

Health Reform 14 Years Later: What's Different

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HEALTH REFORM 14 YEARS LATER
Webinar Hosted by ERIU

Operator: Good day everyone. Welcome to the Economic Research Initiative on the Uninsured Web seminar, *Health Reform 14 Years Later*. This program is being recorded. At this time, I'd like to introduce your host for today's program, Becky Watt Knight.

Becky Watt Knight: Hello everyone. Thank you for joining us today. We appreciate you participating. To begin, I'd like to introduce Brian Quinn, program officer at the Robert Wood Johnson Foundation. Brian will make just a few opening remarks before turning things over to today's speakers.

Brian Quinn: Thank you, Becky. Good afternoon everybody and welcome to this afternoon's Webinar. Health care reform has remained elusive over the last 14 years, yet the urgency for reform is greater than ever. The number of uninsured Americans continues to rise unabated, as do health care costs. At the same time, the quality of care is uneven and in many cases substandard.

At RWJF, a key element of our coverage strategy involves nurturing and sustaining policy dialogue around health care reform, with the intent that it will help policy-makers craft a sound and sustainable plan in what we hope is a robust national debate on health care reform.

Today's Webinar offers a unique opportunity to discuss the economics of reform with four of the field's preeminent health economists. Their insights will be particularly important, given their long-run perspective on issues of health care reform.

With that, I'll turn it over to Catherine McLaughlin. Catherine is a professor of health economics at the University of Michigan School of Public Health. There, she is also director of the Economic Research Initiatives on the Uninsured, which is funded by the Robert Wood Johnson Foundation.

Catherine McLaughlin: Thank you very much, Brian. I would like to echo his welcome to all of you who are participating today. It's wonderful to know that there is a high level of interest in health care reform and what economists can bring to the table in that discussion.

In 1994, the Robert Wood Johnson Foundation funded a conference of four of the people that are here today speaking, as well as a few others, to talk about how they viewed health care reform at the time and what they thought about some of the issues that had been brought to bear.

That led to a collaboration with *Health Affairs*, the journal *Health Affairs*, and several articles in the spring 1994 issue of *Health Affairs*. I just put up on the slide for you some of the articles that were in fact included in those issues, with the titles. Those titles foreshadow what was on their minds at the time, what the issues were that they were thinking about.

The major economic questions asked, and sometimes answered, by economists, focused on what are known as the two pillars of economic analysis: efficiency and equity concerns. Some of the subsets of those two particular questions were, for example, market forces versus government intervention. Should we rely on markets to contain costs and improve access to high-quality care, or do the markets alone fail to achieve an efficient, equitable allocation of resources? And therefore we need some form of government intervention.

They also talked about mandates, which were a big part of the Clinton reform proposals, and does it make a difference whether they are individual mandates or employer mandates. The link between

employment and coverage. Historically, this country has had a coverage, a link to employment, for the overwhelming majority of workers, and the question was, does this make sense to still continue? What are the positives of having that linkage? Do they outweigh the negatives?

Who pays? If we do in fact some kind of universal coverage, some kind of coverage expansion, do we rely on the private sector again to help subsidize this and can afford it, or do we need public payers to do it? What is the cost of that expansion and who would bear the burden? And then, finally, some of the articles also talked about premium setting. Do we do community rating, risk adjustment? Do we look at an individual's behavior and risk or do we look at a pooling of it?

There are different incentives involved with those different kind of premium setting that lead to different results. So some of these questions should sound very familiar. We're looking 14 years later and we see that some of the questions are still there.

So one of the things that Brian and I were interested in is bringing these four people back and saying, would you write the same articles today that you wrote 14 years ago? Would you ask the same questions? Do you think that there's anything in the health care system that would lead to different questions? Or has there been research in the last 14 years that led to different questions or conclusions?

Part of that second issue about research is in fact answered by the Foundation's funding of a lot of different initiatives since 1994. One of them is the Economic Research Initiative on the Uninsured (ERIU), which I've directed at Michigan for the last seven years, which has funded over 50 research projects, some of which provide new insight into some of the questions that were asked 14 years ago.

Others ask new questions that were not touched on. If you go to the ERIU Web site, you can see discussions of those 50 research projects, as well as a searchable database that has over 4,000 articles that have been written about the uninsured since 1990 and which should help those of you who are interested in this topic after this Webinar to go and look at what some of the things that we know that we didn't know before.

It's now my pleasure to introduce Susan Dentzer, one of the nation's most respected health policy journalists, who is now the new editor of *Health Affairs*, the journal that cosponsored these articles 14 years ago. Before becoming the editor, which is a month ago, Susan was a regular on the *News Hour*. Many of us saw her over the years talking about health care issues as she headed up their health unit.

She also has appeared frequently on programs such as *Nightline* and the *McLaughlin Group*, and has nearly three decades of journalistic experience on both broadcast and print media. And so I could think of no one better to lead the conversation today and answer some of those questions of what do we know now that we didn't know then and will health reform be any different?

Susan Dentzer: Thank you very much, Catherine, and hello to all of you out there in cyberspace. It's great to be here with you today. I have the pleasure of introducing our four panelists today and in conjunction with Catherine McLaughlin, let me say that these are really five of the top people anywhere in health economics.

We were joking earlier that if we were in Japan, where people get even fancier titles than we tend to give out here, they would all be designated living national treasures, so compelling is the work that they've contributed to this field. And of course we've been privileged to publish much of that in *Health Affairs*.

As Catherine said, as we ask today, what's different now from 14 years ago, we're going to hear that many of the facts on the ground are different than they were 14 years ago, but many issues remain the same and all of them—or many of them, I should say—falling under the headings of efficiency versus equity concerns, as Catherine said. But what we think about some of the questions that we face, she

mentioned all the work that has been done under this project on mandates.

Well, we know that most of the discussion that went on between the two leading Democratic candidates this year, Senators Hillary Clinton and Barack Obama so far have been over whether there should be mandates inherent in any health reform plan.

When we hear discussions about what achieves the optimal results, market forces or government intervention, we know that the bulk of what Sen. McCain is saying now with respect to health reform is that we need to rely as much as possible on market forces, not on government intervention.

So all of these issues that have been prevalent over the last few years are as important today as ever, and that's what our panelists will talk about. Let me introduce them now in sequence, and then after I introduce them all, we'll begin the panel presentations.

First, we're delighted to have with us Henry Aaron, who is the Bruce and Virginia MacLaury Senior Fellow in the Economic Studies Program at the Brookings Institution, having previously directed that program from 1990 to 1996.

He came to Brookings in 1968. From 1967 to 1989, he also taught at the University of Maryland. He served in the late 1970s as assistant secretary for planning and evaluation at the department that was then known as the Department of Health Education and Welfare.

