beyond and far better than we were in 1994, I see in this discussion some discomfort. I see some sort of sense of rather than trying to find that fulcrum point that is appropriate, sort of looking at the worst case scenarios, and to some extent the best case scenarios, both of which are likely to be incorrect, by the way.

The question whether we can design an approach that really is a good mixed-model is really just a testament about how smart we are. And let me tell you one particular case in point, which you sort of touched on in a couple of different cases [that] I want to come back to.

The question is can we create what I would call a fair payment system, which I fooled around with back in the ‘80s on [what] essentially is a single payment system for everybody. It uses the best experience we have had from the private sector [and] public sector; payment levels are the same, essentially. It is done collaboratively between the public and private sectors. And there is a political balance that is built into that, which I know Stuart is worried about, and rightfully so.

So can we go to a fair payment system that really everybody plays by the same rules? And would that be one of the building blocks toward good health reform?

Ed Howard: Go ahead, Stuart and then Karen.

Stuart Butler: I think that the idea that you can set a, quote, "fair payment system"-- which is something that has eluded us for thousands of years--that we can sort of do that within the next few weeks and be really happy with it is just a non-starter.

I mean the idea of using essentially a price control system, which is what you are talking about, to set prices and to use that throughout the system, to conduct one-sixth of the U.S. economy. I think the results will be disastrous. It is as simple as that.

And that is your threshold-sort of consideration. I do think that as the numbers have said this is not a question of saying you do not have government involved in any way in the process. It is the issue of what is the appropriate role.

And I think Karen, myself, and maybe others too sort of feel that the right approach, and actually if you ask only Americans about the role of government in health care, they say we want somebody to have fairness in the system, to make sure it operates fairly, and that everybody plays by the rules.

You have heard this over and over again on this panel. So the idea of saying, let us have the government play that role, through an exchange of some form, I think there is agreement. I think there is agreement across the spectrum, really, among people who have been working on this, about dealing with various pieces of the architecture.

The problem is what we are seeing today; that once you bring in the idea of a public plan that is administered and beholding in some way to a government also setting the rules is inherently unstable, politically unstable. It will not remain like that. Something will change over time.

And that is the problem that we have to deal with. So I think there is a problem with price controls. That is where I do not agree with Karen about migrating these Medicare rules and Medicare pricing in the rest of the system. That is a simple

price control issue. And price control has failed for centuries.

And then the second is the idea of where the government's role is--and you limit it to this setting of the rules. If you get that right, as we see in the FEHBP, as we have seen in most European countries, and so on, then you can have something that people can all agree on.

And that is what we need to be focused on; how we can agree on the end result.

Ed Howard: Karen.

Karen Davis: Well, I think there is a lot to commend a mixed public/private system, and encourage each to do what they do best. First of all, on administering claims, I think everyone agrees that it makes sense to contract with private insurers to do that.

Stuart said there is no public plan in FEHBP. He said it over and over, no public plan in FEHBP. But truthfully, the federal government does contract with a private insurer, pays them an administrative services fee, but self-insures for

that coverage. And the government holds the reserves. And that is the Blue Cross/Blue Shield standard option. You could call that a public plan.

It is not underwritten. It is not [for]-profit. It is paying the claims they are paid in administrative services fee. But they also use their own provider payment rates. So that is a separate issue.

I think the second thing which we agree is the need to move to innovative payment methods. If we are just talking about fee for service, we are not going to succeed, whether that is private plans or public plans.

I think the third thing that we agree on is the importance of expanding and letting thrive the private integrated delivery systems and regional plans that Karen and her slides show in California, which is dominated, I would assume, by Kaiser Permanente. But in other areas by regional plans, that when you have a health system, when you own a hospital, when you have physicians who work in that, when you have systems of care, electronic health records, quality improvement units, innovation units, you can achieve those kinds of savings.

So those competing on that basis I think we could all agree on. In fact, if we look at the Medicare experience with bids, and you are talking about HMOs that have these kinds of systems, their bid is 98-percent of Medicare fee for service cost. Those kinds of private plans can compete.

