

AARP

**WHAT SHOULD OUR NEXT PRESIDENT DO
ABOUT HEALTH CARE COSTS?**

**WELCOME:
JOHN ROTHER,
DIRECTOR OF POLICY,
AARP**

**MODERATOR:
JULIE ROVNER,
HEALTH POLICY CORRESPONDENT,
NATIONAL PUBLIC RADIO**

**PANELISTS:
DAVID CUTLER,
PROFESSOR OF ECONOMICS,
HARVARD UNIVERSITY**

**THOMAS MILLER,
RESIDENT FELLOW,
AMERICAN ENTERPRISE INSTITUTE**

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JOHN ROTHER: First of all, my name is John Rother. I am the director for policy at AARP, and I want to welcome you all to this event: What should our next president do about healthcare costs? And I don't think I need to remind you too much that healthcare costs have been steadily outperforming both inflation and the economy now for many years. And the projected growth trend becomes cause for alarm. It is not that health care is bad. It's just that we have so much evidence that we are not spending wisely or efficiently compared to other countries, compared to other parts of our own country, or compared to reviews of actual cases and patient records.

And so there does seem to be a lot of opportunity, shall we say, for positive action with regard to healthcare costs. And I think one of the striking things now about our representatives of the two campaigns is there is overlap, to some extent, about how they would go about dealing with healthcare costs. Now, there is not a lot of overlap in terms of coverage, but we are going to try to keep the focus today on costs.

I'm extremely pleased to be able to turn the program over today to a good friend and colleague, Julie Rovner, from National Public Radio. Julie covers this – I won't say for how long – but she is one of the best informed people in the press corps working this issue. And it is always a pleasure to hear her reports on "All Things Considered" every evening. So Julie, if I could ask you to introduce our speakers and take it from here.

JULIE ROVNER: Thank you, John. And I first want to apologize in advance. I'm just back from a 10-day reporting trip to Switzerland, where I came back with a really fascinating working knowledge of the Swiss healthcare system, which you will be hearing more about on "All Things Considered" and "Morning Edition," and a lot of chocolate, and a really miserable cold. (Laughter.) So I hope my voice holds up for this entire hour.

I will start by introducing our two representatives of the campaigns, who are experts in their own right, which is why I am so happy to be here today with them. I think you are probably familiar with them and you have their full bios in your packet, so I will not belabor this. But as a quick introduction, Dave Cutler, to my left, is the Otto Eckstein professor of applied economics in the department of economics in the Kennedy School of Government and associate dean of the faculty of arts and sciences for social sciences at Harvard University.

And just as a personal aside, I got a chance to meet with Dr. Cutler in his office at Harvard last year. And I have to tell you, I spent a week at Harvard Medical School doing a little fellowship on the Massachusetts health plan last year. And the only thing that intimidated me in the entire week of tromping around Boston and meeting with all these high-powered people talking about the Massachusetts health plan was asking at Harvard Yard where Dr. Cutler's office was and having him point directly across the middle of Harvard Yard to the administration building. He said, it's there. (Laughter.) So he has got quite the office. (Laughter.)

Some of you may know David Cutler. He served on the Council of Economic Advisers in the National Economic Council during the Clinton administration and advised the presidential campaigns of Bill Bradley and John Kerry. So I hope that doesn't mean something for this current campaign. (Chuckles.)

And to David's left, not ideologically, just physically, is Tom Miller, who is a resident fellow at the American Enterprise Institute, where he focuses on health policy with a particular emphasis on such issues as information transparency, health-insurance regulation, and consumer-driven health care. He is also a member of the National Advisory Council for the Agency for Healthcare Research and Quality. Before joining AEI, as I'm sure many of you know, Miller served for three years as senior health economist for the Joint Economic Committee of the U.S. Congress, where he organized a series of hearings focusing on promising reforms in private healthcare markets, many of which I attended. And I don't know how many others of you did, but they were really very interesting hearings. And he drafted several Social Security reform bills. He has also been director of health policy studies at the Cato Institute and director of economic policy studies at the Competitive Enterprise Institute. If you want to know more about our guest, I refer you to your packet.

So I'm going to jump right in here into our discussion. We have decided not to have opening statements by our experts, rather to have as much of a discussion as we possibly can. I am going to ask some questions, and then later on, we will open it up to the audience for questions. So I am going to – as John suggested that there are actually some similarities here. Really, one of the few aspects of the health problem on which the candidates do agree is that, as a nation, we spend too much on health care. And that seems to be a good place to kick off this discussion.

Among the things mentioned most frequently by experts as drivers of high healthcare spending are, in no particular order, new technology, third-party insurance, making people insensitive to cost, and an increase of chronic disease, particularly obesity. How would you rank these drivers? And are there any you would add to the list? And David, you're next to me, so you get to start. (Chuckles.)

DAVID CUTLER: Okay. Thanks, Julie. Just one point of good news, which is I am dean soon, so I will have a much calmer place – (laughter) – a much easier place for you.

MS. ROVNER: Oh, no, it was very impressive.

(Laughter.)

MR. CUTLER: You mentioned a few different factors. And I think probably the right order is the order in which you read them, which is that, over time, the increase in medical spending is due to a great extent because we can do more and we can treat more people. And as John Rother mentioned at the beginning, not all of that is bad news. And so there is a reason why we like to spend on medical care and that is one reason.

I guess I just want to make one distinction up at the front that saying that doesn't mean there isn't a lot of ways, or what John said, that we don't spend wisely or inefficiently. And for example, administrative expenses in the U.S. healthcare system haven't grown any more rapidly than anything else, but also haven't grown any less rapidly than anything else. And so there is still roughly the same share of medical spending as there used to be. And just to sort of presage the discussion that we are going to have, if you – my impression is if you look at the academic literature, you can convince yourself without breaking too much of a sweat that somewhere between a third and a half of all medical spending is not buying anything useful.

And on a \$2-trillion medical system, that is somewhere \$600 billion and \$1 trillion. So I think of roughly what we are talking about here as being, in the first instance, what can you do to save the country \$600 billion to \$1 trillion, which is a lot of money. And then over time, how do you deal with a system that spends more – and I think it is helpful to separate out the short-term imperative in saving that, and then the longer term – what will we do as we can develop more and more?

MS. ROVNER: Tom?

THOMAS MILLER: Thank you, Julie. I know you told me I would be bulletproof by not having all my comments attributed to the McCain campaign, but I took extra steps – (laughter) – so that when I am talking with my AEI – and I tried to get a hat, they were out of inventory and didn't want to make a contribution to the McCain campaign through AEI because that would be violating all kinds of federal laws. (Laughter.) So this is when I'm talking is AEI; and over here will be later, will be McCain advisor. And it may spin around several times in the course of a single answer because I am used to doing these contortions. But I have got plausible deniability and so does the campaign, probably even more important for them. (Laughter.)

Okay, drivers of high health spending. I would change the order and add one other element. The most important driver is what we pay, how we pay. That is largely the function of an extensive third-party payment system. Secondarily, that we tend not to pay for value, but for volume. And those who are delivering health care or even spending someone else's money and not necessarily is accountable for those results because they are kind of paying through someone else.

The traditional metric, which says, oh, it's mostly due to the march of technology. It just arrived in the doorstep this morning. We have to pay for it. And I know there has been a lot of work in this regard, but it tends to be a lazy residual, which doesn't actually analyze what drives that technology. Just like an army doesn't march on an empty stomach, neither does the march of technology. If there is not the prospective likelihood of substantial payment for all those investments in technology in earlier years, you wouldn't have that lag defect in terms of increasing healthcare costs. We also get technology, which as a result of that system tends to be cost increasing in the aggregate, rather than cost decreasing.

The other element, of course, is more than just the increase of chronic disease, and particularly obesity – those are important elements. It is the larger issue of population health. All the things that go into kind of those upstream factors, which are going to deliver the various

conditions, complaints, claims for health care that come into the system. And they have long antecedents well before kind of the healthcare system often gets their hands on that population.

So that is how I tend to rank the order of that. I agree with David in terms of kind of the distinction between the average value of the healthcare – in the installed base we already have, as opposed to the marginal effects. There are a lot of good things in the healthcare system. But we have an immense amount of things that we are paying for that don't deliver value, as opposed to volume.

That is kind of the downstream side of healthcare delivery that regardless of kind of how we are financing it in the middle, the larger determinants aside from that population health at the beginning point is what is the efficiency and effectiveness of the care that is actually delivered in practice? And those two factors can overwhelm whatever type of insurance system, coverage basis you have, or the means of financing health care.

MS. ROVNER: Which leads us very neatly to our next question, which is what I call the holy grail: cutting costs while boosting value. Most policy analysts agree that we not only spend too much, we get too little benefit for the money that we do spend. Yet so far, we haven't been able to harness what, at least on paper, seemed potentially promising value-for-money strategies.