He chaired the 1979 Advisory Council on Social Security. He's been a Guggenheim Fellow at the Center for Advanced Studies in the Behavioral Sciences at Stanford. He graduated from UCLA and received a Ph.D. from Harvard. He's a member of the Institute of Medicine, the American Academy of Arts and Sciences and is on the Advisory Committee of the Stanford Institute for Economic Policy Research. His most recent publication is *Medicare Reform: Options, Tradeoffs, Opportunities*, written with Jeanne Lambrew.

Also with us is Joseph Newhouse, who is the John D. MacArthur Professor of Health Policy and Management at Harvard University, director of the Division of Health Policy Research and Education and chair of the Committee on Higher Degrees of Health Policy, as well as director of the Interfaculty Initiative in Health Policy.

He is a member of the faculties of the John F. Kennedy School of Government, the Harvard Medical School, the Harvard School of Public Health and the faculty of Arts and Sciences, as well as a faculty research associate of the National Bureau of Economic Research. He earned a B.A. and Ph.D. in economics from Harvard and became the founding editor in 1991 of the *Journal of Health Economics*, which he continues to edit to this day.

Also with us is Mark Pauly, the Benheim Professor in the Department of Health Care Systems at the Wharton School at the University of Pennsylvania. He is professor of Health Care Systems, Insurance and Risk Management and Business and Public Policy at the Wharton School and also serves as professor of economics in the School of Arts and Sciences at the University of Pennsylvania.

He's a former commissioner on the Physician Payment Review Commission, former member of the Advisory Committee to the Agency for Healthcare Research and Quality, most recently a member of the Medicare Technical Advisory Panel and an active member of the Institute of Medicine. He's co-editor in chief of the International Journal of Healthcare Finance and Economics, and also an associate editor of the *Journal of Risk and Uncertainty*.

And then finally with us is Uwe Reinhardt. Uwe, as many of you know, is professor of Economics and Public Affairs at Princeton University, where he's the James Madison Professor of Political Economy. He's a native of Germany. He's taught at Princeton since 1968, rising through the ranks there from assistant professor of Economics to his current position. He teaches courses in both micro and macroeconomic theory of policy, accounting for commercial, private, nonprofit and governmental enterprises, financial

management for commercial and nonprofit enterprises and health economics and policy.

He earned a bachelor of commerce degree from the University of Saskatchewan, Canada, in 1964, and a Ph.D. in economics from Yale in 1970. In 2002, readers of *Modern Healthcare* voted him among the top 10 most influential personalities in American health policy. And I'm sure, Uwe, the living national treasure designation is just around the bend.

In June of 2004, Uwe was honored with the Distinguished Investigator Award by Academy Health, the National Association of American Health Services Research. He is a member of the Institute of Medicine and has served on the governing council there. Previously, he has also served on a number of IOM study panels, among them the Committee on the Implications of For-Profit Medicine.

So for that, let us go to our first presenter today, Henry Aaron.

Henry Aaron: Thank you very much, Susan. There's an old saying that as we grow older, we don't change, we just become more so. Well, the same can be said for the problems associated with the U.S. health care financing system. Compared to 14 years ago, we're spending more in total, the government is spending more, there are more uninsured people and we are nearer to what many people regard as an impending fiscal meltdown arising from rapidly growing Medicare and Medicaid spending by the federal government.

One of the differences now from 14 years ago is that some of the groups that 14 years ago were adamantly opposed to significant federal action seem now to be far more interested in such reform.

Well, how are things the same as they were 14, or really 16, years ago, at the time that the Clinton health reform effort got underway? I think a key fact that is too often forgotten is that if we're going to change the way the health system operates and we're not going to spend significantly more money—nobody is really proposing that—that health care reform equals income redistribution and that means there is a loser for every gainer.

That means there is an adamant opponent to action for everybody who may be in favor of action, as well. It still takes 60 votes in the United States Senate and the American public to pass anything, and the American public is, if anything, more acutely concerned about the increasing financial burden that each person or family has to bear, notwithstanding the fact that the share of total health care spending that each of those families bears has been trending down for the last decade and a half.

We remain divided intellectually about what the best avenues for reform are, and there is still a distressing degree, I think to all health analysts—a distressing degree of faith on the part of the public and many elected officials in solutions to rising health care spending that no expert believes has any significant chance of materially working. We can come back to those during question period, if you like.

So somewhat in the manner of the periodical cicada, which emerges from the ground about 15 to 17 years, makes a lot of noise and then dies, leaving no material after its death, health care reform seems now to be reemerging on the national stage, and the great fear that many of us have is that excessive expectations may lead to yet another round of nothing significant happening regarding a problem that desperately demands effective intervention.

The reasons, the obstacles to action remain the same as they have been before. For this reason, for the reason that I believe large-scale sudden reform of something as large as the U.S. health care system is simply not going to happen. It is vitally important, in my view, that people identify enactable, specific changes that can take place within the next year or two and leave us not like the periodic eruptions of insects that just leave their shells behind.

But, in this case, after the next couple of years, we can hope that there can be successful legislation in a number of specific areas, and, again, we can come back to that later, as well.

Dentzer: Very good, thank you very much. And now we will move to Joe Newhouse.

Joseph Newhouse: Thanks, Susan. Let me begin by setting a little context. Most Americans, as I'm sure everybody on the call knows, gets insurance through their employer and, as the Lone Ranger used to say, going back to the days of yesteryear, in 1993, President Clinton proposed moving away from that and having most Americans getting their care through health care alliances, or health alliances, that would offer competing health plans. And that theme of having individuals choose among competing plans and moving away from employer-based insurance has survived.

It's in the Wyden-Bennett bill. It's proposed as reforms for the small group and individual market, for example, in the Massachusetts Connector, and it's also what we see in Medicare Advantage. So the idea is how best to promote competition among health plans and to try to prevent health plans from just making money by getting healthy persons in their plan, there is this device called risk adjustment, which basically adjusts payments to plans according to the expected costs of the people in those plans.

So if a plan enrolled somebody who was expected to be sicker and spend more, they would get more money and, conversely, and although I'm not sure it's being proposed in the present debate, I should add that the reason some of us, at least, like this or see the virtue of this is that price setting, as in traditional Medicare, has inevitable distortions.

In fact, many of us think that the rise of specialty hospitals, for example, has to do with mispricing in the traditional Medicare system. So the best example we have of risk adjustment is in Medicare. In Medicare, in 1994, which was the avant-garde of risk adjustment in those days, Medicare adjusted for age and sex and the county of residents and a few other things, but that was really inadequate because there could be a 70-year-old person, for example, who had cancer and was on death's door and there could be another 70-year-old who was out on the tennis court or the golf links every day and having no chronic disease, and those two people were likely to cost very different amounts of money to take care of.

What we have now is a different situation. Medicare now includes a person's diagnosis or diagnoses, and if a person has cancer, the health plan that enrolls that person will get quite a bit more money for that person than the person that has no chronic disease.

Now what we don't know, unfortunately, since Medicare basically just started this system, is whether this is good enough. We know that the old system was not good enough. Health plans got a favorable mix of enrollees on balance, that is, less costly enrollees. But this new system on paper should be a lot better. And, as I say, whether it is not known, and if we want to in the question period, I can get to my points about employers, but why don't I stop there?