But the final point has to do with Stu's harping on administered prices. The truth of the matter is the private fee-for-service plans, and the dominant commercial insurers that do not represent health care delivery system, use Medicare's payment system to pay physicians.

They may pay at a higher level, but they have used the resource base relative value schedule in Medicare. So if Medicare leads, develops new innovative payment methods, it is likely that private plans will follow that. The only question is whether we have a sensible process for getting a reasonable rate, not the method.

Ed Howard: Karen, let me just follow up if you will bear with me just a second. I have heard, having been privileged to sit in on a few meetings of the Commission on a High Performance Health System, some

of the members talk about the need of the public plan option as a way of extending whatever payment reforms that Medicare puts in place. And they point to the RBRVS. They point to the DRG system. Is that a big deal? Is that a big part of the savings that you show on your slides?

Karen Davis: Absolutely. Again Karen and I agree that we ought to slow the rate of increase from roughly 6.5-percent to 5.5-percent. We ought to get one percentage point savings over time. And that is what gets you the $3 trillion over time.

It is just that we have laid out a plan for getting there. Karen has a chart, but not a plan; a goal, but not a plan. And one of the big advantages of having a public health insurance plan offered through a national health insurance exchange, it would be to charge that plan with using these types of innovative methods that can slow the rate of increase over time, because they are achieving savings from reduced complications, better control of chronic conditions, shorter lengths of stay, fewer readmissions, and sharing those savings between the payer and the provider. It is that type

of mechanism that a public health insurance plan would introduce into the system.

Ed Howard: And I have got to give Karen Ignagni the chance to reveal her plan right now.

Karen Ignagni: Yes, I would never have the temerity to come up in front of this important group and have a chart without a plan.

But you are right. I did not get a chance to talk about it, because I ran out of time. It is the Italian in me. I am sorry. I ended up talking too much about previous slides. I will do it very, very quickly.

The plan is the following, and it is radical. So let me say that just at the outset. The idea is we have tried this, and Gary made a very good point. We tried this in a number of different ways in our country, and it is hard to get through the politics of actually doing cost containment.

So our radical idea is that we challenge the different stakeholders to come forward and identify savings in their areas that could be scoreable, [and that] would be effective. No one

knows more about their relative area than they do from a standpoint of a particular stakeholder.

We have actually been talking a lot to different communities, and it is very exciting. But this is different from government saying, you will do this, you will do that. It is not squishy, however, because we have to hit the target that Karen is talking about. She is absolutely right.

And it is built on this idea of how do we change the payment system radically to go back to some of the ideas in a kinder, gentler, way that were discarded maybe 10 to 15 years ago, but that really work. It is about managing care.

And there is a reason that California has some of the lowest rates of increase in health care costs; because it is about the only state that really manages care. You have physicians organized in physicians groups. They are called IPAs, and they work very, very effectively. They work to guidelines. They work to standards. So we have learned a lot from the old things [that] didn't work. We have learned a lot from listening to our colleagues in the different specialty societies and the hospital community, the pharmaceutical

community.

So we do not have the temerity anymore to say, you should do this, you should do that. But this idea of shared responsibility is what we have been talking about, and to bake that into health care reform. So I appreciate the opportunity. I can say much more. I know this is not the topic of that issue. But we have many more thoughts and very specific ideas and proposals along that line of thinking.

Ed Howard: Good. Thank you. Yes, you have been very patient.

Chris Jacobs: Thanks, Chris Jacobs with the House Republican Conference. Hearing all this discussion of secret plots and crowd-out and everything else like that, there is a quote that I think would be relevant to the debate.

"We are not taking a free enterprise system and federalizing it. We are in fact improving the entrepreneurial and competitive possibilities by going toward a public option, because plans are going to have to compete for the business. They are

going to have to compete on the basis of price and on the basis of quality. And the beneficiary will be the taxpayer."

Now, I do not know if that is an accurate characterization of what the advocates of a public option see as the benefits of it. But I can tell you that this is a quote from the Clinton Administration in 1993, talking about the federal government run direct student lending program, which the Obama administration is now proposing to federalize in its entirety.