So here is sort of a three-part question. What do you as an expert – and I guess you get to keep your sign facing that way, though – (laughter) – think are the three or four most promising ways to save money and improve value in health care? What are the biggest obstacles in implementing these ideas and how do you overcome them? And are there examples of cost containment in other countries that are worth considering here? And I guess, Tom, you get to start since you are –

MR. MILLER: Okay.

MS. ROVNER: Since his sign is facing the right way.

MR. MILLER: All right. And there is such wide waterfront; I'll try to be relatively brief while being long, I suppose. Strategies for getting better value for money: I think – and this is increasingly recognized – our execution is somewhat lagging in this regard. We need better measurement of performance – relative performance, not perfect performance – and it's not necessarily an individual provider of health care. We would like to have a system in which they are accountable teams of care and it's aggregated. But in essence, we need to do a better job of first, measuring on an outcome basis, rather than a process basis, what is being delivered for what we are paying. And a way to kind of account for the all-in cost for the appropriate episode of care – the way you kind of bundle that together is you cause kind of an isolated circumstance.

Secondly, as I mentioned before, the early upstream factors kind of shape a lot of kind of what the system is going to deliver and how it faces things. We see a tremendous premium. Well, there is two factors to this. One is kind of there is this long time lag. A lot of what we are seeing in the healthcare system today has its causes and antecedents – could be 50, 60, 70 years ago among the retired population.

All of these chronic conditions you are seeing arise today, you can often go back to prenatal, early childhood, early development, and things happen in your body that are going to show up later. I'm actually doing a conference on this in about a month from now. I have got to cross plug on that – July 23rd. But these are significant things. I'm going to get back to that in a second, but it kind of indicates the limits on what we can actually accomplish with some of these approaches because a lot of this is installed into the base, as much as we want to change that future base.

A third element is not kind of the cartoon, you know, cookie-cutter, silly cost sharing, but smarter cost sharing. Obviously, there is early probes in terms of value-based benefits, which suggest there is smarter ways to kind of incentivize people to kind of go toward better providers, the right type of care. We talk a lot about tiered-cost sharing. It doesn't really exist that much out in the marketplace. But to kind of provide at least some marginal, financial incentives – not an end-all and a be-all – to suggest that there is ways to kind of steer people in better directions based on evidence hopefully.

Also, potentially, we can do a better job in treating chronic conditions. There are some pockets of kind of good models of care, which we would like to encourage in the mainstream and broad-base it. The healthcare system may not be entirely ready to execute it perfectly; but it is an essential ingredient because unless we treat the high-cost people who are going to be the recurring costs in a better way, we are always going to be kind of behind the curve of that.

Now, some limits in this regard. Well, actually, let me add another element for this audience. It is important we invest more in the young than in the old. Talk about installed basis – you know, at least, redirect some of our kind of investments, so that we are thinking about kind of the health population, the future of the health needs. We need a healthy young population, which are going to be the folks who are going kind of paying all the things that we kind of need later on as we retire, or are already retired. And that is a redirection in kind of what has been the primary thrust in our healthcare system.

There is some limits on all this. We would like to kind of have this nimble, you know, agile Medicare system, which kind of does all the right things and pays differently. We are going to have Medicare fee-for-service in its structure for quite a time, and we are not going to have massive enrollment in private plans. So on the one hand, we imagine the private sector can go flexible, innovative, trial and error, bottom line; it's your own money at stake. They can do all these things, but without the involvement of Medicare, and also sending similar signals to how care is delivered and what we are paying for, there are going to be cross purposes. Yet, Medicare is not as structurally capable of pulling it off this time. Medicare has the information, the data, the knowledge, the leverage in the system. That is not a conundrum, but it is a difficult dance we need to recognize in that regard.

I mentioned before, early investments to turn around a lot of these conditions. As important as that is, we also have an installed base of very sick people and people who are going to be sick in the future. And the time when you can best intervene is when people are young. Yet, when you are middle-aged and older, there are things we can do; but they are not as

effective. They are not – you can't turn around the curve as much. And that is just the reality as to kind of what we are facing. It doesn't mean we should ignore what is coming ahead in future decades, but there is a bit of a dance in that regard, as well.

Finally, we talk so much about – we enjoy coordinated care, team care, that type of thing. You need to look at the healthcare delivery system, the infrastructure you currently have. You can imagine that everybody is going to be at Mayo Clinic, at Kaiser Coordinated Care, at Cleveland – name your – (inaudible) – all this. That is not what is out there. We have still got small medical practices. We have got folks relatively uncoordinated in their own little kind of burrows. We have to think more creatively about how to virtually integrate these folks, so they are kind of pulling together in the same direction whether it is – medical home is one model of that.

Most recently, Mark McClellan and Elliott Fisher try to talk about accountable care organizations as kind of a halfway measure to kind of bring these folks together. We want to have more coordinated care. We have to recognize it is not a coordinated system currently and it is not going to become one a year from now. I will get back to some other stuff later.

MS. ROVNER: I'm going to give – yeah, I said I'm going to give David equal time. Can you turn your little sign around and tell me what in a McCain plan gets you towards –

(Laughter.)

MR. MILLER: Damn. You told me that was going to be later.

MS. ROVNER: It is, but you really keep – (inaudible).

MR. MILLER: All right, all right, all right. Look, I have to read off the cards for this one.

(Laughter.)

I believe –

MR. CUTLER: I can give you a set of cards if you'd like.

(Laughter.)

MR. MILLER: No, no, no. I don't like the way that deck is being shuffled. (Laughter.) In terms of the McCain campaign and kind of the first cut, it's been in favor of everything that's good. (Laughter.) It's true. I mean, I couldn't stop them, as hard as I tried. And, you know, the buzz words – everybody uses the same language: coordinated care, paying smarter, paying for value in Medicare.

Subtly – I was going to get to this later. Even though it's not spelled out, if you really look ahead over the next four years or longer – and it's going to be a lot of heavy lifting, a lot of change – the inherent logic is to kind of fundamentally rework the whole – not the entire because

you can't do that – a lot of the reimbursement system for Medicare. You have to pay for different things; you have to pay on a different basis, bundle things in a different manner than kind of the current codes are, cognitive services, differentially paid to kind of get things better than they currently are. That's harder to do in kind of a universal entitlement system.

But, inevitably, what was constructed – the DRGs made some progress in the mid-'80s. The stuff for physicians was kind of more of a mixed bag. That's fundamentally got to be looked at again to kind of – if we want this type of smarter, coordinated care, we're going to have to signal it by how we pay for it through Medicare. It's going to upset some interests, but, ultimately, some of those dollars are going to get moved around on the table.

MS. ROVNER: But the theory is – I just wanted to make this clear – the theory is to use Medicare as it has been as the model to try and to lead the private sector.

MR. MILLER: The sense I've had kind of from on high is we're more ready to kind of provide guidance and instructions through Medicare. Hey, you know, the money's lost already, might as well do something with it, as opposed to the private sector to inform the private players that here's what you can kind of find out through measurement what works. You should be already motivated, incentivized to do this kind of in your various ways and we'll get kind of better product out of it. But Medicare is going to have to lead on a lot of this and you really can't have the system going in two directions at once.

MR. CUTLER: I may try and borrow Tom's sign and jump in.

(Laughter.)

MR. MILLER: He's spoken at AEI.

(Laughter.)

MR. CUTLER: I'm not sure that either side of the sign would be happy with that.

(Laughter.)

MR. MILLER: How about this?

(Laughter.)

MR. CUTLER: Let me try and take the question and give – sort of start off with what are the most promising ways to save money and then try and weave some of the other parts into that.

What I would say is three things. Three big areas strike me. The first is that we need to do a better job on prevention and care management. There's a lot – let me just acknowledge; there's a lot of controversy about whether that will save a lot of money or not. Nobody thinks it's a bad idea, so we ought to do it whether or not it saves money. But there are a lot of folks who think that you'll save a lot.

You know, I consider the classic example of that is one you brought up initially, which is obesity. That is, people who are obese spend a lot while they're alive and if they were not obese and they lived to a later age, many of the things that happen to you at a later age are less expensive than the things that happen at a younger age.

There are ways of saving money. That's not true about everything, but there are ways of saving money and it's good policy. And so that's the first part. I do worry – sort of, to just jump into an issue about proposals for a second – I worry a lot about policies that say, if you give people more cost-sharing, they'll figure out that they should have more prevention because, in fact, most of the evidence we have is that, if you give people more cost-sharing, they don't use services and the services they don't use are the ones that have longer-term benefits. And those are exactly the kind of prevention in chronic-care management. So that's just a worrying point. And so that's the first broad area, that people – we should do it – people are going to need help.

And, by the way, I think the help is probably more than just cost-sharing. I think it's, in many ways, you look at the most innovative models of prevention and chronic care management, they're actually about reaching out to people and being very, very interventionist, not just kind of held back.

