Where are HSAs and High-Deductible Health Plans Headed?
Alliance For Health Reform and Kaiser Family Foundation
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ROY RAMTHUN: —the value of the payroll taxes paid on those HSA contributions. Coupled with that, the President is proposing to raise the contribution limits that can be put into the health savings account each year. As Diane correctly pointed out earlier, the contributions are currently limited to the policy deductible under the high-deductible that the individual chooses, but not all policies pay 100-percent after you hit your deductible. And certainly, in her example, she showed a very common situation where people would pay 20-percent of their health expenses up until they hit an out-of-pocket maximum under their policy. The President is proposing that the individuals would be able to put enough into their HSAs to cover all of their out-of-pocket expenses. So not only the deductible, but also those 20-percent co-insurance expenses up to their out-of-pocket maximum under their policy. This will give individuals who are chronically ill a way, with tax advantages, to cover all of their out-of-pocket expenses and get the tax savings for those contributions into the account. For healthier individuals, in a particular year, they will be able to put aside additional savings from one year to the next, so that they can build up their account balance for future anticipated expenses. Let me briefly run through the other proposals that the President has put on the table before I turn

to Kate and have her talk about the impact of the President's proposals.

He would allow employers to make additional contributions to the health savings accounts of workers who have a chronic illness or condition or who may have a family member with a chronic illness or condition. Today, the tax rules do not allow that. Employers have to treat all of their employees equally. So if I put $100 each month into my employee's health savings account, I pretty much have to do that for everyone. Employers have asked us for this flexibility and the President has proposed to give that to them. Some employers took advantage of the treasury regulations in 2002 and offered health reimbursement arrangements, which were a little bit of a precursor to HSAs. Some of them would like the ability to convert them over to HSAs and move forward with their benefits under an HSA structure. They can't do that with us allowing them to convert those policies over to HSAs.

Next we would allow individuals to actually pay their health insurance premiums out of their health savings accounts funds, which today you can't do unless you're receiving federal or state unemployment compensation or have COBRA continuation coverage. We're not sure why Congress limited it to those two situations, but certainly early retirees would benefit from being able to pay their health insurance premiums since they

won't likely qualify for the other two. Also, for individuals who are just getting started with their accounts, we want to make sure that nobody gets caught by the IRS, so we're clarifying that they can open their account and make their contributions through April 15 of the following year and reimburse the expenses they've incurred up to that point.

The last proposal I want to make you aware of is the President's Refundable Tax Credit proposal for low-income Americans, offering up to a $1000 refundable tax credit for individuals, $3000 for families. This year, we modified the proposal that they must buy an HSA policy in order to qualify for the credit. The President felt that it has not gone very far in the Congress, and felt that retooling it to make it consistent with the rest of our HSA proposals was consistent with that.

Let me turn to Kate; she'll talk about some of the economic impacts of the President's proposals.

KATHERINE BAICKER: Great, thanks. As Roy mentioned at the beginning, the goal of this proposal is to put all sorts of healthcare consumption on equal footing. Right now, if you consume healthcare that you get through an employer health insurance account, that's subsidized by tax dollars. But if you consume care outside of that employer insurance, it's not subsidized. So you have incentives to get more and more employer provided insurance instead of paying for routine care

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out-of-pocket. If you pay for routine care out-of-pocket, you would be a more cost-conscious, sensitive consumer, but if you had a high-deductible health policy to go along with it, you would have financial protection against the risk of potentially high expenditures. So think about your home insurance or your auto insurance. You have insurance against unexpected, catastrophic events that would be a real financial hardship to you, but you do not have insurance against things like oil changes, cleaning your house, or cleaning out your gutters. If you did have insurance against those, you would consume a lot more of them, and there would be a lot less competition among providers to get you to the best value, the best quality service that you could. We want to make health insurance look a little bit more like that through these proposals, but that might raise some questions in your mind. You might be worried, "Well, what happens to people who have employer insurance? Are these proposals really going to lower costs through the healthcare system? How much good are they going to do? And how much are they going to potentially low-income people who are facing these high deductibles or sick people?" Well, we'd like to address those concerns.

First of all, I'd like to convince you that moving to this approach really could reign in spending. Some of you might be thinking, "Wow, if I had a high-deductible health policy, maybe I would pay attention to the first $1000 of

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spending." But all of our healthcare dollars are spent by people with really high expenditures; we've all heard that 80-percent of the healthcare dollars are spent by the people with the 20-percent highest spending and that's true. So you might think, "Well gee, are these accounts going to do any good in getting people to put resources towards the highest value use?" The answer is yes. In fact, because of that cost sharing that we talked about, the typical person with a high-deductible health policy would be aware of how much health insurance or health consumption costs up to about $12,000. Well, more than half of healthcare spending is done by people with less than $12,000 a year of spending, so people have plenty of "skin in the game." People have an incentive to pay attention to their health expenditures when they have a policy like this. Also, these are not meant to replace all the other cost containment tools that we have at our disposal. You might think, "Gee, insurance companies do a better job of negotiating with providers than individual people can." Yes they do, and they will continue to do so. People with high-deductible health policies are still covered by an insurer who is negotiating with providers. So this just adds to our toolkit of cost containment, it doesn't substitute for all of the other tools we have available.

Now great, this encourages cost-sensitive consumption, but you think, "Gee, does that mean we're being penny wise and

pound foolish? What about people who might not consume preventive care and cost a lot more in the long run?" Well, health savings accounts and the high-deductible policies that go along with them allow preventive care to be covered first-dollar. In fact, the studies by the GAO of the Federal Employees Health Benefits Program showed that FEHB policies that were high-deductible policies were more likely to offer preventive care at a more generous rate than other insurance policies under the same umbrella.

So now I hope I've convinced you that, in fact, spending would be affected by people having more of these accounts; people would be more cost conscious. But does that expose people to too much financial risk? Are we erring too far on the side of putting the burden on individuals? And what about low-income people who can't afford these high-deductible policies? You hear high-deductible policy and it sounds expensive. But in fact, that's only half of the equation. The other half is that the premiums for these policies are much, much lower. In fact, the premiums are so much lower, that unless you hit your deductible every year for 3 or 4 or 5 years in a row, you're saving money. You have more money in your pocket and especially for low-income families, that's important. They want health insurance protection. They also want to pay their rent and buy food and clothes. So these policies put more money at their disposal to use for other

family priorities. We can go to a more specific example, but the typical premium for a high-deductible health policy is a couple of thousand dollars lower than for a non-high-deductible policy and the deductible is only about $1500 to $4000 higher, and the employer is kicking in $1000 into the health savings account of the typical policy. So really, almost every family is better off under one of these policies. And as it turns out, the enrollees are not particularly healthier, wealthier, or younger than the enrollees in other health policies. The evidence we have suggests that people signing up represent a wide cross-section of the population.

