

American Enterprise Institute for Public Policy Research
Health Reform Then and Now: What Do We Need to Know?
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Joseph Antos: I want to welcome everyone here to this morning's discussion of health reform, focusing on what the public knows about the proposals and what they and the Congress need to know to make an informed decision. I'm Joe Antos of the American Enterprise Institute and I will introduce the panel in just a minute.

Much of the recent debate over health reform has been acrimonious as we all know with heated statements really from both sides on these issues. However, before we begin, let's place this debate in perspective by taking a moment to remember the sacrifice and heroism that occurred on another September 11th. Thank you.

So, people have been arguing over the president's plan but until Wednesday night, no one had actually seen it. Now, in case you missed it, here it is. That didn't work.

Robert Reischauer: Yes, there it is. You're right.

Joseph Antos: There it is. Now, it's a little blurry but that's appropriate. This is actually the card. I read yesterday that the Democrats have been given a card from the White House and, fortunately, I found online somewhere the card. So this is the image of the card and I'm not going to

read the details because there's too much to read here but the key is that this is a very slimmed down piece of legislation. It's not the 1,100 pages that we've grown to expect.

Male Voice: We can read that.

Joseph Antos: And we can read that, right. All those words have some sort of meaning, although, as I think many of us found listening to the speech on Wednesday night, everybody came away with a different sense of what that meaning was. And that, of course, is one of the problems that's fueling the ongoing uproar over health reform. The House has produced two versions of a bill. The Senate HELP Committee has produced a fragment of legislation conveniently leaving the nasty bits about how they're going to pay for it to the committee of jurisdiction. If in doubt, join the HELP Committee; it's easier. And then Senator Baucus a couple of days ago issued an 18-page framework for his Gang of Six that in fact might well become the core of the final legislation. Certainly, many of the things that the president referred to in his speech on Wednesday night seemed to come right out of the Baucus playbook, but that remains to be seen.

In any event, we're having arguments now that are likely to be moot in another month -- well, or three or more. So what do we know about this? This is a sharp contrast to the rollout of the Clinton health reform in '93 and '94. The Clinton

reform of course really had something like a year's head start. When Bill Clinton was inaugurated, it was completely clear there was going to be health reform just like this time but he set into motion a complex, and some people claim mysterious but actually just boring and tedious process - although Len may have a different view on that - to develop within the confines of essentially the White House the detailed specifications that we're still waiting for from the Congress.

Now, some people say that the Health Security Act was released on October 27, 1993 but actually I don't think that's true. I did a little research and I think the actual legislation probably didn't become public until sometime in November, right? So -- but in any event, there was - what would you say - about nine months or so of actual policy development.

Len Nichols: It's like 20 years in those lines.

Joseph Antos: Well, 20 years and nine months [cross-talking] so we've had another 10, Len. That's good news. But a very long period of policy development that brought in literally hundreds of experts but not very many congressmen to develop a complex bill. This time around -- well, and then we have kind of to get to the rest of the timeline, so CBO got their hands on the bill and by sometime in February of 1994 produced this volume which would still be a bestseller, except

they give their products away for free. This is a very, very thorough analysis of the Clinton reform. It goes in some ways beyond what most people think of as the CBO cost estimate but it provided a great deal of very useful information and I'll say something more about it specifically and then of course we had the political process that followed on throughout 1994.

It seems to me that we are politically where -- right now, we are politically where the Clinton reform was in February or maybe June or maybe even September - although probably not that late - of 1994, in the sense that the political process this year, from what we heard from the president, suggests that if there's going to be a bill to sign, it's going to be signed on or before Christmas Eve. So that gives only a few months to complete the political process; however, from the policy development and analytic standpoint I would argue that we haven't gotten to January of '94 and we may not have gotten -- or February of '94 and we may not have gotten to June of '93 either. We know some things about what's emerging but we don't know an awful lot and we don't know really what the bill looks like, and so you can't fault CBO for not being able to analyze in detail that which doesn't fully exist yet.

Now, I wanted to just mention some of the key points by regaling you with a little bit of the table of contents here for this book. They did a very long summary of the proposal

which is very helpful because it actually explained very complicated provisions in actual English words that many people could understand - a remarkable accomplishment. They of course hit the budgetary aspects of the bill. That's CBO's main job. They also discussed a question that is a question -- could be a question this year which is essentially how do you treat what they called health alliances back then and you might think of it as either the exchanges or the public plan - it depends on what exactly those things actually mean - but how to treat those concepts in the budget.

Then, economic effects of the proposal, including interesting questions such as: How would total national health spending be affected by the bill? What would be the business reaction? How much would they end up paying or saving? Who would carry the burden of additional costs? Who would benefit from additional savings? At least in general terms, what would happen to employment in the labor force? And then finally, the runaway, best part of this whole volume, a section called "Other Considerations," which raised the ugly question, just how is it possible to implement such a gigantic and complicated bill?

The contrast is contained in my -- let's see. Is this my folder? The contrast is contained in -- I think I have all of the CBO letters that have come out this year on specific

questions raised about either the -- any of the versions of the House or Senate bills and it's this much. It's a lot of writing but a lot of it stays very close to the kind of narrower budget estimate and impact on the number who get covered and the other sorts of questions that come up aren't dealt with nearly as well as CBO was able to do 15 years ago.

So, there is the dilemma. We really do need -- and by, we, I mean not just the public, the Congress needs to have a better understanding of what they might well be voting on in the next month or two. And CBO is a reliable source of that information. You may not necessarily agree with them but they don't particularly have an axe to grind other than the traditional economists' acts which we'll probably talk about here. So, we're really, I think, at a great disadvantage in terms of public policymaking this year, simply because the process hasn't ripened to the point where this kind of analysis can be done and yet the politics may well drive the vote ahead before we really understand what might be in the bill to come.

Okay. So with that introduction, let me briefly introduce the panel and at some point, I will reserve some time to blather on myself about some things that have occurred to me, but I think I've done enough of an introduction here. We're going to speak in the following order: Bob Reischauer is going to be the first speaker. Bob was the director of CBO during

the Clinton health reform era and was responsible for getting this very important and complex and interesting report out as quickly as it did, along with several hundred of his colleagues.

Bill Gradison -- I think everyone -- by the way, I think everyone has the bios so I'm only going to mention their roles with respect to health reform. Bill Gradison back in those days was the president of what was called the Health Insurance Association of America. This was the trade association for traditional health insurers, and his organization played a particularly interesting role; they put up a series of ads that are now being reprised through two actors named Harry and Louise.

Then, we have Dean Rosen. Dean Rosen was on the Hill then and more recently, he was the chief health advisor - I hope I have that right - to Senator Frist when the senator was the senate majority leader. Len Nichols was the -- I think you were the chief health policy advisor at OMB back in the good old days and continues to toil in these vineyards. And then finally, Jim Capretta who was also on the Hill back then spent some time at OMB and has been talking about these issues for a long, long time. So with that, let me turn it over to Bob and continue.

Robert Reischauer: Okay, yeah. Thank you, Joe. First of all, let me just say that I agree with Joe's basic premise here which is it's very hard to talk in any kind of specificity about that which we don't have the specifics to look at, and the most important things we need to know are the impacts of this on the economy, on people, on the distribution and the ways in which we might have government and private entities administer the changes that we have. I thought it might be useful if I quickly went through as a context for the remarks of others what's different now and what's the same and the extent to which these factors will either make this task harder or more difficult. And I have eight areas in which I think the situation is quite different now from how it was before and a couple that are quite similar.

First, there's the budget context and if you recall back in '93, we had just enacted the Omnibus Budget Reconciliation Act in the summer of '93 and that was to put the deficit on a path that we wanted to adhere to and the task for health reformers is "don't screw that up," but the budget in a sense wasn't a big focus here. Now, we're in an environment in which we're told that the budget problem is the growth of healthcare costs problem, and we're not going to deal with our unsustainable fiscal path unless we can devise a health reform that over the long run at least, will lower, not just federal

costs, healthcare costs, but also costs in the broader economy. There's a consensus -- we have a consensus as the president suggests that I think could be reached if we had \$300 billion to \$600 billion to throw at it but we don't.