The second broad area for saving money is a kind of nexus that I think of as being “know more and pay smarter”. And this is some of what Tom was talking about. We ought to know more. We ought to know which providers are better than which other providers, which treatments are more appropriate than which other treatments, which services are really needed in a particular case, and then we ought to pay smarter for them.

But I think of the “know more” and the “pay smarter” as going hand in hand. And there's a very, very big thing, which is, we're really not going to know more until we've invested in healthcare information technology. And one of the things I think that's not been discussed particularly much about Senator Obama's healthcare plan is that it proposes \$50 billion for healthcare IT. And that, to me, is going to be a center part of this because just changing the payment incentives, if you don't know what to do, is not going to work. And just throwing a bunch of IT out there, if you don't have the right incentives right, is not going to work; so it's really go to be together.

And you've got to think about a transformation together. I think one of the things we've learned in the past decade is that just announcing, oh, by the way, there's incentives to do X without providing the knowledge base that you can do it doesn't lead to very good things happening. And so there's a very big deal; yes, it's going to involve Medicare, but it's going to involve more than just Medicare saying, oh, by the way, in five or six years, we're going to beat you up if you don't do this because you've got to help people figure out when it's going – you need to do that. So that's the secondary, is knowing more and paying smarter.

The third area, where there's, quite honestly, easy money to be saved, is in administrative expenses. Even relative to mixed public-private or predominantly private systems in other countries, the administrative expense in the U.S. is significantly higher. And, for example, in

Switzerland, if you look in detail, most of the additional administrative expense is in the individual and the small-firm market. That is, that's where most of the profits that insurance companies make are from. And the big firms that are doing administrative-services contracts, they're not making a whole lot of money.

MS. : Could you speak up, please?

MR. CUTLER: Yes.

MS. : Thank you.

MR. CUTLER: So the administrative expense issue, where I come down, based on the literature, is that the single biggest thing we can do to reduce administrative expenses is to group individuals and small firms together and say, you can't underwrite each one individually; you can't figure out who's healthy and who's sick; you've got to deal with them in a group the way that you deal with large employers in a group so that we can drive the 40-percent administrative expense down to maybe 15 percent, maybe 10 percent, maybe 5 percent. That's why, in a lot of the proposals, not just the Obama proposal, not just the Clinton proposal, but a lot of the bipartisan proposals that you're seeing, you see these kind of insurance exchanges that, in essence, act like what a big firm benefits manager does for individuals in small firms.

And that's a worry of mine about things that just say to people, okay, you shouldn't be in employer coverage; you should be in the individual market, because I think that's a recipe for raising the administrative expense. So those – so that's what I think.

Just a word on the big obstacles. We're in a kind of bad setting now where the public sector is – doesn't want to be the first mover and doesn't have any money to do things and the private sector doesn't want to do anything without the government and isn't big enough on its own to make big changes. And so, as a result, what we've seen for the past decade since managed care has sort of gone away is a kind of complete stasis.

We've seen employers saying, we need help; what do we do? We've seen governments saying, we need help; what do we do? And it's not going to get broken until we do something big. And that big is going to have to mean Medicare changes, but it's also going to have to mean a big commitment to IT and it's going to have to mean a big commitment to preventive stuff, and it's going to have to mean a big effort to group people together.

So I don't have a lot of hope that, without something big, you know, in four years, if you were to do this again, that things would be materially different.

MS. ROVNER: We have to move on, but just one question for both of you.

MR. MILLER: I was happy to give you some disagreements if you'd like.

(Laughter.)

MS. ROVNER: Well, yeah, and you can. But, you know, IT is certainly a focus of everybody's health plan and certainly something they're grappling with on the Hill. One of the big obstacles there is this concern about privacy and privacy issues. I think there was just a story the other day about another company who lost an enormous amount of medical records and now they're having to pay for identity monitoring, identity-theft monitoring for people whose Social Security numbers were part of their health records.

I mean, how do you – that seems to be one of the biggest obstacles to this. And another obstacle, of course, is that it's a lot easier in countries that have, you know, a single payer to computerize medical records or even the VA than it is for when you have so many different health insurers. How do we ever get over that hurdle?

MR. CUTLER: Just to take the last part of that first, not only with different – the different health insurers – I can barely figure out how to turn on my computer, so I'm not the right person to do this. What I'm told is, different health insurers isn't such a big problem. What turns out to be a bigger problem is 50 million uninsured people because those are people for whom you're not getting any regular records at all and they're in and out of coverage and so on. And so a lot of this will be made easier if you cover a lot of people. And I think that's a general point about a lot of cost-sharing, is that it will be made easier.

My impression based on just kind of casual talking with people is that the privacy issues are there, but they're not insurmountable. So, for example, you can do opt-out features. You can have things that are – there are different versions of electronic records that are more personal things that you keep and you decide who they go to or there are more kind of electronic sort of back-office things.

I think, in talking with kind of the experts I know, and even some of the kind of consumer groups that I know, they think that the privacy issues are surmountable, not that they're easy but that they're surmountable, and that the bigger issues have to do with the kind of, can you get there to be a model that works and something that you can get people to buy into?

MR. MILLER: There are a lot of hurdles. On the privacy front, I'm sure we'll legislate just as nimbly as we did with HIPAA – (laughter) – and then defaulted it to a great massive exercise by lawyers writing dense rules which all, at the end of the day, increased your burdens marginally and didn't do much to protect your privacy.

There's also a disconnect between kind of what patients think is their right to these records and how they're going to use them as opposed to the healthcare system says, finally, I've got all of this data. It's like the electronic health record versus the personal health record. At the end of the day, we're going to have to – the provider communities have to grudgingly admit to the patients, yeah, you get to look at the stuff. It matters to you and then you give us permissions.

Opt-out is a better way to go. You start out in one place, but allow people to kind of go offline and bail out of the system. There are going to be more than just a few million people, though, who will tend to do that, will get enough information – it won't be perfect; it won't be

air-tight – but it's predictive enough to kind of learn a lot more about what matters and also to drive the type of reminders and the better delivery of care.

Nevertheless, when you kind of look at the whole health IT thing and, at the campaign level, we're very enthusiastic about health IT. (Laughter.) It's going to save a lot of money. We don't know how we're going to pay – sorry. (Laughter.) And the campaign approach is to say, rather than kind of force-feed it through federal grants, you can spend \$50 billion on lots of things. We have defense weapons systems that have kind of reached that level, I suppose. Does this really mean it kind of works the first time out?

What you want to do is kind of – and it's not there yet, surprisingly, despite all of the meetings – you want to have the agreement on the consensus interoperable standards so they can talk to each other. At least get that done and, believe me, there are log jams on that when everybody is around the table. See, and you want to do it at the lowest level of simplicity so you can kind of vary off once you're kind of at that common base. I mean, it worked for the Internet; it worked for the Worldwide Web. You should be able to kind of figure that out, but it hasn't happened just yet.

Nevertheless, all of these kind of magnificent cost projections – I do have the AEI one up here, right?

MR. CUTLER: Yeah.

MR. MILLER: Good. I mean, you take apart the RAND study and they do terrific work in terms of modeling, but these are highly optimistic. You know, this stuff delivers much later, it assumes full implementation. Let's understand the way we think of the things in this country, which will be longer and it won't be that kind of full adoption. It's a great concept; it's essential. It's necessary, but not sufficient to do these other types of things, but it's going to be later. It's not going to pay for itself right away. We've got a mismatch between kind of who benefits and who would be asked to pay for it.

The payers are going to have to pay for it, a combination of Medicare, taxpayers, private payers – because they're the folks who capture the benefits. We're going to have to pay differentially in order to kind of incentivize the adoption of this. If this really saves money, someone should be willing to kind of pay for it and have it pay off. If it doesn't, if there's not a business case for it, it's going to be slower.

You can't imagine savings that don't occur. It admittedly is a bit of a chicken and egg in that regard. And all of the stuff is front-loaded. We're not going to spend \$50 billion in five years. On the other hand, it's clear that some of this is going to have to have a driving force and, even though it's not been spelled out in the campaign, there's going to be a point at which there's enough commonality to have, in effect, a public program say, here's what we favor and here's – we're going to kind of give you less burdens or more payments if you do that and that will tend to kind of create the significant mass to move other folks into that direction.

But we don't want to wire this so tight that you can't ever change it because we've learned before that software malfunctions and we want to do things better on a continuing, evolving, learning basis.

MR. ROTHER: So what I'd like to ask is, if we ask this question outside the Beltway to an audience of AARP members or anyone else, the first two things they would mention, I believe, are the cost of prescription drugs and costs associated with end of life. I wonder if you can address those two elements of the cost equation.

MR. CUTLER: Let me try and take a stab just a little and Tom, as well. The prescription drug costs, I think – one of the reasons why it shows up as being such a deal to people is that the out-of-pocket share of prescription drug costs is significantly higher than the out-of-pocket share of other medical spending. So people notice it a lot more.

