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REFORMING MEDICARE: OPTIONS, TRADEOFFS, AND OPPORTUNITIES

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PROCEEDINGS

MR. DIONNE: I want to welcome everyone here today. I am E.J. Dionne. I'm a Senior Fellow here at Brookings, and I am an unabashed fan of Henry and Jeanne's and am very honored to be able to do this today for their fantastic book, *Reforming Medicare*.

It is this -- this event is brilliantly timed. Some of you may already know this, but tomorrow is Medicare's birthday. Medicare is actually younger than many of us. It was born on July 31, 1965, when Lyndon Johnson signed it into law.

And Henry and Jeanne have a wonderfully affecting story at the beginning of their book, when they talk about L.B.J. choosing to go down to Independence, Missouri, the site of Harry Truman's library in order to honor Truman, who had been trying, as many of you know, to get passage of national health insurance since the late '40s when he was President of the United States.

And explaining why he did this, L.B.J. said to Wilbur Cohen, who was the Administration's point man on Medicare, he said, "Don't you understand? I'm doing this for Harry Truman. He's old, and he's tired, and he's been left all alone down there. I want him to know that his country has not forgotten him. I wonder if anyone will do the same for me."

And so I want to say to L.B.J., wherever you are, we are remembering you today. And indeed Medicare is one of your finest achievements.

Medicare was not passed. There was some controversy. They also -- Henry and Jeanne -- also note what a certain prominent conservative spokesman named Ronald Reagan said about Medicare. He warned that Medicare would invite socialism to "invade every area of freedom in this country, and forced Americans to spend their 'sunset years' telling our children and our children's children what it was like in America when men were free."

Now, fortunately, the Gipper was far more philosophically flexible and pragmatic than many gave him credit for, and he did not keep this view of Medicare when he became President.

This is a great book. In fact, it bends over backwards to be fair. I think the main criticism of this book will come from people who will say, Jeanne and Henry, why were you so fair to those folks you disagreed with. And, in fact, they were so fair that the panel today reflects that commitment to fairness.

And I just want to say that I think this book is a perfect kind of thing for a think tank to do. In presidential elections, we're supposed to discuss the big issues facing the country, but it is often the case that candidates themselves are not the ones who can be counted on to talk about the hardest issues facing the country.

Indeed, I dare say, that neither John McCain nor Barack Obama want to touch a hair on Medicare's head until at least after November of this year; don't want to talk too much about it.

And I personally don't blame them for that. I was just on vacation and read a wonderful book on the 1932 election, where F.D.R., frustrated that some of his aides are not putting forward some of their more adventurous ideas, and he looked at one one day and said, “You guys have to remember the purpose of an election is to get elected.”

On the other hand, it is the obligation of people at think tanks and people who care about policy to begin the debates that inevitably are going to happen after the election takes place. And, so, this book lays out the options for Medicare.

As I say, it is genuinely balanced. It talks about Medicare’s great successes in monthly meeting it goal of providing affordable access to health care for the elderly and to people with disabilities.

It also talks about the rising costs of Medicare. Between 2008 and 2018, our authors write, “Medicare’s share of non-interest federal spending” -- you can tell they’re economists -- “is expected to rise from 14.8 percent to 17.1 percent.”

And they also talk about the burdens of out-of-pocket spending on seniors. So something will be done about Medicare, and I'm going to push all our participants, once we get to the Q&A, to talk about reform of Medicare might relate to our efforts to get health insurance to every American, which I believe will be a central issue no matter who is elected president.

The book lays out three options, which they will -- Henry and Jeanne will -- talk about. The first would simplify the system, but retain its

social insurance structure. The second involves premium support, which would replace the current system with a cap per-person payment. And the third, more radical, strategy would make individuals responsible for paying expenses up to a relatively high deductible.

We have brilliant representatives of each of these points of view who will speak after Jeanne and Henry present their overall view. I also -- there are so many distinguished people in this audience. I do want to welcome former HHS Secretary Donna Shalala, whom I've invited to ask the first question. I also see Bill Nascanan here. Welcome, Bill. And I'm sorry I can't welcome everyone here today, but thanks for coming.

I will do very brief introductions, because, for most of you, these folks need very little introduction.

Henry Aaron is currently the Bruce and Virginia McCory Senior Fellow in Economic Studies here at Brookings. From 1990 to 1996, he was Director of the Economic Studies Program. He joined the Brookings staff in 1968. From 1967 to 1989, he taught at the University of Maryland. He was Assistant Secretary for Planning and Evaluation at the Department of Health, Education, and Welfare in '77 and '78. He was on the Advisory Council for Social Security. He's done all sorts of extraordinary things in public policy that has also written a whole slew of books which I won't plug today, although I do like the title of one of them, "Coping with Methuselah: The Impact of Molecular Biology on Medicine and Society," co-edited with William Schwartz.

He's a graduate of UCLA; holds a Ph.D. in Economics from Harvard.

And Jeanne Lambrew, whose bio is supposed to be here, but appears to have disappeared or is out of order, but Jeanne -- ah, there we are -- Jeanne is a Senior Fellow at the Center for -- it's better than the poor person who was announcing her candidacy for Governor of New York, and hit a point in her speech, and stopped for 30 seconds and said, "Finally, I'm missing page 10." She shortly after dropped out of the race.

Jeanne is a Senior Fellow at the Center for American Progress, an Associate Professor of Public Affairs at the L.B.J. School of Public Affairs at the University of Texas. She specializes in health care and policy -- health care policy, conducts research on the uninsured, Medicaid, Medicare, and long-term care. She was an Associate Professor at George Washington University's School of Public Health. From 1997 to 2001, she worked on health policy in the Clinton White House. She was a Program Associate, Director of Health at the Office of Management and Budget, and she has done an extraordinary number of things, an extraordinary amount of public service.

She received her master's and Ph.D. from the Department of Health Policy at the University of North Carolina at Chapel Hill and a bachelor's degree from Amherst College.

I will welcome Henry and Jeanne to present their book, and then I will introduce our respondents. Henry Aaron.

MR. AARON: Thank you. Jeanne and I are going to do a bit of a tag team this morning, but E.J.'s story about the hapless candidate for governor in New York reminded me about the story of the obnoxious senator whose staff hated him, and they devised a way to get even with him. One day he had to give a speech, and he was in a horrible rush, so they just handed him the speech and he ran off. And he got up on stage and he started to read from the document. He said, "Today, I'm going to talk about problems of economic development in the Third World, the energy crisis, inflation and poverty in the United States." And he turned the page and then said, "All right," expletive deleted, "you're on your own bucko."

(Laughter)

MR. AARON: Well, right now, the election day is just a hundred days away. You all may have seen projections released this week by the administration that whoever is elected president is going to confront some pretty terrible deficits. Moreover, those deficits are projected to keep on growing, and among the health fraternity or sorority, it is well understood that the primary force driving those projected deficits are increases in Medicare spending.

Nonetheless, the health programs of both Senators Obama and McCain focus on reform of the overall health-care system, not focusing on Medicare. That reflects a core fact, and the fact is that as a practical matter, it's going to be impossible significantly to slow Medicare spending without undermining the nation's commitment to provide care,

standard care, to the elderly and disabled unless it is part of a larger health care reform.

Now, Medicare has dramatically improved access to health care for the elderly and disabled, but, at the same time, I think everybody recognizes that the program has some serious flaws. Fixing them is going to take some combination of changes in the way the program is administered, more use of markets and consumer choice, and, not paradoxically, in my view, simultaneously more regulatory oversight by government, probably some combination of all three of those.

But whatever the nature of the reform, implementing it is going to cost a lot more money than the share of government spending currently devoted to Medicare.

What Jeanne and I have tried to do in this book is provide a guide to the debate about Medicare reform, even if the candidates are currently shying away from it. And they shied away from it for the reason that E.J. mentioned: there's some really nasty choices involved, and the job of people running for office is to get elected.

Sooner or later, however, one of the three major options for reform that Jeanne is going to describe will have to be chosen.

I want to take time to express my very sincere thanks to Richard Leonne and the Century Foundation who supported this effort. Only he and I really understand the extent of his patience with his enterprise, which is tremendously overdue, and I want to thank him and the Foundation for the support and the patience.

If you turn to the title page in the book, you will discover that there is a third name of a person not currently on the stage listed, and that is Patrick Healy. Patrick Healy's been working at Brookings for a couple of years. It's to him that we owe the fact that the facts are right and up to date. We didn't set out, when we started this book, to write a reference work on Medicare, but if those of you who go into the notes and much of the text will find a wealth of information about the program, and I have to say it would not be there were it not for Pat's effort.

In fact, if you have some detailed questions, and Jeanne and I don't know the answer, Pat, where are you right now? There he is right there. He will, I think, have the answer.

Okay. It's Jeanne's turn. She's going to describe the challenges that Medicare faces to the options for reform, and then I'm going to give a report card on each of the three options. It's a complicated report card.

MS. LAMBREW: And I also have to begin with my thanks, first of all thank you to Henry for making this an incredibly rich learning experience. I need to thank Bob Reichauer, who began this project with us, who helped with the early parts of the drafts, and I also need to thank Secretary Shalala, who is here today, because, under her stewardship, for eight years, we saw Medicare's solvency improve, benefits improve, and the agency really did thrive under her leadership. So thank you so much. It's a privilege to talk to you all today.

So I'm basically going to start, very briefly, with the successes, because we really can't began by saying this program is a failure. It has succeeded in many metrics. It has contributed to lengthening people's lives, their quality of life. It has produced poverty among seniors and people with disability.

It has achieved other societal goals, like desegregation of hospitals, improving language services in hospitals, and even in ensuring that people who are uninsured have access to emergency care.

Its satisfaction and access are enormously high, we know, when we compare Medicare beneficiaries to people ages 45 to 64, they are three-fifths as likely to report failing to obtain health care due to costs.

And we also know that it has performed as well on costs as the private sector. We can get back to this point. But its cost trends are no better and no worse, according to the Medicare actuaries than the private sector.

But it does face these challenges that we've heard about, the first being its persistent benefit gaps.

We know that Medicare does not cover the same benefits that most typical private insurance plans do; nor does it include catastrophic protection. People on Medicare could become quite bankrupt, in a way, by having high out-of-pocket costs because there's no limit on Medicare's out-of-pocket spending.

As a result, the vast majority of Medicare beneficiaries have to turn to supplemental coverage to fill in Medicare's gaps, and that's

particularly important for low income beneficiaries for whom access would be compromised without some sort of extra help.

Its focus on quality is low. In this nation, about six percent of Medicare beneficiaries, after they're discharged from the hospital, has some sort of complication. We know that only 48 percent of Medicare beneficiaries receive recommended antibiotics when prescribed.

This is not unique to Medicare. We have quality problems that are pervasive in the system, but Medicare, given its vulnerable population, as an extra burden to try to figure out how to address that.