Dentzer: Thank you very much, Joe. And now we'll move on to Mark Pauly.

Mark Pauly: Well, so, from my point of view, what's different between now and 14 years ago is that then I was a pessimist, but now I'm an optimist, and that's unusual for an economist to take on that character, so I want to hang onto it for as long as I can.

I do think that the stars and planets may be coming together in a way that will actually allow us to do something substantial to reduce the number of uninsured and perhaps move toward universal coverage. One of the developments is what I now call the Three M's, and these were things that I had mentioned 14 years ago as what seemed to me to be desirable features of a plan to reduce the number of uninsured people and make the system run well.

One element or proposal of all of the three candidates still viable would be an arrangement that

envisioned the use of markets or market-like arrangements, at least in the sense that people could choose among a variety of health plans with price differences or premium differences between the different options, reflecting the differences in generosity of benefits and claims cost amongst those plans. And that would look more like a market and less like a traditional monopoly government provision of a public good.

The second M is means testing. The idea that I had then, which seems to be present now in all three candidates' proposals is that the redistribution that would accompany initiation of a plan would be generous to low-income people and stingy to high-income people.

One way to make that happen is to make coverage for the poor virtually free and then as you go up the income distribution to make the subsidy diminish. Another aspect of means testing, which is not so prominent in what's been proposed, but I would still advocate it, would be to make the generosity of benefits very high for low-income people and at least the minimum generosity of benefits much lower for upper-income people.

The notion here is even if you agree, as I do, that it's not such a great idea—we have a country where income is not distributed very equally—given unequal distribution of income, giving everybody the same plan will allow the well-off and the better-educated to out bid and out-talk their way through the system compared to the poor and less advantaged. We need to unbalance the system to the advantage of the poor.

And then, finally, mandates. I was always careful to make this a conditional statement, like economists make all their statements. If you want to get to universal coverage, it's my conviction you need a mandate to do it. Personally, I'd like to get to universal coverage, and so I'd favor a mandate, but the part of this that I can draw my authoritarian robes about me and pronounce on is there will always be the Evel Knievels of health insurance who, believe it or not, don't get up every morning and think about whether they're adequately insured, who can only be brought to insurance by some kind of penalty, as well as by a subsidy.

There is also—this is more of a political comment, but I think it's true. There's less static and less distraction in the current debate, at least for the moment—hang onto that, because it may not persist. But there is much less distraction in the current debate that has been occurring in the previous iteration and through the years.

One thing that's off the table, no show number one, is no support for single-payer, uniform public coverage. Whatever you think about it is, is it a good idea, is it a bad idea? Is it efficient or inefficient? It is not in the cards in any candidate's proposal at the moment.

And the other notion, or number two, is that tax-shielded health savings accounts are enough to achieve universal coverage and control health care spending. That also seems off the table.

So what are the messages from 1994 that apply today and how would I modify them? My judgment is that it will be desirable to be honest with the public in discussing health reform. Henry has, I think, mentioned this as well. Of course, economists with tenure find it easy to be level with the public and the same may not be true for politicians.

But the basic message that we have to deliver now is our usual, sad message, that in order to get something you have to give up something. There is no magic way to improve health care quality and make it cost less, although there probably are some things that could be done around the edges, they can't influence the total to any appreciable extent.

It's clearer now I think than in the past that health care reform is going to have to cost something. Part of the problem with the Clinton plan is it was billed as something you wouldn't have to pay for. Now we know it's going to cost something. There is still, of course, in each candidate's pronouncement, a

recourse to the traditional politician's view of how to pay for things that cost a lot but that people want.

Imagine taking a lot of the money out of reduced waste, fraud and abuse. I want to go on record as saying I'm in favor of reduced waste, fraud and abuse, but I have a fear that although there's plenty of all of that in health care, there may not be enough to pay for the kind of adequate subsidies you'd need to be equitable, to allow people to afford the health insurance you're wanting them to have and to motivate them to go get it.

The second point—and for me the part that still remains in the current debate that, if I could, I would like to clear away—is the reliance on employer mandates. As we'll probably hear in the further discussions, contrary to other, ordinary human beings, economists do not believe that the boss pays for the health insurance you get on your job. You pay. It's part of your compensation. If you didn't get it, you could get more money.

So, consequently, requiring the employer to pay is really just causing the employer to be an agent of the IRS, collecting money out of your future raises which would be used to pay for health insurance.

My general view is that not only is it economically inefficient to have employer mandates, but primarily they serve to confuse the debate. Employers think it's their money, they object, and in the previous version they objected quite effectively, even though, in fact, the cost was going to fall on workers and in some cases that might have been OK, but in other cases not.

Last comment, I think there is a role for employers to help administer and enforce mandate, but it should be viewed as an individual mandate. And I believe there is now a greater willingness to view a mandate as a tax that workers should pay, like they pay income taxes, at least if you want to get to universal coverage. You need to have an individual mandate as a backup to make sure that people get there and the primary role of the employer there is as just a humble emissary from the IRS or from the government in general, helping to arrange things in a good way.

As I began by saying, I am an optimist here. I think with suitable goodwill, the three M's can actually lead towards a plan that not only has a chance of passing politically, but if it is passed has a chance of functioning well to substantially improve the health and welfare of the American public.

Dentzer: Thank you very much, Mark. And now we'll go to Uwe Reinhardt.

Uwe Reinhardt: Well, you asked earlier what more do we know now that we didn't know then. I think we do know a little bit more on how the individual insurance market works or doesn't work, mainly because of the painstaking good work that Mark Pauly did on it. We know something more about the link between being uninsured and health status. Robert Wood Johnson Foundation put a lot of money into that.

We know exactly who the uninsured are, and what is often not appreciated, there are quite a few people who, when you call them, say they are uninsured but they're actually entitled to insurance. They just for some reason didn't take up insurance, so that needs more research. And we know a whole lot more about the quality or lack of it in American health care.

But, as to the issue of universal coverage, I'm a little less optimistic than Mark is. To be sure, there is a consensus now that markets and private insurance are not the devil. Whether you believe that or not, but all of the candidates basically rely on expanding, at least in good part, private insurance to cover the uninsured. That's really not the issue.

What I believe is we're on an escalator. We're trying to run up an escalator that goes down. If you look at the Milliman Medical Index, which you can find on the Web, they put together for privately insured Americans the total cost of health care of a typical family of four. So it's really averaged over a

huge risk pool, and then has the out of pocket, the employee contribution total, the premium at work and the employer's. It's all added up. That's what it really costs to maintain an American family of four in the health care we know: \$15,000.

This over the years has, as an aggregate, compound interest growth of 9.5 percent, but at the bottom I give you in blue these numbers that there is some abatement there. But still, it's fast growth.