I think the Medicare Part D was a great start at doing things on that and I think there are a number of changes to that, some of which Senators McCain and Obama agree upon. And so I'm hopeful that, after the election, in the new year, we can do things on that.

The end-of-life care is extremely tricky. I think it's tied up in the – in this issue about care that's provided that doesn't have an enormous amount of value. And everyone agrees on it; so far, we've been unable to get – to sort of come up with interventions that work very well. And I think, to a great extent, it comes into the kind of human side of medical care. That is, it's very hard at the end of life to let go and things like that.

I guess some of my hope is that some of these other changes will sort of bring that along the way. That is, by figuring out the kinds of things that work and don't work, we'll be better able to go to people at the end of life and say, you know what? It's just not effective to do this. That is, we know very well that you shouldn't do it. And we're going to have to do that through the things that we were talking about in terms of the kind of knowledge-generation-type stuff because we're never – we never do the clinical trials in those kinds of people, or very rarely do the clinical trials in those kinds of people with the exception of some chemotherapy agents.

And so my hope is that, as you learn more, as we learn more, we'll be better able to do that. And it sort of gets at this issue about, you know, if you have more – you know, how much is it just that we're going to do everything we can whenever you can or how much is it that by learning more and by changing the incentives of the system, we'll do much better?

And my sense is the latter. And at least partly, we see that by the huge variation in end-of-life spending across even very comparable institutions across the country. It's clear that you can have different standards that coexist and that people are not unhappy about in the less intensive areas. And so figuring out how to learn about that move to the less intensive areas will be a key part.

MR. MILLER: Okay, this is definitely a spinning-sign answer. (Laughter.) Prescription drugs – I'll do the AEI version. At the end of the day, look, first of all, I mean, if you actually look at kind of the trends in drug spending overall, it's been on the low side as a component of

health care. I know what we went through earlier in the decade, but if you track the last couple of years, some of this is patent expirations, a huge increase in generics, a broader base of consumers through Medicare Part D. Ultimately, that's been bringing it down.

When you also look at kind of the tradeoffs across the board, what we're getting in terms of kind of less concentration of spending, better overall all-in costs, improved outcomes across what you're saving elsewhere, a positive story in that regard. And as much as kind of some unique drugs look incredibly expensive, when you look at kind of what they can produce in terms of whether you want to do quality-adjusted life years or cost of an additional year of life, even the European governments will pay for these things and they don't have a substitute for it.

Now, the campaign side: Senator McCain has been in favor of re-importation, not even the personal-use version but the Byron-Dorgan, full-strength one. He's running for president, not me, and I think he's still in favor of it. So we'll see how that goes. I'll do my speculation when I turn the sign around in a second.

Certainly, pushing for kind of more generics so – I don't know how we can get any more generics right now, at about 65 percent. Everybody's hoping for kind of a route for bio-similars; you have to be a little cautious about this. Aside from safety concerns – just in execution, but it's not the same as kind of the small molecule compounds, which you can just knock them off. At the same time, there's kind of some issues of –

MS. ROVNER: You might want to explain a little bit more, with bio-similars.

MR. MILLER: Well, bio – I mean, you can't get any bio equivalent of a biotech drug because they're large molecules; they're kind of created differently. It's not the same if you just kind of had the roadmap from kind of what was filed for kind of the old-style brand-name drugs that are more chemically based, that you can do it that way. You have to do a lot more; you can't just kind of start and kind of be ready to go in six months.

There's also some issues about kind of getting away from kind of the padded incentives in that regard, to probably moving toward kind of an expanded period of data exclusivity. I don't know whether the campaign has spoken to this, but even in Europe they're better off in that regard and that kind of matters towards having that being delivered.

But at the end of the day, sorry to say, you know, profits and patents drive innovation. You want to take them away? You can have today's drugs at kind of lower prices, you just won't get as many of the ones tomorrow. Doesn't mean, you know – David has written about, kind of, gradually possible end to the blockbuster approach. And I think as we see personalized medicine, more targeted information about kind of what works, these drugs are more valuable for a smaller population but it's not the same type of all-or-nothing bonanza. Hopefully, we can reduce the cost to kind of get them through the system.

Now, end-of-life care – oh, just one small thing on the – how it'll actually work in re-importation. They have parallel imports in Europe, doesn't mean squat. There's a very small number that actually moved, doesn't change the prices because they have the very best means to

get around it, even without being able to kind of do the restriction in the supply shares. Without a Republican daddy putting a veto on this legislation, it's gone on to Congress. You'll get a lot less things moving through because people will suddenly be accountable for what they propose, as opposed to kind of getting a free ride in a vote. But everybody will feel good about it for a while.

Now, let's see, back to this, end-of-life. Actually, the campaign doesn't say anything about end-of-life and Senator McCain's mother is 96, so I think we don't have to worry about that. (Laughter.)

What I know about end-of-life care is hopefully not personal, but in general the older work – and I think it still holds up – is it's incredibly difficult to have that type of predictive certainty that says okay, book it, you know. We're kind of – it is what it is. Aside from the mixed emotions it's the family, often, that kind of has different views on kind of the person who's suffering through all the tubes. There's still lagging things within the medical culture where the doctors and nurses still think they've got to do everything, regardless of what kind of people want. It's a hard one to deal with and it's not really about dollars and cents; it's about the quality of life, comfort and kind of being sent to kind of what people would really like to have done. We can try to improve that a little bit, but there's mixed emotions that aren't going away.

The stats indicate that it used to be kind of pretty consistent that for – and these all came out of Medicare, you know, the factoids that kind of – it was, you know, 25 or 30 percent of spending was due to the last six months of life – they were pretty steady for awhile. The last set of numbers I saw were not really scrubbed at CMS, in a working paper, said that kind of it's actually been going up a little bit, about 3 percent or so. So we're showing a little bit more of that end – of total costs coming from end-of-life care.

Yet, at the same time, and David's done work in this regard, we're seeing the younger cohorts – even the young Medicare, even the next population of the Boomers – they seem to be kind of picking up more of these costs in the very old elderly. We stop torturing people once they're over 85. If they've gotten that far, we really can't throw the deck at them anymore. They're pretty hearty souls and we leave them alone. So although there are excesses of end-of-life care, probably the worst excesses of kind of the high-tech intensive medicine, we may be letting up a little bit among the folks who've been able to kind of get further along past the finish line.

MS. ROVNER: Well, I want to talk about those doctors and nurses for a minute because we haven't yet. The Institute of Medicine, among others, has recently pointed out that we're going to need a much different mix of healthcare professionals to meet the needs of our aging society, particularly more primary care practitioners and nurses. Yet, today's medical students all want to be radiologists or dermatologists, and the nursing workforce is aging along with the rest of the population.

At the same time, our good friends up at Dartmouth point to excess provider supply as one of the biggest drivers in higher healthcare costs across the country; basically in areas with more doctors, you get more care but not necessarily better outcomes. And we've all seen a lot of

those charts with all the dots. So we face a conundrum: Are there ways to make these investments without simply accelerating cost growth? Anybody got a solution?

MR. MILLER: I went to the same conference as you did. In fact, those folks were pretty persuasive in that regard, although everybody kind of wanting to sell us a lot on the medical college was out there, looking for kind of more subsidies.

The short-term answer is there's not much of a correlation between the aggregate supply of physicians and kind of the quality of care, kind of the – what the results are. And even if you try to train the physicians they kind of, you know, go to the magnet or they go back into the city. So as much as we keep saying we need these physicians out in the rural areas or in these specialties, the reason why health care is only – or medical care is only skin-deep is because it pays better to be a dermatologist, and people kind of will go where the incentives are.

If we want to change this – and we've tried this in the past – you can try to pay differently for it or pretend until the larger forces rearrange the code, and they end up kind of getting up to the top of the food chain anyway. So ideally, I suppose we want to talk about kind of more integrated teams of care where you make the most out of the resources you have, loosen up on the scope of practice, use the senior nurses and physicians more creatively; you want to import folks. But the dollars are going to make the short term moves; it takes a long time to turn around that base of what you train, and you're going to have folks retrained.

But if we at least incentivize care so that it produces the right outcomes at a lower cost, regardless of kind of what label you're carrying on you, hopefully, we'll kind of get redeployed in the right direction.

MS. ROVNER: Is there anything in the McCain plan to think about future healthcare workforce needs?

MR. MILLER: I'm sure that we think we need a better workforce in the future.

(Laughter.)

MR. MILLER: No, I'm being unfair, but you have to understand political campaigns. You're in favor of everything, except it doesn't necessarily add up.

Look, I went in front – personal – I went in front of the American College of Physicians; I nearly got barbecued. Those are angry doctors, trust me. They got a grudge. They want their loans forgiven, they want you to pay more and cover everybody, and make sure they get the cash.

MS. ROVNER: And they'd like not to have a 10-percent cut in pay starting July.

