



# The NEW ENGLAND JOURNAL of MEDICINE

## **Perspective Roundtable: Health Care in the Next Administration.**

### Introduction

**DR. ARNOLD EPSTEIN:** What I wanted to do is set the tone for this, say a little bit about the context and try and get us all on the same page to start. I'm going to start probably where many of you might expect, with that triad of issues that's so important in defining the challenges in health policy: access to care, quality of care, and cost of care.

I'm going to start with access because in some ways, that's where it starts, getting people in the system. Access can be really multifactorial and mean many things. But in our country, it has a special association with insurance status. In part because of the developed countries, we really lag way at the rear. We've got 45 million Americans who are uninsured, eight million children who are uninsured. And I can tell you that that's not cosmetic characterization.

If you are uninsured, you are less likely to go see the doctor. When you see the doctor, the doctor is less likely to be your regular doctor. You are likely to get less preventive care. You are likely to get less routine care. And I think, maybe most startling of all, if you are sick and you see the doctor, whether it is in his or her office or in the hospital or in the intensive care unit, you still get less. You still get less. And that shows up in increased morbidity and higher mortality. And it's going in the wrong direction. Since the turn of the decade, we've got roughly a million persons more each year who are uninsured.

But insurance status is not the be all and the end all, and there are many issues in the health care system. And for those of you are comforted because you've got insurance, it's not all clear you will get all the things that are indicated for you. We've become increasingly knowledgeable in recent years that quality of care in America, which we assume is the best in the world, has got real problems with it.

The landmark study, I'm proud to say, published in the *New England Journal*, was Beth McGlynn's work with her colleagues at Rand. And their number was 55%. Some 6000 patients, and they found 55% of the time patients got what was indicated for their high-quality care.

Well, I can tell you, it is not just a number like that. I've studied this literature closely and you can choose the condition — hypertension or congestive heart failure or asthma, chronic destructive pulmonary disease, colorectal cancer, whatever it is, breast cancer — the chances are 30, 40, 50% of the time you won't get the high-quality services, even if you are in the care system. And it's not just underuse. As Barry said, we've had professors here, Lucian Leape and Troy Brennan

early on, who exposed us to the knowledge that the way care is delivered also can have deleterious consequences. And patient safety we now know is a major problem. And it's not clearly getting better.

The third part of this, and this is going to seem almost like Woody Allen. You know, I've already told you that access is bad and quality is bad. Now I'm going to tell you the portions are small. Well, costs are really just raining out of control. We not only have a lot of care that isn't doing us well, but it's costing us a huge amount of money. In the last 4 years, premiums have gone up roughly 35%, 8.5% annually. The CPI at the same time has gone up 3%. An individual insurance policy costs \$4,400. A family policy costs more than \$12,000.

Let me put that in context. If you were the leader of the median American household, you'd be looking at a pre-tax income of just over \$50,000. Imagine what it's like to have a pre-tax income of \$50,000 and you potentially have to give — this might be you, especially if you are self-employed, have to give more than \$12,000 of that away up front to cover health insurance, not to mention coinsurance, not to mention deductibles, not to mention the things that aren't covered. And, again, there are no signs that this is changing.

How do we move ahead? I think we come to convergence in part by pursuing honest, straightforward, forthright dialogue, like we are about to have this afternoon. What's going to happen come the new year? I don't know for sure. But I can tell you one thing. I can tell you that what the president does, what he puts on the table, and the strength and resolve that he brings to moving it forward, is going to have a huge effect on what Congress may or may not pass.

#### Obama Plan — Goals

**DR. DAVID CUTLER:** I want to follow up on Arnie's comments and start off by laying the foundations of what Senator Obama said he wants to do in health care. And there are three things and they match up extremely well with the things that Arnie told you were the fundamental problems of health care. The first point is that all Americans should have access to quality, affordable health care. The statistics that Arnie told you about the uninsured are real. The estimates are that about 20,000 Americans die every year because they don't have health insurance. It's a moral issue. It is also an economic issue. Whatever your view is about social and technical change in the economy, you've got to have everyone having health insurance or else our ability to undertake anything else that we want to do socially or economically is going to be diminished. So everyone has to have access to quality, affordable health care. That is tenet number one.

Tenet number two is we need to modernize the health care system so that it improves health, it lowers spending, and makes medical practice more rewarding. We cannot continue to have a system that costs 40% more than other countries do, that wastes somewhere between 40 and 50% of all medical dollars on services that are not improving patients' health, that in many cases harms people, and that turns off doctors left and right, gets them not to go into primary care, makes them be embittered about the profession, tell their children they do not want to become doctors, and runs itself over and over again.

We need a modern health care system that is in synch with where we are, which is to do what it does well, to do it at the lowest cost that it can, and to get the services to people when they really need it. So that is the second tenet.

