DAVID

My name is David Teece. I'm Chairman of the Berkeley Research Group, and it's my great pleasure on behalf of my colleagues and co-founders at the Berkeley Research Group to welcome all of you; many of our friends and importantly our clients, and especially our speakers. As most of you know, we're a company that's fairly new. We're about eighteen months old. We are about three hundred and thirty people and we're anchored by two large offices; one on the west coast and one here in Washington, D.C. The one here in Washington is very much focused on health care issues so we thought it appropriate to organize a panel that would address health care issues, not just because it's something we're interested in, but because it's of critical importance to our nation.

We have at the Berkeley Research Group two special advisors: Laura Tyson and Susan Kennedy, with us this evening is also Michael Tanner from the Cato Institute. I think you know them all and you've read their credentials but just briefly, Laura is a dear friend of mine and a colleague at Berkeley. She was the Dean at Berkeley and went off to be the Chief Economic Advisor to President Clinton for quite a number of years and then was Dean of the London Business School, and I'm pleased to say she's now back on the west coast and a Special Advisor to President Obama.

Susan Kennedy has a distinguished career, first with Governor Gray Davis as his Chief of Staff and then moving on to Governor Schwarzenegger. Nobody has been as active and as efficacious in California's government as Susan. One of Governor Schwarzenegger's parting nominations was to put her on the Health Exchange. She had formerly been on the Public Utilities Commission, I might mention, but she's now on the Health Exchange and, as you know, California is moving aggressively and quickly in this area to get something started; so her credentials, her experience and her ability to explain complex things in plain language is always an asset to us all. So let me thank the panel for coming and invite Laura to start but let me just say a few words about Michael first. I'm sorry, Michael.

Michael is an expert not just in health care, but in Social Security. He has been following the nation's deepest problems which have taken him from Social Security to health care. His work is well recognized. I'm sure many of you will find it provocative. He is very well credentialed in this area and has some very, very clear insights to share with us this evening.

Our panel discussion this evening is billed as a conversation. No one's here to give speeches, but I have asked each one of the speakers to maybe do an opening five or ten minutes as they see fit to lay a little bit of foundation and then we hope there will be an interesting dialogue that follows with the opportunity, we hope, for a few questions from the floor. In the Berkeley Research Group we actually have a number of experts in this area and I'm hoping at least one of them will put up their hands. If not, then some of our clients can put questions to the panel. So, Laura…

LAURA

Thank you very much. It's a pleasure to be here with all of you. As David mentioned, but I want to underscore, I'm a very old friend of David's. It's always a pleasure to do work with him. I think BRG is a great group and I'm happy to be associated with it.

David asked me set the context for the discussion. When I worked for President Clinton, I was dragged into learning about the Health Care System. This time around I've made a point of trying to stay out of the Health Care debate. {Laughter}

I have worked for President Obama on his Economic Recovery Advisory Board and now I'm on his Council on Jobs and Competitiveness. In neither body do we discuss health care. {Laughter}

I think we can describe the challenges facing the United States in terms of three deficits -- the jobs deficit, the fiscal deficit and the growth deficit.

The jobs deficit is straight forward. We certainly know the numbers -- 9.1% unemployment rate versus the full unemployment rate of 5 or maybe 5.5%. The Brookings Hamilton Project in Washington, D.C. has this wonderful and sobering graph they do each month called the Jobs Gap Graph. It essentially says how many jobs we have to create to get back to the peak employment we were at before the great financial crisis while also absorbing the 125,000 people who enter the labor force each month.

The estimate of the jobs gaps is about 12.1 million jobs. If we do as well as we did on average in the 1990s when the fastest year was about 321,000 jobs a month, we would not get back to filling the jobs gap until the middle of 2016. If we do as well as we did in the 2000s with 208,000 jobs a month - the average monthly rate for the best year of job creation - we will not close the gap until July 2023.

Today, the news reported that Bernanke said a surprising thing today -- It will take years to get back to full employment. {Laughter} They obviously haven't read the Hamilton Project Jobs Gap.

Interestingly enough another consultant firm, which will remain unmentioned here, recently did a jobs projection. They said that health care is one of the sectors that is projected to growth rapidly in a high growth jobs market through 2023.

That brings me to the second deficit which is the fiscal deficit. If we're thinking about health care as a possible way to solve a jobs deficit, we better not forget the fiscal deficit.

The fiscal deficit numbers are equally sobering. I would say the main thing that leads me to believe we have an unsustainable situation is to look at the debt to GDP ratio. It is right now on a net debt basis at levels we've seen before and it's projected to go up for the next few years at levels that we've seen before. But, on its current path, the debt to GDP ratio is expected to rise by 150% by 2030. It is clearly unsustainable.

