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**Putting the Brakes on Health Care Costs: Would
the Candidates' Plans Work? Are There Better
Solutions?
Alliance for Health Reform and Robert Wood
Johnson Foundation
June 3, 2008**

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[START RECORDING]

ED HOWARD, J.D.: Everybody know the general situation, that is health care costs are rising at a rate far exceeding the growth in the economy, the growth in wages, general inflation and one hears the word unsustainable a lot in this context and here we are on the last day of the primary season, though presumably not the last day of the campaign or even of the fight for the Democratic nomination, and we have about as distinguished a panel of health economists to examine the candidates' plans as we could possibly assemble.

The plan is here I am going to take a few minutes to lay out the bare bones of the different approaches, then we will let our panel evaluate a few of the specific aspects of the cost containment proposals in the candidates' plans and then we will open it up to your questions. If you

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have any questions beyond the substance or even with the substance, Bill Irwin, our Communications Director, who did the heavy lifting putting this briefing together, would be delighted to help you. As you see, he is the man with the camera.

Let us take a quick look. This room is not equipped for big screens and slides. There are some graphics that we put together that start off two distinct approaches to overall reform that you might make reference to. And of course just to keep you alert, I want you to turn to page 3 of that handout. Note in the bottom slide there are a lot of polls floating around on what issues are important.

Here are just a couple of representative data points. There is a Pew Center poll that was release just a few days ago showing that health care is an important secondary issue to people but the economy trumps all these other concerns. If

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you go over to the next page, if you ask people what their top economic concerns are, and these are numbers from a bipartisan poll published in the spring issue of *Ms Magazine* of all places, you see that health care costs are right at the top of the list of economic worries for both men and women.

Now let us just look briefly at the candidates' plans. I put some basic information about those plans in both the distinct approaches box and the next several boxes where you see lists of areas where the candidates agree and disagree. It is clear that there are two basic approaches. Senator McCain's built around market forces, Senators Clinton, Obama with a very different way of tackling the issue and much more in common with each other than with Senator McCain.

In the cost containment area specifically, there are a couple of graphics labeled cost

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containment tools. Let me just walk through a few of them very quickly. There were more items in the candidates' plans labeled as aimed at containing costs than I could possibly have put on to a simple graphic. But you can see that there is an awful lot of overlap. All three candidates would encourage the growth of health information technology.

With respect to prescription drugs, I am sorry we have managed to separate these items on the list. Let me get back to drugs in just a moment. Both Senators Clinton and Obama on the Democratic side and Senator McCain on the Republican side endorse the idea of greater transparency, both with respect to prices and with respect to quality as a way of promoting competition the right way.

On the area of private insurance both Senators Clinton and Obama would set up a form of

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what Massachusetts has done in its reform plan, they call it a connector, there is some kind of a national exchange in each of those plans. Whereas Senator McCain does not have that provision but would promote competition among private insurers by allowing the sale of insurance nationwide no matter where the company was licensed.

Chronic care coordination, all of them like it. Comparative effectiveness, both Senators Clinton and Obama have an explicit provision. In the case of Senator McCain he talks more about developing national standards for outcome measurement and supporting research on what effective medical treatments are, particularly in chronic disease and that is sort of the same thing. So we gave him a question mark.

All of the candidates strongly endorse promoting prevention as a way of both improving health and getting a handle on costs. All of them

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would pay for correct high-quality care and not pay in some way, or pay less, for care that did not meet that standard. All of them are concerned about medical malpractice and its impact on healthcare costs. They take very different approaches. Senator McCain includes caps on damages which is an approach that Republicans in Congress have favored. The Democrats recognize the problem but propose other steps to deal with the impact of malpractice and liability on the cost of care.

Finally, get to drugs. All of them favor re-importation of drugs manufactured in the United States and shipped to other countries where they are sold at lower costs as a way of trying to save money for American consumers. All of them would promote greater use of generics. With respect to government directly negotiating drug prices there is a Democrat Republican split.

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If you have any specific questions on any of these items you can either address them to me or one of the panel members now. We will try to respond. Or we can get on to some of the meat of this analysis from our panelists. I do want to emphasize that what we have been able to assemble for you in the packets, what there is available for those analysts who want to take a serious look at these proposals, are campaign plans. Campaign proposals and not legislative proposals that would get submitted to Congress. So there are some gaps.

As you might have inferred from the piece in *The Wall Street Journal* about high-risk pools, there are a lot of missing pieces to a proposal at that level, so you may not be able to get precise answers on some of your questions. But if there is anybody who can interpret and interpolate from the outlines from the campaign proposals, it is the three folks we have assembled for you today.

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Let me not take your time, nor theirs, by giving them the introductions they deserve. There is a fair amount of biographical information in your kits, but they are from my far left, Paul Ginsburg, who is President of the Center for Studying Health Systems Change, who is fresh from telling the Senate Finance Committee this morning exactly how to control costs. There is a copy of his testimony in your packets. Mark McClellan who is the Senior Fellow and Director of the Engelberg Center for Health Care Reform at Brookings and holder of every important health-related position in the George W. Bush Administration. He also happens to be the only physician on the panel as well. And to my right, Uwe Reinhardt, the James Madison Professor of Political Economy at Princeton, and lately reformer of the New Jersey health care system through his chairmanship of the Governor's Reform Commission. I cannot imagine a

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better qualified group of folks and what we will try to do is to give them a chance to comment on specific aspects and then we will get to your questions.

And let us start right at the top of that chart. Paul, why do we not start with you? All three of the candidates propose a bigger role for health information technology and I wondered what your opinion and the other panelists can chime in at their discretion. How effective you think that tool will be in holding down costs.

PAUL GINSBURG: There are a number of things that you mentioned that all the candidates agree on. And we have to be suspicious of how significant they are. Let me focus on health IT because you - And there are two key things to say. One, is that it is one thing to be in favor of health information technology becoming a more important factor in the delivery of health care.

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It is another to say what should the federal government do to accelerate this or make it happen. The campaign materials really do not have much on that.

The other thing I wanted to say, which is also relevant, is that health information technology is probably a really worthwhile thing to do because of its potential to improve quality care, to open the door for more transparency quality. Will it contain costs? Very uncertain. A number of the other things they are talking about, will they contain costs? Very uncertain.

Malpractice reform, here is where the candidates differ. I am not sure that either approach has the potential to be a major factor. So I would criticize all the candidates because a lot of the things they say certainly are not on the list of things that can really make a big dent in our cost trends.