The third tenet is that we need a public health system that works with the medical care system to prevent disease and improve population health. We have major issues ranging from continued need to promote continued reductions in smoking to an obesity epidemic to questions about food and water safety and imported goods and global catastrophes. We need a public health system that is up to the challenge of doing that, that is not separate and that is not turned into a politicized public health system.

Those are the three fundamental parts of what Senator Obama believes. And the way that he judges health care reform is by how they reach these three goals. The way that he deals with political issues is by how well they work with him and with each other towards realizing those goals.

#### Obama Plan — Reforms

**DR. DAVID CUTLER:** So let me just start off with coverage. How is it that you get coverage? It's actually not very hard. If you ask people who are uninsured why they don't have coverage, they say because they can't afford it and they don't know where to get it. So what you need to do if you want to get people coverage is you have to make it affordable and you have to make it accessible. And once you do that, then the vast, vast bulk of people will buy coverage.

How do you make it affordable? One thing that you do is you reduce the cost of medical care — by getting rid of all the fluff, all the stuff that we don't need, all the duplicative tests, all the waste, all the redundancies, everything that fills the pages of the medical journals, that's been the subject of IOM reports for at least the past decade, that says that we can do better, we have to do better.

Second, we need to provide help to low- and middle-income people so that they can afford coverage. Senator Obama has proposed a very, very generous set of tax credits for people who are low- and middle-income so that they can afford to have health insurance, coverage that doesn't leave them \$7,000 in the hole for health insurance. That's expensive. In the short run, it's going to cost money. Okay? And one of the big differences between the candidates is, are they willing in the short term to spend money that it will take to reform the health care system. Senator Obama has said yes, and he has identified the source of money that he would use for this. The source of money is the tax cuts that President Bush enacted for people earning over \$250,000 a year. Senator McCain has said no.

Finally, you need to set up a mechanism where people can get insurance. The biggest problems in the market now are for individuals and small firms, they face insurance premiums that are 20 to 40% higher than what people in large firms get. We know from the experience in Massachusetts that when you group individuals and small firms together, you can get greater choice, lower cost, incredible satisfaction with the system. Senator Obama wants to replicate the experience of what we've seen in Massachusetts and other places. Massachusetts' individual premiums have fallen in half by grouping the individuals and the small firms together and creating a place where they can buy. We know how to get people

coverage. The issue is two things. One is: do you have the political will to do it? And second is: are you willing to say that this is a more important priority than other priorities are? And Senator Obama is willing to say, says yes to that.

The second part: Modernizing the health system means focusing on good care. And what does that mean? What we need, what we all know that we need is a radical transformation of the medical system, and in several dimensions. One is the medical care system needs to stress prevention, not just treatment when people get sick. Despite the fact that about 75% of medical care is associated with conditions that could be prevented, we spend less than 1 in every \$25 on preventing things. Health plans cover it very poorly. When you stick people in individual markets they will cover it even poorer. We need to have a commitment to state-of-the-art preventive services that will keep people healthy as long as we can and that will save money in many cases down the road. And Senator Obama has said that that's one of the things that he is committed to.

Second, we need to know more and we need to pay smarter. We need to have comparative-effectiveness analysis that tells us what works and what doesn't work. We need to invest in health information technology. We need to move medical care from a 19th-century industry into a 21st-century industry, where we know what is happening and we know what people need and we know what works and what doesn't work and how it should be done. We need to measure quality, give that information out to individuals, get the information to providers so that they can learn about it. And we need to pay for good-quality care, not just more care.

And then, finally, we need malpractice reform. And what we know from the literature is that the most important malpractice reform is going to be reforms that reduce errors. Just like preventive care is the best care, preventing errors in the first place is the best way to reform malpractice. The health information technology would be extremely important there, in addition to innovative ways to settle disputes that don't involve going to court, telling doctors that if they do the right thing, they can't get sued for doing the right thing the way that it's defined.

We can make enormous progress in terms of making medical practice cheaper, making it work for doctors, making it work for patients as well. We know that these things work. There are a variety of initiatives to stress prevention. At least 18 states have initiatives ongoing that stress prevention in chronic care management instead of just acute treatment. Comparative-effectiveness analysis, while it's not done in a major way in the U.S., it is done in other countries. And also, various areas in the U.S. have stressed, gotten doctors involved in stressing what works and trying to care for patients in a way that the doctors' guidelines say works. And it's having very good effect. We know it's possible to share health information. In places like Indianapolis, they are doing that. We know that you can have payment reform. Detroit is a leader there. We know that we can reduce errors from many of the studies that were mentioned earlier, studies of computerization in hospitals, studies reducing hospital-caused infections, hospital-acquired infections in Pittsburgh. We know this can be done. What we need is the leadership that will get us there.

Finally, we need to depoliticize the public health system and make it work better. I was stunned when five former CDC directors complained about the politicization of science in the Bush administration. We need to end the war on science. We also need to deal with pressing public health priorities.