And so the real test here in my mind is sort of not what this is to look like over the next 10 years - Is it deficit neutral? Do we pay for every penny that we spend? But, looking out at the ninth and 10th year, is the new spending less than the savings and is that gap growing? And if the answer to that is no, I think we've then failed in the fundamental objective, one of the two fundamental objectives, of this whole effort.

The second area in which things are considerably different is the economic context. When we took this up in '93 and '94, we were two and a half years beyond the trough of the recession and the unemployment rate had peaked at 7.8 percent in the summer of 1992 and was slowly falling. It peaked at 7.8 percent. By the time this was introduced, it was 6.5 percent. By the time it died, it was 6 percent. So people weren't happy. The economy wasn't chugging but it was improving. Where are we now while the thing was unveiled or the effort was initiated? When the economy was when in freefall, unemployment is still rising. We were on the brink of worldwide financial meltdown. The government took extraordinary actions which have

clearly made the American people leery about the role which government is now playing in the economy's life.

No one is asking what's the counterfactual? If it hadn't rescued GM, if it hadn't -- if the Fed hadn't poured money into the system, what -- where would we be now? The answer is clearly we don't know but I think most of us would say a whole lot worse off than we are right now. But this has created a situation, economic context, which makes this challenge much harder to succeed on.

I don't need to really say anything about the political context. It was very partisan. The budget debate back in '93-- OBRA was passed without a single Republican vote but it's hard to look at then versus now and say it's not more contentious now. I think it certainly is. And we have far fewer moderates, far fewer legislative giants like Bob Dole or Chaffee or George Mitchell or people who were willing to go beyond their party's narrow political interests to try and work out a deal.

The media environment is clearly more inhospitable to any major policy change, particularly issues like health reform which are very, very easy to demagogue. We got our news back then through three network channels. People still read newspapers back then. There were no widespread cable talk show hosts that had no reins of responsibility placed on them.

Joseph Antos: Other than C-SPAN. We want to mention C-SPAN.

Robert Reischauer: Oh, okay. Well, that's a positive. And, unfortunately, the viewers of this will be a tiny fraction of those watching any of the shouting shows.

Len Nichols: [Inaudible]

Robert Reischauer: Well, we're waiting for you, Len - defined roles here.

The fifth difference which I think makes things a bit easier is we have the ability to understand and measure quality and risk to a degree that we didn't back then, and when you think of putting together a sensible health reform plan, one that will work, I think this is terribly important. We aren't where we should be on this. We aren't where we will be in five years, but we're moving quite rapidly down a road here to get the kinds of information and ability to adjust payments that Len and I would've given our right arm to have back in 1993.

Another area of difference is the perception of the U.S. healthcare system relative to that of the rest of the world. Back in '93, we were pretty smug and we had no problem saying, "You know, we might pay more than everybody else and we might leave 10 or 12 percent of the population uninsured but the healthcare in America is the best in the world for those who are getting it." A lot of studies have brought that into

question now, and while certainly for some people in some circumstances that is still true, the evidence gathered by the Commonwealth Fund and others show that we have fallen pretty far behind a number of western European countries on all sorts of measures of quality, even ones that we used to pride ourselves in, which is how fast can I get a doctor's appointment, or can I get a doctor's appointment on the weekends. So that -- I don't think that has seeped into the nation's consciousness yet, but that is a factor that should help reform advocates.

A seventh area of difference is our consciousness about the geographic differences in the cost of care and the lack of relationship between the cost and the quality of care. We know that for same families, same incomes, same composition, same insurance policy will cost twice as much in Miami as it will cost in Minneapolis. And this is an important set of knowledge that we have now but it makes reform infinitely harder in a political system that is geographically based, because what this means is for standard policies either the subsidy level for a low-income person has to be very different in the geographic areas of the country or the burden placed on that family for insurance has to be very different. And this is an issue which people haven't focused on yet because as Joe said, the detail just isn't out there.

An eighth and last sort of area of difference is the consensus that exists among stakeholders, now, provider groups, suppliers, insurance - insurers - whatever, that reform is inevitable. The question is not whether we're going to have it; it's when and how. And so at least at a superficial level, we have a lot more agreement now than we had back then which makes at least the first steps of this a lot easier.

What's the same? One thing that strikes me as the same is the American people and many of their leaders remain woefully confused and misinformed about health. And they don't understand who's footing the bill; is it the employer or the worker? They don't fully appreciate what the insurance they're receiving through an employer costs. They think their premiums are outrageous. Even though they're paying a rather small fraction of the total, they're sure that they could have the same thing but a whole lot cheaper and there must be somebody out there screwing them.

I mean it's the insurer, it's the drug company, and it's providers of one sort or another. They don't want to look in the mirror and say, "Hey, I might be a part of this. I want an MRI for things" which in other countries people don't get MRIs for and the value provided by that MRI for better healthcare is of marginal importance. It's very hard to change something in a rational way which people don't understand and that's what

we've been trying to do. And I think a huge education task lies before us whether we are successful in this realm or not.

Lastly, something that's the same is, our ability to estimate with any confidence the consequences of various health reform bills is quite limited, and this is a confession of somebody who spent a good part of his life doing this. And it's not for a lack of trying. CBO, various independent organizations - the Urban Institute, for one, RAND, Mathematica and others - have really devoted a lot of resources, a lot of talent in doing this but it is an unbelievable devilishly complicated task and we don't really have the fundamental database that one would want to have to try and develop models which you had a lot of confidence in.

What you ideally would want is a database, longitudinal database of individuals with their socioeconomic characteristics, their relationships to other people in family or an insurance unit, characteristics of their employers, of the insurance that they could have available to them under different circumstances, then some ability to see how all of this change for significant changes in policy. We're estimating models based on small changes in policy and we're talking about rather large changes in policy and so we don't know really how will employers respond when the whole situation changes. Will there be tipping points where many bail out or

not? How will providers think about changing the way they organize themselves and they deliver care? These are questions which we're making good educated guesses about, but there's a huge range of uncertainties surrounding those estimates.

Joseph Antos: Thanks Bob. Let me ask you two quick questions. On your last point about the limited ability to analyze complicated proposals, do you think the ability has improved or just become more -- it's more of we can do more analysis but it's not necessarily better analysis. Is the data better? Are the methods better? Are the studies that have taken place over the last 15 years something you can rely on?

Robert Reischauer: I think they're better but modestly better. I don't think they're significantly better, and so were I'm betting my retirement on this, I wouldn't place a bigger bet. Of course I don't have the retirement that I had back then.

Joseph Antos: Well, that's a great source of comfort. Your point about the mis -- people and politicians being misinformed about basically how healthcare works, I think it's certainly right, but -- and this is not really a question so much as a statement I suppose. It raises a real issue it seems to me in how you get a political consensus over an individual personal decision when it comes to the use of healthcare, that MRI for example. And we economists say, "Well, we need to put

some financial incentives in there." But that's probably not completely it, so that's something we ought to talk about maybe later in the panel.

Robert Reischauer: Well, I think basically the American people and certainly their political leaders don't have a realistic view of what the range of viable options are for the long run because they're politically difficult to swallow. And it's easy for all of us to prescribe systems for society as a whole but when my kid's sick, I'm not sure I want to go along with that.

Joseph Antos: Right, exactly.

Bill Gradison: Bob, I'm sorry to hear about your retirement but I think the public will benefit if you continue to labor even longer in the vineyards on this subject.

Since over 80 percent of the public had some kind of health insurance back during the days the Clinton plan was being considered as well as now, the views of the public I felt were the key to success or failure of healthcare legislation, and the insured do vote. Ken Thorp has estimated that 96 percent of those who voted in 2006 had health insurance. Poll after poll then - that is in 1993 and 1994 and now - indicate that people want to keep what they have and the main change they want is to pay less for it. The vague assurances that you can keep what you have and not have to pay more I think are

insufficient to give reassurance to people who are obviously concerned about what these plans mean to them, what they mean to their family.