Now Roy hit upon, and I don't have time to go into, a number of other policies that are also targeted at low-income families in particular. The payroll tax goes disproportionately to low-income people. There is a low-income tax credit. And, in fact, making premiums tax preferred for people who don't have employer insurance also disproportionately benefits low-income people, because they're more likely to work for employers who don't offer them insurance. I won't go through the example now, but the point is that even for families with very high expenditures, they are, if anything, only slightly worse off under the HSA and in most cases, much better off in terms of just having more money in their pockets while still having financial protection.

Now you might also think, “That’s all well and good for people who don’t have employer insurance; what about people who do have employer insurance? Is this going to cause employers to drop coverage?” Well, in fact, employers are dropping coverage now, and it’s because healthcare is so expensive. We’ve seen a 10-percentage-point decline in the number of employers offering health insurance, and that’s going to keep going unless there’s an affordable policy available. The recent AHIP survey that was just mentioned shows that a third of employers offering health savings accounts were not offering any insurance before. People are getting access to insurance where they did not have it.

The last piece is, are people actually able to make better decisions? Are we just giving them more money and they’re going to spend it in the same inefficient ways that we’ve seen in healthcare spending before? The answer, again, is no. If people have adequate information and have information not only about cost, but about quality, we have ample evidence that they make better healthcare decisions than a bureaucratic system that dictates which things are covered and which things are not. Even in cases of emergency, like cardiac care, we see that if better information is available about the quality of hospitals and the value, the cost versus the benefits, people make better decisions. So the government needs to lead the way in getting that information to people,

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both through the FEHB program, through Medicare, and through fostering public/private alliances to get people the information they need to really take advantage of these accounts. So the ultimate goal can definitely be reached through these proposals. The ultimate goal is to get people at a place where they are evaluating the cost versus the benefits of the care available to them. They're not only allocating healthcare dollars better, dollars are going to higher-value care, but they're also getting to choose whether they want healthcare or rent based on the value of that care; we're not there yet, but I think we'll get there.

ED HOWARD: Very good, thanks very much Kate. Next we hear from Uwe Reinhardt who is on the faculty at Princeton, he is a frequent panelist at Alliance briefings, I'm pleased to say. He is a prolific writer, a memorable speaker, and has been sharing his opinions on HSAs and related mechanisms for a number of years. We look forward to hearing some of those opinions and his reactions to the proposals that are on the table this afternoon. Uwe?

UWE REINHARDT, PH.D.: Yes, thank you very much for inviting me. I am going to focus on the ethical facet of this proposal. I work in health policy and in many different countries; I notice a difference between us and the way they do policy. They usually begin with a distributive ethic that they

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want to observe, view that as a constraint, and then make the technical parameters of their policies subject to that. For example, in Germany, it is the principle of social solidarity. They will then say a certain policy is cool, but it violates that principle, so they won't look at it. In the US, our tendency tends to be to debate policies in terms of technical parameters, cost sharing, and this and that, and then sort of let the ethics sort of fall where they may. Personally, I don't find this very acceptable; that's not what we teach in schools of public policy. So I think the expectation might have been that I would engage in sort of a discussion on technical matters and using judiciously the empirical evidence on the price elasticity of demand, what kinds of services consumers, formerly patients, will forgo and the high deductibles. All of these issues, I don't want to run through them, but basically focus on technical issues. So I decided to be a skunk and the garden party and say I'd like to explore what the ethical implications of this approach were if we embrace it the way President Bush would like us to embrace it.

I would argue that if it is widely adopted, it will have the following effect. It will make healthcare cheaper in absolute dollars for high-income Americans than for low-income Americans. That's implicit in the progressive tax structure and, of course, the President says, "Well, I'm doing that because I want to level the playing field." But I would

quibble with him a little bit about it. If it were leveling the playing field, he would have adopted the Kogan, Hubbard, Kessler proposal, which makes all out-of-pocket spending tax deductible, regardless of what kind of insurance policy you have, then you would have employed and non-employed on an equal level, and insured and non-insured services on an equal level. What the President is doing is something quite different. He is saying I'm going to tax Americans and with the tax money, I will reward only those Americans who buy the health insurance policy that I, the President, prefer them to have. No matter what they themselves might prefer. This is really more social engineering through the tax code, which Doug Holtz-Eakin, the former CBO head, not a Democrat, said is an egregious misuse of the tax code. And I would say, in general, behavior modification through the tax code is something that economists generally don't like.

If you look at this, yesterday we had on the Kaiser Commission of the Uninsured and Medicaid, this slide was presented. Among people with less than $30,0000, they're in fairly low tax marginal brackets. The way I describe it is if I have a really rip-roaring toothache, and I need a root canal, and where I live it's about a thousand bucks to get a root canal and another thousand for the crown. When I pay that out of the HSA, it will cost me, at most, $600, because if you add up all these taxes that I face at the margin, for every dollar

I put into the HSA, it cost me only, at most, $0.60. The gas station attendant, the waitress, the WalMart worker, it cost them around $900 for the same root canal in after-tax dollars. I personally think that that's an ethical proposition that we should debate. I'm not saying we shouldn't do it, but I do argue that it should be openly debated. This is not neutral.

The second issue is, obviously this is meant to be a cost control and benefit cost-control device, but we are looking mainly to the lower part of the national income distribution to do the belt tightening and to do all this stuff. And, of course, as I mentioned and I never fail to remind you that those are the people to whom America looks to go abroad to fight. It is not our children, though our son did, but that's almost weird, it isn't the elite's children who do the fighting, it is mainly people in the lower half, not the very poorest, but in the lower half of incomes who fight for us. So they bear already the blood and financial burden of the war, and we want to load that on top of them. I personally think we should debate that. How much can you load on these wonderful people?