We supposedly set up a level playing field, and private lenders ended up getting about 80-percent of the business on a level playing field. And all of a sudden, Barack Obama and Ted Kennedy, as part of the budget proposal, said we need to eliminate these wasteful overpayments. We need to federalize and have the government running the entire student lending industry.

So my question is how does this build trust that people? The politicians in charge of running a government plan, would not sooner or later wake up three, five, ten years down the line and say, oh, this isn't the level playing field we established.

And we need to do something to shift the playing field in favor of the government plan, or eliminate private insurance entirely.

Ed Howard: Good question. Karen Ignagni.

Karen Ignagni: I wanted to start because I think that it is, as we look at the different issues of whether it is student lending, financial services, health care, or what have you, generally what you see is one of the number one problems is that the private sector entities that are in the middle of those industries do not generally come forth with a diagnosis that there is a problem that needs to be solved. And there is leadership that needs to be taken on behalf of those private entities.

In our case, for health care, I can only speak about health care, because that is really what I know; but in health care, I can tell you that our board had a great deal of discussion about what role were we going to play? What role were we expected to play in 2009? This began about two-and-a-half to three years ago. And they uniformly said it's our responsibility to earn a seat at the table, to

demonstrate our value, to be very clear about what is working and what is not working, and how we could recommend doing the deep dive for entities that are in the middle of the health care system, doing a deep dive to say, here is the way we should move from A to B to solve the public program.

So I am glad you asked the question, because that is what led us to a proposal about guarantee issue, ending health status rating; not writing out people or making it difficult for them with pre-existing conditions.

But you need to keep in mind there was never a social policy that everybody should be in, in this country. And that is why the market grew up the way it did, which is why we spent so much time actually looking at what we can offer by way of a solution, so people do not feel like they have to drop back to a public strategy to get the kind of reform that people want.

So I am glad you asked the question about how you get from here to there, because it is important that everybody here understand that we represent a group of people who are integrally involved in the health care system, and want to

participate with you in trying to solve it.

And I do not necessarily think the private-sector people here on this side of the Hill, all of you, are used to hearing that from the private sector. It is important that you do, because there are no entities that know better than we about what kinds of things are working and not working. So I appreciate your asking the question.

Ed Howard: Karen?

Karen Davis: Well, I am not going to get into student lending, but this mixed public/private system has a lot of checks and balances built in. And I would say the most important one that we have not talked about is the role of employers.

Again under our estimates, the number of people covered under employer plans would in fact grow from 164 million today to 196 million. Those employers have the choice of buying privately, if they are not getting good quality, good value out of the plans, through an insurance exchange.

So it is not a government system. It is a mixed public/private system, with very strong built-

in checks and balances that come from offering people choices, but also a strong role for employers in deciding whether to take their group into such an exchange or to buy directly.

Ed Howard: John?

John Holahan: Just a real quick comment. I think this goes back to the whole thing again about trying to predict the future. It is sort of like saying let us do X, and X may look good, but it is really going to lead to Y, and you are really going to hate Y, so let us not do X.

And it is just--how do you know? I could lay out a hypothesis that if you stay with just private plans in this world of market concentration, particularly among hospitals and specialists, the private plans can not control that 10 years from now, there will be no disagreement. We will have a single payer system. Honestly, I really do believe that.

I think if you do not have a mixed plan, the next thing is single payer. And 80-percent of the population will want it because they can not

afford what we have.

So I think we can all play that game of what is the future going to look like if we do this, but we can all do it.

Ed Howard: Yes.

Beth Hadley: Hi, my name is Beth Hadley. And I wanted to follow up exactly on that question raised by Mr. Holahan about market concentration. And I would like to hear Mr. Butler respond to that reason for a public plan. And then I would love to hear Mr. Holahan respond to Mr. Butler. Thank you.

Stuart Butler: Well, let me just say, I was going to comment on the end of what John said that yes, of course, nobody can predict the future with certainty. What you have to do is to look at probabilities. What you have to do is look at past performance. And talking about the student loan system is a good example of that. And saying what has happened in the past when we have tried to do these sorts of things.