What would be the impact of doing this? Let me give you a few dimensions of it. One is that we estimate that 98 to 99% of all Americans would have coverage by making health insurance be affordable and accessible and reducing the cost of that coverage.

Second, costs would fall. Our estimates are that the cost of health care would fall by about \$2,500 for the typical family. Ten million more people would have employer-based coverage because the costs of employer-based insurance would fall.

More rewarding practice environment. Physicians will actually be freed up from spending their time dealing with unnecessary administrative expense and actually taking care of patients.

#### Obama Plan — Differences

**DR. DAVID CUTLER:** The two candidates agree on many things. They disagree on many others. One is what should be done with health care savings. Senator Obama said that money saved in the health care system should be used to expand coverage. He wants to take that money and make sure we can use it to help low- and middle-income people afford health insurance. Senator McCain has proposed extending the Bush high-income tax cuts and doubling them again. And also balancing the budget in four years. The only way to do that mathematically, the only way to do that is huge cuts in health care programs.

Should we encourage employer-based health insurance? Senator Obama says let's build on what works. That is the part of the private health insurance system that works most functionally now. Let's not tear it down. Senator McCain proposes to tax people's health benefits at work. That will inevitably encourage employers to drop coverage, individuals not to be able to afford it. Twenty million people, the best estimates are, will lose health insurance through employment as a result of the McCain plan. My sense is we shouldn't tear down something before we know what's going to replace it.

Should preexisting-condition exclusions be eliminated? Senator Obama says yes. No insurance company should ever deny someone coverage because they're sick. Senator McCain says no. Insurance companies should be allowed to deny people coverage because they're sick. Basic difference between the candidates.

If you look at the last two very big health care issues that have come up in public policy, you can see where the candidates stand. Should we expand the SCHIP program? Senator Obama said yes. Senator McCain said no, it was too expensive. It's too expensive if you're doing it in the context of, we need to keep the Bush tax cuts and we don't have any money left. By the way, this was actually paid for by a tobacco tax increase.

Just a few weeks ago, there was a question about should we go ahead with the Medicare cut of physicians' income of 11%. Should we protect that? Senator Obama said yes. Senator McCain didn't vote, but he indicated he was opposed to it. The way that was paid for was by reducing the overpayment to private health insurance plans that participate in Medicare. Senator McCain didn't feel like reducing that overpayment.

I come back to those principles that I want to start off with. We need to make sure that everybody has access to quality, affordable health insurance coverage. We need to modernize the medical care system. We need to have a public health system that works. That is going to take a lot of effort bringing people together. It is going to take money in the short term. It's going to take intense good will, and it's going to take someone who's willing to see the longer-term gain and place health care high enough on the priority scale that we actually get it done.

Thank you very, very much.

#### McCain Plan — Issues

**DR. GAIL WILENSKY:** Let me talk a little bit about the issues as the McCain campaign has seen them. We do agree in describing what the problems are that this country faces: unsustainable health care spending, quality problems and patient-safety issues, and way too many people without insurance coverage. And the question is, how is it that we get our arms wrapped around these issues? Not surprisingly, we have some differences in terms of where we think we need to start and how we need to roll out changes.

There are some tough issues that any health care reform plan needs to resolve. There are no easy wins without downsides. Each of the solutions has positives and negatives. And one of the issues that the country and, ultimately, the Congress will have to decide is, on balance, which of these strategies works best?

Let me give you some examples of what I mean. If you tie insurance to employers, in a mobile labor economy, and there is nothing more mobile than the American labor economy, you are ensuring disruption, because when people change jobs they will change the insurance they have and usually, therefore, the network of physicians that they have and the nurses that they have available to them. It also tends to hide the cost of insurance. The single most unknown piece of information is how much does your employer contribute to your insurance? People don't know, and it's frequently not what they would have chosen, even in terms of just the benefits.

Second problem is some people are predictably high spenders. How you need to deal with that or how you choose to deal with that can differ. You need to compensate at some point for people who are predictably high spenders. Whether you force insurance companies to pretend they can't tell that some people are predictably high spenders and try to fix so they don't have windfall gains and losses is one strategy. Or you can try to compensate individuals or make other means of adjusting for these predictably high spenders. The problem is there. The strategies are varied as to how to try to respond.

If insurance is not compulsory, you run the risk of free riders. If you have more support and more access, you will have some people who will be free riders. How much you choose to be bothered by that is an issue.

If insurance is required — in Senator Obama's case, the mandate, the only mandate that exists is for children; it's not clear what it is they are mandated to have or how it would be enforced — but once you have a mandate, you have to define what it is that people have to have. That raises a whole series of other issues. And be prepared to enforce them somehow.