Another way to put the fiscal problem is to look at projected government revenues by 2025. We would reach full employment in 2023 if the Hamilton Project numbers are right. In 2025, the projected government revenues would only be adequate to finance interest payments on Medicare, Medicaid and Social Security. Every other dollar spent by the U.S. government would have to be borrowed. That's 2025 -- so that can't be right. I mean that doesn't seem like we're on the same path. So what do we do?

I'm not going to talk about revenues tonight. Let me just lay out on the table my general view to this problem. I believe that at the end of the day to get the long term deficit problem under control there has to be a revenue part of this.

I would associate myself with Simpson/Bowles and perhaps even more with Domenici/Rivlin in terms of the broad strokes of composition between the revenue share of deficit reduction and the government spending share of deficit reduction.

I am compelled by the view that the spending problem of the federal government is essentially primarily health. It is both the health care costs per covered person and it's the demographics as well. Any reasonable, balanced plan to get at the long run deficit problem is going to have to be serious about health.

Now that being said, I think we have to recognize that if all you cared about was deficit reduction, there is a simple way to handle the health problem -- reduce the quality of care and drop people. I just want to be clear here. When some people talk about deficit reduction and focusing on health, they're not talking about what happens to the quality of care and they're not talking about access.

I think that is an important distinction because it is the case that on average un-insured Americans spend less than half of similarly situated Americans. So if we want to reduce the health care cost for the federal government, you either un-insure people or reduce their insurance. That is not my position.

My position is more along the lines of what do we want as a just society? A just society is one in which health care is based on the principal of social solidarity. Health care should be financed by individuals on the basis of their ability to pay, but also should be available to all the needed on roughly the same terms. That's my position.

So that suggests, if we're going to control health care costs for the deficit and we have that principal, what do we know might be true? I was just on a panel with Glenn Hubbard. As you know Glenn and I are in different parties, but we both agreed that you can't get the federal government's spending line bent. You can't bring the rate of growth of federal health care spending down without bending the entire health care system line.

It's a mistake to think that you can go in and pay attention to quality and access and just bend the federal health care spending line. You've got to think about things to contain costs in the entire system.

Then the question is what to do about that? I will only mention a few things because there are many people here who know more than I do about what to do.

First, I will start with a sobering point and probably one that Mike Tanner disagrees with. The health care experts that I've read say that all of the things we currently know how to do in the health care system to bring down costs without reducing access are embedded in the Health Care Reform.

That's a very controversial statement but let me just go through the list --payment innovations like bundling, patient center primary care, shared savings and capitation based on accountable care organizations, and pay for performance incentives from Medicare. What about giving patients more information about the quality of their providers? What about increased funding for comparative effectiveness of research to improve the evidence base for care? I've read some statistics that say 20 percent of the care in the United States is based on evidence and that's it. Limit the tax exclusion on employer provided health care. This is only done on the very high end Cadillac plans in the Health Care Reform. Have an independent Advisory Board, who looks at what we're spending money on and says "No, that actually is not cost effective. It is not effective relative to the quality of life additional years that are added." So there are so many things in the Health Care Reform Bill that are listed to try to get at the cost curve and to bend the cost curve.

Let me end on the issue of capping and premium support. In 1998, I was put on the Medicare Commission to look at things to do to bend the cost curve. It wasn't called bending the cost curve then. We discussed premium support and actually I was one of two Democrats who almost supported the plan. But, what we felt was frankly that the cap for the projected rate of growth of the premium support that the government would offer was simply in no way based on any reasonable estimate of what competition through premium support could save. So we said alright premium support might save something, we accept that. Competition is good and premium support might do something, but any numbers we've seen out there suggest the savings is actually pretty small and nonetheless you want to cap the premium at that very low rate? What you really want to do is actually reduce access and reduce the quality of care. So that trade off of how much you allow the premium to grow if you move towards premium support and competition through premium support is something one has to recognize. So I'll leave it at that. I've thrown some ideas out there. I hope I created a little controversy. {Laughter}

SUSAN

Thank you. Well, I've had the distinction of working for California's two of the most famous Governors in U.S. history. {Laughter} I did such a good job for Gray Davis that he sentenced me to the Public Utilities Commission for a number of years where then three years later I was rescued by Governor Schwarzenegger to come back to Sacramento and firm into the worst financial crisis in world history. {Laughter} But it's been a great ride. As a parting gift, Governor Schwarzenegger appointed me to the Health Benefit Exchange which is a five member board that will design the individual and small business