MR. MILLER: Absolutely, and you can't please everybody. What you have to think about is who's serving the patients. I mean, if you get into this kind of auction among which

provider group gets what, that's kind of a lot of what is the past history of the system and misdirection's kind of what we need to focus on.

MR. CUTLER: Actually, in Senator Obama's plan there is actually quite a fair amount of effort and resources associated with changing the mix of the workforce and really – and it's not just primary care providers, I should say, but it's also the kind of personnel that goes along with better primary care. Very frequently, that will not be a physician; it'll be a nurse practitioner or a physician's assistant or something like that. If you look at, you know, the thing that motivated – when I spoke of the emphasis on prevention, the thing that motivates that is the very successful examples we have of either big physician groups or big integrated managed-care companies that really do a very good job on prevention.

And one of the things that they do is they do a lot of coordination internally, and so that's what things like the IT and so on help. And another thing that they do is a lot of outreach, not particularly at the doctor level because you don't necessarily need the training of a doctor to do that kind of outreach, but at either a physician assistant or nurses-type level. And when you do that you can actually get very good outcomes. And so in thinking about the workforce, together with the prevention issue and doing that, and the IT issue, I think, brings you to a point where – and the payment issues brings you to a point where you start to see all those changes happening.

And again, it's something where I think you leave out any pieces of the puzzle; you're really trying to drive a car on two wheels or something, it just doesn't go very far.

MS. ROVNER: I skipped over Medicare but I want to come back now because I know that's important to this audience.

Where does Medicare fit into the whole idea – certainly both candidates are anxious to do fairly major health reforms. Is it possible to reform the health system without Medicare? I mean, I know Medicare's going to sort of take the lead under the McCain plan. Or is it, you know, too big a lift to try and fix Medicare and fix the health system at the same time? David, why don't you go first?

MR. CUTLER: Half of medical care is bought by the public sector, in one form or another, Medicare or Medicaid. So it's virtually impossible to think about big-scale changes in medical system without changes in public programs.

Probably the most interesting changes in health care in the past few years have been not in Washington, but in lots of localities where the providers and the insurers and the businesses would get together and say how do we think about fixing this. And so you see experimentation with payment system changes in places like California; you saw generics in places like Michigan, provider recommendations, guidelines, in Minnesota; measurement issues in Wisconsin; illuminating infections in hospitals in Pittsburgh. All of that – you see all of that going on. And if you talk to all of those folks, what they say is we did it on our own. We did it without the government. Gosh, our life would have been a whole lot easier if we could have had the government be on our side rather than working against us.

And to me, that's a kind of sign of why it is we're in this bad place, is because to get anything interesting done you've had to do it in the absence of the government being helpful, not with the help of it. So I think it's going to be Medicare, but it's more than just Medicare; it's the whole federal government and state and local governments.

MR. MILLER: I've talked before about kind of in effect you're going to have to drive a lot of these things through Medicare to have leverage. But at the same time, there have been efforts to try to do these things in Medicare. It's difficult. You know, how many of you kind of read the studies on – what is it about a dozen demos? And kind of like, well, sorry; didn't kind of work out; not provable, although you learn little things along the way. As much as we can kind of experiment with Medicare demos, ultimately, you're going to kind of – you don't want to close your eyes and just go forward; but you're going to have to take that kind of partial evidence and wisdom and begin to kind of make some decisions as to kind of what you're going to try to do.

It's a difficult type of structure and program, which, as long as it will not distinguish among who is providing care and kind of how you incentivize them differently and recognize that different people are different, it's hard to get that type of more granular flexible approach to health reform than you can get kind of in the private sector.

Outside of the campaign, it'd be nice to kind of figure out a way to kind of have the competition from private plans on what, in the long-term basis, is more sustainable, level playing field basis. It doesn't mean taking fee-for-service costs as the baseline, because that's not the right price either. We're not on the table on that.

Let's see, McCain is kind of income-related, Part D premiums. That will save you a billion or two, won't it?

MS. ROVNER: It's a start.

MR. MILLER: I think that, you know, to be fair, neither campaign is willing to kind of step up to what we are suddenly going to turn around 180 degrees on in 2009 and say, oh sorry; we didn't mention that kind of Medicare was a big part of this while we were talking about the private sector and healthcare coverage. Oops, well, we'll get to it now, because, first, more of the population is moving into that program.

Even the health insurers can't sell enough of their over-priced product without kind of getting into Medicare. That's where the action is going to be, not just as a budget issue – although that will drive some forces – but fundamentally is how the care delivery system operates. We're going to have to pay a lot more attention to Medicare than we haven't been willing to address publicly. And that's going to set us behind politically because the ground has not been laid for that. But that's presidential campaigns.

MS. ROVNER: No matter where I go, anytime I take questions about health care, somebody – not necessarily a doctor – brings up the issue of malpractice. I guess they've been listening to their doctors – malpractice premiums, capping damages. In your estimations as

experts – not necessarily candidate advisors – would capping non-economic damages actually have an impact on health costs overall, either through the lowering of premiums or the lessening of defensive medicine? And if not, are there other changes to the medical malpractice system that might? Or is this simply a diversion from the real cost problems in the healthcare system?

MR. MILLER: You're right – (laughter) – on every front. Damage caps do work, if that's what you're trying to do to kind of bring down costs. There's enough evidence on that – the non-economic damages. There are a little bit of fairness concerns with some kind of unique individuals you have to do some overrides for. But the evidence is, it'll work. It's a crude approach to a very crude system, which doesn't work for many other reasons as well. It's hard to defend the current tort system, civil liability system for medical malpractice in health care.

It doesn't mean that it's kind of the largest factor behind kind of all these cost increases. I mean, CBO has been skeptical on it. You can extrapolate the old Mark McCohen (sp) evidence only so far before you run out of kind of evidence. But it's a nice effort.

Doctors, though, believe it's very important. Psychologically, you've got to deal with that because if people believe something's true, it makes a difference in sometimes how they act regardless of the underlying evidence. Damage caps are the shortcut. There are more creative thoughts that I don't think are going to get through. You know, there is the elitist approach – medical courts. You're not going to get around kind of juries. But that's kind of an evidence-based scientific approach. Early offers, the alternative dispute resolution – there's a whole medley out there in kind of the med mal debate – kind of comes around in cycles. It's not like the cicadas; it's more often than 18 years. But you can kind of ride the insurance cycle to kind of figure out how it's going to come back.

Now, I would be guilty of malpractice of my own sort as a policy practitioner if I didn't address some things around the table before – you like that transition? David said that cost-sharing means you don't get preventive care. Now, that's the Pitney Bowes argument to kind of get drugs for free. But if you look at kind of what's been going on in the consumer-driven health plans – go back to the McKinsey study in terms of how consumers use information more aggressively – if you look at the evidence on preventive care used by people with HSAs, in fact, they're using more preventive care because they've got more at stake. They have some resources to get the front-end stuff. So it does not kind of dampen preventive care by having a smarter version of cost sharing with some resources behind it.

In the same way, if you want to get out in the extreme, when you run short of resources, go to donut-hole coverage. We did it for the drug Part D by mistake. But if you think about kind of cover the front end, preventive care, early intervention stuff, cover the catastrophic stuff. You ran out of money? Work it out on your own in the middle. That might be kind of what we're defaulting to in a resource-constrained environment for people who can't have comprehensive affordable coverage.

On performance valuation, as much as, you know, we can learn something from comparative effectiveness, which is kind of the abstraction as to kind of what's the best treatment; what's the product you want to cover or not cover, it's really the comparative

efficiency of what they do in practice. You can know abstractly what might be a better treatment. It's never 100 percent in each case. But you need to know what kind of, out in the field, is it's translated – different organizations of care or individuals practitioners, what they're doing? So it's what they do, not just kind of what they know in theory. And we kind of miss the boat and we kind of focus too much on the comparative effectiveness without understanding the efficiency of kind of what outcomes are they producing at the cost and kind of going about for it.

Just in kind of some of the limits of kind of what – (inaudible) – cost drivers. I should have mentioned what I would refer to as the bounded rationality of policymakers and the time inconsistency. You know, there are a lot of things that kind of make sense in the long run. But we always kind of view things in a two to four-year span. We criticize consumers for being shortsighted. But it's fundamentally policy-makers who are more guilty of that in the long run.

MS. ROVNER: Malpractice first and then anything you want to respond to.

MR. CUTLER: Let me start with the malpractice. No one that I know of, other than lawyers, likes to be in court. So I start off with the presumption that in a much better medical care system, malpractice would be – I'm not sure the analogy is right – (safely going rare ?). So that's the place to start off. Now, what we know is that the right way to get people out of court and get doctors out of court is by having fewer mistakes and fewer things that go wrong. And so, the single-biggest thing we can do is not fool around afterwards once the thing has become adversarial and there's been a bad outcome but to try and intervene beforehand so we get the right data that we need; we get the right preventive things in place; we get the right environment set up so that when you admit mistakes, you don't face a penalty for them so that we're always trying to learn and not trying to literally bury the mistakes – all those things in place.