And the third, this is the income distribution of the United States 2002, 33-percent have an annual income of $40,000 or less. Interestingly, most health policy wonks and policy makers are in the upper two. Think about it, if you are a young professional and you are married to another young

professional, you are up there. That's what I tell my students, "You're going to be living up there. You're not part of American society as it reveals itself in the hinterland at all." And so, we have these images of "skin in the game" and so on, but I would say someone with a $200,000 family income, is anyone here willing to tell me that their healthcare behavior would be even in the slightest impacted by a $4000 deductible? I know it because I've always had them; not at all. This is peanuts; it's a skiing trip. To a waitress and a husband with $40,000 or less income, $4000 and then more on top of it is a huge hit. They will modify. So it's fair to say we're looking to the bottom half of the income distribution to carry the load of cost containment in American healthcare. I saw this in *Business Week*, 1 in 4 workers makes less than $18,000; if they're married, that's $40,000.

So I go to eHealthInsurance, where you can buy these individual policies, the farmers' market of that, and I made myself a 35-year-old woman with three kids and no husband; that's what I put in. I picked Dallas, Texas because that's where the National Center for Policy now is. [Laughter] Let's see what you can get there. What you see is if she is healthy; I think if she's sick, in that market she'd have trouble getting it because they're underwritten. But if she's not sick, she can get a policy for $148 a month with a $10,000 deductible. Those are the deductibles that you find on that

web site, and Diane already walked you through this. I say that surely we don't believe a family with an annual income of $20,000 will respond to a $10,000 deductible the same way you and I would if we have $200,000. So, what I'm arguing is, I think, unassailable. Now, of course, you could avoid this by making the deductible and maximum risk exposure, linking it to income. So that would say if a household of $40,000 can bear a deductible of $4000 and a maximum risk of say, $6000, it would mean that for congressmen and policy wonks, that deductible should be $20,000 with a maximum exposure of $30,000. Then you would have the same sensation of empowerment, or whatever you may call that, that the waitress and her husband will have. That means all of the Congress, the entire Congress, should have a minimum deductible of $20,000. It would mean executives of corporations shouldn't have any health insurance at all. Because when you make $20 million, why do you need insurance? Ask yourself this. Yet, I saw this in *The New York Times*, here is Mr. Wile [misspelled?] who probably was paid $30 million that year, he had $61,000 out-of-pocket dental and health insurance, the company paid it, and because it's imputable income, they paid his taxes too. There was a piece in *The Wall Street Journal* a couple of years ago on how many, many corporate executives have first-dollar coverage; corporation pays everything plus the taxes. I personally wonder if these people, who are so risk adverse and of such an entitlement

mentality, as you have in the corporate suites, ever think what they're saying when they say that people "skin in the game," right? That is sort of, to me, that is a form of Marie Antoinetteism [misspelled?].

Finally, there is no question that we are talking about shifting the financial burden of ill health more out of the households of the chronically healthy to the chronically sick. I saw this, it must be the Jerry Andersen's study, but more than half of healthcare spending is on behalf of multiple chronic conditions. As Katherine pointed out, this is in fact the 2001 per capita health spending of insured, the privately insured people below 65. Ken Thorp gave me these numbers; you could see that if you had a $4000 deductible, in fact, the bulk of Americans would be saving money. But those people, the ones who are chronically ill year after year after year, would have to pay this deductible. It doesn't take much to do that.

My concluding timing is perfect. My concluding remarks are I can style the HSA high deductible as a liberation from the shackles of government regulation or private health plans, managed care, and it is often marketed that way. I saw this thing "Reclaiming Personal Power and Freedom in Decision Making." That sounds mellow and it sounds good; it's a way to market this idea. But I could also say I could present it to the nation the way it is now being proposed by the President. One can describe it, fairly, as one more policy to redistribute

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economic privilege, big tax cuts, and healthcare resources upward in the nation's income distribution. That's another way to describe it. I'm not saying we shouldn't do it. Maybe we up there are very meritorious and should have these privileges, but I plead only for an open and honest discussion of these ethical facets, and not just reduce it to a technical discussion. I particularly take some umbrage of the issue of "skin in the game," particularly how it's often pronounced by people who don't really know what that would mean because they're in an income class where there is no "skin in the game." So that's where I'm at. [Applause]

ED HOWARD: Just so you'll know, Uwe's time was roughly equivalent to the first presentations. I've tried to do my Jim Lehrer imitation from the presidential debates. We're now going to get a little bit of actual experience with these folks, not theoretical analyses from any perspective or ethical judgments. Frank McArdle is the manager of the Washington D.C. Research Office of Hewitt Associates, which is described as a global human resources outsourcing and consulting firm. Hewitt provides services to large employers and their workers. They consult with 2400 companies. They administer benefit programs to millions of employees and retirees worldwide. In addition, you ought to know that Frank is not stranger to Capitol Hill himself. He served on the professional staff at the Senate Aging Committee. We're going to hear from him today about some

of the experiences HSA and Hewitt have had with their clients over these first two years of experience. Frank thanks very much for being with us.

FRANK MCARDLE, PH.D.: You're welcome. The first thing I want to say is, Uwe, the next time I need a root canal, I'm going to drive up to Princeton, because it's a lot cheaper up there than it is down in Washington. Ed kindly did an introduction for us, so the agenda that we have it basically to look very quickly at the current market. And by this I mean the large employer market with 1000 or more employees. You have to pay attention to that definition because, even in the AHIP materials just released, they'll refer to a large group as having 50 or more employees. So we're really talking about the very big companies as the most likely to provide health benefits. We'll talk about the prevalence, what employers and employees see in these programs, and also some areas where things might need to change in the future.

In terms of high-deductible health plans, we have data of our own from large employers, and it's not a random sample, but I've compared it to the data in KFF HRET and it actually lines up pretty well with what they have there. Basically what this data shows is that roughly a third of large employers now have a high-deductible health plan plus and account. That account is not necessarily an HSA, it can also be an HRA, as Diane explained, and HRAs often have more flexibility for

employers than an HSA. About half are considering it for a future data, and 1/5 basically have no interest at all. Now this is looking at the HSA with a qualified high-deductible plan, and here the percentages are lower. We have about 8-percent who are currently offering a high-deductible health plan along with an HSA, and 5-percent are adopting one in 2006. Now in this market, when it's offered the HSA, 90-percent of the time it's offered as an option alongside other options that the company offers. The vast majority of these situations apply to salaried employes, not to bargain employees. I don't know in the private sector of any situation yet where it's been applied to bargain employees, but I may have missed that. The employee participation, where offered, in an HSA is pretty modest. That's because, in part, it's offered as part of an option, as I said. You can get some higher situations where there is more participation, and generally, if the employer is contributing to the HSA, you'll get some higher participation, but it's not unusual for us to see in the first year of an option like this that the enrollment might be 2- to 5-percent. Again, that's a first-year effect, but we'll be watching that in the future.