group market as part of the Federal Health Care Reform effort. I'm not a health care expert, I'm not an economist. He asked me to go on this primarily because I know how to land a plane. {Laughter} This is a very, very big plane. {Laughter} Actually, to give you a sense of kind of what the Health Benefit Exchange from my perspective, has anyone here seen the movie Armageddon with Bruce Willis and Ben Affleck? {Laughter} Okay, well, in this movie there is a very large asteroid aimed at the earth. It's going to destroy everything we love and know about the earth today and around the world the government leaders have absolutely no clue how to solve this so they look to the wildcat oil drillers who know how to do two things; land on something, blow it up and do the impossible. So these guys train inside of four weeks from being oil drillers to being astronauts. They get on this ship, go up and land this nuclear weapon deep into the heart of this asteroid, blow it up so it splits in two and misses the earth by mere miles on both sides. If they fail, it ends life as we know it. That's what the Health Benefit Exchange is like. {Laughter & applause}

So it's important to put this into context because if you look back at the history of efforts to reform health care in the United States, it's been primarily driven year after year, decade after decade by three primary issues. The first and most important issue is cost: the cost to the government, the cost to people, the cost to hospitals. The second is a moral issue, which is the number of un-insured; people who don't have health care and people who view health care as a right, not as something that is a commodity to be purchased. The third is a political problem: the cost of health care for individuals that purchase health care with their premiums going up. It's constantly a political issue in every election. In some ways the Obama Administration is the dog that caught the car. {Laughter} It's important to understand the context and understand kind of what we anticipate where this will go in the trajectory or regulation and implementing the reforms. There are three views of the world in terms of what the costs, why there are such rising costs of health care. From the provider's perspective you've got the aging population, unhealthy lifestyles and expensive new drugs and technologies. From the health plans, the insurance side of the equation, they believe this is the market power of the providers; the third party payer system where the payer is completely separated from the transaction between the buyer and the seller and the fact that consumers are completely shielded from the actual costs of care. From the government side, they believe that the problem is the un-insured population, the cost shift to public programs and the lack of regulatory oversight. They're responding in large part to angry consumers that are angry at their premiums being increased constantly and their fear of using it and losing it and they hate the insurance plans but they love their providers. Now here's the big secret in Federal Health Care Reform. It was the government that drafted the Bill. Whose problem do you think they're going to solve? The government drafted the bill to solve the government's view of the problem so the whole impetus for reform which has driven politicians over the brink here time and time again for cost reductions, is not on the list of issues. They talk about it and they need to do it but if you look at the way the Bill is drafted, I would take issue with some of the things, some of the tools that are supposedly handed to people like me to try to bring down health care costs. If you look at what Secretary Sebelius said on the anniversary of the Health Care Reform Bill being passed, you know the Health Care Reform

Bill is already bringing new protections, greater freedom, lower costs, freedom to get preventive care for free, Patients' Bill of Rights, freeing families from some of the worst abuses of insurance companies, free mammograms, free colonoscopies, free preventive care, no caps, no life time limits, free, free, free. The way the administration is promoting the Health Care Reform Bill is exactly the opposite of what is actually happening in health care and what's going to happen in health care. By the standard, by the measures that they have already put out there in the public domain, we have already failed. So as someone who is charged with going and trying to figure out how do we implement these reforms given the tools that we have, we have a very difficult task trying to figure out how do you address some of the actual cost drivers which I think are outlined fairly by both the plans and the providers with the tools that we've been given which are really designed to increase access to care. So we've got a very, very difficult task ahead. What we did in California because we're a little further ahead than I think some other states are primarily because in 2007, well the political stars were aligned to do something on Health Care Reform, you know a Republican Governor willing to move forward on Health Care Reform and a Democratic Majority willing to do the lifting so we managed to get it passed. In 2007 we tried to get Health Care Reform passed in California so we did a lot of the work and I was involved in that effort so unfortunately I do know something about it; just enough to be dangerous about Health Care Reform. So we're a little further ahead than I think other states are but you've still got a state like California who is not alone at all with eleven percent unemployment rate and a huge budget deficit and these new mandates that are going to come down under Health Care Reform are going to increase costs by the billions. And a state that is struggling on figuring how to cut its Medicaid costs just to balance a budget. Every state's in the same position. We're not going to be out of this for a number of years. So in trying to implement Health Care Reform with this new program at this particular time is going to be extremely challenging. But like Bruce Willis, I hope to not be the last one on the asteroid. I want to be Ben Affleck in that film. {Laughter}