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ED HOWARD, J.D.: Mark, Uwe, do you want to add anything to that?

MARK McCLELLAN: Just to pick up on some of the points that Paul made. There was a report recently that, I think it is in the packet, from the Congressional Budget Office on the potential for savings from health information technology and the CBO basically said it is not clear and certainly not tens or hundreds of billions of dollars of savings per year are likely. Basically they said that it depends on other underlying changes in the health care system. And this gets back to a fundamental issue that we are facing right now in the campaign.

Which is on one hand, a tremendous amount of spending on health care by the federal government and by all Americans, a couple of trillion dollars, 16-percent plus and rapidly growing as a share of GDP. And at the same time,

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when you look at the spending, a lot of it is clearly going to treatments and services. And to delivery of care in ways that are far less efficient and effective than they could be. You all are familiar with all the stats on overuse and underuse of medical technologies and misuse. And health information technology, like a lot of these other common elements on the candidates' lists are steps that could help us close that gap. And in theory save tens, if not hundreds of billions of dollars.

But the hard question asked for all of you as you are covering the election, is how would you do it. And that picks up on Paul's point. There is this big gap between how well our health care is performing, how well it could be performing. There are a lot of ideas that could potentially help close that gap but the general consensus among budget experts and policy experts seems to be that

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it is not going to happen automatically. In CBO's general words underlying changes in the health care system are needed. And these underlying changes include things like changes in the way we pay for health care, not paying for more services and more intensity. Not paying for more complications but rather focusing on what we really want, better quality and a lower cost.

Changing benefits. Other underlying changes that could help facilitate changes in the way that care is delivered. And this is going to be a central issue, if not in the campaign, it could be determined by other things between now and November. Certainly in approaching health care reform in 2009. Because with costs as high as they are. With government spending as high as it already is. And with the budget as tight as it is, it is going to be hard to take steps and make care more affordable and available for all Americans

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without doing something about these fundamental problems, these fundamental challenges in underlying costs.

So if we do not get better answers to the question of how do we close these gaps using health IT or care coordination or other services, it is going to be awfully hard to make progress in 2009.

ED HOWARD, J.D.: Uwe, Mark was talking about changes in payment policy and maybe you could pick up on that. Both to comment on how efficacious that might be as a cost containment plan and maybe how difficult given how Congress has been wrestling with the sustained growth rate formula in Medicare as a payment method for physicians. How likely it is that we could get over the hump and do something significant in payment reform, if that is efficacious.

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UWE REINHARDT, PH.D. First of all, on the proposals in the candidates' campaign, I think most policy wants would write them down. And if you sort of looked at them and said would I favor this or not, most of us would favor them. But if you gave us a truth serum, a couple glasses of wine, say, we would probably all come out saying whether it saves dollars per year is not so clear. But it will give us more value for the dollar. That would pretty assure us I think. So these are not to be laughed off, but I do not think that will get us out of the box.

As somebody who as you can tell by my accent just emigrated, I take the liberty of flying way up to take a bird's eye view. And I say these are the countries that do it for roughly, except for Switzerland, half of what we spend per capita in purchasing power parity. How do they do it? And if you look, all of them have a very

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powerful, strong demand side. Maybe too strong. Ranging from what we economists call monopsony which is single payer, you just dictate prices, to quasi-markets like Germany where associations of insurers negotiate what associations doctors and hospitals to hash out prices that are not really totally free market but quasi-market.

By contrast, all of U.S. policy, I observed it very closely for almost forty years, is consciously geared to keep the demand side splintered and weak. The supply side will go along with anything you propose. But the minute you propose really strengthening the demand side of the health care system, the supply side springs into action. And they happen to be the largest shareholders of the United States Congress. And purchase from them systematically protection from a strong demand side. That is how I from a bird's eye view would describe what we are in and

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nothing, pay-for-performance, nothing will change that power relationship.

These people ultimately can dictate prices to us. In fact, as this Commission proceeded in New Jersey, I asked an insurer a very silly question - what do you pay for a colonoscopy. And he said what do you mean? You cannot answer that. It turns out the prices they pay to different hospitals vary by a factor of three. In California, I asked the same thing. Give me some prices for an appendectomy. It ranged anywhere from \$800 to \$13,000. So I am not sure what this market actually needs. There are no prices in this. It is whatever you can grab or negotiate. I hand out here a little thing that was done by McKinsey, a very distinguished colleagues of ours, advised this study that shows Americans actually consume less health care in real services than most people other than some high tech stuff where

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we get it and they do not. But overall, less, but we spend a lot more on prices. This was 1990 data. But today's would read just like that. And we spend a lot more, of course, on administration because we have a very complicated system.

So I do not think if you look at this McKinsey chart, I do not think anything the candidates propose is going to address these differences in a major way. There is really no - yeah we are calling for evidence-based medicine. Has anyone ever asked for evidence-based administration? We are spending \$500 billion estimated on administration. No other country would spend more than \$250 on our size health system. Why is that? And why can we not get rid of it?

So I think tinkering at the margin with pay-for-performance we know it has not worked for corporate executives. I am not sure it is going to

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do a lot. It may be more therapeutic for us to do this, but I doubt very much (a) that it is easy to implement, we just had a conference in Princeton on it, very hard to do, and if we did it, it is a useful thing to do alongside with others. But until we address the weakness, the deliberate built-in weakness of the demand side of the American health system, we are stuck with these costs. I am convinced of it.

PAUL GINSBURG: I would like to say some more things about the potential for payment. I think all three candidates did talk about reforming provider payments. I want to say to step back and this is really not in either agreement or disagreement with what Uwe said. This is really about how we pay and payment structures. We have a piecework system. We pay providers fee-for-service for the most part for whatever they do. No one looks at what does it cost to serve a patient, to

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treat this acute episode of care, to manage chronic disease. As a result of the way we pay for care I suspect that our delivery system has much lower productivity in delivery care because it is not being pressured on the right things. It is being pressured sometimes on what it costs to provide a unit of service. It is not being pressured by how does it organize the treatment of a patient. How does it coordinate that treatment.

I think that we have the good fortune that because the Medicare program is such an influential payer in our country, not in the aggregate amount they pay, but in the structure with which they pay. Many of the innovations in Medicare have been followed by Medicaid programs and private insurers. I think there is potential to use the Medicare system not as a regulator, by as a payer, to restructure payments.