To me, the most critical of the issues we have to solve is finding ways to moderate spending. We are absolutely in a path of unsustainable spending increases. And because health insurance spending increases is the single biggest predictor of increased numbers of people without insurance coverage, it exacerbates the problems that we've been facing in this country.

#### McCain Plan — Reforms

**DR. GAIL WILENSKY:** What Senator McCain has done is to focus on making insurance more affordable by trying to look at some of the underlying drivers of health care spending and recognizing that when people change jobs frequently, having insurance portable for many will become an important part of going forward.

So what the McCain proposal has focused on is that the current tax exclusion, where you don't have to count what your employer pays as part of your taxable income, is extremely inefficient and extremely unfair. And the reason it's inefficient is because it distorts the choice between wages and insurance coverage, because you get to use pre-tax dollars for one and not for the other. And it's unfair because the higher your income, the more value it is to us.

It's therefore why the notion of changing the tax code and in its place having a refundable tax credit is so important. It puts the money to the individual, and it makes it into a much fairer way in terms of how it is being distributed, \$5,000 for couples, \$2,500 for individuals. These are not small amounts of money. Most middle-class people get actually far less from the current subsidy now that we have in terms of how health insurance is being subsidized by employers.

Why is this important? Well, it will help make insurance clearer, what it is you're buying, what it is it costs, and if you change jobs, whether or not you want to keep your insurance or whether or not you want to have the insurance that your employer offers elsewhere. And, as I've indicated, it make it more equitable — and portable if you want it.

He has also proposed having access to an open insurance market where people can buy insurance in other states. Now, why has this been an issue? There are a lot of places where the insurance market is effectively dominated by a Blues plan — 70%, 80% of the market. You don't get a lot of competition or pressure. You frequently don't get variation in terms of what benefits are offered, sometimes because of what the state has required and sometimes because of what the plans make available.

This is to put pressure on companies, on plans, to offer the kind of insurance benefits that people want and to reduce their overhead expenditures because people can go elsewhere in order to reduce that. Of course, if states want to continue trying to make pooling arrangements available, McCain's plan encourages, both in terms of Medicaid and in terms of this, state

flexibility. So there's no reason that states can't continue to experiment in ways with making insurance more available to the population. But it is really to allow people to access markets that have been closed to them.

One of the issues that has been raised is what do you do about predictably high spenders, high-cost individuals? Well, there are some provisions that are already in place and that would continue in terms of state law. That is, we have a HIPAA law. And people who have employer-sponsored insurance — and our presumption is that right now 98, 99% of large employers provide insurance, and our presumption going forward is that almost all large employers will continue to provide insurance — for people who have insurance coverage and continue in a group coverage, which is basically two and more, the HIPAA rules provide a lot of protection with regard to preexisting conditions. It is less true for people who start out in the individual coverage or who never had any coverage and who have some preexisting conditions, and making sure there's a way to help people who are predictably high spenders and who won't have access to group insurance is an important issue. And what the senator has proposed is having subsidized state high-risk pools. Now, high-risk pools at the state level have gotten a bad rap, and usually for one good reason. Nobody has been willing to put the money up. And Senator McCain has indicated this requires new money. He is going to be willing to put new money on the line. He would like to encourage flexibility in terms of how states would do this, he's said he will get the governors together to talk about various strategies that they have found to work. It is not a problem that can be ignored, and it isn't ignored in the plan.

There are various other strategies that have been proposed in order to try to moderate spending. David's talked about some of them. Spending more money in terms of federal research for chronic disease and more of a prevention focus. Promoting information technology — there has been an interesting way that was included in the bill passed in July that had the first couple of years with a small incentive for e-prescribing followed by a penalty in years four and five. I think this is an interesting model. We'll see how it works in terms of how you might go forward without having a large new cost involved.

Emphasis on price and quality transparency. And an understanding of the need to reform payment for the entitlements, Medicare and Medicaid, not just not paying for the “never events,” but certainly that — but also rewarding the kind of behavior and response that we want from physicians and institutions.

#### McCain Plan — Politics

**DR. GAIL WILENSKY:** I want to talk a little bit about what's likely to happen. When you go through a campaign and you hear the issues that the candidates raise and have a chance to hear how the philosophical differences between the candidates affect issues of concern, as, in this case, in terms of health care, you understand the kind of directional guidance that presidents are able to provide — how much regulation and who does the regulation, how much reliance on incentives and who receives those incentives, how much a plan might cost. But it's important to remember that in our system the president proposes and the Congress disposes. Each of these proposals, the Obama proposal and the McCain proposal, are going to face serious challenges, as I see them, when it comes to working with the Congress.