{Applause}

MICHAEL

Well now for something completely different, I'd like to give you a couple of contextual statements and then I'll have some specific comments on the Bill itself. They are somewhat different contextual statements. The first is on the fiscal issue. The numbers you've heard on the debt and the deficit and all that, I agree that they are truly scary but I would suggest that the deficit is just a symptom. It's not the underlying disease. Just to give you a little background, traditionally the government's taking in about eighteen percent of GDP in taxes and spent about twenty-one percent of GDP. It's why we have, well, traditionally run a small deficit. Right now tax revenue is down partly because of the Bush tax cuts but also largely because of the recession. We're taking in about sixteen percent of GDP in taxes and we're spending about twenty-five and a half percent in GDP which is why we've got this huge gap. Going forward however, when we get out to 2050, the federal government will consume forty-two percent of GDP by current CBO (?) projections. Throw in about ten to fifteen percent at state and local levels and

you get the government at all levels consuming sixty percent of GDP. No economy can continue to survive with the government consuming at that level regardless of how you pay for it so it's not a question of can we just raise taxes up to sixty percent of GDP and then we're fine. You've simply got to do something about the spending and that does, I agree, involve health care which is the eight hundred pound gorilla in the spending equation. The second contextual thing is just a statement. I'm asked a lot if health care a right or a privilege? That's sort of always the big debate question. I will always say it's neither one. Health care is essentially a commodity and it is a finite commodity. There are only so many hospitals, so many doctors and so much money. Therefore what you're really talking about it allocating this commodity not about having an infinite amount of it. Which brings me to my third contextual thing; there is no health care system in the world, never had been and never will be that will provide everyone with all the health care they could possibly want. All health care systems are ultimately about rationing. The question is not so much are you going to ration, but about who is going to make the rationing decisions in many ways. Let me give you an example. If every year, every American got a physical and as part of that physical you got a CT Brain Scan. We would save half a dozen, maybe a dozen lives every year because we would catch brain cancers early enough to be able to save that person's life. We would also bankrupt the country overnight in trying to provide that. We're not going to provide every American with a CT scan every year. The question is how then are you going to make that determination? Are you going to go from the top down and decide it's not cost effective to give every American a brain scan so therefore we'll simply prohibit it? So like what the National Institute for Clinical Effectiveness does in Britain; too expensive is not worth it dollar for dollar per year of extended life so if it costs too much we're simply going to say no, no one can have a brain scan. Or you can sort of do it down at the patient end which is what I prefer and say yeah you can have a brain scan if you want. Maybe it's not going to probably catch anything and chances are it's not worth a whole lot but maybe you come from a family where your father and your uncle both died of brain cancer and you're just going to sleep better at night if you get that brain scan and know more about it. You can have it as long as you pay for it yourself and bear some of that cost yourself so you can ration it from the bottom up. I think that ultimately is the debate we should be having. Now as far as the Health Care Bill itself, I would suggest that it fails on almost every level. Does it bend the cost curve? We're going to hear a lot about health care cost tonight; does it bend the cost curve? Yes it does. It bends it up. {Laughter} CMS, the Chief Actuary of CMS put out a report and suggests that it adds about three hundred billion dollars to health care costs over ten years; that you actually spend more as a result of having passed the Bill than you did before. Now part of that is because we're covering more people but the total cost is going to go up, not necessarily per unit cost but the total cost is going to go up. That's assuming that all of the cuts actually take place. Even the Chief Actuary, again, David Foster over at CMS suggests that those cuts aren't really going to happen; that Congress will back down when the rubber actually hits the road. Is it going to reduce premiums? Before the Bill passed, the President warned and I think he was absolutely correct and CBO had said that if we did not pass this Health Care Bill, you could expect insurance premiums to double in the next six to ten years. Now having passed a Bill, CBO now says insurance premiums can expect to double in the next six to ten years. There will be very little impact on this. On