And on this cost issue, it may be that this issue that it performs as well as the private sector is not good enough. We know that the population covered by Medicare is going to increased from 14 percent in the year 2005 to 22 percent by 2040; that Medicare costs are primarily covered by government, yet the revenue that's supporting Medicare is not growing as fast as health care costs. This is creating this fiscal gap that Henry just talked about.

This gap can be narrowed -- oops, I'm sorry. This gap can be narrowed Medicare policy changes that promote efficiency, that reduce prices, that reduce utilization. And it also could be narrowed by systemic health that gets at the cost drivers of the system.

But short of bringing the healthcare cost trends in line with our revenue growth, we will continue to see a challenge in trying to continue to provide Medicare services to its beneficiaries without raising revenue.

Henry mentioned this. I just want to underscore it. We probably cannot solve Medicare's problems through Medicare alone. We will likely need to consider new revenue sources.

But the good news is we're not going to do that today. We have focused only on trying to figure out how we think through the structure of Medicare and larger health system designed to achieve the types of goals that we'd like to see.

And Henry will talk about the goals that we’re going to try to maximize, but what we did in the book was take these three approaches that E.J. outlined that I'll talk about in a second, and assume pure applications.

We envisioned that Medicare were fully reformed under these three different models; that they adhere to be advocates’ visions of them. And then we walk through examples and those policy details that would likely affect the outcomes.

But the goal of doing it in this idealistic way is to really show the contrast of the major pieces. Sometimes, when we do incremental reform, it gets all muddled up, because you can't figure out what is the increment and what is the idea beneath it.

So what we tried to do is say here's what these ideals look like, and here's how they operate.

The first. The first idea is to really revamp Medicare as a social insurance program. What this basically means is that all beneficiaries would have a common and collective set of protections. This

would be publicly administered or through a non -- profit to really pool the purchasing power of individuals, and there would be direct payments to individuals. The mechanism in social insurance is using the collective to try to achieve the results that you're trying to accomplish.

The origins of social insurance are old. This is the idea that really emerge from the industrial revolution. We first saw this in Germany. We saw the movements back in the early parts of the 20th century to bring that proposal here. It has its roots in kind of a Judeo Christian common good theory, and this is something that E.J. Dionne has written about quite articulately. How do we think what is a collective responsibility.

In Medicare, it has its roots in the Democratic Party and the political tradition. As we heard, L.B.J. was the president who brought this about with a Democratic Congress. Over time, it has gained some bipartisan support, but it really is kind of the core basis of Medicare today.

So what this proposal would be that we describe in the book would be to strengthen governance in Medicare, eliminate the private plan components of that, so there would be no Part C and no private plans administering the drug benefit; integrate the drug benefit into Medicare; charge one uniform premium; and then offer a Medicare's supplemental benefit not through Medigap, but through Medicare as a way to offer extra protections to low income people.

So it really is trying to say let's take Medicare as it is, and strengthen it.

Our second option is really looking at a different model: premium support. With this proposal would do is have Medicare no longer pay providers, but instead play pay plans.

Medicare would now capitate its payments. It would have private plans make most of the decisions in Medicare, as we'll talk about. And it would really try to use competition to drive the outcomes that we want.

But it is competition within bounds. This idea has its origins in the managed competition theory, and I call that sometimes the marriage between economists and health policy people. Sometimes it might be called the collision between the two of them. But irrespective, it's trying to say how do we marry regulation and competition to achieve the types of goals that we want.

This idea originated probably in the late ‘80s, earl ‘90s. It had its -- it had some bearing in the Health Security Act debate of 1994. We saw it kind of come into full fruition during the Medicare Commission debate in the late 1990s.

And in 2003, with the Medicare drug benefit, we really saw this idea move from theory to practice. It really is the basis of the Medicare Advantage payments, how the drug benefit is designed today, and if it continues to go forward, the premium support demonstration in the year 2010.

And our third major approach that we examined is really, as I think E.J. said, more radical. It's converting Medicare into more of a

defined contribution program. Medicare would pay into both a high deductible health plan and an account, an amount with very little regulation, really letting individuals take that primary control over many decisions. So it really is moving Medicare from a collective social insurance model to individual market-based model.

The theory here is that with responsibility and liability, we'll be able to achieve some of those outcomes that we seek in Medicare. And its origins also kind of date back to when we saw the managed competition of ideas emerge. It began sort of as a reaction to the health reform debates in the late 1980s and early 1990s. Whereas, there was a desire to have some sort of alternative to some of the plans that were on the table.

There were several demonstrations, as some of you all may remember. There was a demonstration for the non-elderly population, passed in 1996; in Medicare in 1997. There was policy that was created in 2003 to make Medicare savings -- State Medicare savings accounts part of Medicare, and because none of those really took off, in the year 2007, the Bush administration created a demonstration authority that did allow these Medicare MSAs to be more flexible.

And the reality is we now do have them in operation. Several thousand people are enrolled. But the idea here is what would Medicare look like if everybody were in those types of models.

There are four functions with which we can see how these different models compare. In terms of who determines benefits, what we

know is that under a social insurance model, it's determined by Medicare, trying to figure out what average or the common Medicare beneficiaries need, and all beneficiaries have the same sets of benefits and protections.

Under premium support, what we see is the plans would make that primary determination based on both what they think would attract individuals, what they think would maximize their goals of keeping costs low and quality high.

And under consumer direction, you really are delegating these decisions to individuals, the model being in an ownership society shouldn't individuals be able to say, "Now I need this. Later I need that. I'll use my account up to my limit. I'll be able to determine what benefits I pay."

So it's all paid out of pocket until you hit your catastrophic -- or your deductible, and then there's a low cost sharing.

When we turn to how payments are determined, what we know is under social insurance, it really is Medicare. We have one set of payments or a regional set of payments for all providers serving Medicare beneficiaries that could be based on some sort of fee schedule. It could be done through competitive bidding, but irrespective the provider community would be facing one set of payment rates for Medicare.

Under premium support, there would be potentially multiple sets of payment rates. Currently, we actually see a lot of relationship between what private plans pay providers in Medicare, because there's lots of interrelationships.

But if Medicare is no longer as a fee-for-service program, we may see a more diverse set of rights that providers would see under this system, and that would be primarily based on how they can kind of restrict or expand their networks.

And under consumer direction, providers really do set their own prices. And the model here is that consumers, armed with their Health Savings Account, would shop for the lowest prices and highest quality and hopefully be able to find the sets of prices that they want.

But that leads to a question about which providers will be covered in this world. And when we think about social insurance, what we know is that we do have little choice in terms of benefits, so everybody gets the same benefits. Providers would basically face one set of rights, but the choice that's maximized in social insurance is choice of doctors. Because of the way that Medicare is set up, we basically have a one-tiered system in our provider community, where all qualified providers would be eligible.

I think we would envision that in this new world order you try to use payment rates and your cost sharing to steer beneficiaries towards those providers that are offering the highest quality. But, needless to say, you really do have maximum choice of providers under social insurance.

Under premium support, what we see is this trade-off that broader networks and providers mean potentially higher prices. The more you can narrow your network, the potentially more you can get discounts.

So access to a given doctor may be more restricted under a premium support model.

And under a consumer direction, there's the theory and then there's the practice. In theory, individuals would be able to choose any provider with their account. But without some of the laws that Medicare has built in to ensure that physicians participate in the program, it may be that an individual with an account can't get in to a doctor's office, so there's a question about the theory versus practice of provider choice under a consumer-driven model.

And the last function I'll talk about before turning it over to Henry is quality. As I mentioned earlier, we're all concerned about how do we figure out how to improve quality nationwide, not just in Medicare. And with social insurance, what you do -- what you have is leverage.

You can, in part, use financial incentives for high-quality providers. We've seen a number of demonstrations and try to figure out how you pay for quality and incentivize it, but you also can do things like build on the quality improvement organizations, create regional forums. Medicare has data that could be fed back to providers in an indirect way to really, you know, in sure that we have the feedback loops to make sure that best practices are propagated. But it also could set minimums and say a condition of submission in the program is that you're providing high quality.

How you measure, that's a challenge. But it could be done. You could use as leverage to try to get high quality.

Under premium support, one theory about how we could improve quality event typically private plans can encourage more integrated care, more medical homes, more organization that could, by definition, promote quality within that organization. And it may also be in our ideal world that these private plans compete on quality, because they want to be able to ensure that they attract the patients were seeking quality.

And under consumer direction, it really is back to the simple model of shopping; that hopefully we will have enough information that individuals knowing the provider report card will go out there and shop for that quality.

We hope that's the case, but, as Henry will say, we'll see how this might work in practice.

MR. AARON: Jeanne's laid out the options for reform. My own belief is that any one of these three strategies, properly implemented, could achieve significant advances and at least some dimensions for which Medicare is responsible.

We've included in the book a report card on each of the reform strategies in three dimensions: how they perform with respect to access, quality, and cost. Like every report card, ours is subject, and we understand that not everyone will agree with the grades we assign. In particular, I'm pretty sure that Karen Ignagni, Michael Tanner, and Bob Berenson will probably make quite clear that not everybody agrees with our grades.

Our point is that how one ranks these plans depends as much on one's own values, the importance that one attaches to each of these goals -- access, quality, and cost -- as it does to one’s appraisal of how the plans perform in each of those dimensions.

Now, access has a couple of meanings, and the first is, are services really available, physically; the second is that people afford them. On both scores, we think social insurance is a clear winner. Services provided by all willing providers are covered under the reformed model, which would fill some of the gaps in current coverage. Medicare could do even better than it now does.

On physical availability, nearly all providers currently take Medicare payment, and the program has helped maintain financial viability for hospitals and other providers in thinly settled areas. So we think social insurance gets an “A” for access.

The essence of premium support is limitation of access to all providers by competing insurance plans in order to control spending. Consumer-directed care would enable physicians and providers to set whatever fees they wish and target their services to particular groups.

There’s also a risk under consumer direction that some patients might exhaust their Health Savings accounts, and find that the high deductibles or other cost sharing hinder access to coverage.

So we think that both premium support and consumer direction get lower grades than social insurance does for access.

Well, like access, quality has at least a couple of dimensions. What do professionals say is high-quality care? And are consumers satisfied with the care they receive?

Expert evaluations are getting increasingly sophisticated and are used increasingly, we live in a market economy and surely satisfaction by consumers counts, and we live in a democracy. So no elected official can or should ignore what their constituents think.

Our report card grades on quality will probably be our most controversial. We give consumer-directed model the lowest grade. The evidence, we believe, shows that individuals are not good at processing complex information on provider quality, and even low cost sharing reduces adherence to treatment regimes.

So even if information dramatically improves and we're pretty sure that it would under consumer-directed health insurance, we doubt that individual buyers would effectively police objectively measured quality.

Furthermore, on the other side, survey evidence indicates to date, at least, higher satisfaction among Medicare or managed care enrollees that among those who have chosen consumer-directed plans, and it's important to note all enrollees to date in consumer-directed plans are volunteers.