It's difficult to be specific as I would -- it's difficult to be as specific as I'd like to be about that because there isn't this specific plan that I can point to, but what if you have a policy you like but it isn't offered through the exchange? What if you have a very high deductible individual health insurance plan, which is not uncommon among farmers and ranchers, and those policies in effect are outlawed? Maybe none of the plans that are permitted in the individual market will permit a \$10,000-deductible as an example. What if your insurer increases -- and this is probably the most important specific that I can raise now, what if your insurer increases your premiums to try to make up for the new excise taxes that are talked about being imposed upon the insurance companies?

I think I can pretty well sum up what I think we knew then by quoting Gradison's law - if you don't mind - which goes back 15 or 20 years, which was simply: health reform will be decided not by speeches or television ads but over the kitchen table as families discuss how it will affect them, which of course was where the Harry and Louise notion came from.

Interestingly, back in those days when I was heading the Health Insurance Association of America, we did something a

little bit unusual internally which was, we did a daily national tracking poll of support for health insurance reform and I recall very specifically that the high point was at the president's -- at the time of President Clinton's speech, which by the way I thought at the time was one of the best speeches I'd ever heard a president give in my lifetime and I haven't changed my mind about that. But what happened afterwards, and we picked this up in our data, support just started to slip, not dramatically but just steadily behind, went down and the longer the plan was out there after his speech, it appeared the less support there was for it at the time. In that I think what happened is that the more the public knew about the plan, the less they liked it or in a sense, to know it was not to love it.

When I was serving in the House, my great mentor and a friend, was Barber Conable who was our ranking member on the Ways and Means Committee. There was some big -- I mean really big bill we had before us. So I voted for and he voted against. It wasn't healthcare; I think it was tax. And I remember saying, "Barber, why did you vote against that?" He said, "Bill," referring to something that thick, "there's something in there for everyone to hate." And I think this is something to keep in mind, that if a bill is rushed through too fast, there may be things in there that once they become

public, it can cause some real concern among the body politic. It's something to think about.

Joe has asked us, "Well, what do we need to know now?" I think the real question is what do American families need to know now. I think the most important thing is just the specifics, a specific plan or even two or three alternative plans. It has been puzzling to me over the last month or so to hear people arguing for or against the plan. Well, there isn't a plan to be for or against at this point of time. Much, far too much of what has passed for public discourse has been based as much on lack of information, probably more on lack of information as it has been on misinformation.

I've been especially interested in how information is disseminated and particularly the role of trade associations and membership groups because that's what I used to do back in that period. I think interest groups do play a key role in this process, not by general statements of support or opposition but by telling their constituents just what this plan or that will mean for them, their policyholders for an insurance company, or the dues-paying members of their association. For example, the AARP, for which I have a very high regard, appears to be supporting the use of very large savings from Medicare as a major source for financing expanded coverage. Should we be surprised that many Medicare

beneficiaries who pay dues to AARP would prefer that such savings be used to bolster the admittedly shaky financing status of Medicare? Is this tradeoff -- it isn't even being discussed very much. I think that's kind of curious.

Insurers with whom I was associated back in those days have quite properly said that preexisting conditions will no longer be a barrier to coverage. Of course, that assumes universal coverage or something very close to it. Question: Will there be adequate funding to avoid a premium death spiral during the transition to new universal coverage? You have to phase these things in and I'm not saying there's been no discussion of it, but this can take a lot of money to make that thing work because the sicker people are likely to be the first ones to sign up once policies become generally available and the premiums come down.

I focus on insurers since reform of insurance regulation is getting a lot of attention. It has almost become the centerpiece of the debate in the last month or two. Insurers who currently, obviously, play a key role in providing health insurance have this time, unlike 1993 and 1994, been offered a seat at the table. I assure you, we weren't back then. And they are on the universal coverage bandwagon which is great. Their great reward for coming to the table is hearing that a public plan is needed to keep health insurance honest.

I heard that again from Senator Reed as I was driving to work this morning; using the word honest. Have they been dishonest? Have dishonest people been invited to the table? Have insurers been violating current state insurance regulations? Perhaps demonizing insurance will help - insurers - will help to sell reform but at what price?

The long-term implications of the current debates extend well beyond health insurance and I'm not hearing any debate about this. Should there be government options at other parts of the economy where people are unhappy with what's going on? Are there other industries which aren't honest? Should we have government oil companies or government pharmaceutical companies or government banks or government real estate appraisers? That might be pretty popular right now.

On the short list of what we need to know, and this is my really major substantive point, where's the capital going to come from to finance coverage for tens of millions of additional people? In my view, there was almost no discussion of this point in 1993 and 1994. Regardless of whether insurers are for-profit, not-for-profit, mutual or coops, they need capital and they need to earn a profit. Criticizing insurers for earning profits is not very constructive. If there is to be a private sector role, capital can only come from reinvesting profits or from borrowing or stock issuances based

upon evidence of likely future profitability, and coops are no different and they do exist in the healthcare field in some of parts of the country right now. They generally rely on reinvested profits to finance expansion and sometimes they run into conflicts between using profits for growth versus using profits to expand benefits or reduce premiums.

Will the new coops currently being discussed have implied federal guarantees on their debt, a la of Fannie and Freddie? Will the coops be permitted to fail if they exhaust their resources or will they be bailed out? Will existing health coops or not-for-profit or mutual insurance companies be treated the same as the new coops? I think these points are worth discussing.

Finally, I want to say a word about financing which there was at least some discussion of how the financing of health reform relates to other priorities. I have already mentioned what I think is the relationship to the solvency of the Medicare program, but along the same lines, wouldn't committing, let's say, increased marginal income tax rates to health reform make it harder in the future to reduce the deficit or to reform the tax system which are also worthy goals? And how high can marginal rates go without slowing economic growth, which at the end of the day is essential to

pay not only for health reform but for all government programs, federal, state and local?

I believe that Congress will act this year. Of course, I thought that the Clinton plan would pass, too, and I did. For what it's worth, my personal preference is for incremental reform and bipartisanship which should be no surprise because that was my approach during my years in the Congress, but I acknowledge that was then and this is now, and incrementalism which was a four-letter word in 1993 and 1994 is once again a four-letter word in 2009.

Joseph Antos: Thank you, Bill. Dean?

Dean Rosen: Thank you very much and thanks again for having me, including me. I have a slightly different list from Bob's but I've tried to focus on about seven things that are the same and about seven things that are different and there's some overlap so I will -- I think you'll hear some very, very similar themes but I have a slightly different perspective. I wanted to focus a little bit more also on some of the intersection between the politics and the substance because I think you can't extract them. You're having a debate about politics, ideology and substance that's all conflated and I think will determine the outcome.

So let's start with the similarities first. You have a young idealistic Democratic president who has staked his

political fortune on healthcare as a priority. That's the same. Number two, you have large Democratic majorities in both the House and the Senate. And I went back and looked, I don't know how many of you remember - Bill probably does - in the House of Representatives we know that even though committees passed bills back in '93 and '94 that health reform didn't come to a vote on the floor of the House and the Senate. There's actually one more - the Democrats had a larger majority in the House at the time than they do now by one - interesting. The Senate's a little different. That's actually the key difference; 60 is a big difference but in the House, it was the same.

A lot's been made in the president's right about the committees moving forward - this is another similarity - but at the time, you also had committees in Congress, the major committees produce bills; in the Senate, the Finance Committee and the -- what was then the Labor Committee under Senator Kennedy both produced bills. So again, similarities: you had then and have now, and Bob referred to this, I think a very, very determined and energized minority in Congress among Republicans - again, very similar to what you have now.

I mentioned this before but this mix of ideological, political and substantive policy debate that you almost can't

extract all these major issues that you sort of feel like you've got one under control and then the other one pops up.

Another similarity but also a difference I think is that at the time - at least it was my recollection - that healthcare reform just dominated the news coverage throughout that two-year period. I mean there was a lot going on with the economy but in terms of the following Congress, it seemed to dominate news coverage although the news outlets were very, very different. And it also I think for those who were there, at least my recollection, just dominated most of the time and energy and oxygen in Congress both in terms of estimating, in terms of committee time. Sheila Burke's here -- limited floor time in the Senate and taking that up. So it was a dominant debate just as it is now and crowds out other major priorities both in terms of congressional focus and in terms of time.