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There is some immediate things to do, which I have written about in *The New England Journal of Medicine* about first eliminating some of the inadvertent distortions in our current fee-for-service system. But then build on that to go beyond fee-for-service, to start bringing capitation payments into the management of chronic disease and patients and creating multi-provider bundle payments for acute episodes of care.

Again, this independent of what Uwe is talking about. There is still this issue of the playing power from the demand side. But I think that if we launched into a more intelligent way of paying for care, we could improve our productivity, could improve efficiency and make a real contribution to slowing cost trends.

MARK McCLELLAN: Maybe I could pick up on the same themes, having been at the organization that is at least the closest thing the United

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States has to a single payer power on the demand side. I can tell you that the impression you get going to work every day at CMS is not that you are out there controlling exactly what happens in the biggest sector of the U.S. economy and the biggest health care delivery infrastructure in the world. It is one of having very little control over what is really going on and that is not because of a lack of Medicare awareness, about Medicare's purchasing power and the government's purchasing power. It is a reflection of the extreme level of detail that Congress has gotten into in setting how Medicare pays and what it pays for and how hard it is to change those kinds of systems.

Everything that Paul just talked about in terms of making Medicare into a smarter purchaser are ideas that Paul and others have put forward over time and that Medicare, if it is lucky, can test out on a demonstration basis and over a

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period of years can gradually move to implement. I think that is why Uwe is right, our recent immigrant over here, is right about the fact that pay-for-performance at least is how it is likely to be done and has been done, is not likely to have a huge effect. Because look at what ends up happening with implementation.

We end up doing what Medicare is doing now. Paying a little bit more for maybe just reporting on some basic aspects of processes of care. Or maybe paying a little bit more in demonstration and test programs for better results. And those kinds of incremental changes in payments on top of a health care payment system that does not really focus on getting the best quality at the lowest cost, are going to have the most incremental effects.

That said, I am not sure, I do not want to mis-state what Uwe said, but I am not sure I

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completely agree that just getting to a stronger demand side in terms of pricing power is going to get there. Medicare does set prices and we have seen what that has done to help control costs and get better value and improved quality of care. And the answer is not much. That is why we are struggling with this problem with physician payment right now. Costs keep going up because volume and intensity rises, so the automatic built-in legislative knee-jerk response, it is in actual legislation, is let us cut prices across the board. And that has not solved the problem

Costs overall have kept rising because spending on health care is not just prices, it is prices times quantities and Uwe is exactly right that a big difference between the U.S. and other countries is that our price levels are higher, not just for drugs, but for everything. And it is primarily due to hospital prices and physician

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prices and other service prices being higher. But in terms of growth, it is the quantities that are accounting for the biggest part of growth.

It is not that prices are rising from year to year much more in the United States than other countries. In fact, other countries are having some of the same kinds of spending pressures that we are. It is because the quantities are going up. We are treating more problems, we are treating them more intensively than we did in the past. Some of that is because of a newer better treatments coming along. But a lot of it, as Paul and all of us have pointed out, is because treatments are being used in a way that does not add the most value at the lowest cost. It does not create the most productivity. In fact, many of the European and other countries that Uwe mentioned seem to be moving towards more of a role for private purchasing on top of your basic government

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services because of concerns about getting the right treatment to the right patient at the right time. As we get to an era of more personalized medicine, there is supposed to be more emphasis on prevention and non-traditional ways of treating health problems before they get serious. Figuring out how to treat patients, it becomes a much more personalized matter and you cannot just cover certain treatments and not cover others. You cannot just set one price and expect that for a specific service and expect that that is going to lead a good result.

We do not know what the price of a service is in this country. Think about colon cancer. What is the cost of colon cancer? Well, it depends on all the services you get. It depends on how many times you see the doctor. How many lab tests are ordered. How many imaging procedures and the like. We have very little transparency around that and

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very little accountability for the overall results of that care. With a greater emphasis on those kinds of steps I think there is some potential for changing the way that health care in the United States works so that we get more value and potentially avoid some significant unnecessary costs.

ED HOWARD, J.D.: A comment from Uwe and then we will open it up to your questions.

UWE REINHARDT, PH.D.: I think Mark, I am glad you picked up on my sloppy exposition, because I do not disagree with you. The other countries also all pay fee-for-service and have exactly the same problem that Medicare has. That you are overpaying for some stuff. The fee schedule is not calibrated right. All of that exists. All they do is get lower prices. That is certainly the case. A lot of us for thirty years or more have dreamed of bundling health care more

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around episode. And of course the DRGs were a gesture in that direction. Where we taught the rest of the world to bundle where they had never figured out how to do that.

So that was a good think. And then you have Reggie Herzlinger and Michael Porter very explicitly coming out with models where you just price bundles of treatment and have one price for it, even if extends over long periods. And it is hard to argue with them other than to say this is hard to do.

And that reminds me, Paul, you and I once thought our dream would come true, we were on PPRC, Physician Payment Review Commission. He was a director, I was a commissioner and we had the bright idea of bundling the services of pathologists, radiologists and what was the third? The rats. We were going to bundle them into the DRG and make the hospital purchase that and hire

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these people and be responsible for their quality and all of this. And as I recall, Paul, somebody purchased protection from that idea. From the Congress. It was dead on arrival. And we are still paying -

Who has recently picked a pathologist when you were in the hospital? Sort of gone shopping for a good pathologist. Or for a good, I mean anesthesiologist you see some eyes over some white stuff. And it is too late. You are there naked and you say what am I going to do. [Laughter] Give me the phone, I want to shop.

So why could you not even something so common sensical, you could not get through this Congress. So unless somehow there is some new food that Congress people get fed that makes them (a) rational and (b) patriotic, I do not know what it would take to get these very sensible thing - The reason Mark was powerless is because of the

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Congress. It is not that he would not be very powerful if he could really do what he wanted to do.

ED HOWARD, J.D.: I lied about giving you a chance to ask your questions, at this instance, because Paul Ginsburg has brought up a topic that he wants to get on the table and that is absolutely essential if you want to understand what is actually in some of these plans. Paul, you want to talk a bit about the tax treatment of health insurance and how Senator McCain in particular will change it?

PAUL GINSBURG: When Ed asked me to do this, the first thing that occurred to me in my mind, the biggest difference between the candidates and perhaps the most powerful cost containment idea that any of them have put forward is not what has been sold as cost containment but Senator McCain's idea about changing the tax

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treatment of health insurance. In a sense, what Senator McCain's idea would do is basically at the margin, encourage through incentives, people to buy less expensive health insurance. And this in a sense is a market-based way of, in Uwe's words, unleashing the demand side to make people more sensitive to what they pay for health care.