For Obama, where does the money come from? I know that David has said he's going to let the Bush tax cuts expire. Fine. That's nice. That pays for a portion, in my view, of the cost of the plan. But there've been many other proposals that have been raised as well. David mentioned the \$2,500 of savings that each family will be able to achieve. Now, I certainly think that there are many ways we can find to spend smarter in this country: changing the reimbursement and the incentives that occur as a result, having more and better information, comparative clinical effectiveness, and other ways. But the likelihood that we will be able to achieve significant savings within a first presidential term, to me, just belies credibility. Now, again, as I've said, it doesn't really matter what I believe. It will matter what the Congressional Budget Office believes. Because when it scores the proposal, that's what it is. Anyone that was part of the Clinton administration knows this well — that was, if not the seal of doom to the Health Security Act, it was a major nail in the coffin.

For Senator McCain, the real challenge is going to be how to get what is assuredly going to be a Democratic Congress to seriously consider the tax-code changes that he is proposing. I'm assuming that there is not going to be 60 sure votes in the Senate going in one direction. And the point of saying that is it means that if we are going to have any health care reform in this next session of Congress, it's going to require crafting a bill that can have a bipartisan majority support, working with the administration.

I think we could have had significant health care reform in 1993 and 1994, and we let that opportunity slip through our fingers because there wasn't a willingness to have all of that happen. I hope that we will not do that again and want to indicate the importance of, as we go into this next period, of understanding that when we end this campaign, that is what it will take to have health care reform. And, of course, I won't resist saying, one of Senator McCain's great strengths has been his ability to reach out, to find people on the other side of the aisle in the other party that he can forge alliances with, occasionally to the consternation of his own party, in order to take positions that resolve issues that he thinks needs to be resolved. It will be a critical element in whether we get health care reform in 2009 or 2010. Thank you.

#### Panelists' Questions

**DR. THOMAS LEE:** Thanks very much to both of you. I share your optimism that we can do better. We have to do better. I'm nervous that some of the potential solutions that we're tossing around could be at least partially myths. And to give three of the potential myths that make me most nervous, you hear people say that better quality can save money, and we can pay for health care that way. Another potential solution — that individuals behaving as consumers can make the health care system work. And then the potential solution that IT can solve all of our problems and save money and lead to major reductions in cost. Do you think these potential solutions, if any of them might be overrated? And if they are, what are the implications for the two candidates' positions?

**DR. DAVID CUTLER:** There are about six or seven ways people have thought of that would rationalize, modernize health care. And we don't have great evidence on which of them will work. In fact, I think thinking of them individually is the wrong way to do it. That is, you could pay for a computer for every doctor, and you'd have a very heavy paperweight. You could give a doctor a performance incentive, and if she has no information, she can't do any better. So it's going to have to be the whole system together.

What Senator Obama has said is the cost problem is so severe that we'd better try everything we can think of. And some will work to save money, and some will not work to save money. But we have to try everything we can think of. The only thing he is not in favor of, that's an idea that a lot of people are in favor of, is making individuals pay a lot of the cost on their own. And it's exactly because of the issue you raised about are consumers being, are individuals really ready to be good consumers?

But everything else he's said we need to try, and we need to try it as much as we can, as rapidly as we can. Now, to me, the right analogy is not the kind of Big Bang savings. But it's what's gone on in manufacturing in the U.S. for the past 30 years or so. Every single year, manufacturing productivity increases by about 2% or so. Manufacturing output per worker increases by about 2%. That's a source of real gains in living standards over time. It's why prices of manufactured goods go down.

And the reason is not because firms do any single thing, not because they bought a computer, but because that's what the focus is, the focus is on how do you deliver a better product cheaper. And that involves getting the right information, getting the right incentives, and getting the right framework in which that happens. And so I see this as creating the framework in which all of this can happen, get investing in the information, getting the incentives right, getting the goals right so that that's what we are focused on is delivering a better product.

Whether that turns out to be a myth — if that turns out to be a myth, the only thing left in our tool bag is to ration access to care, if we really care that much about cost. Everything else is in this set of proposals. And it may be that will fail and that what we will come to is an explicit set of rationing of care. But what Senator Obama wanted to do is try every single thing short of that.

**DR. GAIL WILENSKY:** Quality can save money, but quality in and of itself doesn't necessarily save money. It depends a lot on the structure and the incentives that go on with it. Health IT as a means — I agree with the notion you have a heavy paperweight. Interesting CBO report that recently came out indicating that people are way too optimistic in terms of looking at health IT. It will take a while to be implemented, introduced and implemented. And access — it's one of the reasons I think we need to be, to temper the notion of how quickly we are likely to actually achieve some of these savings.

I think individuals can participate in some of this decision making. They need to have information about prices and quality. They certainly can't do anything if they also don't know something about comparative clinical effectiveness, the quality of the institutions and the physicians they see, the prices that they are going to face. Senator McCain is not trying to push everybody into high-deductible plans. Most high-deductible plans do exempt prevention, or at least those areas of prevention that appear to be cost-effective. But for people who don't want to do that, that's certainly not an issue.