Now, if you look at the U.S. increase distribution, this is family money income, after taxes, but (cancer) is included, you find an awful lot of people actually making on the screen that's blue, the blues, who are too rich to be in Medicare and Medicaid—we do a lot for the very poor, the greens. But we've never done anything for the hard-working stiffs, the Home Depot workers, the gas station, the limo driver, the waitress and waitresses. All these people who make life for us in the upper part of the income distribution, we've never subsidized them.

And the issue is we will have to subsidize them or give them a second-tier health system in the coming decade. And you can see that—I do this little experiment. Think of people with a wage base of \$25,000 each, one works at Wal-Mart, one at Home Depot, they're married. The gross wage base is all the debits to payroll expense. Out of that has to come the Social Security, the unemployment contribution, taxes, whether paid by employer or employee. It doesn't matter here.

Let that wage base grow by 3 percent per year, which is roughly what it's been growing at, and let health spending for such families grow at 8 percent per year. And then that slide isn't in here, but it would show at those rates, in 2010, one-third of that gross wage base will be absorbed just by health care. And in the year 2018 it will be 50 percent. So I don't think that computes anymore. I think these people will basically be uninsured, and idea that high-deductible policies that are cheap can solve this problem is actually—I find that silly. In fact, it's somewhat cruel to say that that actually would work.

So I think the system will push more and more of the blues in my earlier slide into the pool of uninsured, even as if Mark is right, we will expand maybe SCHIP and give subsidies to people to buy into private insurance. I think it's in that regard a losing battle.

Then you come, what has changed about the people's willingness to be their brother's and sister's keeper in health care. And I must say, with the World War II generation dying off, they had a sense of social solidarity. I don't think we have that anymore.

I was stunned, frankly, how easily we discussed HSAs from the President on down, not realizing the ethical implication of the construct the President proposed. Making contributions to an HSA tax deductible means it's cheaper for Mark Pauly and me than for a gas station attendant on an after-tax basis.

Now, that of course, the reason they propose it is to make it equal to the employer-based insurance, but I think most economists would say then limit the tax privilege of employer-provided insurance, but don't make it cheaper for rich people than poor.

The same is the HSA, the high-deductible policies basically say poor people should do all the rationing, rich people won't, because we wouldn't. None of us on the phone would ever deprive our kids of anything because of a \$5,000 deductible.

So that was one thing that made me think we've really changed social ethics in this country, and the other one is—I'm close to it, because we're a military family. But the way this country treats the military and in fact the entire conduct of the war, suggests to me we are much less a nation than just a group of people sharing a geography who are basically very selfish.

I think I could tell you a lot about this from our own son. They came back from the field shocked at the selfishness of the American people they encountered, having served in the field.

So I think there is less social solidarity in this country, and I'm just wondering whether we, the haves

in the upper part of this income distribution, are willing to cough up the \$120 billion or so a year, growing at 6 percent, that it would cost to get universal coverage. So I'm more pessimistic than Mark, mainly on the money side.

I don't think we're willing to be our brother's and sister's keeper anymore. So let me stop there.

Dentzer: Very good. Uwe, thank you so much.

Well, by my count, roughly speaking, we have at least two pessimist, one neutralist and one optimist in the form of Mark Pauly. Joe, I gave you the benefit of the doubt in being the neutralist here in terms of whether the facts on the ground will dispose us even more toward health reform than they did 14 years ago or not.

Let's turn to a couple of questions, first, from me specifically, following up on some points that you all dangled in front of us. I want to go to Henry first and ask you about two points that you made.

One is that you implied that the public and the politicians still believe in more—I guess we could use the phrase—fairytales. It's a popular one in this election-year debate that the public and the politicians still believe in more fairytales about health care cost containment than real things that economists and others might think would work, and that people are still making the mistake of talking about large-scale health care reform as opposed to truly enactable, smaller reforms.

So let's talk a little bit more about those two. What are the fairytales you think the public and the politicians are still believing in about cost containment and what are the smaller, more enactable reforms that you think should be on the table.

Aaron: Well, there's a long list of fairytales. Let me start with three. One is that if we invest more in preventive health care we will somehow take the wind out of the sails of rising health care spending.

This is a, quote, solution to rising health care spending that has been repeatedly studied and repeatedly, the same conclusions have emerged, which is preventive health care is good for your health but probably in the long run is close to neutral with respect to its impact on total health care spending, because we spend a lot on testing, behavioral modification, drug therapies, to control illnesses that might not have proceeded to a more serious state, in order to avoid those cases where prevention really does make a difference and spend money.

Information technology. Once again, those who are closest to it believe that the potential for improving the quality of care is enormous, but it's expensive, it's going to take a long time to bring into use and we will in the policy discover that we're under-providing in a lot of situations where we are not giving sufficient care.

As a third, going after those evil you can fill in the blank, drug companies, HMOs, insurance companies, who are making excess profits. In each case, the maximum possible contribution to growing health care spending is extremely small when measured against total outlays, so that even if one eliminated profit entirely from all of them, the impact on total outlays would be temporary and small.

The fact is, the problem is, the problem, we want a lot of health care that is expensive, a good deal of which is highly beneficial, some of which is only slightly beneficial, and we have not yet figured out how to get rid of the care that isn't really worth what it costs without getting rid of other care that is worth a great deal more.

As for the practical program for action, I think each of us probably would have his or her own favorites. I have five. The first would be to early next year pass the SCHIP extension that President Bush vetoed. I would extend the extension to include not only children who are currently not covered by the program but would have been covered by that legislation, but also the parents of families, at least among

those eligible for Medicaid or SCHIP with very low income.

I think that the innovation in Massachusetts, the insurance reform that goes under the heading of the Connector, to improve the equity and fairness of the marketing of health insurance, is something that the federal government ought to do everything in its capacity to encourage all 49 other states to bring into existence. We should, I believe, encourage state reforms through one version or another of the three bills that have been introduced in Congress, variously called the Health Partnership Act or some variation on that, which would give some financial assistance and a good deal of regulatory flexibility to states interested in reform, extending coverage.

It is so long overdue as to be a joke, I believe, that the federal government should be supporting financially thorough and much more far-reaching studies of the cost-effectiveness of various medical interventions. We've tried it and failed for political reasons. The solutions need to be political and I think there are ways to do that. And finally, although I don't think it's going to save a great deal of money, the day should be over when we urge the adoption of information technology and set up a federal agency to do it, but OES, that agency, gets no funding in order to carry out its task.

That's exactly what happened when David Brailer was asked to head up an agency to promote information technology a few years ago during the current administration. We should get serious about this, put some money behind it, see to interoperability standards, make some hard decisions and move ahead.

If we did all five of those things, whether or not there's sweeping health reform during the next presidential administration, we could go home at night—the president could go home at night, our elected officials could go home at night—and say we've done a good day's work. We've moved the ball down the road and built upon those steps for future reforms.