Now, why might employers want a high-deductible plan with an HRA or an HSA? There really is, as I think you've heard from the previous speakers, a strong assumption on the part of employers that if you give people money to manage

themselves, they will be more careful in how they use that and how they spend it. And, indeed, look at the KFF HRET data, the majority of employers say that this kind of plan is going to be effective in reducing cost growth; 16-percent said very effective and 45-percent said somewhat effective. Next week, the National Business Group on Health is having a conference called Consumers in Charge of Transforming Healthcare. So I just cite that to let you know that businesses, not just the [inaudible] who thinks that there is promise in this approach.

The other point, and I think maybe Roy and Kate made this is, we often read that people are going to forgo wellness care or preventive care. That's not the case; in fact, we would design a plan with the company encouraging them to provide generous preventive benefits, because what they want, what we want, is to have the employee be healthy and to manage their care well. So sometimes you'll see it provided with a zero deductible; it's going to depend a lot on the plan design. The Foundation and Hewitt have done a lot of work on retiree health and in the beginning at least, people were very excited about it, less so now, that this may be a way to accumulate assets for future healthcare needs. Another reason they do it is because it appeals to employees. Employees like the lower employee contributions. When you hear data about savings from going from plan to another, you have to really dig in a little bit and say, "What kind of plan are they leaving and what kind

of plan are they going to?" To try and hold that constant we looked a PPO design where everything was basically the same, but you went from a $500 deductible to a $1500 deductible. There the premium savings were in the range of 15- to 20-percent. Employees like it because it's tax effective. Having worked in the retirement area as well, a lot of young employees don't want to plan too much for the future; but if they have a way that they can get a tax-effective way to save money, it can appeal to that spectrum more effectively perhaps than what we do now. Also, it gives them a freedom that they can spend the dollars to fit their needs, Uwe referred to that, but I think it's important people have that feeling that they have control of it. Again, they see it as perhaps the chance to accumulate assets.

The reason I think that the penetration to date among the large employer market has been relatively modest, those reasons are shown on this slide. One reason is that prescription drugs are generally deductible. I can tell you, from working with companies and their employees, that's a show stopper for a lot of employees. And that helps to explain, too, that where the company puts it in, you might get more modest participation. It's also unclear, but there are IRS regs pending, the extent that employers can vary contributions for low-income people or for those who are chronically ill. And we're hopeful that we'll get the permission to do that in

the near future. Also, an HSA, as Diane explained, can be used for other purposes, whereas an alternative arrangement, the HRA, can be conditioned for healthcare use only. Some companies say, “We don’t want to put money in this account and then at the end of the day, have the employee be able to use it for some purpose other than healthcare.” I think are other reasons here; you can’t use a flexible spending account along with it right now very effectively. You can’t roll over these HRA balances at all, and the limits on contributions, as Diane mentioned, the lower of the deductible or the permitted maximum really makes it hard to accumulate much given current healthcare needs as you’re going along.

In this slide there are some of the administration proposals that are considered very helpful. Increasing the HSA maximum contribution would allow for more accumulation. Employers could convert their existing HRAs to an HSA. They could make higher contribution, as Roy explained, for people with chronic illness. This hasn’t got as much attention, and I’d love to hear more details about it, enabling portable insurance policies that the employee could actually carry from one employer to the next is, I think, a potentially fascinating idea, but again, we’d love to hear more about the details. The employers like very much what the administration is saying about transparency and what that means in terms of disclosing information about prices and quality, but there is also, Diane

put up these big numbers about the cost, I think there's also concern about the cost and maybe some worry, "Will we have to pay for this in another way?"

There are also some other areas where employers would like to see even further action. One of them is permitting coverage of drugs outside the high deductible. Again, varying the contributions and being able to coordinate some of these other programs with HSAs and allowing a rollover of the FSA for a limited amount. But I want to talk about the last two in particular, because I think they stretch the conversation a little bit.

One is, people are thinking about how you can put more flexibility in the design so that it doesn't necessarily have to be tied to a high-deductible health plan, but yet it will have consumers spending their money more carefully and more wisely. And I have to say that even when we look at account-based plans, it's not the accounts, per se, that we think really drives the behavioral change. It has to be accompanied by tools for the employee to understand the differences in cost, when a generic might be more appropriate than a brand and visa vera, to be able to see which doctors are in their network that are both higher quality and more cost effective. We think that combining those tools with the account can reduce healthcare trends by one or two percentage points over time, but you have to get that behavioral effect.

The last thing is that, again referring to our experience with retiree health, many companies are taking away benefits for future retirees, in particular new hires, but these companies are also concerned that they'll make their plan available when the employee reaches retirement age, but how are they going to pay for it, the employees. And so they would like to see some dedicated kind of account, not tied to any kind of health plan, which they could use for that purpose.

So in conclusion, the account-based plans are seen as very important and interest is growing, but contrary a little bit to what you see in the small employer market, it's been growing more slowly among the very large employer. Generally, these plans are not full replacement plans. They're within an option, as I said. We know of instances where they are a full replacement plan, and we're going to look at those very carefully. But in two of the cases that I know of, the replacement plan is very generous. One of which basically the company is saying, "We're going to put in exactly what we put in before, but we're hoping for this behavioral effect over time to help reduce our costs." And then, in my opinion, with only two years of experience, you can't forecast too much about the cost and utilization of HSAs. We'll need a little bit more time for that, but that certainly won't stop many people from forecasting, and it probably won't stop me either. But it also takes time to clear up some misconceptions. There was a

hearing in Senate Finance the other day where a very learned witness, very expert, said that somebody could accumulate money in their HSA and then use it for cosmetic dental care. Well, the rules prohibit that; it has to be a code-approved medical expense, and cosmetic activities are not code approved.

So, as I indicate, I think some of these proposals from the administration employers will be found as very attractive, but they're still looking for some additional flexibility along the lines that I described. Thank you. [Applause]

ED HOWARD: Thank you, Frank. We have gotten to the point here where you get a chance to speak up. Mind you, you have green question cards; if you would like to write out the question, hold it up and a staff person will snatch it from your fingers. There are microphones here and over to the left, you can use that. There are plenty of opportunities to voice your questions. Before we do that, if any of the speakers would like to make a quick observation in response to anything they've heard that would be appropriate at this point. Kate?