So I think we need to be realistic, not about the importance of trying to improve the delivery system, but to recognize that this is going to require some time to happen and some time to see the effects of that, either in terms of improved

quality and outcomes, and to slow down spending — and to not have expectations that, to me, are simply unreasonable and unrealistic. We can't do everything at once. We have to pick and choose areas that we think are going to be most important and start there and put a lot of effort. And then sequence the other changes as quickly as we can. The good news is that there is a lot of agreement, even during campaign season, about the kind of delivery changes that need to occur in our system.

**DR. KAREN DAVIS:** Both of you have stressed the urgency of the problem. David said the cost problem is severe. Gail, I think in your earlier remarks you said it's the most critical issue is to slow growth. So we're at 2 trillion in health spending now. By 2017, we'll be over 4 trillion. Under your candidate's administration, how much would they bend the curve? How would they do that? And, most importantly, how would they deal with the interests that would lose money, since someone's spending is someone else's income?

**DR. GAIL WILENSKY:** I can't answer specifically the estimate of over the course of the decade how much they would be able to bend the curve, so let me try to indicate more generally how it is viewed that these changes will occur — you definitely have correctly assessed that slowing down spending by the variety of mechanisms of emphasizing chronic disease intervention, changing how we pay for chronic disease and prevention, specifically going after smoking cessation, I assume obesity, but there has been more emphasis, at least in print, in terms of smoking cessation, trying to have — this is at a much smaller level — increase the use of generics in terms of drugs, looking at reimportation, if that can be done safely. So there are big items, there are little items, making better information available. The real question is, how do you try to put enough in place early, the first two or three years, that over the course of a decade you really can bend the curve. And part of this is to be able to bring patients as consumers and families as potential patients into the mix, rather than only looking at the delivery system. And I think that's probably one of the biggest differences.

**DR. DAVID CUTLER:** Let me start off with where I think the academic landscape is, which is that about 40 to 50% of medical spending is not doing any good. Relative to that, what we have said is that we believe our plan can save 8% of medical spending. And people say that's overly optimistic. And you just sort of look at the disconnect between how much is there, if you take all the ideas that are on the table and you do them, and you save 8%. If you're willing to use the Bush tax cut as one source of revenue and you're willing to take a lot of the savings that you'd be able to get from covering people, you'd need 4% of savings to be able to afford to cover everybody. So yes, it's a hard process. But relative to the scale of what people believe, it is manageable.

**DR. GAIL WILENSKY:** I just don't accept that number because I don't think we understand now how much is waste. Now, I will say I have a bias. Somebody says "waste," it means zero value or harm. So it's zero and negative. If you mean things that we do in the United States that we have a lot of uncertainty, have a low probability of success, don't get much clinical value relative to the cost—I don't believe 40 or 50%. I don't even buy the 30% number, to tell you the truth. But I don't believe we know. I think there clearly are things we do that have zero value. We need a lot more effort to figure out where they are and for whom and what to do about it. But this notion of do we think and can we likely know before the fact about whether they're zero value or do we only know it after they're done and they don't have zero value? We're not going to, the two of us are not going to resolve this.

**DR. DAVID CUTLER:** I think it's not all care that's received but how much it costs to provide it. Let me just give you one example. I was talking with the CEO of a big, integrated, group-staff-model plan a couple weeks ago. And I was asking him how his various IT investments were doing and so on. He said, "Let me give you an example of how they work for us. It used to take 43 minutes for one nurse at the end of a shift to explain to the next nurse all about the patients and what specific things they needed and the medications and so on. And because we put in a better IT system, it now takes 12 minutes. Which means that we now have 31 more minutes of nursing time per shift than we had before." And so that's 31 more minutes of patients to be saved or 31 fewer minutes that they have to pay for the same thing.

And so that's the kind of stuff I think that's in there, not just who is getting an operation that doesn't need to get it. But how efficiently is it delivered. And the efficiency with which it's delivered is so poor that you kind of have the sense that doing anything to save those 30 minutes — those 30 minutes add up very quickly.

**DR. JON KINGS DALE:** David, you said the Obama plan would cover 98 to 99%, which means taking 16% of uninsured down to 1 or 2. That's quite ambitious. So my question to you is, without mandates on adults (it's easy, relatively, to mandate kids) or other means, what's your thinking about how to get those free riders? I'm thinking about myself when I was 22 and hitchhiking around the country. I can tell you that health insurance at two bucks a month was not cheap enough to get my interest.

And then, the question that I have for Gail is, actually, is universal coverage your candidate's objective?

**DR. DAVID CUTLER:** For essentially everyone out of the immortal range [laughter] — you know, the people who know they're immortal and don't want to hear otherwise — when you ask them why they're uninsured, they will tell you it's not because they don't want it but because they can't afford it and they don't find it accessible. So that the vast bulk of the uninsured you pick up that way, by making it affordable and accessible.