average if you actually work for a large company, insurance premiums will probably come down slightly. If you buy an individual policy they are going to go up ten to thirteen percent more than before the Bill had passed. If you're older and sicker, your premiums are probably going to come down. If you're young and healthy, your premiums are going to go up a lot. So you have to look at it in that sense. What about the effect on the federal budget? Well you know there's a lot of debate going on and you have somebody who works for CBO that this says a couple hundred billion dollars off the budget deficit and if you take the strict parameters of the Bill, that's absolutely true. But those strict parameters of the Bill leave out a lot of costs associated with the Bill. Just to give you one, there are one hundred and fifteen billion dollars in implementation costs over ten years. These are authorized but not appropriated in the Bill so therefore they don't actually count in terms of the Bill but they are still going to ultimately have to be spent. This is for things like hiring new IRS agents to enforce the mandate and their office staff and things like that. The new regulators are going to have to come down and oversee the state exchange and make sure they're doing it the way the Secretary wants and all these sorts of things are all going to add costs to the Bill and of course there's the cost of the doc fix and there's a lot of double counting where they take Social Security taxes that they expect in the Bill and they assume that they're going to pay Social Security benefits but they're also going to pay for the Bill because it's additional revenue. They do the same thing with Medicare savings if you assume the Medicare savings is. In reality after you look at it, the Bill is probably going to add close to eight hundred billion dollars to the deficit over ten years and will cost closer to three trillion dollars than to the one trillion if you actually want to look at all that. For all this in the end, you don't even get universal coverage. The whole reason we supposedly did all this was because there was supposed to be fifty million un-insured and you know I'm very skeptical of that number but let's use that number since it's the baseline everyone uses. Well the Bill would still leave twenty-three million people un-insured at the end of the decade and that number would be rising as you got to the end of the decade. If those newly insured people, I mean twenty-three million is better than fifty million, but half of them wouldn't be getting insurance; they'd just be dumped in the Medicaid programs. That's money that California and other places are going to have to come up with in order to pay for all those new Medicaid patients. We know how difficult it is for people on Medicaid to actually see a doctor. About a third of primary care physicians won't accept Medicaid patients because they're under-reimbursed as it is. So we're simply going to dump some twenty million more people into that system. We know that actually for all the talk about people who are un-insured showing up at the emergency room, the most likely people to use the emergency room are people on Medicaid so we're going to have more people showing up in emergency rooms with less capacity. Then at the end we're going to basically clamp down through IPAB (?) and I actually think that cutting Medicare is a great idea but IPAB doesn't actually cut benefits under Medicare, it simply cuts reimbursements. In fact it's forbidden to actually charge seniors more or change the benefits that they get. The only thing it's really allowed to cut is the reimbursement rates to hospitals and doctors which is why again CMS says that if all those cuts were to go through, about fifteen percent of hospitals would close as a result of those cuts and you can expect fewer physicians to accept people on Medicaid and Medicare and it would be harder to get it and get in to see a doctor. You're already seeing this in Massachusetts where Romney Care

which is absolutely identical to Obama Care except on a state level, despite what Governor Romney might think. You already saw the wait time to see a physician in Massachusetts has gone from thirty-three days to fifty-five days on average since the plan went into effect because you can't increase the demand while retarding the supply and expect anything except shortages.

DAVID Well that was a great opening. {Laughter}

LAURA I want to ask a question. My basic question would be, you've given us a lot of facts and you started with the commodity and the pricing mechanisms so I want to know, is your conception of society that basically people get or do not get health care on the basis of their ability to pay and nothing else?

MICHAEL No. I believe that we can subsidize people but I believe the Health Care System is a lousy subsidy mechanism. I believe if you essentially have an income problem; people can't afford health care so it's an income problem not a health care problem so I'm happy to deal with giving them income to purchase health care but I believe that ultimately you essentially have market pricing of the health care in order for it to be affective that you can't essentially have price controls because they will ultimately will always lead to this shortage problem.

LAURA Ok I just wanted to understand that. I think that's an important issue about how you would get it because I was trying to get at the notion that to some extent it's different from, you know the notion because you also said we live in a society where some say health care is a right and basically people can spend whatever they spend. One of the challenges for us as a society is to say what do we think is the amount of health care, what kind of a society do we want to live in? What is the amount of health care that we think our citizens should have access to independent of their level of income? That's a separate issue for whether you stop people who are wealthy enough to have a brain scan whenever they want. That's actually quite a separate issue. {Applause} I think we really need to sort of get out into this discussion, what do we value as a society and then how do we figure out how to?

MICHAEL Yeah but there are lots of things…

SUSAN Can I add a practical perspective into these two wings here? {Laughter} Yes we treat health care as a commodity in the market system that we have in place but we can't even get to the question of what level of health care do we want people to have. The fact is that I don't know a state that doesn't have a law that says if a sick person who doesn't have any money walks into a county hospital, they have to care for them or walks into a prison system and California and if they need a heart transplant, they get a heart transplant. The problem with the way we have the system set up is that the sickest people and the people who have no money are dumped onto the tax payer and the government is a lousy entity to run a private sector commodity.

LAURA Except it is the case by the way. As I said, the average un-insured American is consuming substantially less health care. That doesn't mean that the sickest person doesn't end up if they have no money, indigent and being shifted on to the tax payer. That actually does happen. But I do think we should note that people who are not insured are not consuming nearly the same amount of those insured.

MICHAEL But the cost of uncompensated care is about two and a half percent of total health care spending; the actual cost, not hospital charges but essentially if you look at the actual costs, two and half percent of health care spending. Now maybe if we could reduce that and cut it in half or something like that we'd be down to an amount that I'm willing to eat as a tax payer in society.

LAURA Yeah but it doesn't solve the problem.

MICHAEL The question ultimately is that we're not going to provide everything for everybody.

LAURA No, that's why I said at the beginning we can't provide everything for everybody.

DAVID So let me just stop there because I hear you all saying one thing in common which is we're on a path of budgetary impossibility.