That, to me, is what – speaking as an academic, is what sensible malpractice is about. The caps on damages, my reading of the evidence was based on the CBO document – that I think Doug Holtz-Eakin was the director at the CBO at the time – is that that by itself saves you about 2 percent of money in medical care. And you know, 2 percent is not small; but that's not where the issue is. The issue is the amount of stuff getting there in the first place, in part because something went wrong in doing something about that before it ever gets to that point.

And so that's where I think we really have to think creatively and stuff, rather than just saying, gee, do we want to restrict access to some. And it's clear, even Tom said, you know, look, there's some people you don't want restrict access to court system for. And so, rather than making –

MS. ROVNER: For those of you who aren't aware – just for a second – Doug is now advising the McCain campaign.

MR. CUTLER: So sort of rather than engaging in that kind of old worn fight, we ought to get into what are the real issues on this?

MR. MILLER: And for the campaign proposal, I think one of the elements is to basically have safe harbors, based upon kind of if you follow the practice guidelines, what is the best evidence you in effect have? Get out of jail card, in terms of med malpractice.

MR. ROTHER: I kind of feel like I'm the voice of every man here. We've been talking about system costs and costs to doctors. What about costs to patients? Do either of your campaigns propose limits and total out-of-pocket costs for patients?

MR. CUTLER: Our estimate is that Senator Obama's plan would save the typical American family about \$2500 a year. And that comes in a variety of different ways. Some of that comes from reduced out-of-pocket expenses associated with better coverage and doing fewer things. Some of that comes from lower premiums that employers face, which all the evidence is that that translates into higher wages for people who work in those firms. And some of it would come through savings in public-sector programs that could either be used to delay future tax changes or allow spending in other areas that people want.

So we are convinced that with the right set of investments, we will save people money. In many cases, it'll be even more than that, particularly for families that are, say, in the individual market where they may be able to afford a \$5,000 deductible and they're paying \$5,000 for a health insurance premium. And so, you can really do a lot. People who are pooled with other very expensive people and wind up paying a lot.

MR. MILLER: I've read the creative cost memo that David did with David Blumenthal and I guess Jeff Liebman. You got to do what you got to do in a presidential campaign. Let's talk about kind of what those elements are. The reinsurance reformulated package, somewhat similar to the Kerry proposal 2004 – shifting costs to another payer doesn't reduce them. I mean, there's a tiny case to be made for slightly dampening volatility.

But the attachment points for this proposal are very low, unlike real private reinsurance. No one ever pays for the reinsurance, which tells you kind of it's just kind of a passthrough subsidy. As opposed to the employers paying for it in one pocket, they'll pay for it in another pocket as taxpayers. It hasn't reduced costs. It just kind of moves them around.

Health information technology savings, maybe if you get out there 10 or 15 years and assume all the assumptions, you'll get there. But you're not going to kind of find those to pay for all the stuff that's kind of being paid for up front in this regard.

Administrative costs – let's go back to that because it was mentioned before. The real numbers on administrative – just in the private sector – that 40-percent figure is way high. I mean, in most cases, you're getting 30 percent in the individual market across the board. You get down in almost the low 20s in the small-group market. The self-insured folks are obviously in the low teens or lower.

Then, let's compare it to the private sector, low administrative costs. Let's kind of count all those costs, not just kind of the official ones that show up in the budget at the 2 percent. You look at other federal costs; that kind of will balloon it a bit more. You look at the costs that are

thrown onto the private sector that aren't encountered in the public budgets, you get higher. There's a decent piece of work. I don't know if Jack Rogers is here, but PricewaterHouse for AHIP – for AHIP, it was a good composition of administrative costs, suggests kind of it's a different picture.

If you then kind of think about economics, in terms of kind of deadweight loss, opportunity cost, what happens when you spend money publicly and you have to finance it through the tax system? You've got another load of costs. You're going to about break even by the time you're done. So you don't actually save any money by rearranging. You know, pooling that is simply averaging risks as opposed to reducing them doesn't change costs; it just moves them around in terms of a different basket. So I don't think we save much money in that regard.

Where the McCain campaign tries to save money for individuals is first letting them have their hands on the dollars as opposed to someone telling them what's going on. That's why the tax credits go directly to the individual and their families. They're much more generous to low-income people than the way the current system does. You want some income-related subsidies? Take a look at those tax credits – 5,000 (dollars) per family; 2,500 (dollars) per individual.

In addition, protections for people who have the preexisting conditions and the high costs through what are being called the guaranteed assistance plans. Serious federal subsidies to kind of provide real coverage for people, unlike the high-risk rules that we've currently criticized – a real commitment of dollars behind that and disease management in that as well to kind of deal with those who have those conditions.

Finally, to get more affordable care, you have to kind of send signals that says we're going to reward more affordable care. If you start out with a baseline that says the only way you can get your nose under the tent is to pay 12, \$13,000 for a family policy, nobody is going to be able to afford that. We have to think about kind of how to deliver better, more valuable care at a lower price, send signals in that direction than simply throwing more dollars on the table and thinking somehow it will trickle down in terms of kind of better health care for people at the bottom.

MR. ROTHER: You know, I'm going to follow up though because it still feels to me like a typical family out there facing the serious illness should know what it is you expect them to pay. How much of those very expensive bills should families be liable for out of pocket or through premiums? Do we have a standard from either of your candidates?

MS. ROVNER: Is there a cap? I mean, I just came back from Switzerland where even in the base package, there is an out-of-pocket cap for everybody.

MR. CUTLER: What we have spoken about is a guaranteed level of benefits that is roughly equivalent to, say, a Medicare plan but dealing with people and dealing with prevention and so on, or something that is equivalent to, say, what a federal employee has, although most people in America don't understand that, so that's not – turns out not to be a good thing – (laughter) – not to be a very helpful way to explain that. But that there would be some minimum

that guarantees people that they're not in a situation where they're paying tens of thousands of dollars a year.

MR. MILLER: I don't think the campaign has bit on the idea of a stop-loss. I'm comfortable with it. But I'd need to have to do it kind of more on a major risk basis. There's all the proposals, which talk about that, whether you want to say it's 10 percent on the low side, 15 percent of adjusted gross income on the high side. And you scale it so it's income-related. That's a sensible theoretical approach, a little more administratively difficult to pull off when you've got kind of private-sector plans who actually kind of count up the income.

But that's a thoughtful product because that's kind of, in effect, if you think about how we were trying to structure the high-risk pools gap plans, it says, look, you're going to have to pay more when you cost more and it's worth more to you. That's generally the case. But we don't want to pound you into the ground. I mean, there's no blood out of a stone. It's not been signed off on yet so I have to be careful in this regard.

My recommendation has been – and this is kind of what the industry is comfortable with – it is basically twice standard rate. Nobody pays a premium above that. So that's kind of a ceiling. Then, you have income-adjusted subsidies within that, so you then recognize that that's too much for people who kind of are lower income. That's a reasonable way to target the population that needs that assistance while not going through the nonsense we've gone on through for the last 10, 15 years of guaranteed issued community rating, which just makes the circle around kind of and go nowhere – marginally reduce coverage for the lower-risk healthier folks and help a few people along the way. But you basically don't expand coverage by doing that approach.

MS. ROVNER: We're going to turn it over to the audience now, let you guys ask some questions. You can beat up on them for a while. There are microphones in the back. So when you ask your question, would you please identify yourself and your organization? Here in front.

Q: Yes, hi, Stephen Langel with CongresNow. I just was wondering if you could elaborate for a moment on Medicare and give sort of the campaign's view on how to deal with the doctor reimbursement issue, especially with what happened yesterday on the Hill.

MR. MILLER: I don't have any talking points on that other than my own. You know, in the larger context, clearly, the annual hide the football, take it back approach kind of like we're going to kind of squeeze down the payment rates, piecemeal rates hypothetically and then make up some of the losses on volume is what the better doctors do. It's not a full offset but it brings it back in that regard. That's a flaw of the current system and we tried to kind of force something partially, which doesn't work.

To escape that, you have to kind of think about paying physicians ultimately on a value basis, not kind of on an isolated fee basis. But politicians use the tools they have. I mean, if you look ahead in the next year or two, unless we kind of suddenly transform ourselves as a political society, we'll go right back to the usual places to save money. Squeeze down on reimbursement rates in one form or another – maybe it will be the hospitals next time – and think we've saved

money. We haven't. But that's kind of the source of first resort because it doesn't look as transparent to the patients.

So hopefully, the reform is to kind of rethink – but it's heavy lifting – the reimbursement system for physicians so it's actually rewarding them for what they do without a bias as to kind of the individual fees. And I think the campaign is open to that, but they haven't kind of made any formal statements in terms of kind of a detailed plan.