As far as objective quality performance is concerned, we think that Medicare can do better than it now does under either a reformed social insurance model or under premium support. The reformed social

insurance model should include extensive publicly funded effectiveness research and information about the quality of providers. And, on the other hand, the premium support model a service that private plans to use quality information to form networks of providers and that it would serve -- quality would serve as key marketing tool.

However, the social insurance edge on access and at least the tie with managed care on -- with premium support on quality comes at a price.

And the price is price, or to be more precise, total expenditures or cost.

For most beneficiaries, Medicare pays administered prices for whatever willing providers actually do. The failure of Congress to control physician expenditures, documented by recent legislation, simply illustrates the problem.

Now, it is true that the overall growth of health care is about -- at the same -- spending is about the same rate as Medicare, but that is certainly not high praise, given the rapid growth of overall health care spending.

The fundamental problem is Medicare can try to control prices. They're not very good at doing that, and they can't really control units.

Now either premium support or consumer-directed reforms would significantly increase the scope for controlling spending. We

believe that premium support or consumer direction would enhance spending discipline, although in quite different ways.

Consumer direction would enable the government to determine just how much of the cost of health care would appear on public budgets, and exposure to cost at the margin would limit how much insurance beneficiaries would choose to buy, and, hence, affect use.

Under consumer direction, however, high-cost episodes would continue to be fully insured, and, indeed, probably more fully insured than they are now under Medicare, and, hence, the limits on cost control in high-cost episodes would be serious.

Premium support would encourage the creation of large private plans that would have considerable leverage over total spending, but such plans might use marketing strategies that gradually shifted total cost of spending onto public budgets.

Now the bottom line on this we think is that if you think that cost control is the primary goal, either premium support or consumer direction trumps social insurance. However, none of the three options is a clear winner in all dimensions. The one you choose will and should depend on the weight that you attach to different and legitimately important goals.

We point out that in practice, any legislator performance likely and probably should crawl on each of these strategies. For example, even if the social insurance strategy is retained, there's ample scope for increased consumer choice and market competition.

And under consumer direction or premium support, in order to make them work the way their advocates would like them to work, we believe that it would take a large amount of government regulation to deliver on their promises.

Now, we've talked about these pure broad strategies reform, but -- for reform of Medicare, but sweeping reform doesn't seem to be in the immediate future. And some improvements in the system just can't wait.

So we conclude the book by listing a few reforms that we think merit serious consideration. I neglected to give you the cost report card.

I'm going to go to the incremental reforms very quickly, just in bullet form. And you can come back to them in questions later on, if you wish.

First, the United States has failed repeatedly in efforts to support publicly the evaluation of what works and what doesn't. This is really low hanging fruit from an analytic standpoint. Politically it's difficult, but the failure to move ahead here is, in my view, an appalling failure of leadership of the part of our government.

Pay for performance is a term that's being used widely. It's quite primitive right now. There is a risk that advocates will claim more than it can deliver. But it can, implemented well, improve quality somewhat, and may lower spending.

Some hospitals and physicians perform a lot better than others do. Telling consumers which do best may help some of them shop judiciously. Our view is that the bigger effect may come from peer pressure among hospitals and physicians shamed if they're ranked low.

Competitive contracting sometimes infuriates those who are subjected to it, particularly if they've been able to charge monopoly prices for a long time, but it clearly should be implemented where possible.

Medicare Advantage, which has been overpaid since enactment of the Medicare Reform Act in 2003 should not be overpaid, and steps were taken in the recent physician payment reform legislation to reduce those overpayments.

My last item here is a political hot potato. I'm not sure even Jeanne and I agree on this one, but one way of dealing with the fiscal challenge posed by Medicare, at least in some measure, is to increase the charges that Medicare imposes -- premiums, deductibles, or other co-payments -- on those like me who can afford to pay it. Thank you very much, and I'll turn it back to you.

MR. DIONNE: Thank you very much. One of favorite commentaries on journalism is the producer sent out to cover Moses in the desert, offering the Ten Commandments, and he gets back to his office, calls his boss, and the boss says, "We only got a minute 20. What are the three most important commandments and report on those."

And so, for those of you with only a minute 20, I do commend the chart on page 121, which neatly summarizes their report

card. And Henry summarized it nicely: basically social insurance is great on access and quality, a problem on cost. The other plans are -- well, are more likely to save money, but at the cost on those other two fronts.

But to dispute that or perhaps to dispute the report card, we've got really some of the very best people to offer briefs on behalf of the various proposals. There is a doctor in the house. You can all be comforted. Robert Berenson is a board certified internist. He practiced for 12 years here in D.C. He's a Fellow of the American College of Physicians.

He's a Senior Fellow at the Urban Institute. He is an expert on health care policy, particularly Medicare. From 1998 to 2000, he was in charge of Medicare payment policy and managed care contracting in the Health Care Financing Administration. He also served in the Carter Administration as Director of the Domestic Policy Staff.

And again, I could go on to a very long list of achievements, but, again, I like good book titles. He is the co-author, with Walter Zelman, of the "Managed Care Blues and How to Cure Them." That comes with a music disk, I think, along with it.

Karen Ignagni is one of the best-known people in town. Washingtonian Magazine named her "one of the three top guns of all trade association heads." That's a wonderful title.

She is president and CEO of America's Health Insurance Plans. But prior to joining one of AHIP's predecessor organizations -- I did not know this about you -- she is a voice of labor here -- she was the

Director of the AFL-CIO's Department of Employee Benefits. She was a staff member on the U.S. -- on the Senate's Labor and Human Resources Committee. She also worked at the Committee for National Health Insurance and at the Department of Health and Human Services.

She's go an MBA from Loyola College's Executive Program, and, again, I could go through a long list of boards and advisory groups that she has been on. I will call her "top gun" for the rest of time except that's too similar to our President's habit of giving nicknames, which I don't like. So I'll refer to her instead as Dr. Ignagni.

Michael Tanner is a Senior Fellow at the Cato Institute. He's got some wonderful book titles, too. He heads their research into a variety of domestic policies, particularly on health care reform, social welfare, and Social Security.

His most recent book is "Leviathan on Right: How Big Government Conservatism Brought Down the Republican Revolution." I must confess, I love to see discord and discontent on the right, so I salute you for that book.

Under his direction, Cato launched the project on Social Security Choice, widely considered to be one of the leading forces in advocating a private savings program. Time Magazine called him "one of the architects of the private accounts movement," and I got to say this one really hurt, this book title for those of us who are New Dealers.

His book, "Proposing Privatization," was called a "New Deal for Social Security," which is sort of invoking Franklin Roosevelt in order to

undo his legacy, but there's been a lot going around. So I salute Michael Tanner also for joining us here today.

We'll start with Dr. Berenson, and we'll go to Karen and then to Michael.

MR. BERENSON: Thank you very much. It's a pleasure to be here, and I will share the praises. It's a great book. I recommend it to everybody, and it is much too evenhanded.

So I'm going to spend my time mostly talking about two things I think they missed, which I think we change the scorecard. I want to start by making a comment about having three mutually -- what are presented as sort of three mutually exclusive models, and there's a discussion near the end of how political reality may have us do things incrementally to take some pieces of each.

I actually think it's more -- it is preferable actually to combine one and two; that if, in fact, we strengthen, as I think we should, traditional Medicare's ability to manage cost and quality, we would also want good private plans offered to Medicare beneficiaries. I don't personally think the choice is either traditional Medicare without private plans or private plans without traditional Medicare. We would have a lot of work to do to figure out how to get it right to create a level playing field of competition I think for a few reasons.

Benchmark competition is the term sometimes used. Post office is better because FedEx and UPS compete with it at least in some of its product lines. I think having private plans helps the traditional

program, and, in fact, I think we want to free up the traditional program to act more like a plan to implement some -- well, I'll use the dirty word -- managed-care kinds of activities of the value for what beneficiaries get.

We certainly need the staffing group model HMOs in traditional Medicare. Their alternative delivery systems -- Kaiser Permanente docs don’t basically function in fee-for-service, so we would certainly want those plans, and if other plans can compete on a level playing field, terrific.

So I think from that point of view, we want traditional Medicare with other plans. I also think if we went to a premium support, I think we want the traditional Medicare program there. My hunch is it would be probably the most successful plan at controlling costs. We'll get to that in a second.

And so I think even if we want -- went to a model, moving somewhat away from a defined benefit to sort of a defined contribution with a defined benefit, we would want traditional Medicare to play.

So, however, in the spirit of today's meeting, I'll accept that we have three sort of separate models. I think the authors do a terrific job of laying out the virtues of social insurance, and then identifying a number of things that the traditional Medicare program needs to be more effective on cost, quality, access, value overall.

I especially like the fact that they have identified governance as an important issue, and the need to think about how it is that the program can make better decisions for taxpayers and for beneficiaries.

Seeing Senator Stevens on the front page of the Washington Post today and Secretary Shalala here, I am reminded of the fact that -- well, I'll make the point that I think we can do better than having a powerful chairman of an appropriations committee determining whether Medicare should cover PT scans or not. Well, that's sort of what happened.

I think we need to address governance. I think -- and so, I applaud the authors are laying that out. It won't be easy to take politics out of politics, but I think that's what we have to try to do.

I'm going to spend the rest of my time, then, talking about what I think are sort of two issues that didn't get attention in the book, which I think change my assessment or would change the way I would create a report card.

The premium support discussion focused solely -- well, it didn't focus solely -- but emphasized demand-side. It correctly went back to Alan and Tobin's managed competition model, and lays out how it could work, and indeed I think in Medicare managed competition could work the best. You can create a fixed-dollar contribution, in this case a subsidy from the government. You can have broad choice of competing plans. You can have, in this case, the government ensuring that a lot of information is provided to beneficiaries to make their choices -- all the elements that Entoven talked about, and Henry and Bob Reichauer talked about in some of their writings can be there in Medicare.

But I think there's a significant development on the provider side that the analysis misses, and that is that hospitals, and increasingly

physicians, have figured out the game. They have figured out the game of contracting, and they have consolidated and developed market power in many markets in this country, and essentially restrain efforts by health plans to control prices, as well as other activities to innovate.

Anti-trust enforcement has been nearly nonexistent, and when it's been tried, it's been overturned by the courts. The explanation in the book that plans will negotiate price discounts for volume -- in other words, we are going to direct our care if we can do away with the large networks, and you'll give us a big discount. We'll give you volume is a quaint notion of the '80s and '90s.

Now, the providers have figured out how they are indispensable in networks have enough market power so they don't have to compromise on price as they get included in networks.

And, so, where I conclude is that even if you set up the demand-side correctly, plans have real incentives to compete on cost, ultimately the premium that individuals have to pay in Medicare.

I don't think they have the ability to actually manage the delivery system, and that's why I suspect that traditional Medicare, with its government powers, actually will do a better job of controlling not only price, but costs.

And we certainly have data to suggest that Medicare now gets much lower rates on a national basis than private plans are able to do.