You have got to look at what the stated

intent is of the various key players, particularly in the congress, who are arguing for this, and the people who support it, and what their stated objective is. You have got to look at all those kinds of things.

And it is not true to say you can not have any knowledge whatsoever of what is likely to happen in the future. You can make some reasonable projections. And that is what I have tried to do. And I think that is what people who are very concerned about this try to do, based on their experience, based on how they read the current situation, what people are really in favor of.

As far as market concentration is concerned, count me as among those who never wants to see strong market concentration in any industry. The idea of getting effective competition is critically important. One of the reasons I favor so much the idea of going to an exchange system is that it opens up vastly new choices for people, not just for employers, per se, but for people who work, who are employees, just as the FEHBP offers the kind of choices to federal employees that most of us in the private sector only dream of.

In other words, there are plenty of devices and ways of setting up markets to insure that there is strong competition. And I absolutely favor doing that. The idea that you can do this by setting up a public system, however, a public program is the way of breaking up concentrations, in some ways; not what I think is the right way to go for all the reasons that I have mentioned; because the strongest one of which is that I do not believe you will in fact get a true break up of concentration with a true level playing field degree of competition between those different players. I just think that is inconceivable in the way in which the political process actually operates.

John Holahan: I do not know that you break up the concentration. I suspect you would not. But I think you would have the ability of a strong player on the buying side to deal with it.

And I think that is at this point all we can really hope for.

I think, as I have said, private insurers would consolidate and get stronger too. And I think

we need that.

In terms of predicting the future, go back to probabilities, Stuart. Would you have predicted 20 years ago or 15 years ago that Medicaid would largely be run by private insurance companies that were contracted by the government? And Medicare has moved now in that direction; and that what was a fee-for-service system with government setting rates would essentially lead to inevitably the entrance of private plans? Maybe you would have. I do not know. But I think it is hard to predict.

Karen Ignagni: I just wanted to – although, you did not invite it, just a [comment] about consolidation in the provider community, in particular.

I think John is right. There are a number of markets where it is very, very difficult to negotiate. The question is, do you drop to an administered pricing system to deal with that? Or are there other factors?

We have thought about somewhere in-between, which is to say that in markets where you simply can not negotiate because there is such scale on the part of particular facilities, to say that if the

price quoted on behalf of all of those facilities were more than X-percent, 110-percent of fee-for-service, 115. Pick your X; then immediately those individual hospitals would have to negotiate individually. That would open up the market in a way that would then get that kind of negotiation out there.

And I am sure there are other strategies. But since you invited some speculation and discussion about, that would be a way of beginning to open things up.

The other issue is [we] must have entities, must have physician groups. And we see some of the same kinds of effects, and you could handle it using similar kinds of remedies. California, in its discussion of health care reform, tried to lay down some of these concepts. They were not accepted, but I think as part of health care reform here, we need to look closely at this.

We also need to look closely at in the name of IT, and some of the activity around IT, is that leading to more consolidation and integration, and will it be even more difficult to negotiate? So we have to have some metrics, and to look at that and

policy remedies, which we have a number of thoughts about as well.

Ed Howard: Okay. We have just about come to the end of our time here. And I do not want to abuse the privilege of your presence.

We have had unfortunately not nearly enough time to discuss the questions that many of you put very thoughtfully onto these cards. And they are thoughtful questions. We may just circulate the text of those questions to our panelists. And if they have the chance to respond, we will be happy to record those, and circulate those answers as well.

I do want to remind you that next Monday we will be talking about another connected piece of this, the so-called connector exchange proposal that is on the table. And we would love to have you back here for that conversation as well.

Please fill out your evaluation forms as you listen to me thank some people, notably Karen Davis and the Commonwealth Fund, for their support and participation in both the meeting and the planning of the meeting.

Thank you for showing up and making this an

interesting and lively conversation, and ask you to join me in thanking our panel for a very thoughtful examination of a tough issue [applause]. Thanks to all.

[END RECORDING]