Dentzer: Thanks very much, Henry, and I just want to ask you one follow up and tie that into a question that came in from a participant. To your point about creating a new federal agency or at least endowing some agency with the responsibility of doing cost-effectiveness research, what's the potential role of an agency akin to the so-called NICE agency in the United Kingdom, which has that role more or less, but also the additional role of really deciding in that case what services are actually going to be purchased, rationalizing the products and services available and the price points at which they're available? Do you think we'll actually go to that kind of a model?

Aaron: My understanding is that NICE does not determine whether procedures will be funded by the National Health Service but does studies of basically the cost per quality adjusted life year and other analyses.

I think the key here is first to develop the information. If you are a Medicare administrator, if you are administering an insurance plan, if you are a business sponsoring health insurance and you have the idea that maybe some new intervention is just not worth it, or maybe isn't effective at all, in most cases you have to make your decision about coverage without solid information on that question.

That means you're not really in a position to defend yourself against the inevitable pressures from sick patients and self-interested providers who are promoting some particular new intervention. I think the first thing we need to do is vastly deepen the stock of information. A way we can do that is by setting up an agency that has a significant degree of administrative independence from Congress and the administration and that has power to do studies, but not in the first instance, to make the decisions about coverage.

Those decisions I think for now, and perhaps forever, need to remain in the hands of Medicare and

their congressional supervisors and in the hands of private insurance companies. But, for now, what we need to do is develop information so that people who are interested in making cost-effective decisions can actually do so.

Dentzer: Thanks very much, Henry.

Joe Newhouse, you talked about the age-old issue of having risk adjustment inherent in moving away from insurers merely competing on cherry-picking to moving to real competition among health care plans. We know that cherry-picking is alive and well. The *New York Times* had a piece, I believe yesterday, about a woman who tried to get coverage out of Golden Rule Insurance but was denied coverage because she had had a C-section and Golden Rule predicted that on that basis she'd have much more medical costs over time and therefore they denied her insurance coverage.

As they think about risk adjustment going forward, we know that Sen. McCain, for example, has proposed in his scheme of tax credits, which essentially—by which he would take the tax exclusion of health insurance to employees who receive it from their employers, recycle those benefits around to all of us in the form of tax credits and when asked about how those tax credits would help people with very high medical costs, his advisers have said, well, we'll try to risk adjust those tax credits.

That would seem to get us into a whole new, interesting realm of complexity, not to mention handing that job to the Treasury Department it seems, or to the IRS. What do you think about a proposal like that in terms of what we know to date about risk adjustment methodology?

Newhouse: I tend to agree with the thrust of your question, Susan. I would start off by saying Victor Fuchs, our colleague, likes to reframe cherry-picking as lemon-dropping, because it's the really expensive people where you take the hit.

I think it's easier to do this in the context of the exchange or the Connector kind of situation that Sen. McCain is talking about and that we have existing in Massachusetts, where a certain number of plans are qualified and then some third body basically does reallocation across the plans according to their mix of health risks.

In the case of the *New York Times* piece on Golden Rule and C-section, it could just be that the rules of getting your plan on the Connector are that you can't adjust premiums that way, that the premium bid, as it is in Medicare, is based on some kind of standard benefit package and then the exchange or the Connector takes it from there and does the risk adjustment across the plans. That seems to me to be much easier and probably will engender less selection.

Dentzer: And is it your understanding that to take the notion of adjusting it at the plan level and through a Connector-like mechanism, is it your understanding that to the degree Senators Clinton and Obama have talked about that approach that they also envision a fair amount of risk adjusting going on?

Newhouse: I'm not familiar enough with what they would want, but it seems to me that if there is not something like risk adjustment that the individual market is—and small group markets are likely to see a lot of competition on trying to arrange the benefits so that a certain type of person will enroll.

Dentzer: All right; thank you.

Mark Pauly, I want to ask you a question about your newfound, I think you called it authoritarian support for individual mandates. You've moved perhaps from being more of a libertarian to more of an authoritarian?

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Pauly: No, that's not true. I supported individual mandates in 1989.

Dentzer: OK, all right.

Pauly: That must have been the other Mark Pauly.

Dentzer: OK, got it. Well, let me ask you a question about individual mandates, and actually we have a question from a member of the audience, as well, from the University of Massachusetts at Amherst, who would like to hear some comment on the Massachusetts individual mandate.

So let me add onto that question, would you talk about in the case of Massachusetts, of course, when it came down to trying to decide for whom the mandate would be required, there were affordability standards which do in fact seem to indicate that a number of people will be exempted from the mandate since it's not affordable. Yet they're not of low enough income that they qualify for the new public sources of coverage.

One imagines if one did this at the national level you'd find a whole lot of people in that same boat, who might not be the kind of people who in Uwe Reinhardt in that new U.S. where we don't like have other all very much, people are not willing to subsidize that coverage, and yet will let them off the hook from an individual mandate because it's up to require that of them would make it unaffordable to them.

Pauly: All right, well let me start with kind of the general question of the relationship between affordability and mandates. And I guess I take a pretty simple view of this, that the appropriate subsidy at any income level should be one that's sufficient to make at least the minimum coverage that would be mandated affordable to that person. I mean, it's fairly silly to say that I'm going to have a subsidy program to make coverage affordable, but then because coverage isn't affordable I can't put in place a mandate.

One way to think of it, and I suppose this is in part what happened in Massachusetts, although the people who live there could tell me, is that when you have a subsidy program when you hook it to the mandate, then there's a kind of canary in the coalmine syndrome where people then actually having to look at what they would be required to pay for the minimum coverage and political process having to look at it, may find the subsidy wanting.

But the solution to that from my point of view is not to fail to enforce the mandate, it's to increase the subsidy. More generally, I guess my comment on the Massachusetts mandate is that it really isn't a mandate, partly because some groups are exempted from it and partly because the groups to whom it does apply, the penalty is only half of the cost of a minimum-qualifying policy, and a real mandate would make the penalty for not complying with the mandate a real penalty.

I personally think that there are ways to do that. I do think, just to pick up on something that Uwe said, that the willingness of the average American taxpaying household to pay the \$1,000 more in taxes a year for every year in the future and growing to cover the uninsured may be somewhat limited.

I personally believe there is an appeal to people's better instincts that might increase the willingness to pay and also some of my recent research points out for the Scrooge McDucks of the world who are totally selfish, there is fairly substantial evidence that if you are an insured person living in a community with a lot of uninsured people, that's going to harm you both in the form of higher costs for your insurance because of cost shifting and because the quality and sophistication of care that's available in your town is going to be limited if many people can't afford it and don't receive it.

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So a combination I think of self interest and altruism, well, I'm an optimist, so I'm assuming and hoping that there is a combination we can find that will actually move things forward.

Dentzer: Joe Newhouse, to go back to you, do you want to comment on the Massachusetts individual mandate?

Newhouse: Well, my main concern is the cost going forward. There's very little new state money in this and at least from where I sit in Massachusetts there is no real willingness to increase taxes appreciably to pay for this, at least for now. So if cost grows at the rate Uwe has projected at eight percent, and I don't have any quarrel with that, this plan, there's just going to be more people that will be exempted as having it unaffordable and the subsidized group is going to run into trouble, as well.