Let me finish by talking a moment about consumer directed, and a number of the arguments are in the book. For me, one of the most powerful is that -- it's the 20/80 rule in Medicare, as well as in virtually every private plan also.

Twenty percent of the beneficiaries generate 80 percent of the costs, and, in that sense, Medicare isn't insurance at all. It is pre-payment. It's the socialization of desirable and predictable health spending, sometimes with some excess which we could and should address. But it's not a moral hazard problem.

Giving people more skin in the game -- I don't like the term -- but giving them skin in the game only will have marginally impact. I agree with the authors that we can modernize the benefit structure in Medicare, provide a real catastrophic coverage in Medicare, reasonable cost sharing in Medicare. People then wouldn't have to go buy inefficient supplemental Medigap insurance, and that actually would result costs having some modest cost sharing that might reduce the use.

But having large deductibles would not affect the large -- where the spending is: people who will blow through what any kind of reasonable out-of-pocket limit that society would tolerate. And, therefore, really the solution is on the supply, the provider side.

But let me make a point that doesn't get attention, and this is mine, and I'm going to revert to being a doc. I've been a quasi-pseudo economist up 'til now. I'm going to be a physician for a moment.

The book, and, in fact, a lot of health policy discussion these days emphasizes transparency, the need for quality measurement, and I'm all for it. I think these are well-intentioned, marginally helpful activities to improve the ability of patients-to find their way through the system. But, and this is the major point I want to make here, is that the quality of care in our system still largely relies on health professionals and mission-driven organizations, such as hospitals, to apply their skills and expertise to act in patients' best interests.

And, in fact, the exceptions to that, such as the unsavory relationships between physicians and pharmaceutical companies, are the exceptions that really prove the importance of relying on professionals to be acting in patients best interests.

We can barely scratch the surface of that quality that is being provided with measures. I'm going to give you an example. MEDPac had a report a couple years ago that found that for my specialty, internal medicine, 80 percent of what an internist does is in 78 -- I believe it was 78 -- different conditions. The other 20 percent, I'm sure, are fairly obscure and not captured.

Currently, Medicare has three measures of what internists do, and that's what they're sort of building their quality reporting mechanism on. One of them at least is sort of silly. I don't think we can capture what professionals are doing, make it transparent.

So one of my concerns here, in the consumer directed approach, is that almost, by design, certainly in the vision that Regina

Hertzlinger lays out in her interesting books laying out this vision, is essentially, in my view, would converge professionals in hospitals into competing focus factories, vendors selling their products and services in a retail consumer market without insurance intermediaries. I think one of the sure results of all of that would be to further diminish sort of professionalism acting in the best interests; will convert our professionals into vendors. It will be commercial ethics. Let the buyer beware. People purchasing in a retail market -- I think we have to be very careful before we want to go in that direction.

So the authors have quality -- already I think quality got a low score. I would bring it -- I would suggest it might be even lower because I don't think health care is like other markets. It is different, and I think that's why we want to build a social insurance model. Thank you very much.

MR. DIONNE: Thank you very much, and with all due respect to economists, better that you be a quasi-pseudo economist than a quasi-pseudo doctor. So, thank you.

(Laughter)

MR. DIONNE: Thank you for that. Karen?

MS. IGNAGNI: Thank you, E.J. Good morning everyone.

It is a pleasure to be here. It's a pleasure to take a moment in this town Washington, D.C., to talk about policy. We don't do that enough. So thank you for the opportunity to do it.

I want to join Bob and E.J. in adding compliments to Henry and Jeanne for a very incisive analysis. It's a very useful book, and I do believe that everyone should read it.

I land where Bob Berenson does that I think for us to achieve the objective of Medicare reform, we're going to do blending of different alternatives, and I want to talk a little bit about that. But I do think it's a very, very helpful prism through which we can evaluate, upside, downside, potential choices, what we might do, and how we might actually along the road of reform.

When Henry Aaron e-mailed me and asked me to participate in this, I immediately said yes, but, in terms of full disclosure, I suggested that we were not purists with respect to premium support. So I want to make sure everyone knows that as well. And, again, I'm not going to repeat what Bob said, but he said it very, very well, which is that there is value, high utility, in our view, of having a competing Medicare program and private-sector plans from both sides. And I want to talk a little bit about that, both on a delivery -- from a delivery perspective, from a cost containment perspective, and I think in terms of good government and what the population should expect in terms of what they want out of these programs.

In addition to the architectural questions, which we're largely discussing here, clearly, if we're going to reform Medicare, to state the obvious, we have to look at some of the larger financing questions. And I know that was outside the scope of the book, but I do think that we have

to have a conversation in our society, in our political system, about to what extent asking people to pay for costs, either at the time of service or in the nature of the premium based on income, really moves us too far across the continuum of social insurance. I suspect that the answer to that question today would be very different than it was in 1965.

I also think it's worth noting, as we are on the precipice of having a national conversation once again about health care reform --

MR. DIONNE: Did the mike just go out?

SPEAKER: Yeah.

MS. IGNAGNI: Oh, I'm so sorry.

MR. DIONNE: It's not your fault.

MS. IGNAGNI: Should I keep going?

MR. DIONNE: Just try again.

MS. IGNAGNI: Okay. I think what is -- can you hear me?

SPEAKER: Here you want to use mine?

MS. IGNAGNI: Oh, thank you. Just trade mikes. Thank you very much.

I think as we're on the precipice of what I think we all hope to be a very energetic and effective health care reform discussion post-November, it's often not remembered -- and I think it needs to be -- that the Medicare legislation was a major bright light in a century of failed attempts at getting overall health care reform.

And I think some of the political issues and decisions around that are actually going to be quite instructive post-November in terms of

stakeholders working together and putting pieces together that actually blend different models.

In terms of the architectural questions, it strikes me that the nation should really have a conversation, if we're going to reform health care reform Medicare, about what do we expect, and what are the outcomes that we expect.

Now that’s going to strike you as either very glib or very simple. And I don’t mean it in either way.

Having gone through the patient protection discussion about what was the nature of what we wanted out of our health care system, do we accept appropriateness review or don't we, do we accept management of the healthcare system or don't we, do we accept coordination of care or don't we. Now, we're talking about medical homes. You know, you could say that that is a revitalization of capitation, just with a different name.

So what did we learn in patient protection in terms of what we want out of the healthcare system, what works well, what doesn't, and what can we apply in the future. And I do think that the discussion in the book about how to we take largely private-sector tools and implement them in a social insurance program. Unless we answer these questions about what did we learn during patient protection, I think we're doomed to repeat the mistakes of the past.

And I want to give you a couple of examples. GAO has just released a fascinating study about imaging, and what's going on in the Medicare program credit-the fact that we do retrospective review, not

prospecting -- the downside of that, which is quite considerable from a quality, safety, and cost perspective, and the value of the tools that our health plans use.

If we move more aggressively in the health plan arena, as well as in traditional Medicare, to implement these tools of appropriateness review, prospective review, we could have the same types of backlash that we did back in the ‘90s.

And I want to stop and mention that because I do think that to improve Medicare, to improve the entire healthcare system, the idea of tools and techniques working effectively appropriately and asking more from providers, from patients, and from either our members or the public programs is going to be very, very important. That's one example.

A second example is how you shrink variation. The literature is replete with examples of where we have wide variation in practice patterns. Elliott Fisher and Jack Wenberg have done an extraordinary job of hitting us over the head very effectively in giving us a message that we're not doing it correctly.

And you see routinely that Mayo Clinic is identified as doing it right. It's a poor needed care environment, and you see very prominent institutions on the East Coast and on the West Coast with the suggestion that, while they may do things very-very well in specific diagnoses, that they're not, on balance, doing as well as Mayo.

Now who’s going to tell those institutions that are some of our best institutions in the country that they're doing it wrong. And to what

extent will we accept as a society that sort of oversight, that review, and that usage of best practice. So who decides, who gives the message, and will it be accepted?

We're doing this in the health plan community. We're pioneering many, many changes with respect to how we reimburse. Paying for performance I think is much more appropriately discussed in terms of paying for quality, using benchmarks. We learned a lot from the utilization review days in the '90s, and we decided three years ago to collaborate with the physician specialty societies, with the AMA -- and the primary care societies to hammer out a template for how we manage performance. That template can be used and should be used for across health plans as well as the social insurance system.

I suspect in the end, however, we in the health plan community will be able to go much farther in terms of paying for quality initiatives and incentives in the social insurance program because of the politics associated with that, meaning it's hard to get through the politics to implement some of these programs. That's not a criticism of the social insurance program. It's a reality that I think we need to discuss.

So we in the private sector use step therapy. We've encouraged generics. We use tiering on prescription drugs. If government were implementing a similar type of program, I don't -- I think they would still be stuck on the generic substitution.

So I think it's useful to take account of the progress that's been made in the private sector. At the same time it's quite appropriate

for the government and for the citizens and for the political system in the public plan arena and the private plan arena to hold us to appropriate standards.

So we are embarking on a very aggressive disease management study that we're actually collaborating with the Brookings Institution on to demonstrate what we know anecdotally that we're not only saving on lengths of stay, ER visits, but we're improving quality, and we hope to demonstrate that, but I think that's incumbent upon us.

We can go on and on about the types of things that are being embedded in health plans that I think could be extended, and I think our members could be called upon in a different model to not only implement health plans, but to also bring these tools to the public social insurance program. So I think there's many more opportunities there. We can do it in a cafeteria-style offering. We could do it in a more aggressive way if the social insurance program desired that. But, nonetheless, I think the lesson is that there are some valuable tools being developed that can work very effectively not only to improve quality, but to improve safety and reduce costs.

I do think that there is an overall structural set of questions that we need to wrestle with that's, again, common to both sides. First, Henry mentioned comparative effectiveness. We're going to have a brutal battle, no other way to put it, in our society on something that, as he said, is a no-brainer, should be done.

The brutal battle will be about whether costs should be considered. If we don't look at costs in terms of comparative effectiveness analysis, we are putting our heads in this in the sand, and we're kidding ourselves, because physicians, patients, employers need to look at the crosswalk developed by the best and the brightest in an objective way.

Second, IT. We do need a comprehensive, systemwide IT strategy, no one size-fits-all, but uniform consensus on what are the mechanisms that we're going to use. I often hear it described as, you know, what is the width of the train tracks. And that's a simple example, but we made a decision long ago in our society to get consensus on that. We need to have a similar approach here.

On the quality side, I mentioned our effort with Brookings. I also want to go back to talk about benchmarks; that they should be the same, public and private. So physicians should not be besieged with different types of measurement systems, from employer coalitions, from many different health plans, from the public sector. We have to get consensus on that. And Mark McClellan and Carolyn Clancy are doing a great job leading an effort to do exactly that.

Finally, in terms of overall things we need to do to make the public sector programs work better as well the private sector -- and you're all going to groan at this -- but if we're talking about quality and want to improve quality, one of the major stumbling blocks from a physician perspective is the medical malpractice system.