KATHERINE BAIKER: Sure, I'd like to briefly, respond to Uwe's very important and well-taken points. But I think he paints a world in which low-income people are giving up hospital care so that Sandy Wilde can have more expensive dental surgery, and I reject that characterization of the set of proposals on the table, as I do reject to the nickname Marie. The advantage to low-income people of these plans being

available is that they have the option of a basic health policy plan that's more affordable, that their employer is more likely to offer, and that they're more likely to be able to pay the premiums for, leaving them extra resources to spend on other family priorities. So I think it's important when thinking about whether these proposals are good for people at different parts of the income distribution, to think about access to the basic care that we think everyone should have access to, not restricting people to the very benefit-rich plans that some people have that they may not find affordable and which their employers may not offer at all.

UWE REINHARDT, PH.D.: I don't want to be construed as being against high-deductible plans that people may want. My wife and I have had them for 20 years at Princeton and if low-income people want them, sure. But to use taxpayers' money, because let's face it, we're borrowing everything from China now, but at some point, US taxpayers have to pay off the deficit. So it is taxpayer money. To use taxpayer money to reward well-to-do people disproportionately for this behavior change is something that I question. If poor people voluntarily want to have a high-deductible policy, I'd be the last person, as an economist, to stand in their way. But to use tax money for behavior modification, which essentially once again, not regressive, but in absolute dollars, funnels more money to upper-income groups, people like me, is something that

I think should at least be debated. You may want to do this; I have my own views that were shaped in Europe and Canada. But I don't want to impose my views on you, other than to say, that's what you're doing. That is what you're doing. You're giving very little tax support to the waitress, and you're giving a lot to the lawyer and economist.

ED HOWARD: Why don't we get started with the questions.

LAURA TRUMAN: Hi, I'm Laura Truman with Coalition for Affordable Health Coverage, and my question has to do with the income levels of people who are purchasing health savings accounts. What we're hearing doesn't seem to comport with what Mr. Reinhardt is saying in that this benefits the rich. Just yesterday I talked to a very modest income widow with three kids. She got a health savings account because she was paying $900 a month in a premium; her premium went down to $350. She had had a $2000 deductible before that. I talked to a fellow, a hardcore Democrat in Baltimore, he doesn't like Bush, but he was uninsured for two years after he went out on his own to start his own human resources consulting business, he had a very modest income while he started his business, and finally got insurance because of health savings accounts. So it seems to me that the real question is who is it helping? And I wonder if the panelists could talk to the data about who is

purchasing it and what their income levels are, because that was not in the AHIP study.

DIANE ROWLAND, SC.D.: My recollection of the data is that about one-third of purchasers had incomes under $50,000. So that's not so different from what the overall pool looks like. We're seeing enrollment in high-deductible HSA policies that looks roughly the same along income distribution, age of the person signing up, and the self-reported health of the person signing up. But I also agree with the point that these are very new policies, so we don't have a lot of really great data, a lot of really rich data on who is signing up, but we also have good information that these are appealing to a wide cross-section of the population. That's my read of the current preliminary data.

ED HOWARD: Quick follow up. What was fascinated about what you said, I thought, was the striking difference in the premium in this new policy from a roughly comparable policy, and I wonder if it was a comparable policy, how that squares with Frank's findings that there are savings on the order of 15- to 20-percents, as opposed to two-thirds.

UWE REINHARDT, Ph.D.: I think that we looked at Kaiser yesterday, and I forget, Diane, what survey that was, that the premium differentials in the employers were there, but they were nothing this substantial. They were not. Do you remember these numbers? We have them somewhere here, but they were

nothing like it. To your point, I think you misunderstand again. I do not wish to stand in the way of poor people being able to buy high-deductible policies at all, not at all. What I question or want you to think about is using tax payers' money to reward someone like me more in absolute dollars for buying the policy the President wants me to buy, than to reward the waitress in absolute dollars; that's what I question, which has nothing to do with the point that you raised.

DIANE ROWLAND, SC.D.: But to put that in the context of the way our policy works today, right now we spend more than $150 billion a year subsidizing high-incomes people's purchase of health insurance, only through employers though. If you have access to employer-provided insurance, you get a subsidy and that's paid for through taxes to the tune of about $150 a year. What these proposals suggest is extending the same tax benefits to people who don't have access to employer-provided insurance, which happens to be disproportionately low-income people. Providing a refundable tax credit to people who don't currently get tax benefits through their employer, and to let people get the payroll tax refunded which, again, disproportionately benefits low-income people. So let's not forget that though we are doing this through the tax system, that it's against the backdrop where we're doing much more of that through the tax system now, and we're extending those benefits to people who don't currently get them.

UWE REINHARDT, PH.D.: But you see, that is why many of us, myself included, Stuart Butler at the Heritage Foundation, have for years argued that in theory, ideally, we would like to get rid of this tax preference in the employment-based system. And since that is extremely difficult, even technically to do, I just had an exchange with Stuart Butler on it, we should at least capping it, sort of going the other way. What you did is you took an existing inequity and extended it, but extended it only to those people who do what you want them to do, rather than to everyone. Then you should have gone the Kogan, Hubbard, and Kessler, at least they are logically consistent by saying, okay, we're going to extend the inequity to everyone. But you do a mixture of it. You extend the inequity and use it as behavior modification.

FRANK MCARDLE: Yeah, I think when you design any kind of program like this that you have to pay special attention to low-income people. That's undeniable. I just wonder when it comes to the HSAs or the high-deductible plans. In the retirement realm there is a thing like the Retirement Savers Credit, it was passed a few years ago, the Democrats supported it very strongly. It is basically a government-matching contribution for low-income people who put money into an IRA or a 401K. But I guess I would say that this issue of low-income people does not have to be a fatal and permanent flaw. But while there are designs that could be developed that could

address that part of it, it leaves the remaining question of whether you want that kind of behavioral change or not.

ED HOWARD: Diane, you've got about three days worth of questions there on cards, and then we'll get to the questions that are at the microphones.

DIANE ROWLAND, SC.D.: We have a series of questions that all speak to the need for the consumer to have perfect information to make the kinds of decisions that they would need to me making in a cost-effective way. One has asked rather or not it isn't a strategy where you should actually post all of the physician's deeds and what are you doing to provide the tools that the consumer would need to use the policy and to be effective.