In addition, there are two other parts of what Senator Obama has said that are important here, actually, and really have not been stressed enough. One is that Senator Obama has proposed that children up to age 25 be covered under their parents' policies, regardless of whether they are in school or not. Those 22-year-olds are very, very cheap. Most of their parents will have insurance. So, actually adding them to their parents' policy does not cost very much and will cover quite a lot of them. That's one thing.

Second is, the thing we know about a lot of people is that they do whatever the kind of default option is. And let me give you an example from pensions. If a firm goes to a worker — we've seen this, you know, a big firm goes to a worker and says, "We have a 401(k) plan. Here is a form. Fill out this form. Give it to us and you will be enrolled in a 401(k) plan," about 40% of people enroll. The rest say, "Yes, I want to enroll, but I have to go study the choices and I'll do it tomorrow night." And "I'm busy this week, and I'll do it next week."

If, instead, the firm does exactly the same thing but it goes to the worker and says, “We have a nice 401(k) plan. We know that most employees want to be enrolled in the 401(k) plan. We’ve put you into the 401(k) plan. But if you want to be out, just sign this form, check this box, and we’ll take you out,” 90% of the people stay enrolled. So the very act of whether you check a box to be in, check a box to be out has an enormous impact.

And the way that you can deal with a lot of people, and Senator Obama has proposed this on pensions and he also believes it on health care, is you make it easy. You make being in the default, not being out the default. And you say, “Look, we believe this is important to you. You’re going to get a tax credit for it, because when you’re 22 you don’t have that much income. We’re going to send it to this insurance company. It’s there for you. But if you really, really don’t want to be in, then you don’t have to.”

What he’s also said is, by the way, if turns out there are pockets of people who still won’t be in, and we know that it’s affordable and we know that it’s accessible, then he’s open to a mandate. But the first thing you have to do is make it be affordable and make it be accessible. Get as many people as you can enrolled and then come back.

**DR. GAIL WILENSKY:** The objective is to provide a financial means for people to buy insurance and to give them ways to access what will be lower-cost insurance. And it is very much to make sure that people are able to have access to a more affordable insurance plan than has been possible in the past and to try to help those who are high-cost be able to be responsive to that. With regard to the immortals, and we know that there is a disproportionate number of people who are in the 18-to-26 category who go without insurance coverage — as David said, Senator Obama lets them be on their parents’ plan. Senator McCain would give them, as individuals, a tax credit, which clearly, for this group, would make it, and at \$2 dollars a day insurance would easily come in your refundable credit. Whether or not some of your other Massachusetts colleagues are correct, who were estimating that without a mandate you could have as many as 5% without insurance coverage, we’ll have to wait and see.

It’s because of all of the problems that arise with regard to mandates, it seems to me that whatever your strategy and whatever your political party, making a significant effort to make more affordable insurance available is a perfectly appropriate first step. And if it doesn’t solve all of the problem, we can see how big the remaining problem is and decide what we want to do about it.

**DR. THOMAS LEE:** What do you think will happen with Medicare under two potential different administrations, particularly with Medicare Advantage, you know, the structure of payment, the overall crisis in physician payment?

**DR. GAIL WILENSKY:** The focus thus far, not surprisingly, has been on the more global issues with regard to expanding coverage and trying to find ways to slow spending. And the level of discourse, as best I can tell in both campaigns, has been laying out the notion that we need to change reimbursement so that we reward the kind of behavior that we want to see.

Senator McCain has indicated in terms of a coverage issue that just as Part B now has smaller subsidies for high-income seniors, that he thinks that's an appropriate consideration for Part D or others but is not a part of the direct campaign. The issue about the delivery change is one that, particularly with the physicians, that really has to be taken up, and the pressure is probably going to be first and foremost on the Congress. Because they, for better or the worse, have been the ones digging themselves into a hole that has grown completely out of any kind of proportion — and have done so in a way that has incentives that are somewhere between unhelpful and perverse.

Senator McCain has talked about encouraging coordinated care — trying to, either through Medicare Advantage or through other mechanisms, be able to have care coordination is something that is very important. I don't know that anything, say, that would be against the medical home model that has been raised. It is the one part of Medicare that is going to force itself on the system. Because as any physician who has paid attention knows, we fall off the proverbial cliff January 1, 2010, when the last patch wears off. And instead of having a 4% decline or a 10% decline, we're now facing a 20% decline.

**DR. KAREN DAVIS:** The first baby boomer will retire in the next president's first term. In 2010, Medicare will be spending more money each year than it takes in. And by 2019, the Medicare hospital insurance trust fund will be exhausted. So what will your candidate do to ensure that Medicare is solvent when the people in this room need it?