I think finally on the sort of big picture similarities, this is an expansive and an expensive proposition. I remember reading the CBO report at the time as a much younger and certainly more junior staff person and just -- and remembering the reaction of some of the key members of Congress. It was just devastating to them how big and costly this was. I think the same is obviously true now; although, folks seemed to have wrestled with that difference.

There are also some really, really big differences and I think again Bob touched on these. I've got a slightly different list but I want to expand on a couple of these. We haven't touched on it today as much, except in Joe's comments, but I think the timing of reform, the decision that the president made, the administration made, early on to go forward with reform this year is really, really key. If you recall in 1993, I think there was an explicit decision made that we're going to deal with the economy first. We're going to try to deal very painfully through tax increases with sending signals to markets that we're going to deal with our deficit. And now, the president has clearly made the argument from the very, very start, at the get-go, that health reform is inextricably linked with the economy and needs to be done at the same time we're dealing with economic conditions and needs to be done now.

I think actually that one piece if I have to pull out others, and I understand why he did it as a political matter, I think will be one of the things that politically comes back to cause him and others great difficulty as they try to sell the plan for some of the reasons Bob stated on the substance, which is it's a very difficult thing to do. When you look at the CBO analysis, what it says at least of the bills we have is that the costs are going to go up as a result; at least the bills that have been produced in the House by -- and in the Senate so

far. But the timing is key, and I want to come back to that. It makes sense -- a ton of sense politically to try to do it. If you talk to pollsters and you look and compare the polling at the time, the president I think clearly had made the gamble that he was more popular at the outset than he will be later on. That's probably the case. We've certainly seen his popularity fall.

I think a lot of us who are -- some of us anyway who are incrementalists at heart - Bill and probably myself - look at this situation and say, "Oh, my, gosh. We're dealing with Afghanistan. We're dealing with Iraq. You're dealing with the economy. Why would you want to take bailouts? Why would you want to take this on too?" But I think that the president has made the calculation, not just substantively but also politically, I think, that Americans who are concerned about their job, concerned about the economy will be more willing to accept a big change early on. I think that's another reason that I think that he's pushing for it now.

The other big difference and Bill obviously is the representative of this, is just, to me, the sort of interest of having the stakeholder groups at the table. I sort of joke that when Republicans did that, it's called drafting bills in secret with special interest but when the president does it and the Democrats do it, it's having stakeholders at the table, but

it is interesting. If the pharmaceutical industry, the health insurance industry and others -- and I think the calculation was made that those were the folks who in organized opposition, at least some of them last time helped to defeat healthcare reform, that keeping them at the table, at least talking, made sense. So that's a big change.

Bob talked about this earlier but I think that this is really to me playing out in the Senate and I think you'll see over the next couple of weeks just this lack of - in numbers - a real center core, particularly in the Senate, and particularly on the Republican side. You mentioned some of the times of Dole and Danforth and Chaffee but it's interesting in watching the news coverage and having the press call Chuck Grassley or Mike Enzi a moderate Republican. It's just interesting when you think about the days of a Chaffee or a Kassebaum or others.

But that, I think if you look at it, and this is why I think it's so challenging in the Senate and you sort of figure out beyond the three Republicans in the Group of Six who are at the table and maybe one or two others, there just are not the centrists out there to the extent that you look at folks who in the Republican party in the Senate have been willing to cross the aisle and work on major reforms with Democrats. You think about people like George Voinovich. You think about people

like Senator Grassley. You think about people like Judd Gregg or John McCain and a lot of those people when you go down the list also happen to be economic conservatives, budget hawks and others.

So I think it's going to be very, very difficult to find more than one or two or three, perhaps, Republicans in the Senate who are willing to do this. So it makes it politically necessary for it to be a Democratic-only enterprise in a way that I don't think was quite there at the start in '93 and '94. And also, I think it frankly increases the political opportunities and risks for the Democratic Party this time around.

The -- another big change for me, and this has to do a little bit I think with the change in the media, is the strength and the passion of -- we talked about the efforts of the president went to, to try to tamp down on organized opposition. But I think this organic opposition that developed and we saw play out in August and some of it I'm sure was furthered by Astroturf and by people getting out there but I think made possible only by the Internet, made possible only by the kind of media we have now of people saying, "I really care about this. I want to know what it means for my family. I'm going to show up." And to me, anyway, from the folks that I talked to and from some of the town halls that I saw seemed to

be very organic and organized that I think would not have been possible 15 years ago given the state of communication.

The president - and again I think another difference - I remember thinking at the time that when President Clinton gave his address to Congress and pulled out his pen and said that, "If you send me a bill that fails to achieve universal coverage, I'm going to veto it," that was essentially the end of reform because I didn't see any way the Congress could do it at the time. Now, this president has retained flexibility. I think that's one of the reasons that all of us, depending on where we sit and where stand, heard a little bit of a different message earlier this week and I think that was quite intentional. We can debate - I'm sure we will later - who he was trying to speak to and energize. But I think this deference to Congress and flexibility at least on the details is going to be a key difference.

Bob touched on this so I won't go into it for a long time. I just have two other differences and I'll end. But I think the substantive debate at the time was also quite different. I think it was in several ways. There was a lot more effort in '93 and '94 I think around what I think was called at the time sort of market reforms. There was great faith in managed competition, in the dominance or growing dominance of private insurers. There was a feeling that if some of those reforms

could be adopted that it would help slow cost overall, and we're already starting to see some evidence of it in the early days of managed care. And that frankly was what brought a lot of folks in the Republican Party to the table because they -- even though they were willing to spend some of the money but they saw the hope that we could have a more organized and reformed system. And I think you hear a lot less of that now.

You hear a little bit more of a quality debate but I think a lot of it, unfortunately for those who are focused on substance and not on politics, has been obscured by this ideological sort of no-win debate about the public plan, which seems to me if you look at the genealogy of it was created by a political scientist and seems to me to be a political and not a substantive exercise. But I think, unfortunately, as a result of it, we haven't had a lot of real debate about what -- about some of the issues that Bill started to raise; what it means when you've got the subsidies at this level and the cost going up at that level. I think that the character of the substantive debate has been different and I think it has been diminished in part because we've had such a dominant discussion of the public plan.

Then, I'll just come to my last difference and I'll end it there. I think the final difference for me is going to be the outcome. And I agree with Bill and I'll kind of on go on

record and say I think that the difference this time is I think the Congress is going to pass a bill. I think for the Democrats to have 60 votes in the Senate and not to pass a bill would be probably be legislative malpractice for them given how much this president has staked politically on reform. He is way out there. He gave a joint address to Congress. He raised and spent more money than any presidential candidate in history. If you believe the press reports, something like 70 to 75 percent of his advertising dollars in the last few months of the campaign were about his healthcare plan and about the downsides of the John McCain healthcare plan.

So I do not think failure is an option. And I think in the Senate, even if you do not go a reconciliation route and even if you don't get all the centrist Democrats in the Senate to vote for the final bill, you can get them to vote for procedural motions on 60 on-budget points of order and other things to move forward. And in my experience just recently with the prescription drug bill, that in fact is what happened. In fact, it was a great relief to people like Senator Gregg and Senator Lott and others who were 51 Republicans and 49 Democrats to be able to go home and say that they voted against a prescription drug bill that wasn't paid for, but they did vote with the president and they did vote with the leadership on the key procedural motions which got them to 60 votes.

So I think it's -- I think the outcome this time will be different. The question for me is not whether a bill will pass but what will become of it in the minds of the American people maybe not in the next election but in the election when the president runs three years from now. And I asked this question at a dinner last night but I ask it again. The question is whether this bill is going to be more like Medicare or whether it's going to be more like Medicare catastrophic. And I'm not saying it'll be repealed but I think that these questions that the American people have and that they seemed to be asking in August if you really talk to people about how is this going to affect me, which even with a very, very detailed plan I don't think can be answered.

And I'll close my comments with this. I heard our August host Joe Antos yesterday on the radio and I was on NPR and I was driving into work and I was thrilled to hear Joe get a question from a woman in Michigan. I don't know if anyone heard this. I thought it was a really great question about health reform, and her question was essentially that she had been paying premiums; she was self-employed. Her premiums were \$1,000 a month to cover herself and her family and she had gotten a letter from her insurer telling her that her premiums were going to go up by 33 percent. And the rationale that she was given apparently by the insurance company was that there

was some change in the law, the regulation that required more preexisting conditions to be covered.