MICHAEL Yeah.

LAURA Yes.

DAVID To varying degrees so the question is where do you draw the line? You have to bring rationing into the open it seems to me and actually begin talking about what are some minimal levels?

LAURA But the rationing, I want to say, because this is important if we're talking about it. I think two things. Why are we so bad at this? Let's be serious here. We're spending seventy percent of GDP compared to the average of other industrial countries of ten. We have the un-insured, they don't and we don't have superior outcomes.

MICHAEL Oh I disagree strongly with that.

LAURA I think there is plenty of evidence with all of that. Lots of people believe that. Certainly they would believe for much on average our health outcomes are not superior. They are not superior.

They're superior for people at the high end and at certain age levels and that's it and for the average they're not. For the average person, for the medium person they're not.

MICHAEL If you look at survival rates for almost any disease; pick a survival rate for cancer, heart disease, AIDS, pneumonia; the survival rate is higher in the U.S. than in other countries.

LAURA Alright so I said at the high end you can get it.

MICHAEL Would you rather it pushed down so that we can all level out at a low level?

LAURA No. You know what I'm saying? I'm actually trying to put it to us as again, we have to think about, when we think about rationing, we have to think about, and I think you agree with this, how you control the overall cost of the system not the federal cost, not the state cost; the overall cost. So whenever we talk about rationing that we need to think about, and you raised a really interesting example which is where there is some very high cost activity and you may want to say that's only rationed by price. There are some other things which won't be rationed by price and then it gets to the debate about what shouldn't be rationed by price.

DAVID Okay let's kind of move it down to a little bit more of what us economists call a micro economic level and sort of, can the panel walk me through what the impact is on different classes of interest groups? You know there was some mention about the hospitals and the providers, the insurance companies and the pharmaceutical industry. In the directions that we're going here, are there any competent predictions about the impact of reform in its current state or some modified state? I know Susan you like to live where the rubber meets the road.

SUSAN Thank you. I was going to say I want to go through a micro, micro level. You see employer based coverage has gone down slightly. You've seen a shift in the individual market to more high deductible plans so just taking that fact for a second as a consumer before we even get to rationing and maybe I'm not just an economist is why I'm missing the point here but we're spending so much on health care. Even if you can disagree on whether or not we have great outcome, good outcome, bad outcome, we're spending way too much for what we're getting for it.

LAURA Yes we are. We all agree.

MICHAEL We all agree.

SUSAN So before we even talk about rationing, we need to figure out how to move some of the money that we're wasting in this part and use that money in able to expand coverage so people who

need the service get the service and you don't have to just continually raise taxes or whatever to do it. So okay as a consumer I went from, as an individual, and I've had a PPO for the last I don't know, twenty years, and my rates were going up. I finally hit the magic fifty and my rates started going up to the point where I shifted to a high deductible plan. Well on my other plan I would go in and if the doctor told me I needed an MRI I would say fine, I'm not paying for that MRI so if he says I need an MRI then I'm getting the MRI. I loaded up the Blue Plan and it wasn't my money and I don't care how much transparency, I don't care if they told what the quality of the outcome was or whatever, it's not my money so I don't care. Just give me the MRI. Now I shifted to a high deductible plan. This actually happened to me. I started running last year and I had a problem with my ankle, went into my orthopedist for something else and I snuck in the question and he said I think it's this but you're going to need an MRI in order for me to be sure and you might need to have surgery on it. I was like whoa, whoa, whoa, whoa. {Laughter} Do I really need that MRI because now I have to pay for that? This thing, I bet you it will heal on its own. {Laughter} And it did. I just ran my first half marathon. I did not get the MRI. {Applause} Now what does that mean? It doesn't mean that we're going to save money by fewer people getting MRI's. It means that somebody who needs an MRI is going to get one and somebody who didn't need one didn't waste the money.

LAURA But there will be fewer MRI's and therefore I think to answer David's question, that's a great example. There will be fewer MRI's. A lot of MRI's are unnecessary. A lot of MRI's have nothing to do with case-based evidence at all. You pay attention as a consumer. The provider of MRI's will be giving fewer MRI's. There's no doubt about that so I think part of this is indeed we have overutilization of all kinds of tests because it's in the interest of the providers to provide the tests and it's not in your interest not to have to test. So if you're a smart consumer the provider will get less money.

SUSAN Right so in terms of Health Care Reform, if states like California use the tools that exist and we wrote in some special magic tools into the Health Exchange Bill that allow us to add whatever criteria we want to for who can sell into the Exchange so if we can find a way to shift more high deductible plans. It's not so much transparency as a direct relationship between the consumer and the cost of health care you're going to see a change in behavior and you're going to see a change in the market. And if we can also deal with some of the transparency issues like, there's a hospital chain and it covers a very large part of California and they're they dominant hospital chain so they can go to the largest, biggest, baddest health insurance plan on the block and say you know what we're going to triple our daily bed rates for hospital beds and you're going to pay it. And they do.