This is happening on its own as employers react to rising health care costs. But I think that this is a potentially powerful idea. People like the various panelists the policy wants have been talking about this for 30 years. This is not a new idea.

ED HOWARD, J.D.: Paul, there may be some people who do not really know what is in it. And you might take thirty seconds to explain the proposal.

PAUL GINSBURG: The current policy is that all employer contributions to employee health

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benefits and if you have a flexible spending account, even the employee contributions to the premiums are from pre-tax income. So in a sense, you can buy health insurance with pre-tax dollars. Most other things you buy with after-tax dollars. And over 30 years there have been many proposals to cap this, in a sense accept the fact that it may be useful to encourage people, employers to provide health insurance. But put limits on it. And what Senator McCain has proposed. And there is something similar to it in the Wyden Bennett Bipartisan proposal is to eliminate the exclusion and replace it with a tax credit that can be used to buy health insurance.

So, if you are getting a tax credit, it means that if you spend more for health insurance, you pay the entire additional cost.

ED HOWARD, J.D.: Very good. Thank you.

Now we can do what I promised. If you would raise

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your hand, we would like to capture what you say with a microphone. So not only that others can hear you but that the recording that is being made will be inclusive of your remarks as well. And would you identify yourself.

CRAIG PALMER: Craig Palmer, ADA News.

There seems to be a consensus forming even at the table around the CBO report and that being that health IT is one part of the health system. We do not know whether it is going to save costs. I read the CBO report saying at least implicitly that we do not know how to measure health costs and there may be hidden costs that we cannot get to. We do not know the cost of a colonoscopy for instance. We are not measuring demand. Do we really know the cost of health care?

MARK McCLELLAN: We certainly know the overall costs. What we do not know is the impact of proposals to reform health care on how health

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care is delivered and the cost of that care. I think it gets back to the point that CBO made in that report that I think all of us are coming back to now. That is the impact of health IT depends. It depends on underlying important forces in the health care system like how demand works, like how supply works. So in particular, if there were better ways of measuring the cost of care, so that if we could identify for colon cancer care, or for doing a colonoscopy, what is the overall cost and also if there are better ways of measuring quality care and what is the overall quality, then it would be possible. Then we would be on a tract to change those underlying forces. You could have reimbursement or benefits, or regulations that were designed to promote better quality at a lower cost. That is a very different environment, a very different set of underlying driving forces for how health IT or care coordination or steps to promote

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prevention, or other reforms affecting the delivery of care would actually operate. That gets to CBO's point. There clearly are some gaps between how we are delivering care and how we could, using information technology and all of these other good ideas that providers have, that consumers have, that new internet-based companies have for improving the delivery of care.

But we seem to be stuck in not being able to close that gap and I think that is the important question for you all to ask the candidates because there is not a whole lot of new money left available to make care more affordable and available. So if we are going to do that it is going to take some steps in approving the actual delivery of care and finding ways to get more value for what we are spending. And that means answering the question of okay, there is all this potential from health IT and other changes and

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delivery to improve how health care actually works. How can we capture that.

I think measuring quality and cost in a meaningful way would be an important step to doing it but it also is going to take some real changes in payments, some real changes in the way that health insurance benefits work, and the other kinds of underlying steps that we have been talking about today.

UWE REINHARDT, PH.D.: When you come to measuring cost in this Commission in New Jersey, we recommended to the Governor a software that exists that is able to track every physician order entry for any patient, for any case, for any input and it is possible. I have seen it actually done at Levolist's [misspelled?] clinic, this guy, a Princeton-based company. So once you have that, you could then really find out what different physicians spend their resources they conscript in

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the hospital for a particular cases and compare them and have them meet and discuss why is one more expensive. The variances I have seen are enormous within the hospital by different physicians. Maybe there could be some cost savings. It turns out sometimes somebody just uses the most expensive antibiotic when a cheaper one would go. Or uses the ICU too much and it is not necessary. So there is some hope in small cases where you can show IT might. But even that software would not be cheap. And you would have to train hospitals to do it. So it is never quite clear. IT is expensive. A hospital usually spend \$50 million, \$60 million a year on buying this stuff and maintaining it.

PAUL GINSBURG: Quick addition to what Uwe said. I think one approach that has a lot of potential is quality transparency and the potential is before you ever get to it in consumer

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choice. Because I think the experience with provider report cards has been not a lot of interest on the part of consumers, but when providers have confidence in the data and they come out poorly their professionalism often leads to a very vigorous response. I think part of the ideas that Mark was sketching out before about having a more efficient quality-oriented deliver system comes from a greater transparency, particularly in the quality area.

BOB WEINER: Bob Weiner from Public News and Radio America. Unfortunately, Ed Howard and I have been working on this issue for way too long, since we worked together for Claude Pepper [misspelled?] in the '70s. A few things that would be very interesting for the panel to address.

Number one, the myths of the United States having the best care, when life expectancy and infant mortality put us at something like 25th and

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35th in the world. And how we can say we have the best health care now and the candidates' approaches on that. And very interesting that Senator Clinton way back when, I forget if it was Bush one or Bush two, but said to President Bush that we are twenty-fifth and thirty-fifth in the world on life expectancy and infant mortality. And he said that is not true. Then about three days later wrote a letter back to her, it is in her book, and said whoops, you were right. We are, we really are not that good in the basic parameters.

And then the other points are. The difference between a requirement and the approach of reducing costs as an incentive for people to get health care for the 47 million that do not have. Can you really get at it with a reduction of costs? Or is that a myth? Can you ever as the panel just stated, is it really likely that restraints would cut costs enough to persuade

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people to buy. Is that a reality or is it like what happened with the Bush drug plan, where the cuts in costs did not really become cuts in costs, they became excuses for the drug companies to raise the prices of the drugs.

And then the third question is will tax treatment really work any more than it has successfully reduced prices for oil and gas.

UWE REINHARDT, PH.D.: Usually I shy away in my international work from these physical measures, life expectancy, infant mortality as comparisons of output because when you - At Princeton we have a whole group of really high-class researchers looking at the non-medical care determinants of health. You know them, Mark, Chris Pax and Angus Beaton [misspelled?]. And there are so many other variables that drive those variables that health care is actually only a fairly small part of it.