I'm not sure whether that's right or that's wrong but she was concerned about how the new -- and she asked Joe and she asked Judy Feder very specifically, "How is this going to affect me?" And it occurred to me as I listened to that and I think there are millions of questions like that that we can't answer that. You can't answer that after you pass a bill. You don't know I don't think as a result of any bills before Congress whether it's the one-page card that the president has distributed or whether it's the 1,300-page bill that's passed in the Energy and Commerce Committee, whether that 33 percent is going to stay there, whether it's going to be 20 percent next year but it would've been 30 percent.

And I think that this is where the economic argument, ultimately, the president began on is going to hurt him because I think most people's definition of reform, particularly those people who vote, particularly those people with insurance, is that I'm going to pay less and get more. My access is going to go up or at least stay the same but I'm going to save money. I think the best argument that folks who support the legislation will be able to make at the end of the day is that your premiums didn't go up as quickly as they would've gone up otherwise. And I think that's going to be a very, very

difficult political argument on top of all the implementation and other issues. So I will end there and look forward to the comments of my other colleagues.

Joseph Antos: Thanks. I'm sure Bob shares my astonishment that people don't think in deviations from baseline terms in their daily lives. It's shocking, but they will be thinking about that I guess in the future. The -- I was going to raise a question with you, Dean. God, it has passed. My joke supplanted my real comment. It'll come back. Okay, Len, go ahead.

Len Nichols: Well, Joe thanks for having me. I can't think of a more fun way to spend a rainy Friday morning than reliving 1993 and 1994, so I'll try to be brief.

I do think there are some important things we know now that we didn't know then and I think they're relevant to everything we're talking about. One is we didn't know that 18,000 Americans die every year from not having health insurance, which is what the Institute of Medicine has taught us. If you do the math -- and by the way, that was in 2002, if you adjust it, it's probably 20,000 a year or more now. We stopped debating the Clinton plan in August of '94; it's been 15 years. That's 300,000 people who've died from lack of access to timely care, which they would've had if they had normal not Cadillac health insurance. We didn't know that

then. I suspect if we had known it, we might have debated at least a week longer or at least thought about it.

Second, back then, premiums were about eight percent of the median family income. Today, it's 18 headed toward 35 if you take out just 10 years current trends of both growth in premium and growth in median income, which of course has been stagnated quite a bit by the recent economic excitement.

Third, while we knew it, only the wonks talked about it and that is the single most important stress on our budget is Medicare cost growth. And we knew because we were taught Algebra that the baby-boomers will actually retire and now they're coming. They're going to come in this president's watch, I guarantee it. And when they do, Medicare cost growth is going to increase, just a tad, if you can believe such a thing, going forward. So we know we have to solve this problem.

We have a lot more knowledge of the system, that is to say, the delivery system. We had a decent sense that there was geographic variation because of the lonely work Jack Wennberg was doing there in Dartmouth, but now he has gotten a lot better funding and we know a lot more about it and we started paying more attention to it and so forth.

And I must say to civilians, a simple country health economist like myself, when you look at the variation in

medical practice and spending around the country, it is simultaneously stunning, scary and also full of promise because it turns out one of the things we've learned is there are some parts of our country that are actually doing the stuff right. There are some parts of our country that are delivering very high quality care at very low cost and no one seems to mind much, also no one seems to know much about it so we're trying to write about it. Anyway, we know a lot more about how to do stuff right.

I would say there is also, I would say differences, there has been a growing and maybe even finally complete consensus that excluding people from insurance because they happen to have a health condition is immoral and it shouldn't be continued. I agree with Bill, it's not that insurance executives are immoral; the rules forced them to play the game so you've got to change the rules. What's interesting to me is Paul Ryan now supports guaranteed issue. This is progress in civilization, I would say, because he doesn't have a mandate of course, it's not really a serious proposal but he does agree you've got to say in public now that you are opposed to preexisting conditions, so this is progress.

Then I would say we're equally aware of the obsolete business model of fee for service. We know now fee for service really does encourage volume not value and when you compare us

to other countries, one part of our country to another, you see we're pretty good at engendering volume. Another difference and a thing we know, is that Harry and Louise are now Democrats. It turns out Harry had a cancer problem, I don't remember the details, but Ron Pollock will give you a recorded information story about them but the point is they got -- had a run-in with the way the real world works once you get sick in this country and they were self-employed actors and had individual [sounds like] insurance, so that's kind of intriguing.

I would say some of the things that are the same: The president's job is impossible. I wonder what Madison would think if we were designing it today. On the one hand we had an articulate ambitious president who had a Democratic majority in the House and the Senate. Remember we thought he was articulate because he could talk to Bubba. Bubba's now screaming at town meetings but nevertheless Clinton could do all that and he designed a plan, actually it was in a hotel room for six months. That's where [indiscernible] went to write it, [indiscernible] in a hotel room, and it was designed to be a perfectly logical construct, which at some level it was.

It was not, however, a very effective political document so this president said, okay, I've got the majority in the

Senate, majority in the House, I'm ambitious, I'm articulate, I can't talk to Bubba but I can talk to lots of people and I'm going to let Congress do it because they told me that if I do it then they'll complain about it being all this -- so I'm going to let Congress do it. Well, with all due respect to the critiques of my colleagues, Congress did pretty well. They had three committees in the House agree - now think about this - agree to do this in tandem and they got it out of all committees in one summer, hell, in two months.

So you got a bill, it's not perfect, I would agree to that, and in the Senate you had a chairman who was dying of cancer but the staff of course had pretty clear instructions and Dodd came in and took over and you got a bill out of the Health Committee. The finance committee is clearly stuck but I think it is fair to say they're going to produce something and so I think Congress did its job. The difficulty is Congress didn't do its job in time for there to be more than a one-pager in August.

And so one similarity in now and then is that explaining complexity when people are scared is really hard and I'm not sure anybody could do it. What I observe from the way these things have gone in various places, once you get past the shouting which indeed after some effort you can, when you talk to people about what it is really about and you see the members

do that or you see the people with the members do that and you see people talk among themselves, people can be calmed down. There is a broad recognition that the system now is broken. People are very worried about the health care cost increases. They see no way to stop it. Eighty percent of workers a year ago were surveyed and said they're worried about how they are going to pay for health care in five years and they're covered.

So I think there is some hope there. The difficulty of not having moderates in the Republican Party is a problem. I would observe two things: the moderates are still in Congress; they're just Democrats now. There are 53 Blue Dogs. There isn't going to be a bill that the critical masses of them don't agree with. Similarly, the 15 or so moderate Democrats in the Senate are in states that voted for McCain at some margin of consequence so there isn't going to be a bill they don't agree to either. The difference is there are very few moderates in the Republican Party.

I would say it this way. There's a struggle for the soul of the Republican Party that is playing out in some ways in the heart of Chuck Grassley. You got the party of Lincoln on one hand and you got the party of Strom Thurmond or maybe Jim DeMint or, some days I think John C. Calhoun and that party is totally opposed to government of any form except National Defense and property rights. So there's no way they are going

to reconcile anything. But what's left is the party of Lincoln thinking about whether it's smarter to try to make this thing moderate and workable and join and make it happen or whether it's better to go sing the song of socialism and government takeover and rationing.

Let me tell you why the rationing song is a particularly bad song to sing. We all agree, I believe, that if we don't get the Medicare cost growth trajectory under control, the Chinese will eventually take their money home. The good news is they can't take it really fast because they've got a big pile of dollars and they've really got to keep them in and they have no place else to put their money for about 10 to 15 years. My calculation is we've got somewhere between 10 and 15 years and then they will take it home. So we've got to do this.

Let me tell you a secret. If what you do is scream rationing every time anybody talks about trying to save money in the system, you are making it impossible. Just imagine closing doors and making it impossible to talk about Medicare reform in a serious way in adult fashion. So I will close with this, what I call difference from the past and then the similarity which I think is a common vision we might actually share in this room anyway.