LAURA Lack of competition.

SUSAN But there's a nondisclosure clause so they can't even say; the health plan can't even disclose what the rates are that they're being charged and why they had to tell consumers their rates are going up by thirty-nine percent or forty percent or whatever it is. As a Health Exchange we might be able to

say, you're not allowed to sign contracts that have those nondisclosure provisions so it becomes transparent. {Applause}

LAURA That's good. That's a regulation by the way.

SUSAN That's a regulation.

LAURA I just want to point that out. Because there have never been regulations of the insurance industry.

DAVID Alright please. Mr. Tanner.

MICHAEL My question would be though in the Health Care Bill it actually cuts back on those mechanisms that involve consumer caution. It for example cuts contributions for flexible spending accounts in half. It basically is going to eliminate health savings accounts as an insurance mechanism.

LAURA I don't support all, as I said I stayed out of the health care legislation. I don't support all of the lines in it.

MICHAEL I won't blame you for it. I'm not trying to blame you.=

DAVID It's clear that we're taking the covers off and have discovered there are some deep conundrums in the health care issue. {Laughter} In the audience, there may be a question or two that will cut to the bottom of it and enable us to get a solution before dinner. {Laughter}

LAURA Oh great. Much appreciated.

DAVID Is there anybody here who would like to put a question to one or to the panel?

LAURA Or an answer. We would like to put an answer to a question.

DAVID Excuse me. Is there anybody here who has an answer that they can give the panel? {Laughter} Dr. Shepherd, please.

DR. SHEPHERD It's really quite splintered now. It's really an excellent panel but I was surprised that the Bill was sold as helping and is doubling our worst premiums. If you go through the arithmetic, you or Laura, you do realize that's not possible. Either employers or consumers aren't going to pay that. They couldn't possibly take that hit so we economists talk about agency problems but there are real

agents out there like employers who either won't offer insurance or they'll increase deductibles or people will get bounced out. That problem is going to solve itself. So if you went a little later you wouldn't see the health care cost if you didn't do anything about access, you wouldn't see this rate increase and cost increases because there couldn't be.

MICHAEL I don't think it's going to solve itself so much as shift the cost. I think what's going to happen is as these costs rise employers are essentially going to decide it's much cheaper to pay than to play and they're essentially going to get out even faster if they're already getting out of the health insurance business but they're going to get even faster and dump these folks into the exchanges for when the subsidy is in place and when federal government's going to have to get in on picking up the cost.

DR. SHEPHERD The interesting question is will the Bill somehow undermine what would have happened anyway for the private sector which would have solved the problem because we can't afford it. The relevant agents would take over and there would be deductibles or anything like that because there is no other way.

MICHAEL But you're limited because deductibles are limited and co-payments and all these things are limited under the Bill.

DR. SHEPHERD Yeah but they've added all sorts of ambulatory things.

LAURA Well I think that may be right. I don't know but again what I would say here is that Susan argued and Michael argued that; Susan argued that the effort was not at all influenced by cost and Michael said it certainly was going to increase cost. I actually think and this is not talking about the Bill itself but it's talking about the motivation of the Bill. The list of things that I mentioned; bundling, IPAD, tax exclusion, prevention, use of information technology, all those things were things that the health care community were saying to the people trying to draft the Bill. This is what will help bend the cost curve per person okay? Now every single one of these things made it into the Bill in extremely weak forms because the politics around the Bill meant that every cost containment mechanism that was suggested; either a provider proposed it or an insurance company proposed it or a congressman proposed it, a consumer proposed it, so you end up with a list which has got just about everything on it that we currently know about bringing that cost per person down, but very weak. So I think that the view, if you let the market do it I think we have to start with the notion that the market for insurance and the market for health care I would say is by the nature of the market, a flawed market. It is always going to have to have for moral hazard reasons, for adverse selections reasons, for the need to pool reasons; it is always going to have to have a significant amount of government regulation. The attempt here was to try to bring the cost curve down. It didn't succeed because of all the, or it will succeed or

not succeed but in a very weak way. I don't think you can solve the health insurance problem of the United States, health care of the United States, just by letting the market determine it.

SUSAN I have to add something here. First of all, I question how the market could solve this problem; how you think the private market could solve this problem when all that's really happening is you're shifting it to the government. You're shifting it to tax payers. It may solve it for themselves, but it means more people are going to walk into the public hospital system that's already collapsing and we don't have the, its state resources that have to go in and shore them up. So I question how, you have to address the problem holistically and not just solve the problem for one sector. I do believe that there are some tools in here that can bend the cost curve if they're implemented properly. The problem is that without dealing with the real drivers of the bigger tickets items, it's going to, I think the costs are going to go up more in other areas.