Dentzer: So, Uwe, we want to go to your scenario here, which Joe has just alluded to, with health expenditures growing to such a degree and so outstripping growth in incomes that, as you suggested, we'd be looking at a situation in 2017 where for the families basically at the median U.S. income, that half of their incomes would be going to pay for health care, just an unimaginable scenario.

I want to tie that observation to a question that came in from one of our participants on the Webinar. He asks, how was it possible to pass Medicare? And I want to tie that question to your observation and say, was it possible to pass Medicare because health care just didn't cost so darn much in 1965, and that now because the cost is just so enormous and the income redistribution inherent in reform would be so enormous, as Henry Aaron suggests, that this really is just off the table?

Reinhardt: Well, first of all, Medicare didn't pass with a resounding majority vote. It kind of squeaked by, and there were a number of things that came together. The first one, health care was cheaper in those days, relative to GDP. Secondly, you still had the World War II generation running this country. They fought together on airplanes, ships, submarines, mixing social classes. And I think they understood that luck is just luck and should be shared, and while the students that teach now seem to think luck is deserved and shouldn't be shared. I think there really is that sentiment, so you had that.

And then, finally, Kennedy had been assassinated and you had a very savvy, legislatively savvy, president who got this through, compared to the Clintons, who, to put it mildly, were klutzes when it came to understanding Congress when they tried to do their health reform.

So these things came together, but it wasn't that the country sort of overwhelmingly embraced the idea. And to get it passed at all, you literally at that time had to give the key to the Federal Treasury to the doctors and the hospitals. We're not willing to do that now.

Dentzer: Henry Aaron, do you want to add?

Aaron: Well, there were a couple of other things that were unusual then. One was the actuaries really did miss on their guesses about long-term costs. And the second is, in addition to Lyndon Johnson, there was an extraordinarily astute Chairman of the Ways and Means Committee, Wilbur Mills.

Reinhardt: Oh, yes.

Aaron: Who put together plans that had been pushed by Republicans and Democrats into the same bill. Actually, Medicare is a shotgun marriage of a proposal that was long pushed by the Democrats, which

was part A, and a proposal—well, actually, a couple of other proposals that were supported by Republicans.

Medicaid, quite remarkably, was the Republican solution to health insurance coverage for the poor, and part B also reflected a fee-based payment system for physicians. So Mills simply put all these together and I won't quite say nobody could vote against it, because, as Uwe pointed out, there was considerable opposition. But he did effectively co-opt all major positions into the same bill. It was a wonderfully unique time.

Newhouse: This is Joe Newhouse. The other thing to say is that the over 65 were clearly the worst-off group because they didn't have employer-based insurance and the under 65, although we certainly have the uninsured, as we're all painfully aware of, predominantly do have employment-based insurance. So, in short, the over 65 were just in a much worse position than the under 65.

Reinhardt: Yes, Uwe Reinhardt here. I remember a figure and you guys can correct me, but I think 38 percent of the elderly were at or below the poverty line then. That's a number I remember.

Newhouse: That's approximately correct.

Dentzer: Catherine McLaughlin.

McLaughlin: I was just going to add, Uwe, and it also goes back, I've seen some people who have talked about the fact that a lot of people making those decisions were people in their 50s whose parents—particularly their moms—were the ones who were at the poverty level or below it, did not have health insurance, and so there was also an enlightened self interest there of getting this passed, because they realized—Uwe, you said we wouldn't deny our children. Well, people, we're not going to deny their moms, either, and if their mom really got sick and needed medical care, they were going to pay for it.

So pooling all the moms into Medicare did in fact make it easier for the adult children of those moms to in fact spread the risk that their mom might be the one who falls and breaks a hip this year. So I think we need to take that into account and look at it today and say, all right, who are the people in their 50s, are they having adult children now?

Pauly: This is Mark Pauly. There was one other similarity between then and now, and it is that the real rate of growth in health care spending was the 7, 8, 9 percent that we see now. Of course, Medicare and Medicaid actually gave it a big boost. The other similarity is although the share of GDP going to health care was only about 7 or 8 percent, everyone was sure that this high rate of growth in spending was unsustainable in the long run.

Reinhardt: Remember, we used to say 10 percent, then we'll put the lid on it.

Pauly: Yes, that's right. That's right.

Dentzer: Let me remind the listeners and those participating in the Webinar today that if you'd like to ask a question, please hit star one on your phone or use the question queue on your computer screen.

Well, the other part of Mr. Sirlan's question was this, how was it justified that children and adults under the age of 65 have less of a right to health care than older people? Is this that society has become

less caring, as Uwe Reinhardt suggested?

Uwe, what do you think about that? And, actually, I'd like to tie that back to Henry's observation that one achievable, enactable small reform next year would be reauthorizing the State Children's Health Insurance Program, which of course the congressional legislation to do that which was vetoed twice by the Bush administration in the past year.

But, Uwe, do you think in tandem with there being less social solidarity overall that we just care even less about children than we used to? And is that why there was so little of an outcry after the SCHIP reauthorization was vetoed?

Reinhardt: I don't think that is what it would be. First of all, the Medicare is in place, and once something is in place, taking away from it is harder, particularly when you have a powerful voting bloc, like we talk about gray power. I think that reflects more political realities.

Secondly, a lot of the children who are uninsured are actually first of all low income, and there is a certain lack of identification with them. But a lot of them are probably even immigrants or children of immigrants. So one doesn't have that sense of solidarity with them, perhaps, that one would with one's own parents.

I remember there was a *Rolling Stone* survey some eight, 10 years ago, and it turned out that Medicare is an exceedingly popular program with younger people, say, in their 40s, of the reason already mentioned, that people like it when the financial burden of ill health of their parents is socialized.

Well, with the kids of some Guatemalan immigrant, legal or not, you don't have that sense of social solidarity as you would with having the health care cost of your parents socialized, so I think that explains it more. But have we become as a nation less a nation? That I firmly believe.

Dentzer: Henry, do you want to comment more on what underlies our collective feeling toward children who would be eligible for SCHIP?

Aaron: I was making what seemed to me to be a political—it was more a political observation. The only thing that stood this year between a very substantial extension of coverage for children and no such extension was the president's veto pad. There was strong support among both congressional Democrats and congressional Republicans, particularly in the Senate—it was bipartisan—for such an extension.

With support rather than opposition from the White House, this is really something that could pass in the first 100 days and be signed and put into effect. It's a doable target. It would make a big difference for a lot of vulnerable people. It is the margin where according to public opinion polls, people are most sympathetic to government intervention to extend health insurance coverage and seem to be most willing to pay for it. So let's go for it as soon as possible and take it.

More can come later, but the main force of my earlier comment was we simply as a nation cannot afford to walk up, say we're going to do something about the largest industry that accounts for 16, 17 percent of our GDP that we all agree is in a state of disorganization, chaos, and is not operating as well as it should, walk up to it and say, we're going to do something about it this time and then walk away with total failure.