In the past the stakeholders opposed reform for all kinds of very reasonable self-interested reasons. What's striking to

me as a would-be observer of these things is how the stakeholders are actually still at the table. And trust me, it's partly about the little deals Rahm is cutting there in the White House but it's mostly about a very hard headed and clear-eyed perception of their self-interest about what will happen if we do nothing.

What will happen if we do nothing is that the Medicare cost problem will continue to exacerbate and since we'd close all the doors of addressing this in any serious adult way, therefore sports fans, when the Chinese start to get nervous about interest rates, we're going to put on price controls because that will work in the short run to hit a budget target and satisfy our Chinese creditors. These people who run health systems, who really run health systems, who understand everything I'm talking about, they know that. They do not want that and that's why they keep telling the few moderates willing to deal with this, get back in there and solve this problem.

Let me tell you a secret, right now, two-thirds of hospitals lose money on Medicare. Now, one-third don't; therefore, you could argue that Medicare doesn't underpay, we've got a bunch of inefficient hospitals. Okay, now let's agree that it's going to be hard to do reform, let's just assume for the moment, DeMint wins and we do nothing, then we've still got the Medicare problem. So then we're going to

go to the hospitals and do what, take money from them without covering people. Good luck with that, really, really, really good luck with that.

There's only one way to do this, sports fans, and that is together. You have got to figure out that it is a moral question to cover people, it is also - let's be frank - a bribe. It is bribe to buy time so that our hospitals can become as efficient as we need them to be because that is the only way we are going to bend that cost curve and you are not going to get that time or that efficiency without an investment in there and covering the uninsured is a big part of that. What's interesting to me, in fact the best part of the president's speech the other night from my point of view was the linkage between his commitment to, he said, spending, he means coverage expansion, the linkage of that to realized savings; he used the word realized savings.

Now, we can argue all day about whether -- and how to do that but he just said he was for linking them. That's the only way we can do this. You got to get Congress on the line, committed to covering people so they will get serious enough about cost control to stick with it, and you've got to give hospitals enough juice to get over the hemorrhaging so they can get with the program and become as efficient as we need them to be. I know enough real people now, I've gotten to be old and

grey-bearded and this is my last shot and I promised my wife, Christmas 2010 I'm done, will coach high school football the rest of my life. If you don't get this solved this time I'll be out of your hair.

But I know enough CEOs who run real health systems now. In fact I made a group, Health CEOs for Health Reform and they've taught me a ton. And the main thing they've taught me is, Len, just give me the frigging rules and give me the incentives and get out of the way and we'll do this because we'd rather do it than have price controls and they will show the country how. Thank you.

Joseph Antos: Thanks, Len. Your last comment here makes me realize the contradiction in the -- or at least the House bill, the only bill that is articulate enough to understand what the contradiction is and that is they're going to pay for most of health coverage expansion by cutting reimbursement rates to, well, let's say hospitals but Medicare providers, right?

Len Nichols: House bill is mostly taxes.

Joseph Antos: Okay. Forty-nine percent will be coming out of Medicare or whatever it is, it does not matter, it's huge amount of money; it's probably \$400 billion. And so we're going to take that money upfront even though the White House and the bill refers to this as efficiency improvements. The

way it really works is that in the traditional Medicare fashion we take the money and if you, hospital, can find an efficiency then good luck to you but if you can't we still took the money. And I agree with you that putting some pressure on providers isn't such a terrible thing, the question in my mind is how much, how fast and how honest. But then we're going to turn around because you say we needed to buy time, we're going to turn around and give the money back, that's what this is really about, right? It's like a circular flow.

Len Nichols: Well, let's be clear Joe, just to be clear. Most of the money in the House bill is Medicare Advantage which MedPAC estimates we overpay them 14 to 18 percent. That's the single biggest chunk. The second biggest chunk is the drug price change which forces the Medicaid prices to the Medicare program. And third is market basket update, one of the [indiscernible] which is what you're talking about. That's a relatively small piece. I'm talking about buying time for them to become equipped to deal with the incentive structures that are also in everybody's proposal.

Joseph Antos: Well, I disagree with you that the \$150 billion or \$200 billion taken out of Medicare Advantage plans is somehow not going to affect providers. But let's move on to Jim Capretta.

James C. Capretta: Thanks, Joe. Thanks. I'm glad to be here. Sorry, I have to hold you up just a little bit longer before we get to questions. I'll try to be brief. Much already had been said here. I think the -- let's start with the observation that the process we're observing this year is intentional and it's a reflection of what happened in '93 and '94. And I think the way to understand it is just to observe what took place in July in the committees that Len was alluding to. I think he thinks they were very successful. My impression of the process at this point is not quite like that, but I mean, basically, what transpired was that there was some sense of what the bills were going to look like.

There was lot of backroom negotiations with various stakeholders for what would be involved in the bills. They were unveiled on July 14th and at the same they also then unveiled, sort of let loose CBO to provide to the public their analysis of what was in those bills and it was their intention to have it passed out of the House by July 31st. So you don't have to be a genius to see that the legislative tactic involved here was to try to truncate the amount of time between public dissemination of some kind of an analysis and votes and that was their clear intention.

And I think the fact that they were trying to jam it through the process that fast without enough people getting a

sense of what's going on here, what's in these bills, what does it mean, I think that contributed very substantially to the public then saying in August, whoa, whoa, whoa, wait a second, let's have some more discussion about this. So the fact that they did get it out of three committees, I'm not quite sure is this positive, the process producing something that is going to be the final verdict in all this. In any event, I do think that it's intentional that they don't want as much analysis done on this as it was done last time.

And one reason why I would argue that we do need a lot more time to look at this is that even in the speech two days ago, the president made three very important assertions about the final product that I think are highly questionable and need to be verified, there's a sort of "says who" kind of factor to this. Who's going to verify that these assertions are actually taking place in the bills being written? Some neutral party needs to say yes or no and they are pretty important questions.

He sort of said three things. He said this will not increase the deficit now or in the future. By the way, it used to be this was going to solve the deficit problem in the long run, but set that aside for the moment. Now it's just it won't increase the deficit now or in the future. There has not been anything presented by anyone that comes close to meeting that test, not by a long shot. I mean the basic structure of what's

taken place in the House is to create a new health care entitlement to get people into the coverage, very predictably CBO and others, anybody else who's looking at this is going to expect that that's going to grow at roughly the same rate as Medicare and Medicaid has grown for 40 years, eight percent a year, more or less, and the offsets for perhaps covered for a 10-year period but more or less they expect will grow at five percent.

And so you have this -- you don't have to be a financial genius to see that this is a problem, right? You got a disconnect and it's going to make the problem much worse, not better, and not by a little bit, by like leaps and bounds. So you have this gigantic disconnect there. I think that's a huge issue that has to be resolved very clearly before they vote on anything by someone not the president himself just making assertions. Someone has got to take a look and say yes or no or probably not. When Dr. Reischauer was running CBO he used "probably" a lot. You don't need a definitive answer all the time but you need good judgment of people looking at this saying, probably yes or probably no. And, you know, when you look at these House bills in particular, let's talk about Senator Baucus's proposal in a minute but the House bills in particular, it's very clearly not; it doesn't come close.

Now, the other contention the president made was that the bills would lower costs for everyone - families, businesses and government. Again, this is an assertion that is -- flies directly in the face of any -- whatever analysis we do have of the bills emerging say essentially the exact opposite - that costs will go up for businesses, costs will go up for the government.

And I'll talk about now, the one analysis that just came out the other day from the Lewin group. Lewin, as Bob alluded to there are some microsimulation models in various places and Lewin has one and his think tank has another and there are some academia in various universities, but Lewin tends to run these things around fairly quickly and so they did do an analysis of the House bill and it brings out some interesting facts about what's really operative in these bills that people probably should know before the final votes occur.

One is that to get coverage under the bills that are moving through the House and the Senate, they essentially do one thing. They make people buy insurance. I mean that's basically what it is. It's an individual mandate that says for the vast majority of lower or moderate wage workers who are in employers who now definitively have to offer them something, they have to take it. So it's going to cost them more money and it's basically going to come out of their wages. Lewin

does an analysis, runs the numbers and lo and behold it shows of course predictably but no one's said this yet that on average the uninsured would pay \$1400 more for health care under the House bill than they do today.