MICHAEL Let me weigh in on this.

DAVID Let me take one more question on the floor because I know that people are on the verge of starvation. {Laughter} There's one here and one back there so two more. So Dr. Miller.

DR. MILLER I did have a question that I realize might cause some trouble but I wanted to pick up on something that Laura Tyson said. We are in a situation or in a world I should say where all of the other western nations are spending as you said, about half of their GDP on health care of what we're spending and regardless of how you want to measure it, the outcomes that they're receiving are at least as good as what we're getting. The ultimate outcome perhaps being the length of time that people live.

MICHAEL It's a terrible measure. The life expectancy has so many endogenous (?) factors; it is a terrible measure of quality of health care system.

DR. MILLER Okay, regardless, how do we continue to support? I think what generated my question is that it sounded so bad, what you were saying. It sounded so dire. It sounds as though there is no way that our health care system can be sustained in terms of what you were describing. I would just like to hear what you have to say about why then do we have to continue to follow our different pattern of the kind of system we have as opposed to a government sponsored single payer system?

MICHAEL Well let me say upfront that as I say I do think that if you look at life expectancy as a measure of health care system, things like murder rates, suicide rates, accident rates, life style; all these things figure in and you actually extract all of those sort of things, our life expectancy does pretty well by world comparisons. Second point I would make is that yes these countries are spending less than us but are starting at a fairly low base. If you actually look at annual increases over the last ten years or so, they

are actually pretty close to ours. They are actually and essentially what's happening is outcomes are converging for slower (?) prices because technology and stuff is now infused so fast around the world that basically their systems begin to look more and more like ours and these things begin to match. The third is when you talk about single payer systems what you actually find is that you have national health care systems but those systems that actually offer the most choice and the best outcomes like France, Switzerland, the Netherlands are not actually single payer systems. They are actually systems that have all a high degree of consumer cost sharing. In fact the average French citizen pays more out of pocket than the average American and so does the average Swiss pays more out of pocket than we do. You know the government spends fifty-two cents out of every health care dollar in the United States and indirectly subsidizes thirty-seven cents more so we hardly have a wildly free market health care system in this country.

DAVID One more question.

FEMALE VOICE #1 Part of Health Care Reform and I think these are wonderful goals are Coronation of Care and Health I.T. The problem with both of those is they cost a lot of money to get the HR's involved and the staff to make calls with appointment reminders and the like, especially around some of the quality initiatives you really actually have to put personnel. What I've noticed is that striving people towards having them feeling like they are integrating with big hospital systems or they have to so the small provider is scared right now. It looks like we're routing back towards the capitation system of the nineties with integrated health care. I know that there is quality now and I know that that's different but how do you see health care moving forward and how do you see the small provider dealing with the cost to comply with Health Care Reform?

LAURA Small provider? I don't know. {Laughter}

FEMALE VOICE #1 Sorry.

LAURA No. I think you've pointed out a very important micro, micro question and I would say that my only point of all of this is I think that and I think David started this. There are major implications. We've talked here a lot about sort of the size of government, the role of government. There are vast implications if you want to really bring that cost curve lying down to GDP plus one or GDP plus .05, there is going to be, the providers are going to take some of this pain and they're going to take it seriously and it may very well be that the small providers take most of it. I really don't know but the point is you cannot, even if the rest of the world is at ten and moving up to twelve, we're at seventeen moving up to twenty. We have, regardless of the system so far has totally failed to slow the health care costs per capita lying down. In terms of providers; not mainly in terms of how's the dollar spent but in terms of the providers, we have the most privatized system in the world and that's how efficient we are? So I clearly think yeah providers here, hospitals here as well as consumers here are going to end up if we

have to bring this cost curve down lying dramatically are going to end up having to take hits relative to their expectations.

MICHAEL The small providers are going to go away. Marcus Welby is no more. These independent physicians are joining these physicians groups and stuff like that. I think that's going to be the future.

LAURA That's what I think she was talking about; joining the integrated health care system with the primary providers.

MICHAEL That's the way it's going under any system regardless of the….

SUSAN It's kind of like when you get a kid in one of the hoods in California, you're going to have to join a gang. {Laughter}

DAVID Well folks, unfortunately we're at the end of time so before inviting you to start your dinner and as you go home tonight, recognize that asteroid is still coming in. I just want you all to provide a hearty round of applause to our excellent panel. Thank you all.

*With light edits to the transcript provided by the Berkeley Research Group.