And the reason for that is if we want to improve quality and we say want to build a system on best practices, every incentive exists for physicians to protect themselves by doing as much as possible. And we have to reconcile that in our society.

Finally, a note on payment: We need to talk about very straightforwardly about payment, we in the private sector, and have this discussion very broadly.

I think both Jeanne and Henry made a point about private health plans being overpaid as it relates to the traditional Medicare program. If you listen to people in the middle of the country, from Minnesota, for example -- I'll just use one example. Dave Durinberger was a pioneer at this analysis many years ago. They made the observation that because of the presence of managed care -- at that time, in those areas; you could talk about Oregon, you talk about Washington State, you can talk about Ohio, upstate New York -- the fee-for-service base was pushed down.

So the question is, is the fee-for-service base an adequate base to make a judgment about payments. We've been going back and forth about this issue MEDPac , but now we're beginning to see anecdotally -- and I mentioned to Bob we're going to try to get a better analysis of this -- that the incidence of cost shifting, both because of consolidation, is quite appropriately observed, but also I think because of that compressed base is, at least anecdotally, seeming to be higher in those areas.

So the question is, is the measurement point effective for us to say that plans who received a small area floor back in 2000 went long prior to the MMA whether or not that's an effective measuring stick.

So I know we're going to talk more about this, but I do think that that is something that we need to do a better job of exploring so that we can assure beneficiaries that they will be adequately protected and we can have a level playing field.

So it's a pleasure to be here. It's a pleasure to talk about policy, and to comment on this very fine, incisive analysis. Thank you.

MR. DIONNE: Thank you very much. I think the idea of going back and looking at how Medicare happened in the first place is very useful. Henry and Jeanne point out that when L.B.J. signed the bill, he had a two-to-one Democratic majority, and the interests were still so complicated that he used 72 pens to sign his name, and then had another additional 150 pens to reward all the people who were involved.

They say of the ceremony brief and bland. It belied the rancorous and protracted political maneuvering that preceded it, and we're going to have more of that.

And Michael Tanner will be part of that, no doubt.

MR. TANNER: No doubt. Well, let me -- first of all, I understand so I'm just sort of the last speaker of me and us and you guys getting involved in this, so I'm going to try to be as brief as I possibly can.

And let me also start off with a little bit of agreement here. I also think that this was a terrific book, remarkably fair, remarkably

thorough. And the fact that I'm praising it now probably means it's doomed. But I do have to say that I agree with everyone else; that this is something that really is a must-read for anybody who's interested in this topic.

The second area of agreement is I'm going to have a little bit of agreement and say that we've been talking a lot about the idea of a blended approach, and I'm also going to suggest that what we're really talking about here is a blended approach. But, whereas, as Bob was suggesting blending between models one and two, I'm going to suggest that what we really need is a blending between models two and three.

And, in fact, I think what most advocates of consumer-oriented health care reform now are suggesting is something for Medicare that essentially is a premium support model in which one of the options is a high cost sharing option which would be, in effect, be the consumer model.

And I think we base this approach on two premises.

The first is that Medicare spending, as we know it now, is unsustainable. The idea if you look at entitlement spending in general, and Medicare is the largest portion of that, if current trends continue, we will end up with a situation in which between a quarter and a third of the GDP in this country is ultimately taken up by entitlements.

And so it's not a question of whether we just need more revenue or if we just end the war in Iraq or if we repeal the Bush tax cuts,

will have all sorts of money and we can pay for all of these growing entitlement programs.

I think we have to come to terms with the fact that we are not going to want, nor are we going to allow, a quarter to a third of everything this country produces to be eaten up by the entitlement programs in this country. And that means we are going to ultimately reduce spending and do something to control spending, and that means we're going to end up essentially some way of cutting back on it now. We're not going to allow unlimited provision of care through something like Medicare.

Our second premise is that Medicare is essentially upside down, if you will; that if you look at what insurance is meant to do, it's meant to protect you against catastrophic risk while you bear much of the sort of routine and low dollar costs yourself. Medicare works almost the other way around: it has very little consumer cost sharing in terms of its deductibles. The result is it pays for a lot of routine, low-cost care, but the sicker you get under Medicare, the less it reimburses you. It doesn't have a long-term care component. The longer you spend in the hospital, the lower its portion it reimburses. It actually cuts out just when you need it the most. It's sort of the pyramid is upside down, if you will.

Therefore, we think that the best way to fix this is, again, to go to some sort of system in which we cap the amount per patient that we're willing to pay, that we develop an amount that we think is a fair amount per patient that we are willing to cover, and that we provide that

amount to the individuals and let them to shop for the type of insurance that they can get for that amount of money.

Some will choose a managed care model, and some, we think, would choose a consumer-directed model with a high cost sharing and a more catastrophic type of insurance over and above that.

We think that that would have a significant impact on cost. I would point out an excellent study by Tom Saithing, who's one of the trustees of the Medicare system, and Andrew Retmeier from Texas A&M that suggests that you could have savings between 21 and 40 percent if you had more consumer cost sharing, a high consumer cost sharing component in this. I think that they're probably being a little optimistic, but even if you take the low end of that, you could significantly reduce costs in here.

Essentially, however, what you're arguing about is a rationing mechanism. If we are determined that we are not going to provide unlimited care to everyone, you were not going to say that regardless of cost, we are simply going to pay every penny of that cost to everyone who wants it. You're ultimately arguing much more you're going to have -- or what type of rationing mechanism you're going to have and who will be that rationing actor. Who will be the rationer ?

And I think under Bob Ereson's proposal, the social insurance model, and ultimately the government becomes the rationer.

And I would suggest that there's nothing in the record that suggest the government makes a very good rationer in terms of making

these decisions. I think one of the best models of this, if you want to see how it works and the government tries to come up with these sort of rational standards for how to ration, it's not done sort of by scientific body; it's done by politics.

Oregon tried this with its Medicaid program a number of years ago. They said they were going to come up with a very scientific way. They were going to have committees come in, and they were going to list every possible medical procedure, and they were going to have them ranked in order of effectiveness. And then they were going to find out how much money they had, and they would reimburse up to the level they ran out of money, and then above that, you'd be on your own. And so you'd definitely reimburse the most effective procedures first. I forget exactly where the cutoff came. It was somewhere around disk surgery was either above or below the level that they came out with.

The list that the scientists and the doctors all came out with lasted about two weeks and then the marches on the capitol came from the disabled constituencies had the right to lifers and the AIDS groups and the this group and the that group. Within weeks, they had rewritten the program to move various politically popular procedures up the list and less politically popular procedures down the list.

They rewrote it several times over the next several months, and then ultimately just said the heck with it. We'll pay for everything, and then they ran out of money.

So I think that that's ultimately what's going to happen. I used to look at the mandated benefits that most states require for their insurance policies. What you find is that the provider is almost capture these -- and the disease constituencies almost always capture these proceedings politically, and you don't get very good rationing decisions.

The second, of course, is it could be the insurance companies, which is essentially managed care, they're going to make the rationing decisions for you. The problem is that many of these decisions I think are idiosyncratic. They don't yield to sort of one-size-fits-all decision-making in terms of the rationing, and, therefore, I think the best rationer is the individual making those decisions for themselves, gauging price and quality, and then if you give them the proper information that they can ultimately make those decisions.

And that leads me into sort of the last -- my one criticism of the book, if you can, and sort of a criticism of the discussion here is that the idea that quality is necessarily an objective measure and the idea that we can determine what is quality in terms of health care, and, therefore, we cannot reimburse non-quality, and we'll reimburse quality or we can nudge people into making the right quality decisions.

Quality in many ways is not, I think, objective. It is idiosyncratic. What is quality to me is not quality to someone else.

And I'll just give you one sort of classic example of this. Let's take the question of prostate cancer. If you go to a surgeon and you have prostate cancer, they will tell you the answer to prostate cancer is to

cut it out, that that's the only thing that can guarantee you a hundred percent survival rate, that it's always the answer. It's always going to be surgery if you talk to surgeon.

However, surgery for prostate cancer has a number of quality-of-life issues. There are other procedures in radiation, brachytherapy, even watchful waiting that have far lower survival rates, but have far fewer side effects. Perhaps people will choose to have a lower survival rate if they think that their quality of life would be improved by one of these other procedures. Is there an objective measure that says which of those procedures is going to be right. Is it radiation? Is it brachytherapy? Is it surgery? Is it watchful waiting? Can we really determine on a one-size-fits-all basis that for every person who comes in with prostate cancer this is the procedure that they should have.

That's why I worry very much about sort of the objective measures. I think that's ultimately something that I'm going to have a make decision of as an individual. I don't think it should be imposed from the outside.

The only way we can avoid that sort of imposition of an outside measure is by having the individual control of money, and the individual ultimately making that decision.

So that I'll throw it back, and we can get into the discussion.

MR. DIONNE: Thank you very much. I'm sure that Jeanne and Henry are grateful that you didn't offer a criticism of the book. They were worried there for a while.

Now I was also thinking that was that kind of a post-modern view of the quality question, but I won't go farther on that. I want to -- I'd ask Jeanne and Henry to hold off on responses, because I really -- this is an extraordinary audience, and I want to sort of bring you in right away, and I'd like to begin with President Shalala. I like the sound of that.

MS. SHALALA: Okay. It's January 25th, 2009. The new president has been elected. The economy is still awful. We're still at war. The president calls you in and says this: "The congressional leaders are about to come and see me. I've got to say something about what I want to do for healthcare. What would you tell me to do? What should I tell them that I want to do my first year?"

MS. LAMBREW: The answer's not in the book. Well, it's a hard question, because I would argue -- and Henry began the discussion with this; I agree -- you can't necessarily solve -- solve -- and let me use the word solve -- Medicare's problem without health system reform; that we know that when people arrive at Medicare's doorstep and they've been uninsured, they come in sicker, more expensive. We know that if we can't figure out how to get technology aligned with value, we're going to keep spending more and more. We don't have the productivity gains in health care that we have in any other field; that if we can't get at some of those root causes, if we can't get, you know, electronic medical records, and I just have to say that it really is -- we can talk about the problems and the width of the rails, but there comes a point where there's no excuse; that

we just have to figure out how to do this. And Medicare could be a vehicle for this.

So trying to think through how do we get a system, using the word system very specifically, where we have people in it. We have the kind of focus on what works well, and then how does Medicare help create that through requiring all doctors or hospitals to have electronic records by a certain date, investing in the research that's going to help us guide those answers.

Medicare is to be part of a larger solution. I would still argue that the incoming president has a unique opportunity to solve the problem that can't be done with Medicare alone. But that's my opinion.

MR. AARON: Well, I'd like to heave it back to the others on the stage as well. My answer is very similar to Jeanne's, but let me phrase the response negatively.

The one thing I would not do would be to come forward with a full-blown, large-scale national health reform plan, similar to the one that President Clinton attempted. This is a road we've been down repeatedly, frustratingly, and unsuccessfully.