We can do some very important things. Let's do them and not let the goal of sweeping transformation of this entity that's as big as the entire economy of France be a prerequisite for doing something. Let's walk away with real achievement this time.

Reinhardt: Over here. I would agree with Henry. I mean, the SCHIP thing I think almost anyone here

agrees could be done and probably will be done in the next Congress. One could—Sen. Clinton's idea of establishing a Medicare-like program for people under 65. If you believe in competition, why not allow that option for people who trust government more?

We always think people don't trust government, but in fact, survey after survey shows people are actually quite fond of Medicare, and I think that option should be available. That's probably not that hard to legislate. I think it's more difficult—this is really Mark Pauly turf—build better risk pools for the individual insurance market. That'll be Mark's next paper, who will solve that one.

And then this other idea of cost effectiveness analysis. I had a piece in Health Affairs saying instead of having the government do it or the insurance industry do it, why not create some Robert Wood Johnson Foundation-like foundation, one or two or three, tasked with doing this research, but it's only information people can use, like Henry says, nice functions. There is a German counterpart that functions that way, too.

It's simply information you make available for decision-makers, but you would have it on their own foundation, not contract. It couldn't be axed by one Senator who happens to head a powerful commission.

I think some of those ideas are eminently doable and they wouldn't cost that much money.

Newhouse: Uwe, this is Joe. Let me ask you a question on the Medicare option. Do you give the private insurers the same unit prices that Medicare pays so the playing field is level? And, if you do, is it politically feasible to pull those kind of dollars out of the health care system that Hank has talked about?

Reinhardt: Yes, that is, of course, a question on what terms would they be folded into the big, powerful Medicare program, or would that much smaller Medicare program have to stand on its own feet and also negotiate rates so that a hospital could snub it.

And to some extent, I would favor the latter, rather than having one big gorilla using monopoly power for everyone, having this program compete more. It's just simply I believe some people trust government more. It's more steady and it's always there for you, while the private sector is very capricious.

I remember I once testified, I said private insurance, it's a little bit like having an affair with Monica Lewinsky, it's quite exciting, but it's ephemeral. You can easily lose it. They can pull out, et cetera. Government is more steady and some people may prefer it. Others may not and there should be choice.

Pauly: Well, this is Mark. If we're talking about Medicare as it actually is, we need to note that about a fifth of the people on Medicare opt out of the government plan towards a private plan and that's growing. So from my point of view, Medicare for all that gave people a neutral—of course, that's the hard part to describe—but a level playing field choice between using the post office or using FedEx to arrange their health insurance seem to me to be a desirable alternative.

Reinhardt: Yes, it is. I actually haven't totally thought it through, but obviously Joe's concern of having a huge monopoly competing with people who don't have that market power, that's a very valid observation. We could somehow maybe figure out how to make that playing field level, but, as Mark says—I for instance like the post office.

Dentzer: Henry Aaron wants to jump in.

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Aaron: I was just going to say, choice and competition are great, but when the people are opting into the private system with a 15 percent subsidy, as the current payment system provides, it's not exactly a level playing field, which supports in a way Uwe's prior statement, because when the choice seemed to be closer to straight up between the private plans and the Medicare plan, people were not switching at anything like the current rate into the private plan. But competition is great. Let's have more of it on a fair price, level playing field.

Dentzer: All right, here's a question from a Webinar participant who's asking to take us to a very basic level. He's from a company called Flexible Medical Systems, and he asks the question, why do we need insurance anyway in health care? Something typically reserved to buffer against catastrophic risks, why do we need these against routine expenditures, which are quite obvious and can be readily anticipated by many people?

So Mark Pauly, I'm sure you've thought about that a lot over the years. Why do we need basic health insurance?

Pauly: I think we do need basic health insurance, and it should cover those expenses which are catastrophic relative to a family's income. For low-income families, though, that's almost any expense. For upper middle-income families, well, I won't speak for everybody, but I have much too much health insurance, personally. Of course, the reason I do is because there's such an enormous tax break that it's hard even for a well-meaning economist to turn it down.

There is, of course, a subset of reasonably sure things that operate as effective preventive care, although I agree with what Henry said, in general, but for which there could be, and appropriately be, coverage. But the design of the minimum optimal pattern of coverage that I talked about earlier would be one that would allow and even encourage upper middle-income people not to insure sure things, which is not an efficient thing to do.

McLaughlin: Well, again, we have to think about the even playing field. Rightly or wrongly, it's not a case that insurers use their market power to negotiate favorable rates from providers. So someone without insurance is often charged a significantly higher price for the same service. So I think that that has to enter into the discussion that if we decide, oh, well, we don't need insurance for all of those issues, then somehow we have to change that kind of pricing mechanism.

Pauly: Well, to say something good about health savings accounts and catastrophic plans, at least in many cases, the catastrophic plan you signed up with was a PPO that made the discounted price available to you for the portion of the cost that would be covered by the deductible, not that I'm in favor of high deductibles for low-income people. I think they should be forbidden from participating in this federal plan.

But there is a way to get, and I think Uwe used this term, the enforcers or the hired guns, there's a way to get insurers to go out and do your bargaining for you, even if for the most part, for a while, it's going to be your money, not their money.

Dentzer: Do you see any argument for exploiting moral hazard in the sense of do you think that there's economic research to support the fact that having people pay a lower price for preventive services would encourage them to use them and that would end up being a favorable thing for the economy?

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Reinhardt: I think many of the HSA plans actually have tried that, as far as I understand, that certain things...

Pauly: Carved them out, yes.

Reinhardt: Yes, carved them out. And the acute part there was that the drug industry says, well, actually, if you think about it, almost all pharmaceutical products are really in the nature of prevention of a calamity and they wanted all of it covered. I don't know if you ever heard these things at conferences. I kind of found that amusing. If you had such a clause, all of a sudden all health care will be preventive.

Pauly: Well, in the sense that all health care is consumed in order to prevent death, that's true.

Reinhardt: Yes, I want to ask Henry, if I may, Susan, ask him a question.

Dentzer: Please go ahead, Uwe.

Reinhardt: On your list of very pragmatic, doable things, this is something I think that was successfully pushed through in New Jersey, saying that you cannot charge an uninsured person more than 115 percent of Medicare, but you can charge them less, and in fact you should, to keep your tax exemption.

Now, Mark Pauly and I—I guess, Mark, I hope I speak correctly for you—would abolish the tax exemption for nonprofits, anyhow. I don't know where you stand on that. I would. But why could we not do that in the next Congress, simply saying you cannot charge an uninsured person, like down at MD Anderson, \$45,000 for a diagnosis. That seems off the wall. And you just put a limit on it. How hard would that be to legislate?

Dentzer: Henry?

Aaron: I'm going to defer this one to Joe, because he is the expert on Medicare pricing I think on this conversation. But my understanding is that the connection between individual Medicare prices and either average or marginal costs of providing those services is at best coincidental, but let me stop before I say something I'll regret.