So it's not like this is all is going to be handed out to people; it's going to come out of their pockets. Now, is that a reason to vote yes or no? I'll leave that to others, but at least people should understand roughly what the financial implications are, and this one is not something that I think -- I don't think is something subject to a lot of dispute. If you have an individual mandate or the vast majority of people who are going to get coverage are lower wage or moderate wage people working in employers who now have to offer and you make them take it and not going to the exchange, they're going to end up paying a lot more money for their coverage. That's how it's designed. Now, that hasn't really been said by anybody else at least as far as I can tell so far, here we are in September. And it certainly kind of leads one to question whether or not this is going to lower cost for everyone - families, businesses and government.

I guess -- let me just then move on to the point that Joe was just raising, which I think is at the heart of the contradiction of what's going on here which is the president said, also he asserted that he's going to be able to pay for

most of this, \$900 billion that expects it will cost in the end through efficiency in Medicare and Medicaid, efficiency and waste in Medicare and Medicaid. There has been a lot of talk about that. And I agree. I mean I agree that our biggest long-term issue is how do we deal with our entitlement programs.

But fundamentally, what's at work in the bill is to push more people into fee for service Medicare, open up potentially, depending on how the public option is settled, more people in the working age population and something that could very well resemble it and, finally, to lever price controls through hospital payment reductions, fees that are imposed on medical manufacturers, pharmaceutical companies and labs. It's essentially a price control system across the board cutting of the provider community to raise money for coverage.

This is not -- this how we've done it, always how we've done it actually. This is how we've done deficit reduction in the past. This is how we've done Medicaid expansions in the past. This is nothing new. And the politics drive you to this, the easiest thing to do is to try to do price setting, to do fees on providers and assume that that's going to somehow cut out waste and inefficiency but there is not one shred of evidence that that would actually occur if the bill passed.

All of the stuff that they've talked about - delivery system reform, on the-ground-changes and accountable care organizations - all the tough stuff is in the bills but in a way that gives no one confidence that it actually will emerge in any kind of robust way and it certainly is not the driving force behind any predictions of savings. And so the political process we're observing is producing exactly the kinds of cuts, fees, taxes that people all bemoan and say just make the system worse not better because they're arbitrary. There's no sense of quality. Every hospital will get the same market basket cut regardless of how well or badly they treat their patients. It's just a cut and that's really how they're paying for this.

Moreover, say what you will about Medicare Advantage but it seems to be the only capitated program that has the -- something that could be built upon to move toward more delivery system reform. Instead of that, they're going to move potentially millions of seniors, single digit millions of seniors, out of Medicare advantage back into fee for service, probably with wrap-around coverage. They're going to be in total fee for service environment, I'm not sure where that gets us. I don't think it gets us anything in terms of on the ground changes in efficiency.

So I think the then and now comparison is that yes, we've taken a different tack this year to try to get to a different

prediction of legislative passage and maybe that'll occur as Dean predicted. I don't -- I have my doubts but that's -- I'll leave that to others who are better at that stuff. But I think what we're suffering from is just some basic analysis of what's going on here so the people have some -- you don't have to have every number on everything but we need a little bit more. I think the public needs a little bit more about who exactly is going to pay for this and what is the likely trajectory going forward. The idea that this bill is going to produce on the ground efficiency changes that's going to transform how Medicare or medical care is delivered in this country is not there, it's not in these bills. And then to say it is, is an assertion not a fact and I think that's what we need much more discussion about before passage, and I'll leave at that.

Thanks.

Joseph Antos. Thanks, Jim. I think I heard both Len and you in essence say managed care shouldn't be a dirty word, is that right?

Len Nichols: I think we have to have coordinated care, you can call it what you like.

Joseph Antos: I'm living in the past. We used to call it managed care.

Joseph Antos: Thank you. I'm sure my colleagues would like to dispute some of the outrageous statements that many of

us made. So would anybody like to make a comment at this point?

Robert Reischauer: I'll just make a comment on Jim's characterization of the timeline and sort of what's happened more as a conspiracy than as sort of this is the way our system works.

I think genuinely the various committees had very ambitious schedules in which they wanted to get bills through a lot sooner than it turned out to be and that's because they knew the summer recess was going to come and if they weren't a certain point, they knew the momentum would begin to ebb. It wasn't sort of let's get this out at the last moment, rush it through before we have the kinds of information we need to do sensible votes. And theirs was the hope, I mean they tried and they weren't successful and so they reported out bills in July when they had hoped to do this in May or June.

And while I agree with Jim that it's really essential before we go down one of these paths that we have a full array of analyses to examine, the legislative process is such that you have many bites at the apple and there's going to be -- they knew, a very different bill from the Senate, coming out of the Senate then would come out of the House. The real place that this will be written, if it's written, will be in conference and at that point one would hope that we would have

a whole lot more information from CBO, from other outside entities so I don't think it was as terrible a thing as you have portrayed it to be.

James C. Capretta: If I could just defend myself on that for one second. I think -- I wasn't trying to say that this was -- everybody maps -- every White House maps out a legislative strategy. It is not -- they have to do that. It's probably professional malpractice if they didn't --

Robert Reischauer: The amazing this is they believe it notwithstanding evidence to the contrary --

James C. Capretta: I mean I just listened to the statements that are being made about it, that's exactly what the point is. If you just get it passed the first vote, you get something through the Senate, we'll fix this thing -- at which point it becomes, a certain momentum builds, toward passage. That's what really what they want. If you start having votes, people start committing, then there's a certain legislative momentum. The fact information can come in at the 11th hour and 50th minute that says, wait a second, this is having effects that people didn't expect. And they'll say, well, look it's too late, we've really got to pass this thing. And I really think that's sort of what's at work here.

Bill Gradison: I think that time was not a friend of the Clinton plan. My recollection is the president said he'd have

a plan in 100 days. He didn't. Because of this 100-day pledge, the media, some of the media developed skills, assigned very able people who had not been looking at health care before but were very much up to speed by the time the plan was actually out there.

One of the striking things at the time, and this amazed me, it was a different world of media I know than today but there was not a single network that had as many as one person assigned full time to cover health care all through that period. I believe that's correct but some of the newspapers did and they counted for more than -- *LA Times, New York Times*, of course, *Washington Post, Wall Street Journal* - I'm not sure how many more I would add to that list. But when the plan finally came out, there were people who could take a look at it, they could write the pro and con articles, try to observe factually then there was time to sit back and take a look at them, so I think that was real challenge.

If I were trying to manage this, I would try to get it through just as fast as possible and then if problems arise later, once the text is out there just say, well, we're going to clean that up next year or after the next election.

Joseph Antos: Actually, for that matter, at least if the House bill is any indication a lot of things Congress probably won't be willing to make a call on, I think the most obvious

example is their five lines on what specific benefits will be covered and then there's a committee that will somehow deliberate on the specifics in some mysterious fashion, so it's not just we'll fix it next year, it'll be we'll fix it over the next five or 10 years.

Len Nichols: I would just like to say you can't please people who don't want to solve the problem. Clinton had a committee work on a detailed benefit package that was frankly more detailed than anything I've ever seen, with the possible exception of the blue prints of a submarine my son got me into one day. And he was accused of one-size-fits-all. You put it to a committee and it's an obfuscation trick to get it through. I mean if you don't want to solve the problem, we can't solve the problem so that's really what you've got here. You got people who don't want the bill to pass, when they do think they can slow it down. People who do want the bill to pass who think can speed it up. Our job, roughly, is to shed some analytical light on this process and to try to push the veil back of ignorance.

And I think it's fair to say maybe one thing needs to be said here. This bill if it does pass isn't going to be perfect. It is also not going to be our last shot at making changes to the healthcare system. We're not trying, no one is trying - some people are trying to claim this is what is being

tried - no one is trying to remake the entire healthcare system. The whole point of you can keep what you've got if you like it was to avoid what Clinton fell into by trying to essentially change every human being's relationship to their health insurance or any -- even if you had big firm out there on your own.

So I think it's fair to say, let's all take a deep breath and realize it's a process. It's not one little model you build and it either flies or it doesn't. It's a process.