The health care financing and quality issues -- and I don't agree with Mike on the quality issue; we can come back to that presently -- are all more pressing and more important than they have ever been before.

And the one thing the nation can't afford is a huge effort that doesn't succeed again. So I believe it's vitally important for whoever

becomes president in 2009 to have a series of likely passages, bills that could be likely passed by Congress, that contribute to longer-term goals.

And I would include the two that Jeanne mentioned -- a really vigorous program on research about what works and what doesn't. To start with, simply providing information is going to change the quality of discussion about determining benefit coverage, both privately and publicly. We don't have much information right now.

Secondly, it isn't quite the case that Medicare could do with the stroke of a pen what it was said that President Kennedy could have done with segregation, which is end it with a stroke of a pen. It's not quite the case that Medicare could establish electronic medical records with the stroke of a pen, but if Medicare moved aggressively and set deadlines after which certain standards had to be met if payments are to be made, I think we would see rapid movement. There has to be a vigorous administrative stick pushing this effort or we could talk about it forever.

An obvious first step will be to -- and legislation I think is going to be to necessary because it expires with respect to SCHIP.

The legislation that President Bush vetoed is ripe for adjustment early next year. The states are going to require additional financial assistance. It's possible to make a significant bite out of the ranks of the uninsured with that kind of a reform. And then my pet, which is I would like to see the federal government genuinely encourage, with modest financial support and abundant regulatory flexibility, state efforts to extend health insurance coverage.

MR. DIONNE: I have a feeling if the President's Obama, he'd say that's fine, Henry, but I have to offer a comprehensive plan to cover everybody, so then what I do?

MR. AARON: I don't think he really will or will have to do will have to so, and quite likely won't do so, because there are so many other very important things he has to do that are going to take a vast amount of political capital, and what he needs to do a show progress in this dimension, with a commitment to moving further when these initial steps have been taken.

I may be wrong about that, but I think it's not going to be appealing to bet the whole first term on the success of something that has been such a long-odds proposition for so long.

MS. LAMBREW: I have to disagree. I don't think -- I think that listening to what Senator Obama has said I think he cares about this. It's one of the top issues that is not only in his campaign plan, and let's be clear of McCain's plan. McCain has a huge, if radical, plan. I think that out in this campaign, unlike it's been, even more so than in '92, because what you see in '92 is there wasn't any real Republican side of this. And we now see it.

I don't think he can do economic reform without doing health. I don't think he can do budget reform without doing health reform.

I don't think that we can continue on the trajectory that we have, and, you know, if we look at past, we'll never have health reform, because, you know, we can't -- you know, all innovations happen with kind

of again, there's the evolutionary theory about opening gradual, but there's the Big Bang, and I think we're ready for the Big Bang.

MR. DIONNE: Karen?

MS. IGNAGNI: I love the sound of President Shalala. I'm from Florida. I think there's plenty of time for you.

But I would tell the next President to bring leaders in the Congress in, and say, "I'm the one. I'm going to do this after 100 years of trying. And I'm going to ask you to do something that you're not going to want to do. And what you're not going to want to do is to see through the politics, put some of it aside, make a commitment to work on a bipartisan basis because that's what it's going to take, so it's not blocked in the Senate, to actually get this done. And I expect that of you. And I'm gong to be wiling to stand behind you and propose a strategy, an architecture. Not every little detail. But I'm going to propose a strategy and architecture to finally get this done, and we can do that together." That's what I'd tell him to say.

MR. DIONNE: Any other advice for President Shalala?

MS. LAMBREW: Well, we'll do that offline. I'd like. Battle ground states. It's a perfect thing. We start it here.

MR. BERENSON: Well, I would -- yeah, I'm -- immediately passed SCHIP, which I think is there ready to be done and then also focus on sort of the -- start the process of proposing and trying to implement a redesign of the healthcare system and going to universal coverage, I don't think we've got a consensus of how to do that yet. So I would exactly

whether I'd propose that and accept SCHIP as the first installment or vice versa, I'm not exactly sure.

But I think the President should show a leadership. The healthcare system is out of control and needs it. But that's the point I want to make here is I think a lot of the changes that are needed Medicare can lead. And I think that's Medicare with private plans leading. So I'd immediately be calling Karen in and asking how do we sort out and be less adversarial, figure out what this level playing field is. I actually think it might be a model of a broad health reform, which has a larger public program, but also has private plans.

And I want to make one specific point about Medicare. I mean, I think he can develop some credibility if -- it's going to be a he in this case -- actually shows progress on Medicare spending. I disagree with Michael that we at least at the beginning have to do rationing. Good researchers as well as practitioners know there's incredible waste in this program. If we just get a small fraction of that waste out of the system, without real rationing, without denying people care they want and need, we can change the curve of Medicare spending. The sort of doomsday scenario has us with the current rate of increase going from Medicare representing three percent of the GDP to something like nine percent of the GDP, which we all agree is sort of not anything we can contemplate.

If we just reduced what's called the excess growth in Medicare spending, that is, the difference between GDP and population demography changes, it's currently about one to two percent above GDP.

If we just reduced that to GDP, the CBO says that we basically keep the percentage of spending at its current level, we basically have to find one to two percent a year in a program that Jack Wenberg at Dartmouth estimates is overspending 30 percent. I understand the political problems of going after 30 percent, the geographic disparities with everybody defending their own area. I think there's a whole menu of proposals, some of them in Henry's and Jeanne's book, others that some of us have been talking about, if we had the political will and leadership, we can reduce Medicare spending in the current program without cutting benefits, without changing the character of the program, without a doomsday.

And so I think the President should be doing that, developing the credibility when he comes forward with the national health plan.

MR. DIONNE: There was a call in the audience. Do you care to answer your question?

MR. BERENSON: No. Okay.

MR. DIONNE: No moral obligation to do that.

MS. LAMBREW: Did Mike have something to say? Sorry.

MR. DIONNE: Yeah. Go ahead.

MR. TANNER: Yeah. I would suggest that neither a President Obama or a President McCain is probably going to be successful in achieving the big vision of health care reform. President Obama's plan is estimated to cost between $65 and $110 billion a year. I don't -- facing the largest budget deficits we've ever had, I don't think there is that kind of money laying around right now to try to do anything like that.

And for Senator McCain to try to move us away from an employer-based system, which I think we should ultimately do, I think is going to take on some of the biggest special interests in town; is going to have some real lack of success.

I think there are some smaller -- the particular one that Senator McCain has proposed to allow people to buy health insurance across state borders, across state lines, so that if you live in a high cost state can buy health insurance from a low cost state. I think that that would be a terrific move that could be done fairly simply to bring down -- help bring down overall health care costs.

I just want to suggest two things in terms of thinking about the overall debate here. One is the question of what we really wanted to. Is it really all about universal coverage, getting every last person that piece of paper that says they have health insurance. I don't think that that should be the central focus of health care reform, and I don't think it is for either Senator McCain or Senator Obama. I think both of them are making costs of health care at least as important an effort in their health-care reforms. And I think that's where it should be.

And the second is the idea that we can do health care cost reduction in a painless way. Everybody's still going to get everything they want, with the doctor of their choice. They’re going to have no waits. They're going to get it all for free. You know, we've been promising that waste, fraud, and mismanagement would solve all our spending problems, at least it's my hero, Ronald Reagan, used to talk about that. So I think

we've learned by now there are no painless choices. There is no free lunch. Some people are going to have to get less than they currently want.

MR. DIONNE: Who wants to come in next? Sir? Let's take a couple at a time. The gentleman in the blue, right there, and then the lady across the aisle, and then the gentleman up here. Can we just get sort of bunch some questions so that we can get more people in? Sir?

SPEAKER: Thanks. I think some of the work for Mark McClellan and the Congressional Budget Office has pointed out that to truly reduce costs, we need more comparative effectiveness work, and we need to (inaudible) for quality rather than quantity of care.

One of Karen's comments about getting -- implementing that really resonated with me, and that was that -- was her point that it's easier to get the private sector to implement these kinds of strategies that would pay doctors and pay hospitals based on how -- on the quality of the care that they're delivering rather than the government, which would be much more susceptible to political forces. Could the other panelists comment on that and whether -- in order for true reform to occur the private sector has to drive it?

MR. DIONNE: Thank you. And could you identify yourself also?

MS. KANTER: Sharon Kanter with the College of Health Information Management Executives. And this question gets to the point of health IT that several of our speakers mentioned in terms of

effectiveness research, Medicare leading, and I would just reference that legislation that was passed over the president's veto about two weeks ago requires physicians to start doing e-prescribing in 2009 and penalizes those who don't do it in 2012.

That is a model of giving some incentives and that essentially a penalty, the carrot, the stick, which also CBO Director Peter Orzsag has talked about. And that might be enough small reform, but Medicare -- where Medicare leads, the private sector follows. It may be a little bit opposite of this question, so I would ask our speakers to comment on that and the use of IT to improve costs and care and quality.

MR. DIONNE: And the gentleman right here. Yeah.

MR. BARNETT: Jim Barnett with AARP. I'm just curious what are some of the political eventualities that might force the new president and Congress to deal with this issue, and would the 45 percent trigger be one of them?

MR. DIONNE: Mm. Who wants to start on any or all of those?

MR. AARON: Well, let me start with the last one. I don't think the 45 percent trigger is going to force anything other political posturing, and it shouldn't, the reason being that the real question is not the proportion of Medicare spending that is represented by general revenues, but whether the structure of the program is as it should be and whether there are opportunities for achieving economies overall.

So I expect formalistic triggers are going to produce formalistic responses.

Does private sector have to drive effectiveness research? I don't think it can't. There is sort of a -- one of the things one learns in basic economics is that knowledge is a public good, which means once produced, is available to everybody free of charge, and, therefore, private entities don't have an adequate incentive to invest in it, because there's no profit in it, and we do live in a system in which private spending is driven, as it should be, but profit motives.

So if we’re going to produce knowledge about the comparative effectiveness of different modes of treating illness or different drugs or different medical devices that are competing, and we want that to be done objectively and compare different modes against others, that is going to have to be done with public funding, and it's going to be damn expensive and time-consuming to do because medicine is very, very complicated. And people are very, very complicated. And there are hundreds and thousands of different combinations that need to be very carefully and patiently evaluated against one another. And new scientist producing new interventions all the time. So it's a continuing responsibility.

This is big money a long time, and it's going to have to be publicly supported if it's to occur. And if it's to occur on a sustained basis, it has to be done by an organization that is protected from the sorts of political attacks that have doomed previous efforts when undertaken,

whenever they have come up with findings that stepped on sensitive political toes.

MS. LAMBREW: And I'll just add three points, quickly. I think there's two parts to that question. One is on development of the public good research. The other is on its use and implementation. And on the implementation, I think we just have to look at the Veterans Administration to show an example of a publicly-backed public system that has actually been able to adopt, adapt, and use that information in a very effective way.