MR. CUTLER: Let me agree with a lot of what Tom said, which is the folly of what we're doing now you can see every six months or every year with the physician update. It just shows you how bankrupt is the current approach. Let me just – there have been a couple of issues about things that would work or wouldn't work or whatever. What do we know about the evidence? Let me just tell you where Senator Obama is on that and where – (inaudible) – where I've advised him and where I think we ought to be.

There are about five or six strategies that we've mentioned for possibly saving money ranging from health IT – Tom doesn't think it will work; other people think it's a big deal –

MR. MILLER: Or slower, smaller.

MR. CUTLER: Prevention, some people don't think it will work; other people think it's a big deal. Payment-based changes – Tom rests a lot in that; other people don't rest so much. Whatever it is, five or six things – what the Obama plan says is let's do all of them as much as we can, as fast as we can, because we've got to deal with this. And now is the time to deal with this. And you don't have to have some religious conviction that one point of view is right or another point of view is wrong. You just have to have the sense that we need to do something and that we have to try everything, because the alternative is even worse than that.

And so you can't stand up and say, well, okay, this one is obviously going to save you a ton of money and this one is not. Every single thing that is in the Obama plan, there is someone who believes with a fervor equivalent to religion that it is the best thing. And there are other people who believe with a fervor equivalent to I don't know what that it will harm, that it won't do very much and it will just cost you a little bit of money. But somehow, if we don't try all of those and we fail, then it's a big shame on all of us.

And so that's – more than talking about any of the specifics, that's really the approach that underlies this. You better try everything. Maybe it all works. If it doesn't, then you've really got to think about what's next after that. And that's much better than just picking one or two and saying this is where I'm going to put all my eggs.

MR. MILLER: We're into everyday experiments and incremental massive reform all at the same time. But you don't place massive bets on a one-sided direction thinking they're actually going to materialize. You keep assessing kind of what the evidence is, whether it's paying off. And if it doesn't pay off along the way, you don't just kind of remain committed to it indefinitely with kind of some quasi-belief it must have been there because it was in the original plan.

The other part of kind of when we talk about kind of costs and value, we're going to spend more on health care, regardless of what we do, but we don't have to spend as much as we do. The difference is kind of we want to kind of have things that actually pay off and kind of improve the lot of kind of the people we're paying for this. And there are limits as to kind of how much they'll pay.

The Obama approach is to say we're going to make all these savings. And what they don't tell you is then they're going to take all those savings and plow it right back into healthcare ink, because the sky is the limit.

I'll use an anecdote from my time as a basketball broadcaster. There used to be an NBA basketball player. He had a little trouble with drugs – Michael Ray Richardson in the 1980s played for the New York Knicks. And they were in the middle of a terrible losing streak. And the sportswriters come into the locker room and they say, what's going on, Michael Ray? And he goes, the ship be sinking. And they'd say, well, what's ahead? The sky's the limit.

That's how folks who kind of believe in public program expansions treat this. We can't afford what we currently have. It's terrible. It's going to fall down on us. And we're just going to expand it some more. It is cognitive dissonance to think of kind of having more of kind of what has not worked is a way to proceed in the future. We need different approaches than kind of what we've tried before.

MS. ROVNER: Another question. Over here?

Q: Bob Rosenblatt, freelance writer. I'd like to ask both of you to expand a little bit more on paying for outcomes. There's a lot of talk in the campaigns and among every meeting in Washington about pay-for-performance and outcomes. If you interview doctors who work in either poor communities or minority communities, they're very fearful of this.

And what they will tell you is that they're dealing with populations with higher than average rates of high blood pressure, diabetes, heart disease, et cetera, and that if you go with a strict measure of pay-for-performance and outcome, they will always look much worse than doctors who serve healthy middle-class communities. And they feel they'll really get screwed by this – what seems to be universally popular idea. Have your campaigns been thinking about this aspect of pay-for-performance?

MR. MILLER: Sure. I mean, what you're – first off, to be fair, people who think seriously, pay-for-performance is pay-for-value, because pay-for-performance kind of gets a bad name. It sounds like you're kind of only going to kind of get a cookie if you kind of are at the top of the scale. You know, we're only going to reward the very best who may be the best yesterday and the best tomorrow.

You want to pay for relative improvement because everybody needs to get better as opposed to just thinking we're only kind of going to reward the excellence. People who are thoughtful about this understand that aside from kind of having a deeper aggregated database and

doing this properly with kind of better common consensus measures, you do have to be sensitive to risk adjustment as best it can be practiced and understand that everybody is not the same.

On the other hand, almost every doctor I talk to has uniquely ill patients who kind of you know are different from everybody else. And they do wonderful jobs. There's mixed opinions within the physician community. Some physicians are very supportive of kind of saying if I do a better job, I want to be rewarded for it. Show me though how to do it, because these measures and kind of the incentives have to be clinically meaningful. They have to be integrated into kind of how physicians and other caregivers go about making their decisions. If we just have an abstract set of, you know, whether they're process measures or other consensus things – which whether or not you did it, it doesn't go about kind of actually producing the total product – we're missing the boat.

So there's some legitimate criticism in terms of kind of the multitude of things we have up now, which don't mean anything in the final analysis. But if you can get folks not to just sit at the table but agree on something, you can move ahead in this regard. And there are mixed incentives as to kind of whether folks are going to –

MS. ROVNER: And there's already evidence in some places where they've had report cards of surgeons not taking high-risk patients for fear of lowering their scores.

MR. CUTLER: Two words that Tom mentioned are very important to keep in mind and those are risk adjustment. And so operationally, what you do if you put something in place – and I don't – and I think Tom and I are going to agree on this – is you'd say something like let's say what you're paid for – let's say you count points for controlling blood pressure, where you get maybe one point for a high-income person, two points for a middle-income person, and four points for a low-income person so that effectively, what you've done is you've said anything you can do in the lower-income population counts for much more of whatever performance bonus you're going to get than anything in the high-income population.

And I think some of what Julie was saying about the – some of the things about not taking the sickest patients is that there's a perception that we haven't done enough of the risk adjustment at the high end. And, you know, there's technical debate about whether it is or isn't, but in fact there's a sense that you're getting penalized for taking those folks. And there are ways that you can design a system that doesn't have that feature.

Q: I'm Mary Agnes Carrey (sp), Congressional Quarterly.

MR. MILLER: Can you speak a little louder, please?

Q: Yeah. I'm Mary Agnes Carrey with Congressional Quarterly.

David Cutler just mentioned some things about – you know, we've got to try a lot of these things to deal with the current healthcare system, whether it's prevention or health IT. A lot of these things are very expensive and Julie just mentioned the problem Congress has in trying to find financing for physician pay-fix.

How would you finance these proposals you're talking about? Where would you find money for them currently, or how would you do that?

MR. CUTLER: Possibly the biggest – one of the biggest differences between the candidates is are they willing to, in the short term, put more money into medical care or not. And in Senator Obama's plan he is, and the money for that will come from the money that is in the Bush administration, high-income tax cuts so that tax cuts on people earning over \$250,000 a year that were enacted in 2001 and 2003. And there's a financing that we put out showing how between that and things like Medicare advantage savings and other kinds of things, you can pay for both tax credits for people to purchase insurance as well as the kinds of investments we proposed making. And it was very explicit that he is willing to put more money into that.

I think, if I – in Senator McCain's proposal he wants to take the money that's in the employer tax exclusion and use that, but that's –

MR. MILLER: The tax credits, yeah.

MR. CUTLER: For the tax credits but without a source of new money, then you can't cover a lot more people and you can't undertake these investments. And so there's a fundamental, broad issue about both proposals, which is are you willing to, at least in the short term, develop more resources to the medical system. In Senator Obama's case, the answer is absolutely yes.

MR. MILLER: Let's remember where we started. We had a healthcare system that cost too much, delivered poor value, so what's the solution? Put some more money into it, that'll work. We do not spend the expiring tax cuts several times over, again and again, that are already in the baseline and we're not even in favor of having it expire. It's kind of a multiplier effect; the Federal Reserve should try that, in terms of kind of – you know, we get the same money kind of leveraged into kind of multiple sources of revenue.

The only way to really pay for this is to – you know, if we actually believe that – whether you want to say 20 percent or 30 percent of what we're spending in health care is not kind of producing the results we want. We've got to have an evidence-based approach to reform which squeezes that out and then pays for the things that are worthwhile, not a faith-based approach which says by kind of putting more money on the table, all these kind of reforms will pay for themselves. We need evidence that they actually do pay off. So it means being more careful in assessing what you actually sign off on, as opposed to kind of hoping it'll all materialize in 10 or 20 years, actually seeing that an effect begins to kind of take a dent in what is the poor value, high cost in the current system. So that's the guidepost for kind of all of these reforms. If they don't actually deliver, there's something wrong with kind of advancing them as kind of the way to go.

MR. CUTLER: Actually, can I just interject one thing?

MS. ROVNER: Yes.