ROY RAMTHUN: The President is very interested in that topic and has met privately with CEOs of insurance companies, large employers, and medical providers to urge them to start doing so voluntarily. This is an area in our health economy that is very different from the rest of our economy where we seldom know what the price is before we go have treatment done, and sometimes when we ask we're told, "Why do you care? You're not paying for it." We'd like that to change, and to help show the way, we're going to be asking Medicare, federal employees, and the Tri-Care programs to start telling their enrollees what it costs before they get actual medical treatment so that we can start to change that dynamic, get people used to asking

about price, and being more sensitive to price going forward. We need to do that also with quality information so that individuals can have a good, valued discussion, but we are probably a little bit ahead on the quality side than we are on the price side, so we're moving in parallel tracks to start making that happen.

UWE REINHARDT, PH.D.: I think the image that everyone has first-dollar coverage and absolutely no interest in the health bill; I don't know how many people still have that. Many people are in PPOs where you are very much exposed to, if you don't go to someone in the network, you'd really like to know their prices, but the information for all the folks who were in PPO, the market has never provided that information. There is very little information on the web on drugs, cost effectiveness. Is Nexium really that much better than Prilosec? Now, Blue Cross invented Rx Intelligent in 2000, which was supposed to do cost-effectiveness analysis for drugs and post them. The web site still exists, I just looked it up. There was great fanfare, *The Wall Street Journal* and everyone reported it, but the organization is dead, it's defunked [misspelled?]. The phone number belongs to someone in the accounting department now. [Laughter] So here again, what I believe, like most economists, that patients, call them consumers, should have information, particularly on the quality of care of individual providers and hospitals, and also on

fees. It's been promised for 20 years, and maybe this time around it will come, but I wouldn't be the farm on that. It's very difficult to do, number one, and then there's great reluctance to have transparency in prices in the American health system. The docs and the hospitals will fight you tooth and nail. I have a proposal in your packet of how this could be done for hospitals; DRGs for every hospital, for every patient and each hospital can set its own conversion factor and post it. I could just see the AHA go nuts over the very idea of forcing that much competition. You saw the airlines, who now want the Transportation Department to allow them to bill as basic fee, a fuel fee, and an airport fee, to de-package so that students can't so easily price shop. That's actually going to be granted, I think, by the Department of Transportation. Providers don't like this, and they are powerful, and they will fight you every step of the way in the quest for price transparency. They have succeeded for 20 years to keep that particular Hannibal off the gates. We'll just see. So maybe five years from now, we'll all be delighted and we'll all have these web site. At the moment, show me where it exists.

DEBORAH MESSIER [PH]: Hi, I'm Deborah Messier with the Ways and Means Committee and I just wanted to make a couple of points relative to the last question that was asked. One of them is that in my research on high-deductible health plans,

I've noticed that a lot of high-deductible policies don't cover maternity coverage, and it seems to me one of the reasons why you might get lower premiums on high-deductible plans is because there are certain benefits that are carved out. I just want everyone in the room to be cautious about how they're talking about high-deductible plans, because many of those policies might not actually be comparable to the coverage that is offered today in other markets.

The other point is since the panelists in the White House invoked the GAO study, which my boss co-requested on the Federal Employee's Health Benefit Program, I wanted point out that the front-line findings from GAO were that indeed enrollees in high-deductible health plans in the Federal Employee's Benefits Program were higher income and younger than enrollees in the rest of the Federal Employee's Program. So we do actually have some evidence now, based on the federal employees' experience, that higher-income people and younger people are more attracted to these schemes. So I just wanted to put that out there.

FEMALE SPEAKER: Many people say that high-deductible plans cover preventive services, so this question just asks is there any data to support this, and do we know to what extent they are?

ROY RAMTHUN: No, we don't have any really good data to know whether every high-deductible policy is offering

preventive care without being subject to the deductible. The law clearly allows them to do so, and we believe that many policies are, in fact, doing that. The GAO certainly indicated on the federal employees that that is the case. If I could just quickly respond to the last question of whether maternity coverage is offered or not, this is a very common question in the individual market for insurance. It's not specific to HSAs. Related to the GAO report, if you took out retirees in that study, the age difference was 44 and 47, not 46 and 59. Retirees are not eligible for HSAs, and it's not fair to put that in the universe.

ED HOWARD: One of the things that the Hewitt findings showed was that employers are reluctant to move in this drug, in part because of the prescription drug coverage under the deductible, which makes it a whole lot tougher. Now you've come a long way to make them more attractive to chronically ill people; is this something that the administration is still considering, or is it beyond the pale, or is it going to be added to the package?

ROY RAMTHUN: I've had many discussions with employers about whether or not prescription drug coverage should be offered below the deductible, and the usual tact is to try to expand the definition of what preventive care is. The arguments go somewhere along the lines of "Well, prescription drugs prevent people from dying." I don't disagree. "Drugs

people prevent from having their conditions worsen." I don't disagree. But if we're looking at what a classic definition of preventive care is, it's usually prior to the onset or symptoms of a particular illness or condition. It is very difficult, beyond that point, to start drawing a line where things are considered preventive or not. Treasury did try to indicate that that would be possible for some drugs to be preventive care, noting some cases where people have risk factors, such as high cholesterol, which doesn't necessarily mean you have a disease or illness, but you have risk factors for a condition and that cholesterol-lowering drugs could be viewed as preventive care under those situations. So I think we have to look very closely at that. When I've talked with members of Congress who supposedly though about these issues, they tell me they clearly wanted all Americans to understand what the price of drugs are. And I can tell you from my own experience, the first time my wife filled a prescription for an antibiotic, the pharmacist came to her and said, "Do you know this costs $102?" And she said, "Well, yes. We have a high-deductible plan, and I expect to pay the full cost." Well, it was a name brand of amoxicillin and afterwards she realized that she probably could have asked for a generic version of amoxicillin and would have spent much less. At least some of the supporters in Congress of HSAs clearly wanted that effect to be there, and believe

that that would be diminished if drugs allowed below the deductible.

FRANK MCARDLE: I agree with Roy that the political odds of getting this done are quite small, particularly this year. It is helpful to have preventive drugs available for coverage, but you also have to think about how you communicate that to employees and how employees actually understand that drug A could be covered, but drug B not. It's very difficult to communicate and for them to understand. Then the bigger issue is whether you differentiate drugs at all. I guess I would argue that you do. We know, from a health status standpoint, that there are a lot of problems with people not complying with their medication regimen. We know that adherence is often very spotty and, as also mentioned, the chronic conditions are rising as such a big part of our healthcare costs. I think the companies feel that this is a sector where you want to encourage compliance with the regimen and preventing and dealing with some of these illnesses, and not put any kind of financial barrier in the way of that.

FEMALE SPEAKER: This question is regarding the implications of the growth of HSAs on the risk pool, and is there any concern about the potential fragmentation of the risk pool as a result of this?