Newhouse: This is Joe. That's right. That's why I said we would like competition among health plans rather than a single payer. But that is not to say that limiting kind of these egregious charges to the uninsured and pegging them to something wouldn't be better. After all, the uninsured person, when they go into care, typically doesn't have a clue about what it's going to cost in the end to do it. And although that would still be true if we pegged it to 115 percent of Medicare or some other external reference, it would be a lot better. In fact, I interpret Mark's comments about HSAs giving their adherents negotiated prices from the insurers is in the same vein as basically relying on some third party to put some limits on pricing here.

Reinhardt: Uwe here.

Aaron: And it may do more harm than good in the current system and I'm quite prepared to believe that Uwe's solution is an improvement, but wouldn't it be the case that somebody like MD Anderson is

engaging in what we economists call price discrimination? They're trying to get a very high price from those who are prepared to pay it and that it's more in the nature of an asking price than a fixed charge?

Newhouse: The Saudi oilman who comes to MD Anderson is probably prepared to pay \$45,000, and that's presumably fine with us. But I think the bulk of the uninsured showing up in the medical care system are not the wealthy foreigner.

Reinhardt: Well, I can tell you here, I was a chair of this commission here, and I proposed—everyone else says, oh, we should use what the private health plans pay. So I called up the CEO of Horizon Health Plan and said, just tell me, what is your price? What do you pay for a colonoscopy? And he said he couldn't answer it because he says they pay each hospital a totally different fee that can vary by a factor of two or three among hospitals. And then for each hospital, there are different prices they pay them depending on the insurance product.

And despairing of the huge bureaucracy it would take to get a representative average of this chaos, I pick Medicare because it exists, knowing how imperfect it is, but also believing that what the privates pay is even less perfect, less rational.

Newhouse: This is Joe again. I interpret that as showing market power on the provider side and one of the things on my list to be done is more vigorous antitrust enforcement in the health care sector than we've seen over the past few decades.

Reinhardt: Henry is right, it is price discrimination and, sure, a Middle Eastern potentate and/or drug lord of Latin America, sure, we should charge whatever we can. But in this case there it was in the *Wall Street Journal*, here somebody frightened to death because of a very serious leukemia and then an American hospital looks at it and says, oh, my goodness, here's an opportunity to take all their assets into our bottom line. I think there is something just unseemly about that, to do that to a fellow American.

Dentzer: Well, let's turn now to a final question from the University of Massachusetts at Amherst. Henry gave us a list of achievable, enactable small reforms. Let's talk about some of these achievable, if there is such a thing, enactable, or at least able to be carried of cost-containment measures, both on the supply side and the demand side. Up in Massachusetts, of course, they're back to looking at certificate of need formulas, again, to limit the growth of future medical supply. They're back to looking at whether there's a way to control expenditures among those with very costly chronic conditions.

What, Henry, would you say might be doable cost-containment measures that aren't fairytales, as you suggested, but also that the American public would accept?

Aaron: I'm not going to give a direct answer, because I think the prospects for significant cost control until such time as essentially everybody in this country is covered, provided basic insurance, is close to nil in any major sense. We could do the kinds of things that Uwe mentioned he was successful in achieving in New Jersey. We can try to reduce medical errors that end up being very costly in the way that Medicare is now trying to reform its payment system. But genuine, long-term cost control is going to require in some fashion the imposition of what we economists call a budget constraint on the U.S. health care system.

The current arrangements for payment are so fragmented, so loose, payments come from so many forms and the incentives operating on both providers and patients are so adverse to cost control that

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attempts to limit the growth of health care spending now substantially have the—well, largely run into a dead end. If we can get everybody inside the tent, then through means that could be the sort that appeal to conservatives—tax incentives, for example, market competition—or that appeal to liberals—regulation, government controls of various kinds—or some combination of the two, I think we have the hope in the very long term of achieving effective cost control.

But right now the U.S. health care system is well designed to frustrate virtually anything that promises to control spending to a significant degree.

Dentzer: Well, on that note, I'd like very quick, 15-second predictions from each of you about what will have happened by the end of the next President's first term. We're going to look ahead now, having spent this conversation looking back 14 years. So you've got 15 seconds each.

Uwe, I'm going to start with you.

Reinhardt: I think there will be some marginal extensions of insurance coverage. I believe these candidates, whoever they are, will take IT more seriously. I think the big music, however, will come in 2012 when, according to my numbers, a lot more Americans are much more desperate and a lot of hospitals will have to deal with them. That's my prediction.

Dentzer: Joe Newhouse?

Newhouse: I agree with a number of things on Henry's list and also Uwe's, so the SCHIP expansion, the institute for assessment or comparative effectiveness or whatever it will be called, some monies for IT and I'm not—I'm not sure, I think keeping Medicare and Medicaid afloat as we've known them will be something of an achievement, as well, given the problems that they're facing.

Dentzer: So you expect some changes there, I gather.

Newhouse: Oh, well, I expect that they will largely stay afloat as we've known them, but that will suck some of the money out of initiatives, other kinds of initiatives.

Dentzer: Mark Pauly, your 15-second prediction?

Pauly: OK, so we will have coverage for children. They're cheap to cover, after all, and they make us feel good. Second, I think we will get rid of the flexible spending account, the most egregious way to borrow money from the Treasury in order to improve your health. Thirdly, I predict that Sen. Specter from Pennsylvania will be running on the basis that when your health plan refuses to provide you care because it doesn't meet some cost effectiveness level about the 36,000 per quality adjusted life year that they have in the U.K., our dear Senator will be on your side to make the insurance company pay for the care you really need.

Dentzer: Hank, do you want to predict that your list of enactable reforms will in fact be enacted?

Aaron: I'm going to give a political spin to this. President McCain will get practically nothing done because enhanced Democratic majorities in both houses will be furious with him. President Obama, on the other hand, I think will push quite hard on health care reform, probably along the dimensions that

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I've described, possibly some that Mark and Uwe and others have mentioned, and will enjoy a modicum of success but in the end is going to have to face up to what Senators Rockefeller, Schumer and Baucus have already said, that this isn't the time for major health care reform.

Dentzer: All right, well, with that, I'd like to turn it back over to Catherine McLaughlin. Catherine, you're free to make your own 15-second prediction or move on to close out the discussion today.

McLaughlin: Well I think my 15-second prediction is that the people who are still on have things to do and are going to be signing off. So I appreciate all of you for joining us and for those of you who sent in questions, I just want to let you know that this Webcast will in fact be available online on the Robert Wood Johnson Foundation Web site or ERIU's Web site. So if there were things that you missed and wanted to revisit, you can go and listen to it again, or you can tell other people who weren't able to join us today that it will be available. And I want to thank Susan and all four of our presenters for participating today. Thank you all.

Operator: And this concludes today's Economic Research Initiative on the Uninsured Web Seminar, *Health Reform 14 Years Later* teleconference. Thank you again for attending, and have a great day.