MR. CUTLER: On the issue of using the money from the tax cuts many times over, the Tax Policy Center at Brookings and the Urban Institute just released a report yesterday that's a comparison of the tax proposals of the two different candidates. And actually, what they show is that the Obama economic and tax plan, as a whole, adds up in exactly the way that he said and that the money is there to pay for the health insurance tax credit. So you don't have to take my word for it.

MS. ROVNER: Another question over here?

Q: Hi, Dan Trapp, American Medical News. I'm going to ask an old question in a new way, I think.

There's a lot of debate in political campaigns about covering the uninsured and how many are going to cover, what's it going to cost. Flip that around: Is there a certain number of people in America that are never going to be insured, that are just beyond reach of the system and are going to do their own thing, you think?

MR. MILLER: You want realistic talk, you know, okay, I got that one. Sure, but we can make a good dent in it.

Now, there are projections on the effect of the tax credits in the early years which have pretty substantial take-up; more than, I think, what you'll get is a joint committee on tax scoring or CBO scoring, but they're realistic. I don't want to tell you what the score looks like for the cost of an Obama or Clinton plan, but you hear often big, big numbers if the plan actually was unfolded the way it's promised.

At the same time, we know from kind of looking at the uninsured that there's different pockets of that population. Some folks are kind of, you know, subterranean, whether they're kind of undocumented immigrants who are not going to kind of show up in the system and no political campaign is going to embrace providing coverage to them. There are other individuals who are simply not going to kind of find it worth their while to purchase the insurance. And there are some folks who kind of aren't going to kind of get all the way up the ladder. What we're trying to do by redirecting the tax subsidy so that it kind of is first focused on kind of giving that floor of foundational support with real dollars kind of on everyone. If you don't pick up the coverage, you're basically paying a penalty.

I mean, that's a self-enforcing mandate without kind of directing from above. You want to leave \$5,000 on the table? That's a pretty serious hit. Why don't you kind of find some coverage that at least kind of gets you that much. Is it everything? No, but it's a start. So I think we could certainly make a substantial dent in the number of uninsured, but until we fundamentally have a healthcare system which delivers those package of services at a more affordable price, no matter how we chase after it with new subsidies and more tax revenue, we're never going to get everybody covered. We pretend we will, but we'll always be kind of chasing after it because the price tag keeps going higher than kind of the subsidy.

MR. CUTLER: Goes back, a little bit, to the previous question, which is your willingness to think about investing in health care as opposed to other things. With the willingness to invest more in health care than in the high-income tax cuts, we estimate that 98 to 99 percent of Americans would have coverage under the Obama health plan, and the rest you could maybe pick up down the road. And I think that's important both for coverage reasons and as we were talking about earlier, a lot of the ways that you save money are going to be hampered by not having everybody in the system in some relatively continuous ways.

The tax credits are, I think, very difficult. What the studies tend to show – the kind of Senator McCain's proposal – what the studies tend to show is that you get a lot of people losing employer-based coverage, typically in the millions to tens of millions. Which way those wash out is a little bit hard to know, and particularly you're not putting in a lot of new money. It's hard to guarantee that you'll get a lot more extra coverage. So I think there will be, by most independent scorings, a very big difference in how many people get covered by the different proposals. That's going to be very reflective of the different priorities that the two candidates put on covering people and the other investments.

MR. MILLER: If you write your code differently than John Gruber does with not static assumptions but dynamic assumptions, you get a lot more pick-up.

MS. ROVNER: I think we have time for maybe one or two more questions. Anybody on this side of the room have a question? You've been very quiet up there. No? Okay, down here.

Q: Hello. Winifred Quinn, with the Center to Champion Nursing in America, which is a center that is both funded and supported by AARP, the AARP Foundation, and the Robert Wood-Johnson Foundation, and is located within AARP Public Policy Institute.

Well, I want to thank both of you for mentioning the role that nurses play in the affordability and the quality of health care. And I would like to ask you if you could expand a little, if you can, on the role that education plays for nurses because the cyclical and sometimes chronic problem of the shortage of nurses actually has to do with the lack of nursing faculty. So we would like to hear what you have to say about supporting more nursing faculty.

MR. MILLER: I don't have a campaign plank, in terms of how many dollars you're getting, but I know we are in support of improved nursing education – (laughter) – how about that? And look, what you're –

MS. ROVNER: You forgot to carry the sign around.

MR. MILLER: I'm sorry, that's right. No, no, no, I'm better off saying that. (Laughter.)

What McCain says – he says we need to be more creative about using our entire healthcare labor force. We don't have enough people, and enough trained people, to do everything we can imagine so you have to kind of break down a lot of the restrictions and boundaries, whether they're geographic, the licensing, to think about kind of how do we get the

most out of all of our assets. And certainly, nurses more creatively used are an important factor in that regard.

I don't think the campaign is top-heavy in terms of kind of saying like, let's rethink kind of, you know, a greater investment in medical education, nursing education, per se. There's a mixed history in terms of kind of how those programs have worked out in the past, so I don't want to kind of just, you know, throw the dollars back into it. But at the end of the day, if you think you have a payment system – which, going back to kind of fundamentals, rewards those who deliver that increment of value more than someone else and you actually get paid for it, then with all that nurses have to offer – and it's not just payment. It's working conditions that kind of are as much of a factor in kind of recruitment and retention on that front. So I think we're sensitive to that.

I don't know kind of all the federal tools that can change that around; some of that just kind of smarter – people where they're placed. But that's as big a factor in kind of folks not burning down and kind of coming back in. We're actually having a little, I think, of an upsurge in folks returning to nursing, but that's somewhat economically driven in the current moment.

Now, while we're talking about education, let me not neglect what I should have said at the start which – here we are, talking once again about all these kind of drivers of health and all the kind of important things and all the dollars we need to spend, and even David co-authored an article, pointed out the kind of – if you look at kind of the gains in life expectancy, where are they coming from, folks with more education. That doesn't mean everybody needs to kind of have a Harvard graduate degree, no. But if you look at kind of what's going on – (laughter) – that's – you've got a big enough endowment, go cover the uninsured.

MS. ROVNER: Yeah, but he's still the dean.

MR. MILLER: But if you look at the real high-school dropout rates, you look at kind of the folks kind of who are falling behind, it's because we're not doing the job in early education at the elementary level, even before they get into school. We may have lost kind of part of a generation, but all this shows up later in terms of how people use the healthcare system, the decisions they make. That's why you get this discrepancy. So we need, in essence, education reform as a payoff for better health almost as much as we need health reform. And that always gets neglected in these healthcare audiences, but if you look at – education is a proxy for kind of your time horizons, how you make your decisions. This is the stuff that actually matters on a long-term basis. But we always blow that aside and say what's your budget and who got covered.

MR. CUTLER: I actually strongly agree on those last points.

Let me come back to just one other issue of the workforce, for a second. I've asked a number of practitioner audiences the following question, which I'll ask this audience. What share of the time that a typical nurse or primary care physician, or physician's assistant involved in primary care – what share of their time is spent doing administrative things as opposed to tending to patient matters? Okay, so think of the answer. What do you say? Twenty percent, 30

percent? Let me just take a very conservative number that I get when I do that, maybe 20 percent, okay.

Now, it's clearly got to be possible if you automate things, if you have everybody insured so you're not worried about how to get coverage and so on, if you don't have a gazillion different things and high deductibles here and there – it's clearly got to be possible to reduce that in half, to 10 percent. Effectively, what that policy does is it's a 10 percent increase in the primary care labor force and that's just – that's without having an additional person, you just get 10 percent more time; people working the same number of hours, 10 percent more time providing primary care.

MS. ROVNER: I think the real answer, in a lot of cases, is like 40 percent.

MR. CUTLER: In which case, then, let me increase the supply by about 30 percent or so.

So I think one way to think about a lot of these changes is not just as saving money, but as increasing the amount that – for what we spend, we can devote to seeing people who need help and doing it the right way. And couple that with what one does on the external margin, that is the number of people who go into these and the training and all of that. But the potential is absolutely enormous.

MS. ROVNER: I think we're going to sum it up here. I've been asked to sort of summarize where we are, which I think is actually fairly simple, which is that our experts seem to agree that better health promotion, prevention, and health IT are good, whether or not they save money and we're going to leave that open for another day; that Medicare needs to be part of whatever cost-containment strategies are pursued; that cost-sharing we don't seem to agree on; and that nobody really still knows how to slay the cost-driver demons. Is that basically where we are?

MR. MILLER: No, if you don't pay for it, you won't get it.

MS. ROVNER: (Chuckles.) Okay. But essentially, have I –

MR. MILLER: Well, there are some downsides to taking that approach.

MS. ROVNER: Have I misquoted anyone desperately here? (Chuckles.) I think we've got it.

I would like to thank our experts for their entertaining approach to a fairly dry subject.

(Applause.)

I'd like to do this again. Thank you all.

(END)