FEMALE SPEAKER: That's an important question, because the goal of any insurance regime is to get people pooling their

risks together, so that healthy people and sick people contribute to a common fund, and then when you get sick, you have access to resources. Right now, there are a lot of people who don't have access to health insurance. When they're healthy, it doesn't seem worth the money, and when they're sick, it's hard to get it. So one of the goals of this expansion is to get healthy people into the system, able to afford a basic insurance policy, and then be in the system and pooled with other people. On the employer's side, as I mentioned before, we see employer erosion of coverage now because of rising costs. So again, anything that keeps employers in the market of offering health insurance helps with risk. Now, as Uwe has alluded to, I think if we were designing a system de novo, we wouldn't set up the system we have. There are problems with having risks pooled through employers. People who get sick can't change jobs, so you have something we call "job lock" where people are stuck in their jobs just because somebody in their family is sick and they feel like they can't get insurance through another source. So we have also proposals, which we didn't have time to talk about today, to make it easier for people to keep their insurance when they move from one employer to another. So all of this is about keeping people insured so that we do have better risk pooling, and anything that we can do to make the non-employer individual market function better to make it more appealing to people who

can't currently afford insurance, or who don't see a basic policy available to them, will improve risk pool.

MEGAN SMITH: Hi, my name is Megan Smith, I'm with Edelman Healthcare. I have a couple of questions back on the transparency point if I could. Roy, you spoke about meeting with the insurance companies and asking them to do this kind of divulgence on a voluntary basis, noting that Uwe's concern and others that this is very hard information to receive, it's been suggested in the media that possible legislation could come out of this, and in absence of that, maybe a standard of the types and kinds of information that would be provided so that the information provided by all these individual companies voluntarily would be uniform. Can you speak to that a little bit?

ROY RAMTHUN: We note that some insurance companies have already started doing this. You may have read in *The Wall Street Journal* about Aetna's experiment in Cincinnati providing the information on the 25 most common procedures performed by physicians in their office being available to their enrollees. Most of the major insurance companies have plans if they're not already doing these types of things, so we believe those are steps in the right direction. If we can get Medicare's information out there, in theory, every American would have access to how much Medicare is paying. We absolutely note that there are four bills pending in Congress which would require

this at least of hospitals and, in some cases, of ambulatory surgery centers. Those are steps in the right direction. The President could call on Congress to enact those bills as steps that we could take to move further down this road. It's not going to happen overnight, as Dr. Reinhardt suggested, but we've got to start somewhere. It's not going to be perfect, but we've got to start somewhere. So, we're trying to take some meaningful steps in moving the market that much further down the road still this year.

UWE REINHARDT, PH.D.: Just to illustrate how hard this is. Medicare has, of course, a fee schedule that it, at least in theory, is somewhat based on relative costs. Some years ago a fellow in Phoenix tried to have a web site where you could get Medicare physician fees for Phoenix, for Princeton, et cetera, and have at least some idea of what things cost when you're in a PPO, so you could tell a doctor, "Hey, three times is a little too much." And it turns out the AMA has a patent right over the CPT4 code that underlies the Medicare, and they wanted to charge him a royalty for every hit. He had a very angry web site with that contract, I have it somewhere still, that was written where the Medicare fee schedule nomenclature actually belongs to the AMA, and of course they didn't want this information out or wanted to make money off it, whatever the motive was, and he couldn't make a go of it. He was a great entrepreneur I thought; I could see the potential,

advertise and so on. But this never came. I am interested because I have a PPO; we have PPO with a high deductible and a flexible spending account, which in my tax bracket, is a wonderful thing. Except as I always tell people, I had to go have a colonoscopy on Christmas Eve to burn down this account. This is a true story. The HSA is, in fact, a rollover FSA, so I appreciate it very much for myself. But don't underestimate the ingenuity the providers will bring to the table to block price transparency.

ROY RAMTHUN: We have much work to do.

FEMALE SPEAKER: Actually, as a follow up to this last comment, this question says, "Rather than a tool to curb the use of healthcare, couldn't HSAs promote the overuse of spending since the account would have the ability to discretionary spend on the employer's [inaudible]?"

KATHERINE BAIKER: First, I want to clarify that the goal isn't necessarily to get people to spend less; it's to get our healthcare dollars to go further. We have a lot of evidence that our healthcare dollars are not buying us nearly as much as they should, because people don't have the information that they need, and physicians don't have the information that they need. You can see we spend a lot more than other countries on healthcare, and our outcomes are not measurably better along a lot of dimensions. And then even within the US, if you look at parts of the country where we

spend a lot more, say through Medicare, we don't see any better outcomes, even if you control for the age and the risk an the preferences of the populations. You spend twice as much per Medicare beneficiary in Miami as you do in Minneapolis. That person does not live long, that person does not live better, that person is not even happier, they just get more care. So the goal is to set up a system where we can allocate our health dollars to where they do the most good. And then, if we're spending this much on healthcare, everybody could be healthier and wealthier. So if that's the goal, than will people consume more of some healthcare with an HSA? Yes, I hope so. And I hope other people will consume less or resources will go to different places, and then I will be less concerned about the total amount that we're spending, because I'll know we're getting our money's worth. We don't care how much we spend on consumer electronics, because we're buying things that are worth it to use; whereas in healthcare right now, sometimes we are and sometimes we're not. Unless we have better information on the table, we're not getting as much value for our spending as we could.

UWE REINHARDT, PH.D.: You know what? Katherine is unduly modest. She wrote a dynamite article, April 7, 2004 *Health Affairs* if I remember correctly, where she related data on process quality to data on health spending for the elderly and gets a negative correlation. I recommend that piece to

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you. I use it all the time; I should pay royalties.

[Laughter]

ED HOWARD: I should say, by the way, as we're winding down here, remember these blue evaluation forms; they'll help us make these programs better. Yes, go ahead Alwin.

ALWIN CASTLE [misspelled?]: Hi, Alwin Castle with the Center for Studying Health System Change. Speaking to Dr. Reinhardt's point, I guess I am in possession of a little known secret, and that is that you can go to the American Medical Association web site and, I think, once you agree that you will not misuse the CPT codes, you can get up to 10 CPT codes a day, by geographic area, that will tell you how much Medicare pays for those CPT codes in a physician's office and in a facility. It's fascinating. You need to keep in mind though that we know that private plan rates vary significantly across communities as a percentage of the Medicare fee schedule, so in some communities that we study, Little Rock for example, the docs get 150-percent of the medicare fee schedule; whereas in Phoenix, they get 100-percent and they consider themselves lucky. Now, that was my observation; I actually do have a question. I want to offer a disclaimer that I have a journalism degree, and I certainly have been accused of practicing economics without a license, but the basic question I have is, if you want to curtail or slow the trend of healthcare spending, why would you possibly subsidize it at a

higher level? Because isn't that just basic Econ 101, the more you subsidize something the more people are going to use it?