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For example, the incidence of obesity in the U.S. is twice what Canada's is for reasons I do not understand. But it is. Much higher in Europe. That must have some effect. The others. For instance the stress living in a competitive market economy with so much insecurity compared to the much more secure European existence or Canadian. People, physicians tell me that could have an effect on outcomes. So I am not so sure I would use those metrics. That is my view. I do not know, Mark, you are the doctor.

MARK McCLELLAN: I think the evidence is pretty overwhelming that if you want to improve population health the place to focus is not on health care but on these other underlying factors which may seem harder to influence. Things like socio-economic status and education and the environment in which people live and work and play. Which it is possible to influence. The

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supporters of this effort, the Robert Wood Johnson Foundation are also sponsoring a commission. A commission to build a stronger America which I have got the privilege of co-chairing which is specifically focused on these non-health care factors that can and are influencing health. And we have heard about a number of initiatives ranging from efforts by employers and communities to help build a healthier environment for nutrition, for exercise, for access to healthy diets, to early childhood interventions, and other factors that change behavior in ways that really lead to measurably, demonstratively better long-term health.

Getting back to some of the other health care-related issues you raise. I want to go back to this point about prices and quantities. You talk about the drug benefit and how that was a net addition to Medicare costs which is was but if you

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look at the numbers and the number of independent analyses that have come out including one recently from *The National Bureau of Economic Research* it did actually lead to lower prices than what seniors were paying before. I think a lot of people can and are arguing about well would it not have been even lower if the government had come in and sort of singly negotiated or set prices. But the overall costs of Part D are now entering about 40-percent below what had been projected at the beginning of 2006 when the program was first implemented.

And that gets back to this point about prices times quantities. What has really changed between 2006 and now an expectations about the drug benefit is how seniors were getting their drugs. So at this point, fortunately none of them are in the standard benefit that was designed by the government in that 2003 wall which was a

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deductible and 25-percent co-insurance and catastrophic coverage with a donut-hole in between, because people did not think they had enough money to subsidize a comprehensive benefit, based on this much higher projections.

Instead, what beneficiaries have chosen is plans with what are called tiered benefits where quality information really is actually having an impact on behavior of consumers. So for drugs people by their behavior seem to be acting like they believe that generics are just about as good as the brand-name drugs. And that is why FDA will tell you and that is what the science will tell you, they are the same active ingredients, they are regulated in the same way. They produce the same kind of health effects in patients, but they cost much, much less. Seventy percent less. Eighty percent less. And in the tiered benefit design the beneficiary gets to keep most of that savings, not

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even 20-percent like a traditional insurance plan. But the difference between say, \$60 or \$70 brand-name drug and a \$1 or \$2 or free generic drug. And that has lead to a huge change in behavior with a very big increase in use of generics in the Medicare population.

Similarly, most of the plans have a second tier that is the so-called preferred brand-name drug. And for the 12 or so categories of drugs that account for most out-patient prescription drug spending there are now a range of brand-name drugs available. These are the ones that are called me-too drugs. They always work the same way and every patient that have similar kinds of effects from any patients and if a beneficiary switches from a non-preferred to a preferred brand, they go from paying \$70 \$80 to \$20. It is a huge amount of savings. Much more than a 25-

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percent co-insurance and a huge amount of that kind of shift in spending has occurred too.

So those are all what I would call quantity shifts, changing the treatments that people are actually getting in a way that enables them to meet their needs at a much lower cost. We do not have that now. For colonoscopies or colon care and the like. But you can start to see the makings of it. In places like Geisenger or Mayo Clinic where they are now putting out meaningful outcome information. What their complication rates after surgery are. How quickly people recover. What the mortality rates are. The outcomes that people really care about. Not just a few so-called process of care measures, but the results that really matter to people. And they are coupling that with overall in some cases, like at Geisenger overall, all-inclusive costs. And they are doing that not because of the fact that they want to be

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good health professionals, but because they see this is where health care may be headed. And they want to get ahead of this trend.

You can envision a time down the road when if we have better measures of quality and costs you could get care for free and be confident that it is really going to do well for you. You could go to other places, but you would pay a much larger part of the cost. Much as we have already got for drugs now. For drugs, we are already a long way towards this point where we have quality and cost information that people are actually using to make decisions and it is now changing. Where there is an opportunity to get these innovative benefit designs, it is now changing the way that people get care. It is really changing the quantities of care and that may be coming in other areas too.

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And that gets back to the same basic point that I was making about if you want health IT to work or care coordination or prevention or all these other steps to really work, you are going to have a lot more effective power to drive that forward if you can change demand and change supply to really encourage and support its use. We are not there yet and those are the kinds of hard questions that the candidates have not yet answered.

When they say they are all behind these kinds of steps to improve the delivery of care.

JULIE APPLEBY: Julie Appleby with USA Today. I am curious about the folks who buy their own insurance, the individual market. And McCain has a proposal that would allow folks to buy across state lines to purchase their insurance. He has a number of reasons for this, but one of the reasons was that he says that it will help lower

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costs, because people will be able to shop across state lines. Obama and Clinton would like to pool purchasers into exchanges and they would buy that way. Could the panel please discuss how effective these two approaches would be in reducing costs.

PAUL GINSBURG: I do not see them as competing proposals because the Obama and Clinton notions of health insurance exchange, it is not really a cost containment proposal. That is a device that I think is essential for the individual insurance market to work in a way that meets society's aims. By that I mean that people who are sick or are old, have to face premiums that they can afford and if medical underwriting can run rampant and different price charge for everyone then it is not going to meet the goals of universal coverage. So I think that is a key thing to using the individual market more.

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I think what Senator McCain is talking about as far as the national regulation of individual health insurance, is really a way to basically put aside mandates and other regulations by states that make coverage more expensive. So in a sense I think we are going to get the combination of avoiding many of the mandates but also avoiding some of the consumer protections.

UWE REINHARDT, PH.D.: The theory that drives this, I have seen New Gingrich advocate that too, is that health insurance packages or premiums vary because different states mandate different things. Some mandate wigs some in-vitro fertilization, others do not. I do not actually know of a study that says how much do these things that one might consider add-ons, actually cost.

When you look at the Wenberg [misspelled?] data it is the same benefit package. It is Medicare. The same prices because you adjust for

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that. You even adjust for demographic differences and you find per capita cost of real health care use across the U.S. varying by a factor of three.