I want to refer back to Bob's comment earlier about, on prices, are, you know, would private plans be able to actually get better prices given the consolidation of the supply in the big hospitals and doctors.

And I could argue that what we're seeing is a lot of following on Medicare's lead, and so if the private sector and private plans are following on Medicare's leads on prices and were able to align those prices with value, high quality, I think we could actually have kind of an interactive back-and-forth on this, because I think, you know, at the end of the day, we really do need to have some leadership on this.

But to Bob's point about costs, which is where -- why you is making that point -- can you actually have private plans achieve lower costs than a social insurance program? We actually in the book are quite careful about looking at this question. We put a question mark about prices. It's the utilization side of it, where we actually do know that there is

an incentive for private plans to focus more on the utilization, and it's much harder in a fee-for-service environment to focus on utilization. And that's why I think, at the end of the day, when you're trying to figure out these grades, which I say everything we put down is better than the current system. Medicare, social insurance under our plan would be better in terms of costs than the current system. But we try to do these relatives, so that's what we did that.

MR. DIONNE: Thank you. Any --

MR. BERENSON: Let me jump in on the last point, and then get to one of the questions. What is, I think, under-recognized as the best way to affect utilization is through price.

On imaging, which has exploded in this country, plans are now going back to doing prior authorization, for good or for bad. We can talk about that. The right way to do it or the easiest way to do it is take the unreasonable profits out a lot of this imaging. You wouldn't have physician groups -- every physician group around trying to buy its own MRI or PT scan. And I would argue that Medicare has been constrained from getting the price is right for political reasons. Plans have been constrained from getting the prices right for market reasons, and that's -- so I think people misunderstand what the potential here -- I think Medicare could be -- is in a better position, if allowed to, to actually address utilization in a different mechanism than what the plans are doing.

On the issue of are plans more flexible, I mean, our plans better able to sort of do change. I think in some ways they have more --

they clearly have or flexibility, but I think on a number of issues in which we think there needs to be improvement, plans sort of don't have, in many cases, enough market share or, again, they don't have the ability to get the providers to respond. So, as an example, a letter to the end or of Health Affairs five years ago or so, by health leaders across the political spectrum saying Medicare has two lead in pay-for-performance.

And, indeed, I think Medicare is learning a lot of things. My preference is that we sort of do multi-pair public private. This medical home thing will work a lot better Medicare participates with the interested plans in trying to give a coherent set of payment and operational instructions to the practices that we want to become medical homes. But I think if -- market maker in this area is Medicare, for the most part, with, I think, plans able to sort of do some things, but ultimately not being able to take them to scale because they don't have the ability to do that.

MS. LAMBREW: I think you’ve asked a very important question, and they all relate to three points, quickly. One is -- I want to be very clear that my comments on comparative effectiveness were for this objective body, because you cannot have one entity doing it. So I agree exactly the way Henry talked about it, and I do think we're not teeing up the issue of cost enough, and that's the quintessential thing to be included in comparative effectiveness, so you can look at costs and benefits.

My comments were directed to what we do with the information and who’s the most effective leader. I do think that there is an argument to make on the right side that the social insurance program can,

because it's an administered pricing system, achieve more short-term results. I think if you look at the year over year increase in health care expenditures, roughly now 50 percent is attributable to utilization. So the point that Sharon made about the e-prescribing, only doing upside until 2012, we don't think -- we would never do that.

What we need is to have upside and downside incentives implemented together as quickly as possible, and that's what you see in the kinds of pay for quality programs developing across the country. We're much more comprehensive in terms of how we think about episodes, bundling, looking at diagnoses, et cetera, and I think we're able to do things far more nimbly -- well, I know we are -- and the question is whether the traditional program can catch up.

So I don't see the traditional program, for all the political reasons that have been very effectively talked about, being as nimble, being as -- having the effectiveness, both on the utilization side and then, thus, on the expenditures side totally.

And I think one final example of that is what happened in the physician fee discussion. All the articles were about to focus on Medicare Advantage and that's where the savings were coming from, not -- I don't remember really one article that I saw -- and maybe I missed a bunch -- that really talked about the fact that we were once again lifting the expenditure cap, the price times utilization equals expenditures. We decided to put an expenditure cap to deal with physician expenditures. It's been exceeded because utilization has soared so actively and

aggressively, and so that's why the reduction in the fee. That's a Cliff Note way of talking about it, but the fact is, as a society, we have no way, I think, in the public program to get to the politics, whether it be mandates, whether it be expenditure caps, whether it be on the utilization side.

And I think that's the conundrum. And the question is, what do you do about that? Could we, in the private health plan arena, offers and services that don't exist now in the public program that could help with that?

So I don't see it as an either or kind of discussion.

MR. TANNER: Let me what -- maybe it's the -- this part of the audacity of hope, but the idea that these decisions ultimately would be made by this group of philosopher-economists-kings, would be totally devoid of politics and would come to these conclusions. I just don't see that in the way that the real world of politics works. You know, I see that the history of medical research has constantly been influenced by whether or not you can get a real good movie star spokesperson to go up with your disease, and stand in front of a congressional committee, and talk about it. Then you get a whole bunch of money for your disease. If you can't, then you won't.

And I think that's going to be -- a lot of the way that this research works it well. If you want to just look at the nimbleness of the private sector versus Medicare -- you can take prescription drug benefits. About 80 some odd percent of private plans had a drug benefits before we ever got to be Medicare prescription drug benefit, which is designed in a

way that I can't think of anybody left, right, or center actually thinks is a good plan, because it was done by a congressional committee, and, in fact, it pleased everybody.

And I think that's the same thing that's going to happen. You're going to have all sorts of interference by the special interests with this effectiveness research.

Now, I just want to clarify earlier what I said -- you know, I'm not against quality research. What I'm concerned about is sort of the imposition of a single standard upon all procedures for something like the Medicare program. Quality control is great until you're the outlier. What we come up with a standard best care standard of practice, it's fine unless you have the condition that doesn't fit that best standard of care, and then sort of locked -- physicians are locked in to a particular way of doing something and can't change; can't go off label because they been told that this-you're going to A, B, and C. Well, maybe you need D for this particular patient. We don't want a situation in which that's not reimbursable suddenly.

MR. DIONNE: Bob, just had a --

MR. BERENSON: Just a real quick one. I just don't get it. Most of the social insurance countries in Europe do for much more to professional judgment. I'm actually a big believer in bedside rationing, not government rationing. They're not incompatible. The government doesn't have to set quality standards. So I just don't think that's real.

MS. LAMBREW: And if I could just add another one, which is I think when we talk about this governance issue, I don't think -- there are politics publicly and privately. I mean, we know that, you know, everybody when they try to take a health plan wants to make sure your doctor is in it; that the technology that they want is covered; that children's hospital is covered in it. I mean, politics are not just exclusively in a public domain. It occurs everywhere but I would argue that to the extent that we can look at models that have worked, that, you know, ways of producing information, how it's produced, how it's disseminated, not necessarily trying to create the cookbook for medicine, but trying to say that there is more science and art here. We need to begin to build that -- put that science out there, you have multiple ways of using it, and when something is clearly not valuable, then say no, because we do ration today on all sorts of different bases. We might as will try to make that -- you know make these decisions were informed rather than a little bit more arbitrary.

MR. TANNER: But how long does it take, for example, to get a new drug on the Medicaid drug formularies? I mean --

MS. LAMBREW: I’m arguing for -- we argue for a new model for governance. We really do think that trying to go through Congress is not the right approach.

MS. IGNAGNI: See I think Jeanne is right. Can I just say that this idea of having more information in the public domain. If we had comparative effectiveness, we would, I think, the government -- Medicare wouldn't have gotten so hung up on CTN geography, because there could

have been research in the public domain that individuals could have evaluated, and I think Congress could have had a more informed discussion as opposed to having a backlash based on interest groups.

So that would be significant improvement. So I don't think it's mutually exclusive. I think there are things that can be done very significantly to improve the political odds of actually social insurance programs doing more of what the private plans do.

MR. DIONNE: Jim Moody, the gentleman over here, the lady over on the right here, and then that gentleman way in the back. Why don't you bring. We'll do four this time.

MR. MOODY: When Congress having been one of the authors of the begotten or ill-begotten single payer system, having lived in several European countries that have single-payer and much lower cost him quite good outcomes in better health indices at about 30 percent lower costs, and knowing our friends to the North, in Canada, are very pleased with their system, what lessons can we learn for the ultimate point we want to get to. I assume we all (inaudible) be great, but I just want to get universal coverage and cost containment. And they obviously need to go together.

Given that these countries have done a great deal on both those dimensions, what lessons can we learn from our European friends and our Canadian friends that are applicable possible here?

MR. DIONNE: Thank you. Sir.

MR. GRISS: Bob Griss with the Institute of Social Medicine and Community Health. The Medicare program is probably the single biggest lever for public accountability in the health care system. I'm interested in how it can be used to restructure the health care delivery system nationally. It was mentioned that we got desegregation of the hospitals in 1965, when that became a requirement for receiving Medicare payment. Are there demands that could be made on the public health-care system at the state level through the leverage of Medicare payments that could actually initiate the kinds of cost containment that we would all like to see, not just in the Medicare program, but through the entire fragmented healthcare delivery system?

MR. DIONNE: Thank you. This lady over there, and then the gentleman in the back.

MS. POPLIN: Hi. Carolyn Poplin , Georgetown University. My question is for Ms. Ignagni. How is it if the private plans are so nimble that they seem to cost more per beneficiary than Medicare, when the numbers were the same. I mean, when you got an average amount for a healthier than average cohort that was Medicare plus Choice, and insurers dropped the program because it wasn't profitable. Now, we have Medicare Advantage, which only seems to work if you get more per patient, even risk adjusted, than a risk adjusted comparable patient under Medicare. We're not going to save money this way.

MR. DIONNE: Thank you, and then the gentleman in the back.

MR. GRUEN: Jeff Gruen with PRT and the global consulting firm. My question really relates to we know that there is substantial waste in the system, and we also know that the delivery system, as has been pointed out, has really become quite refractory to a number of efforts to innovate.

So my question is what the panelists think about the opportunity for Medicare to become a driver of delivery system innovation, perhaps through public-and private partnerships or other means. Now, it's clear, as has been pointed out, that Medicare is a market maker for the most part in delivery system innovation has not joined hands well with the private sector. We also know that comparative effectiveness research is necessary but not sufficient. There's been very little effort placed on trying to actually drive forward effective innovation, and I'll just point out to the Medicare health support example, which spent a lot of money but came up with inconclusive results as sort of one poster child of how to best practices from the private sector, which we know are necessary in order to get rapid cycle innovation and to systematize those and spread the results of pilots, or not at the moment being well utilized in Medicare.

So how could we actually get at the substantial waste in the delivery system by reforming Medicare and using its considerable heft in the market to drive effective innovation?