KATHERINE BAIKER: Your Econ 101 is right on. When something is subsidized relative to something else, we expect a distortion in the consumption. Right now, employer-provided insurance is subsidized relative to out-of-pocket spending, so you see that people, in fact, consume all of their healthcare through employer-sponsored insurance if they have it, and not through out-of-pocket spending. So now we're saying, "Let's level the playing field; let's make out-of-pocket spending have the same tax preference as employer-sponsored insurance does." And your question is, are people going to consume more of that? I think there are three avenues through which we're going to see peoples' behavior change, and a reallocation of resources towards higher value care.

The first is, when people are more price sensitive, we've seen evidence through other sectors of medial spending and the economy more broadly. Like Lasix surgery, like in vitro fertilization, like dental care, like vision care; when people are more price sensitive, providers compete more and you get both increases in quality and decreases in price. So we expect provider competition to be a big force in that direction. We also expect that when people have a choice about how to allocate their resources, they'll be allocated more efficiently, and so we'll see a decrease in quantity, although

I think the change in price is going to be the bigger, longer-run effect. The third effect is that right now, and I think this is the big one, but not one that we're going to see in the first five or ten years, there is no incentive to develop cost-saving technologies. So you see, if you're an innovator and you have a new way to do something we can already do, but it costs half as much, there's very little incentive to develop that because people aren't price sensitive to chose that. If, on the other hand, people are being price sensitive, we'll not only see life-saving technologies and I think all the technological innovation we've seen is, on average, wonderful, but you'll also see cost-saving technology. The same way we have in computer processors or in Lasix surgery or in vitro fertilization where in the long run, you'll end up getting roughly the same amount of healthcare at a much lower price. In the end, you may end up spending more or less than you spend now, but I'm not going to be as worried about it, because I know you'll get your money's worth from it.

ALWIN CASTLE: I guess the only thing I would respond with is that we're actually looking at some of those self-paid markets right now, and they're often touted as these models of market efficiency, and when you actually begin to look under the rock, there's not a lot of price competition going on. There's a big difference between getting a nose job and needing a bypass and it is not interchangeable. Healthcare is not hog

bellies; it's not a commodity. If you get prices, that will be great, but if you don't have the quality information to go along with it, I would argue that we will be penny wise and pound foolish and not get value, which is what I think we're all after.

UWE REINHARDT, PH.D.: If I could add, I think you do deserve a degree in Economics. I'll give you a certificate later. But you don't have to worry that much about low-income people, because we're not giving them much of a subsidy. What I worry about is people like me. You're making it half-price.

ALWIN CASTLE: I think our research [interposing].

UWE REINHARDT, PH.D.: For me, the price elasticity is very, very low. The government pays roughly half of it, plus my income is high. So that's the folks that you have to worry about, our social class, not the poor, because we don't give them much.

MALE SPEAKER: The underlying assumption seems to be that by putting people at financial risk, they will make decisions that are better, both for the economy and, presumably, for their own health. My question to you is, is anybody concerned about the fact that putting people at financial risk might encourage them not to seek healthcare when they need it? Is a person who is 60 years old and has chest pain every two weeks going to blow it off if they're going to have to pay the first $500? As opposed to if they had a health

plan, they would go see their cardiologist. So, do the HSAs produce results not only that are good for the economy, but are good for individuals' health?

KATHERINE BAIKER: That's a great question, and I think people have a very strong interest in preserving their own health. I don't think that people go to the doctor because we subsidize it. Nobody enjoys a colonoscopy, especially on December 24, but people have a strong interest in getting the care that is going to make them healthier and live longer. What they don't have sometimes is the information and resources that they need. And that is where these policies come in. We have ample evidence that armed with the right information, people do, in fact, make better healthcare consumption decisions. There are lots of clinical studies. For example, the sports study of spinal surgery choices; there are two different treatments available if you have a certain kind of back pain. You can have surgery and there are surgical complications and the risk of problems for that, or you can have bed rest, and there are problems with bed rest and it takes a longer time. In the end, those two procedures have roughly the same success rate, but with very different risks and complications, and people should choose among them based on what their preferences are for those different risks, given that they're going to have roughly the same outcome. There's a clinical trial that shows if you give people about a half-an-

hour's worth of information on this, they make very different choices. And, in fact, many fewer people opt for the surgery than they would otherwise. These are people who had access to the funds to have the surgery, but discovered through the information that was made available to them, that they would rather not. So just providing people with key information really does change consumption patterns. Sometimes they're going to spend more; sometimes they're going to spend less. We see that people who are specifically in consumer-directed health plans, again the data is very young and we can argue that they've only been in existence for a few years, but if anything, we see higher compliance with treatment regimens, and we see insurance companies continuing to provide disease management help and programs for their enrollees, because they still have a financial stake. Remember, people are not going without insurance in these plans; they have catastrophic backstops of $5000, $10,000. The insurance company still cares about making sure they spend the money wisely, and people are not exposed to an infinite amount of financial risk.

UWE REINHARDT, PH.D.: I think I would add that the most thorough study of this behavior was several years ago, the RAND Corporation experiment, and Joe Newhouse, about one or two years ago, wrote an article in *Health Affairs* on the RAND Experiment and HSAs. He observed in that study low-income people facing high cost-sharing did neglect high blood

pressure, I think I'm quoting him correctly, and you could calculate that it drove up death rates by 10-percent. That is why, of course, as Roy and Katherine both said, and Frank has to get it done, that the preventive care and this kind of care, asthma for children and high blood pressure, is actually exempt from the high cost-sharing and you actually sort of seduce people into consuming it. But that's a design problem that Frank has to solve for us.

ED HOWARD: All right, Diane, closing comments?

DIANE ROWLAND, SC.D.: I just want to say that I'm sorry that we couldn't get to the very many questions that were left on the table, so I think it speaks to this being an issue that we should continue to keep on the agenda and revisit.

ED HOWARD: Absolutely. I want to thank you for coming, and I want you to help me to thank our panelists for a very good discussion. [Applause] Please fill out your blue evaluation forms as you go.

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