So I do not think that health insurance premiums would be cheap in Massachusetts because their practice an extremely resource-intensive style relative to Minnesota, for example. Some of these mandates may add a little bit of cost but I do not think that will bail us out. I think it is going to be a small effect. What is really interesting, and what we do not know, is why did these huge regional variations in cuts which dwarf actually cross-national comparisons, why did they arise. We obviously were twice as expensive than other countries. But if you look at the sun belt, it is almost sometime three times as expensive as the wheat belt. Yet all the research, Jack Wenberg, Elliot Fisher & Associates [misspelled] have done show that this has no discernable effect

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on outcome, patient satisfaction or process quality.

The intriguing question is Congress has known this for 20 years. Why have they studiously avoided even looking at it, let alone asking what is going on.

MARK McCLELLAN: It is hard question to answer. And it gets back to - Look, the reason that costs vary so much from area to area is not prices. Prices are not three times as high for all these services in Massachusetts as they are in Iowa. It is the quantity. That practices are being delivered and I think it is back to that lack of information about quality and about cost. About the things that we really care about that have made this a hard problem to address.

But one thing that is coming through loud and clear from the candidates' proposals is they recognize that we need to take this on. We need to

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do a better job of delivering care effectively.
Better evidence on what works and more
accountability for overall quality and cost. And
now the hard question is how do we actually do
that. Okay. As Uwe said, Dartmouth has been
documenting this for 30 years. People in Congress
have been talking about it for at least 20 years
and yet all we see is these variations and these
opportunities, these gaps in the quality of our
health care system persisting.

I think there are some promising steps
that can be taken to address it but it has not
really been as prominent a part of the public
debate about health care reform as it should be.
And there is an opportunity to change that now as
there are less and less opportunities to find new
money to try to make our current way of delivering
care more affordable than it is.

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JENNIFER LABELLE: Jennifer Labelle

[misspelled?], Monarch HealthCare. I wanted to talk for a minute about your brother's book. In the book he describes how the Bush Administration lied about the Iraq war. I am just kind of wondering what you thought of the book and whether or not that thing applies to their health care policies.

MARK McCLELLAN: I do not want to speak for Scott. As some of you may have noticed in the past week, he has been doing a pretty good job of speaking for himself. I do want to say that he spent an awful lot of time and effort on that book and it is a heartfelt reflection of his thinking about his experiences in the White House. My experiences in policy jobs in the Bush Administration were very different. I was working on different issues. I was in a policy position but I can tell you that the importance of being

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transparent, straight forward, the importance of candor, the importance of finding bipartisan ways to work on issues. All of these I think are really important. We are a vital part of what I try to bring to my time in government, both in this administration and previously when I worked in the Clinton Administration.

JILL WECHSLER: Jill Wechsler with Managed Health Care Executive Magazine. Ed, I was interested in your introductory comment about how we should look at these candidates' proposals versus what will eventually hopefully be policy proposals and I am wondering as a reporter sort of covering this issue which is going to go on for at least another five or six months, is there anything that the panel can see that would be really intelligent to say about the candidates' proposals, which I think you have all agreed in the cost cutting area are kind of political comments that do not perhaps

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have a lot of substance. And what is really useful or you think can move the debate on at this point where we still have a long political season to go.

ED HOWARD, J.D.: Panelists might want to just agree or disagree with Jill's characterization of the candidates' plans explicitly. That would make news.

UWE REINHARDT, PH.D.: If you look at the proposals of Senator Obama, Senator Clinton, those are actually fairly staid old traditional ideas that are always good to trot out and some of them might come about. I do believe if Mark had stayed longer some of this stuff because of the sheer force he put behind it, with his personality, might have come about. But I think what can be said is the true radical in this among these three is Senator McCain. And Paul explained why. To think that you could abolish a tax preference that is almost sacred to Americans, the employment-

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provided insurance, and what it would mean is you would find something like 6,000 bucks added to your W2 Form and have to pay taxes on it.

You would of course get a tax credit check and it might balance out but somehow this is a shocking idea and not easily gotten through the Congress. And then if you have this money and you had to buy health insurance I think there is a story there. That this is radical. And the other two are not so radical. But very common sensical and very American. This is almost I mean from what I know, almost un-American, which is to take away a tax preference, which he proposes. Right? That is bold.

PAUL GINSBURG: I would agree with Uwe. Say that aside from that, the cost containment approaches of the different candidates, not a dramatic difference to write about. I would recommend writing about their approaches to

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expanding health insurance coverage where the differences are much greater. And in a sense what unfortunately though the way that all three of them have couched their ideas that are somewhat common to them is not in the way this panel discussed it, but really almost like a wish - I wish there was better care coordination and I wish there was IT. As opposed to the fairly fundamental change that we need from our delivery system to become more productive and to execute better. That neither of them are addressing directly. I think they could have a real debate over how best to do that, but we are not hearing that.

MARK McCLELLAN: Maybe three questions that are worth continuing to ask the candidates. I know many of you are trying to do this. One is, where is the money. So if you are going to propose expanding access to coverage or bringing down the cost of insurance that people are paying now. And

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you are not going to change the way health care actually works, the money for that has to come from somewhere. And some of the approaches that have been mentioned, particularly on the Democratic side include things like rolling back the tax cuts for the wealthy or maybe savings from the war in Iraq and the War on Terror. Keep in mind that the tax cuts for the wealthy are all scheduled to expire in 2010 along with all the other tax cuts from 2001 and 2003. So from the standpoint of the CBO, we talked about earlier that tells you what new money is available for programs. That is not new money. CBO is already assuming that those tax cuts go away.

There is going to be a big tax reform debate next year but it is going to be over which and how many of those tax cuts are continued. And also over things like alternative minimum tax, AMT relief, things that are going to require new

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budget funding that are unlikely to be major sources of a new kind of government entitlement or major expansion of government entitlement. I am not an expert on the Iraq war and on our military spending but as you all know in following that issue, much of that spending is handled now through supplemental appropriations by Congress. Spending is only partially and incompletely reflected in CBO budget projections. That plus our economic outlook right now tells us that next year is going to be a very tight year fiscally and a very busy year for Congress on tax reform, on dealing with next steps in Iraq and Afghanistan, the War on Terror and on taking further steps to help people with their number one domestic concern now - which is the economic state of the country and worries about jobs and gas prices and housing and things like that.