**DR. DAVID CUTLER:** Let me give a couple of answers to it. One is, the current standard that we use for thinking about Medicare is 75-year actuarial projections. Nobody has a plan for 75-year actuarial balancing Medicare the way the program looks now. What we need to do, I think, is to take the steps now that put us on the best path to being able to realize financial solvency for Medicare. And there are a couple of parts to that. One is, the kinds of things that we were both talking about in terms of reforming the delivery system inside and outside Medicare.

Second, there are issues about trying to allow and create incentives for people to work at older ages when they are really productive so that they can be contributing in terms of Medicare taxes coming in. Each of those are solutions. And finally, I do want to come back to this because, you know, the public finance person in me really cringes. I think it's just completely irresponsible to promise the Bush tax cuts two times over when you know you don't know how to afford Medicare and that's the only source of money. So one of the things that Senator Obama has been very clear about is not using whatever money we may save in those programs to fund high-income tax cuts.

**DR. GAIL WILENSKY:** One of the issues that actually has some agreement on analysts in both parties is that the best way to help Medicare is to slow down health care spending. Many of us have seen the reports that indicate aging per se is not really what is going to do us in. It is the spending gap, the two-and-a-half-percentage-point growth faster than the rest of the economy that we have in health care, have had for the last 45 years, combined with the aging baby boomers, that we can't sustain. So it really indicates that the importance of finding strategies that will slow down spending is not just that it'll help us extend coverage to the 45 million people without health insurance coverage, but it'll also be an important part of helping us with Medicare.

Karen had raised an issue that's important that I forgot to respond to, which is, if we are going to slow down spending, the people who have been used to having the two-and-a-half-percentage-point excess growth, the institutions and the physicians and the industry sector, are probably not going to be happy about this. And how are we, or will we be able to respond to the pressures they'll bring to the system? My belief as an analyst and policy person is that only with good, credible information, through comparative effectiveness or other information on quality and value and outcomes — if we can show in convincing ways that what is being reduced has little value, we have a chance. Otherwise, we know what the argument will be. Some payer — private, government, whatever it is — trying to keep some physician or other health practitioner from doing what he or she thinks best for that person, and that's why we're not doing something.

I don't know whether good, credible data will be enough. I am absolutely positive that in the absence of good, credible data that certain procedures we've been doing, interventions we've been doing for some subsets of the population that have very little value, maybe primarily harm — we have no chance without that.

**DR. JON KINGSDALE:** I'm impressed as a historian, but also as a businessman formerly, that we've had 60 years of failure to enact national health insurance. And I wonder, since you are long-time observers and very familiar with some of the workings of government, if either of you has some observations or suggestions about what to do differently.

**DR. GAIL WILENSKY:** At various moments in time there are pieces of legislation that can be passed. And the real issue is whether there is an ability, typically by the White House, to recognize the best package that is likely to be able to be passed at a moment in time — and decide, after whatever first efforts are made to get what that administration really wants, whether they will embrace and try to drive forward with the best that they can get or not. We could have, in my opinion, had in 1993 and '94 a federally funded health care benefit for everyone who was poor and some parts of the low income, and a variety of insurance changes as well, at the very minimum. Maybe a little more than that. But definitely not universal coverage. And because it was not that, it really was not allowed to push together a coalition of Republicans and Democrats that could have passed legislation.

In 2003, and I don't want to pretend like I am enamored with the Medicare Modernization Act, because I am not. There are more warts on that bill than most pieces of legislation have. But there was recognition that that was the best bill or the only bill that was likely to be able to get through the Congress at that point in time. And a majority, although just barely a majority and with a lot of last-minute pushing, decided that rather than wait until 2009 or '10, which is when the next opportunity would have been, to go forward and try to deal with various problems after the fact.

We are not going to have the neater-looking version of national health insurance in this country in any time in my vision going forward. I think we can have all or most people with insurance coverage. And the question is, whether we will aggressively move forward in the pieces that we can do when the opportunity presents itself.

**DR. DAVID CUTLER:** I see several reasons to be optimistic. One is, of course, the problem is worse now than it was 15 years ago, and that makes more people be ready to do something. On the more hopeful end, there's a lot of bipartisan interest — and Gail remarked on this — there's a lot of bipartisan interest in getting things done. So you have Senators

Wyden and Bennett with a bill that would essentially cover everybody. You have about 10 or 15 bills on health information technology and on changing payment and delivery system reform. So you've really got a lot of activity going on.

In addition, you've got people being involved in politics for, in many cases, the first times in their lives. The message that we are trying to send, that Senator Obama is trying to send to everyone is, we need citizens to be involved in government, we need everyone to be involved in government. And if you want to be part of the solution, then you are welcome to join the discussion. He wants a table that is open, where people discuss it, where we go forward trying to find what is the consensus. And I think that is a very hopeful way to proceed, and that makes me more optimistic than we've been in some time.

**DR. ARNOLD EPSTEIN:** I feel enormously enriched by this symposium today. And I'm enormously grateful both to the speakers and to the expert panel here who have helped us move ahead. Thank you.