MR. DIONNE: Thank you. Actually, I was thinking three of those questions overlap. There were two clear overlaps about Medicare as a driver, but also single-payer lessons from other countries, but

Medicare itself is, in a sense, a single-payer system, and then I'll let Karen answered that, the good question here about what are your plans so expensive compared to Medicare.

MS. IGNAGNI: Do you want me to start?

MR. DIONNE: Yeah.

MS. IGNAGNI: Well, thank you for the question. If you look at the MEDPac data, as you're obviously familiar with, the ratio is roughly 113 percent on average. If you exclude the floors, the rural floor that was developed in 1997 and the small area floor that was developed in 2000, it brings you down to roughly 105 percent. And then there's a debate and discussion about how you include IME in the base. It won't be as relevant now because they've taken it out of the base in the latest round. But that was roughly four percent on average.

So you can see that the question is what's a true -- and the base is estimated. It doesn't have some of the most catastrophic costs in it, et cetera, et cetera.

So not being overly wonky, the question is, is the base adequate. And where you see the plans that are at a high level were a high proportion relative to fee-for-service is in those areas that -- it's Minnesota. It's Oregon. It's Washington. It's New Mexico. It's the middle of Ohio. It's upstate New York. And it's San Francisco, and he was in Boston. These are the areas that benefited from the floor so they have a ratio now that's over roughly the average.

So the question is, is the base interface? Is it adequate to actually serve as a benchmark? And I don't say that from a wonky perspective to dodge your question. It's a very legitimate question, because from the point Dave Durenberger started saying Minnesota isn't paid as much as Florida or New York, et cetera, et cetera. It's a very legitimate issue based on some of the interactions that happened pre-BBA in 1997 with managed care driving down costs.

And if we find the hypothesis is right, that cost shifting is much higher in those areas, I think it indicates something very important.

MR. DIONNE: Could we use the rest of the questions is a chance for everyone to close, because we're just about at time. Maybe I could start with Michael and we could just move down the panel with Henry closing the day.

MR. TANNER: Well, let me just briefly hit on the national -- other countries national health care systems. I just recently completed a lengthy survey of them, and essentially what I found was that those countries that were successful in holding down costs without the rationing that we hear about so much with those countries that involved a high degree of consumer cost sharing, essentially the French, the Swiss, the Dutch. There's a high degree of consumer cost sharing in them, very high deductibles, or high co-payments, balanced billing in the French system so that they had -- they avoid rationing by queue.

Those countries that had very centralized systems, very low consumer cost sharing like France and Britain and so on, they had very long rationing by queue, the waiting lists and stuff that we hear about.

So I think this sort of goes back to my earlier question of who is the best rationer, whether it is the individual, whether it is the insurer, or whether it is the government. I think that these countries also show that the best answer is to get money in the consumer's pocket and let the consumer make those decisions.

MR. DIONNE: The headline of the event now is Cato scholar endorses French health care system.

(Laughter)

MR. DIONNE: Karen, go ahead.

MS. IGNAGNI: I think this is a very important question and if you look at a study Ken Thorpe did in Health Affairs in October, we have more of everything. We have more obesity. We have more diabetes. We have more smoking. We have more of everything. And I don't know whether -- yeah -- I don't know whether it's because they drink wine over there and we don't, and they walk more and we don't. But whatever it is, I think that one of the most exciting things from my perspective is that our members now are offering services to the Canadians, to the British system, to the French, the German -- across Europe. They’ve asked for disease management care coordination systems from us. They want to lay them on top of their systems that generally work very effectively, but they want more of these tools and techniques, which has led us to think

that there is, I think, real opportunity for this kind of public-and private collaboration in the traditional public program, whether it's Medicare or Medicaid.

And so we have a number of ideas about that, and I think it offers some new models.

MR. BERENSON: Let me just make two points, one on the European comparison. I do think, but I haven't studied them as much as Mike has, that there's a fair amount of complementary insurance to fill in some of that cost sharing --

MR. TANNER: Yeah. He classified it.

MR. BERENSON: Well, again, I think those countries are structured differently in the sense of much lower administrative costs from a greatly reduced complexity of the number of payers and how you get your healthcare.

The plans have to confront the following: they have about 11 or 13 percent administrative costs in their private plan offerings for Medicare, and Medicare has three percent or so, three, four percent.

And Medicare gets better prices, so plans really have to do an awful lot on this utilization management to beat that inherent advantage traditional Medicare has, and I agreed that they are not as inefficient as the 13 percent would agree, but I think, as I said earlier, with an inability to really effectively have any leverage over providers, they really are swimming uphill, whatever that means.

Let me make the other point on the delivery system reform, I think Medicare can lead. DRGs was a very good innovation; has reduced spending; has reduced hospital incentives. It's not enough. It was put on automatic pilot for a while, and some price distortions came in. I think Medicare can lead in a number of areas, and to make the -- to just finish, I think we need to be talking about governance, just as this book does. We can't let the Congress were to be able to -- anybody who is going to be negatively impacted by any reasonable decision that Medicare as a purchaser would make be able to go and get relief.

We need to deal with that governance issue, if we can somehow. I think Medicare really can't take the lead and to work collaboratively with providers and to work with private payers and Medicaid agencies to do that.

MS. LAMBREW: I'll just say four closing points. One on this delivery system reform question is, you know, if in our health care system, we could recognize the fact that there still is a disagreement about what the right thing is to do, but take where we do think that there is a best practice, kind of evidence-based, and just do it; right? Take the information, figure out the networks to get that information throughout the system, not just to the urban areas, but to rule doctors practicing alone. That's a human connection as well as an IT connection, and then align our financial systems to do that, I think we could go a long way to squeezing out that, you know, whatever amount in our system is a waste. (inaudible)

at $700 billion. I'm not sure what the right answer is. There clearly is some there.

And Medicare could and should lead the way. There’s no doubt about that. And I do think what we learn from other countries is that it is possible. I mean, like, the idea that it is impossible to get better outcomes for lower value is just -- we can quibble over how we do international comparisons. We should make sure we do it carefully, but you can't deny the conclusion that we could do it better for less.

And in that vein, I think we put forward in this book prototypes to begin to think through how these different big moving pieces work. Of course, we’re going to have a hybrid system, not just because getting from here to there is hard, but because I think Americans -- and this is one of our political lessons -- are reluctant to pick one thing. We like choice, and we like to figure out how to get there gradually.

And I think what’s been interesting that we’ve see in the evolution of some of the campaign plans is this concept of choice playing out in different ways.

Senator McCain wants it to be lots and lots of choices, choices of tax credit and maybe you have a choice of individual market insurance, buy it across state lines. I could argue that actually, at the end of the day, that may significantly limit your choices, especially if you're sick, especially if you -- you know, you have some sort of high health care needs, because high-risk pools, which is what the answer is, will not get you there.

I think the type of choices that we've seen in the other side, in the Obama plan, and other plans, have been why don't we see if we can structure this level playing field choice.

So if people prefer a public plan like option, they have it, not just seniors, but all Americans. And I think that if we can figure out how to get it right in Medicare, I think we probably would agree on that, that we should figure out a way to structure public and private choices in Medicare to make it fair and work. Why not offer that to the rest of the nation? And I think that we hope to, again, illustrate the trade-offs and the problems.

So one closing point is but not all choices work well together, and I guess I would argue, Michael, with the idea that we could do -- you know, let individual do this rationing, because, at the end of the day, for the same reasons that we have trouble doing this politically, when somebody is sick, I think the high-end costs of somebody with -- in a universal system with high deductibles will be paid for. We'll find a way to do it. We'll find some way to do it, because that's human nature, and we have a high value on health care. We really do value life.

All that said and you give an account for somebody with low health care needs, that's just spending, and I think that we could find ourselves giving money through accounts to low -- you know, people with low needs and spending a lot on the high cost need people anyway, end up not achieving our goals.

So I think we need to be careful about these high (inaudible) because they don’t always work together, and we do talk about that in the book.

MR. DIONNE: Thank you. Henry?

MR. AARON: Well, I’d like to thank everybody on the panel for being so kind to us, and in that same spirit, I would like to be kind to Mike. I have read the piece that he did for Cato, comparing systems around the world. It is chock full of useful information, and I commend it to you all.

That said, I don't agree with his conclusion about the correlation between cost sharing and either achievement of lower spending or the avoidance of rationing. First of all, just a factoid, one you can take away with you: take the 10 richest countries other than the United States. On the average, they spend half as much per capita on health care as we do. So the -- off of Jim Moody’s question, we spend an awful lot, and we do not get demonstrably better health care across the board than other countries do. The peaks are very high, but there are a lot of valleys in the U.S. healthcare system that are not present in those of other countries.

I’d like to express a little more pessimism about the likelihood or the ease of achieving significant economies in the near term, not withstanding the huge gap between what we spend in what other countries spend.

First of all, simply in terms of implementing lessons from other countries, the important thing here is that every country is very path dependent. If evolves into the next stage from where they were initially. The U.S. healthcare system represents $2.5 trillion of interests in how things are done. Moving those funds is going to be extremely difficult. The variations documented by Wenberg and Elliott Fisher and others between different modes of delivery across the United States were first identified 30 years ago, and I asked one of the people on their team, "Do you think they're smaller today than they were 30 years ago?" He said, "No, I don't think so."

They are very resistant to change because physicians practice medicine as they were trained, as their peers are doing, and as they think, in good conscience, is the best way to deliver medicine. Changing that is going to be a difficult and slow process, and so there may be many, many illusions of dollars of expenditure out there that, on sober second thought, we wish weren't made, but getting things changed is going to be very difficult.

Furthermore, a lot of what we identify ex-post as waste, an intervention that did not, in fact, make a difference is not so clearly identifiable ex ante as wasteful.

A person with a particular condition there is a small probability of beneficial outcome from doing a particular procedure, and if you're fully insured -- and our goal is to maintain insurance coverage -- and if your provider makes at least some additional income from providing

that procedure, getting rid of that low probability of success procedure is going to be very, very difficult.

That is why I think the thing that Jeanne and I have emphasized, the need for aggressive research on effectiveness -- what works, what works better than something else, is an essential first step. It isn't sufficient. It is necessary. And if the next president doesn't undertake, doesn't support a really aggressive program of examining effectiveness, then I think the whole process of eventually achieving, of slowing down the growth of health care spending in the United States is going to be sent back very seriously.

So I would almost put that at the top of my list of things to do.

MR. DIONNE: Thank you, Henry. You know, Henry's right about almost everything. But if he -- were Obama to be elected and if he is wrong about what he would do about universal health care, I hope we can reconvene this very same panel to discuss that plan.

And two other quick points: I have decided that Aaron -- Henry said a great thing here that should be said at every single Brookings panel on every subject. You will recall, he said, "People are very complicated." And I suddenly realized how much that would help the discussion of so many subjects.

Lastly, Henry also said, "Knowledge is a public good." And I want to thank Michael and Karen and Bob and Jeanne and Henry for contributing to that public good and to you all as well. Thank you.

(Applause)

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