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Congress and the President are going to have to do something about all those things. In fact, if you look at the McCain proposal. This is the first time I ever remember this. I mean I have not been around that long. I have been around a while now it seems like. This is the first time I can remember a Republican candidate not really proposing anything new in the way of subsidies for health insurance. In 2000, 2004 President Bush proposed this partial Medicare expansion through Part D and Medicare Advantage. He proposed a tax credit which did not get enacted. He proposed HSAs which did. Those were all kind of net new spending on health care.

This time around, none of the Republican candidates proposed any real new spending. Why? Because there is no way to do it and continue the tax cuts of 2001 and 2003. And continue a serious level of military spending that we have seen in

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the last few years. So, whichever side you are on, the money is going to be very tight next year. So where is the money going to be to actually pay for coverage expansion. And then if you are not going to have net new money, there really are only two other places to go. One is to reduce the cost of health care as we have talked about already today. And there I think it would be very good to ask the question of how are you actually going to make this happen. How will care coordination or health IT or prevention. All this stuff that we have talked about today, how will you make that promise turn into reality. And look at what CBO has said and look at the discussion we have had today around the underlying drivers or lack of drivers for getting to more efficiency in our health care system.

There has been very little public discussion of that. But I think there is a

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potential for much more public concern. That people are becoming more aware of now. That they are paying maybe three times as much as Uwe says they need to for similar services. They are often not getting care that is up to the latest medical standards. We do not have in many ways the best health care system in the world. Particularly for treating chronic diseases effectively and preventing them in the first place. There is not as much public concern and frustration, anger about that as there is about health care cost now. It seems like the two could become more tightly linked if this gets to be a bigger issue. If there is kind of more awareness of this is what is at least a big part of the real annoying problem.

And the third question is what are you going to do about entitlements. It is a hard topic but no matter how much, this is safe to say, no matter how much we improve the delivery of care,

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we are still looking at a real enormous long-term fiscal challenge for the country due to Medicare and Medicaid. And also our third health care entitlement, which is this employer tax deduction. That by itself is by far the largest and the fastest growing tax expenditure in the United States. Between the federal and state and Medicare and social security tax exemptions that is worth \$225 to \$240 billion a year now, and growing rapidly. It is a very regressive subsidy with more of the subsidy going to families with incomes over \$100,000 and families with incomes under \$50,000. And if we are entering an era when there is not a whole lot of new money available to make health care more affordable, we are going to have to answer increasingly hard questions about how do we make care more affordable for families right now who have incomes of \$50,000 and are uninsured and are not taking advantage of this tax break. Are

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paying in in their Medicare and social security taxes. Subsidies for wealthy or older Americans that are getting bigger and bigger.

And these are challenges that are clearly part of making health care work better in the United States.

ALICIA AULT: Alicia Ault with *Internal Medicine News*. Just sort of following up on this discussion. As we move into the General Election, do you think there is going to be a change at all in the candidates' tones. Will they get away from the feel-good message of increased access, let us get everybody insured. And sort of shift more to cost, especially with the economy sort of continuing to tank?

UWE REINHARDT, PH.D.: I think politically Senator Obama has pretty much committed to continue the theme of expanded coverage, not as radical as Senator Clinton. She was going to go

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the whole hog and he is going to go, sort of two-thirds of the hog, not even that. I do not think he can retreat from that. In that regard Senator McCain of course, not having promised a lot, has a lot more freedom.

MARK McCLELLAN: Major health care reform is always, people always view it as a long-shot and I think the concerns about the economy of Rone [misspelled?] has other issues and budgetary challenges or overtaking health care on the national surveys and the concerns about Americans. People saying well it is getting to be a longer shot. I think it would be a missed opportunity if we do not have major health care reform next year. I personally am not ready to write that off. I am spending a lot of my time now working with this group sponsored by the Bipartisan Policy Center made up of former majority leaders in the U.S. Senate on a bipartisan basis. I am working with

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Chris Jennings who did health policy for the Clinton Administration, Clinton White House on a framework that we are going to release soon after the election to help to drive all this forward.

So my hope is that it does not get pushed to the back burner. But I do think the kinds of questions we have been talking about today need to be asked and hopefully answered. But at least asked and used to educate the American public about just what it is going to take to get to high-quality, affordable sustainable health care reform. And it is not just a matter of finding new money for more subsidies. I do not think we can afford to do that any longer. I think that there needs to be further steps on improving delivery in conjunction with trying to make coverage more affordable. If all we do next year is fall back to some minor steps towards reform and say that we

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have done what we could, I think that would be a missed opportunity.

PAUL GINSBURG: Even though the interest of the voters is swinging now towards affordability, there is still a lot of interest in coverage but sort of affordability. I think it is much easier to draw a distinction between say, Senator Obama and Senator McCain on coverage than it is on affordability or cost containment. And maybe that is going to be okay. Because even if they cannot draw a distinction that the voters can really get into to the degree that the voters keep speaking this way in the polls, it will actually give somewhat of a mandate to whoever is elected to go do something about affordability in addition to the approach that they advocated as far as expanding coverage.

UWE REINHARDT, PH.D.: The words affordability and sustainability are tricky words.

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Certainly to economists. We have in the U.S. some unwritten law that says the federal government on average cannot raise more than 18-percent of GDP in the form of taxes. That has been constant for about 30 years with some wiggles. That could go to 23. If it went to 23, a lot of the problems would go away. Now if you add state and local taxes on top of that, you get to 26-percent of GDP is taxed in the U.S. And with the lowest, no other mention taxes as little as we do. So in terms of competitive advantage, we could raise taxes. To give you some numbers. I read the Social Security Trust Fund report and they predict that by 2050 10-percent of GDP will go to just fund Medicare. In its current form.

Now it is about three, roughly around three. I said 10-percent, but then I thought, let us just draw a pie, see how big it is. And we are now real income per capita is \$40,000. It will be

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close to \$80,000 even if growth is only one and a half percent, rather than the two we have had per year growth in GDP. So if you have \$80,000 and you take 10-percent away, that is eight. You still have \$72,000 non-Medicare stuff. Well, now we have \$40,000 minus three percent, that is about \$38,000. So you cannot look at god frankly, and say, god, we cannot afford it. God will laugh at you.

What you are really saying is we do not want to afford it. We do not want to raise taxes above eight. If you keep federal taxes at 18-percent, lots of bad stuff will happen. We probably cannot even afford the military because everything is just going to bump into it. But if we are going to raise taxes, as one of the very rich nations on earth, a lot of these problems actually go away. I cannot get that ever published as an op-ed piece but that is something people

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should know. It is not that you could not afford it, it is that for some reason we say we do not want to do that. And I will add one more thing as a caution, the health care sector has been virtually the only sector that has added jobs since 2001 on a net basis. All other sectors have added and taken away. The health sector is the economic locomotive of the American economy.

If it had not been for health care growth, the first term of President Bush would have been an economic disaster. Between 2002 and 2003 53-percent of the growth in GDP was health care. This gives you some idea the issue is larger than just Medicare is not sustainable. I am looking you in the eye and say it is sustainable. Even as sloppily as we run it, Wenberg says we could shave 30-percent off it and still treat the elderly well. I believe that. But even if we wanted to be as sloppy as we are now, we could afford it. The

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question is would the political process sustain it. And that is not my department.

JERRY BRAZZO: Jerry Brazzo [misspelled?], old hand around. Uwe and Mark, I would like to hear both of you deliver your frank and free opinion. Do you think that health care will emerge as a major issue in the campaign and if so, what do you think about Medicare for all?

UWE REINHARDT, PH.D.: You always see these Kaiser surveys where people say health care is a major issue to them. But I think for the great bulk of voters, health care is actually sort of okay. They either are not sick or if they got sick the employer-based insurance is pretty good. They had a little to pay but they got good treatment, etcetera. So when they are in the booth, I think there are other issues that actually dominate for those people. It could be very personal things that are routed in religion. I do not think that

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is because people are, what did Senator Obama say, bitter. I think they just have different priorities. Because for them the health care is okay. They hear all the time health care is bad. But the bulk of Americans have had pretty good experiences in health care. Because the bulk are well-insured. So that is number one. That there are other issues. The war may, I think, could be a major issue, depending on what Al Qaeda and other people decide to do. Who knows? They have some leeway there. I think the general economy, if the dollar keeps tanking and Americans go to Europe and really realize how poor they are. I think that could have a big effect. So I am not personally persuaded that health care will, in fact, drive the agenda in the fall.

MARK McCLELLAN: I think I agree. And if there is a new international event. A major turn in the war, that would put international issues

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back more to the fore. Failing that, it looks like it is going to be the economy, tax reform, big things going into the next year. Again, I do not think that means that health care reform does not have to be front and center. I want to pick up on something Uwe said. Which is, if you look at the surveys, a vast majority of Americans think that the U.S. health care system needs major reform. But if you ask them about their personal care and whether they would support a reform if it affected their access to their doctors and their medicines and their treatments, the support goes way down. In order to get to real broad support for significant reform that number is going to have to come up. We are going to have to find some way to convince Americans that it is worth trusting a significant reform in this country. I think that gets back to some of the issues that we were talking about before.

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People are generally satisfied with the care that they are getting and that is a little bit surprising given the fact that the care they are getting varies by three- or four-fold costs. Fifty percent of the time it does not involve following even the treatments that we know works well. And every American I think and certainly I have, has had an experience with a parent or grandparent, someone they care about who has had a serious illness or a serious set of complicated illnesses and frailty and has just done very poorly in some aspects of their care. Because there is not good coordination because you personally have to take care of all of it yourself. Yet those concerns have not translated into energy and support for major specific kinds of reforms. Even those we have been talking about today. These huge gaps and huge opportunities for

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improving the quality and value of care. And that again brings it back to all of you.

Are there ways that you can present this issue that would change those perceptions about the fact that 70%, 80% of Americans are satisfied with the care that they are getting personally. Despite the potential for doing it less expensively and despite the tremendous potential for better outcomes and more prevention that we are just not following through on now. And there is one final point about this. If you look at states that have gone down this road. They have not gone down the road of a single, big government program expansion. You can argue about whether that is right or wrong on philosophical or policy grounds. It just is not what is happening. In fact, what typically happens if that is the debate we have, is what happened with SCHIP this past year. Many on the Democratic side arguing for at

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least an incremental program expansion. Many on the Republican side arguing against expanding and entitlement program and crowding out private insurance. You end up with kind of a stalemate like we have with SCHIP.

If you really want to get to an agreement, it is going to be more along the lines of what Massachusetts and other states have done. Where you recognize that government programs are really important for lower income Americans where they need a 90-percent plus subsidy for their coverage paid for by the government. That people who are wealthier may be able to do okay on their own, but may need some insurance reforms and the like to help them get better. And quality of care reform, like we have been talking about, to help them get better care. But in the middle, particularly for people that do not have coverage through their jobs, they do need some help with costs. And the

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McCain proposal does that. The Massachusetts reform proposal does that. It is a partial subsidy. It is not delivered through the public sector alone with competing private plans. There are a lot of different ways you can go about it. But that seems to be where most states have really pushed down the road of bipartisanship have gone getting support for health care reform and conceivably that could happen next year here too. It is just going to take some real work to get there.

ED HOWARD, J.D.: Paul, you got the last word.

PAUL GINSBURG: Yes, well you know as far as fought a lot of presidential campaigns I remember so many cases where the policy wonks got excited, health care is going to be important in this election. And they are invariably disappointed. I think it has a lot to do with the

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fact that it is so complicated. So difficult to really draw a difference from your opponents that you can really engage people on.

Jerry, you asked about Medicare for all? I think in this election cycle, Medicare for all died at the very beginning of the Democratic primary process. When the leading Democratic candidates came out with proposals that looked like Massachusetts because they decided that Medicare for all is not politically feasible. I do not want to run on it. I want to run on something that has a chance that I can compromise with Republicans and actually get it done. And I think that is very much the mindset today. See if you can accomplish something significant. Do not go for your first choice. Settle for your second.

ED HOWARD, J.D.: For those of you not on daily deadlines you should know that there will be a transcript of this event posted in the next

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three or four days, both on our website and on the website of Kaisernetwork.org, which is providing the transcript, thank you very much.

Let me just quickly thank Bill Irwin and the rest of the staff of the Alliance who did such a great job putting this event together. I want to thank Sarah Collins from the Commonwealth Fund whose slides I ripped off shamelessly in putting together the graphics that we passed out to you.

The Robert Wood Johnson Foundation for its support and co-sponsorship and especially I want to thank our panelists for an incredibly thoughtful and useful description of the candidates' plans and what you ought to think about them.

Thank you all for coming and let us do this again when the situation gets sorted out a little more.

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