Joseph Antos: You're absolutely right. Let's see if the audience can bring some new insight to at least the panel. When you -- let's see I hope somebody is out there with the microphone; are you? Step right up. We have some questions here in the front so please come quickly. Come quickly, the TV audience is getting restless. There's someone, come on, come on. Okay, go ahead and please identify yourself and actually ask a question.

Susan Friedman: Susan Friedman, American Osteopathic Association. As the process moves to a conclusion can you comment on what the impact of not having Senator Kennedy in the room could be? Thank you.

Len Nichols: I would certainly -- I'm sure everybody's got an opinion here but I would say the impact of his illness has already been seriously felt because I know for a fact

Senator Hatch and Senator Enzi fully expected to work with him to shape a bipartisan bill in the HELP Committee and his illness prevented that from being possible and what you got is what you got. And, unfortunately, that had the spillover effect of taking that frustration and sadness and hurt into the Finance Committee where it was even harder to deal with. So he's already -- his illness was hugely impactful in preventing what I would call a decent chance at bipartisan conversation very early on.

Joseph Antos: Traditional AEI fiddle with the microphone. It never makes them any better.

Art Leifson: Art Leifson [phonetic], in '93 and '94 there was a group of Republican and Democratic members who worked in the middle. They had the Cooper-Grandy Bill, Senator Breaux and Senator Boren were very involved. One doesn't have the sense -- and there was also a deal to be had at that point that some folks rejected - one doesn't have the sense now that there are Democrats as well as Republicans -- there aren't enough moderate Democrats willing to buck their leadership and moderate Republicans willing maybe to buck their leadership to create that center that compromised plan that is the 75 percent or 80 percent that we "all agree with."

Dean Rosen: I guess I would say, Art, I think that while that's true in number, I think that that process to an extent

this time while it's not a perfect analogy has been taking place inside of the Gang of Six. I mean I think those guys in the Finance Committee -- in part the difference last time was in the Senate if you think about the mainstream group in '93 and '94 they were -- the chairman of the Finance Committee was not involved - I'll leave it at that - and so I think there is -- and I think when you talk to those members and despite some of the accusations that maybe some of the Republicans don't really want a deal, I think that those guys genuinely are having serious discussions from what I can tell, and I think that is the closest thing in this debate.

I think what's changed is that in part that you're right, there are fewer of those folks on both sides - Republican and Democrat - who are willing to create something in the middle that might work. Having said that, it didn't work in '93 and '94. My view may be a little different than Len's, I think if that president would have sent a signal like this president that he was flexible it might have worked but it didn't work in '93 and '94. And so I think that the Democrats have decided and from a political standpoint it is a smart move that they're going to take their pretty big majorities in the House and now in the Senate and they're going to try do something which more or less, while it's not everything that the party would want, is closer to what the Democrats would pass rather than

something in the middle. But I do think that there has been honest, legitimate give and take within that group.

Bill Grandison: One of the striking difference to me is the number, the decrease in the number of members of Congress who have really immersed themselves in the details of health issues. And I don't think that's a surprise after 1993 and 1994 there were more profitable - that's maybe the wrong word - but areas where you could achieve more for your input of work, get better results than healthcare, for heaven's sake. It was really taken off the table for a long time. As I think about the Republican side and I don't mean to leave names out but the people who were involved, they were really were immersed to this.

It wasn't just something they got involved in the last year or two, Dole, Danforth, Chaffee, Packwood, later Dr. Frist and others. I think that the list is pretty short now which is -- I don't mean that is a negative thing, healthcare is extremely complicated. And I know; I'm a slow earner and I was immersed in this thing but honest to God I didn't think I really had a feel for the interrelationships of some of the stuff for four or five -- I was really into it for four or five years. So I don't know what impact that has one way or the other on what we're talking about today, but I think it is worthwhile seeing that one of the impacts of what happened in

'93 and '94 was to see a lot of congressional energies channeled in other directions.

Len Nichols: I just want to get back to Art's question about the sub-rosa bipartisan conversations. I think there's two going on maybe, but the Wyden-Bennet team which before the election had 17 cosponsors, 9 Republican, 8 Democrat depending on how you count Lieberman - your choice - but the point is it had a pretty decent bipartisan coalition. After the election, a couple of retirements here and there, I think there are like 15 now but that process has never really stopped and that keeps some bipartisan -- and then there is conversation going, and then there is the 13 or so moderate Democrats that have a little group co-chaired by Carper, Lincoln and Bayh.

And I would agree with Dean, the bill is going to be mostly Democratic if it passes, maybe all, hopefully not, but mostly. But that centrist core and the Blue Dogs in the House will exert, I would submit, moderation in a serious way. It would be better if we could get Republicans to participate. And I do agree with Dean completely that the process in Finance is sincere and there are people outside that process on our side that are also sincere who know healthcare.

Joseph Antos: Okay, let's see this gentleman here, and actually anybody who wants to ask a question if you could keep

your hands up so I can see where you are. Okay, I sort of have it. Go ahead.

Tom Errol: Hi I'm Tom Errol [phonetic] from American University. I've got a question for Len. I suspect that Len's got a lot of headaches these days, and I just want to bring one up that we haven't talked about very much and that's the public option. As a lot of people know there are several different versions of what the public option might mean. I think one of the ambiguities of the Obama speech earlier this week is which one was he talking about? One is basically like a nonprofit just regular insurance company that happens to have the words "U.S. Government" slapped on it; the other is a much more robust kind of Medicare style thing. And you get the sense that a lot of people in the House are going to say no; unless, they get that second thing. And so, since I know you've thought a lot about this, just one question -- two questions. One, where do we stand on that issue; and two, is it going to blow up the process?

Len Nichols: Well, it's a great question, Tom, and I would go back to Dean's point earlier that this issue has gotten a ridiculous amount of attention. And I would say, frankly, if I could, the reason it's gotten so much attention is that it's a convenient device for the far left and the far right to drive the bipartisan conversation away. What the left

wanted when they saw the majorities was a Democrat-only bill that they could get most of what they want which some of the left really do want government run healthcare. That's true. Not a majority of the Democratic Party but it's a critical mass. The right because the *Union* started emphasizing this as a sine qua non, remember right after the elections suddenly this became the big issue; this is the sine qua non. Heritage was smart enough to figure out, "Boy, thank you very much. You just gave me the perfect issue. Now I can use - see I told they want to do government to stop the Grassley-Baucus conversation from really gaining traction." So you have the left and the right saying, "The public option is what's it all about."

What the President said Wednesday night, by my lights, was the public option is important to me; I think it could add value. It's not first order importance; it's not sine qua non. And he for the first time, at least in my watching of his tea leaves, opened the door to Olympia Snowe's idea which is to use a kind of back door trigger. That is to say, like in the MMA, in the Drug Bill where the provision was if we don't have enough competition in every market in the country then we could allow a public provision of the Medicare drug benefit.

As it turned out, of course, as lot of us would have predicted, you got plenty of competition so you don't need it.

Well, geez, that's not a bad way to frame because it gives the left something to say, okay, if the market really isn't working -- and by the way there are a lot of insurance markets but there's not a lot of competition in the small group market, let's be clear. If it's not working then we'll have it but if it is working what's the point?

A lot of what we've done, Tom, in the last three or four months believe it or not is teach Democrats - it's a struggle but you can - that in fact you can't pay Medicare rates because you're going to kill these hospitals that are losing money. And the Blue Dogs had an amendment to push it up to market rates. And, in fact, you probably are not going to add competitive value in markets like Denver or Seattle where they got really robust competition, so you've got a much greater awareness. And my view of the president was open the door to the prospect that he is not going to say it's a sine qua non.

Dean Rosen: Can I add one thing on the public plan even though I said we've debated it too much, but I think one thing in response to the Medicare thing which -- at least from my perspective. I think that the problem with the public plan was it was a compromise between two wings of the Democratic Party who -- one who wanted single payer and one who wanted to build on the employment-based system, so it was a compromise that was probably hard fought among Democrats but it made it very, very

difficult to reach a bipartisan consensus once people were bought in because both sides felt like they had given up on it.

I think one thing at least from my perspective that's different and I hear this a lot, so I think it's just worth responding is that I think the Medicare prescription drug sort of fallback was different in at least two or three different ways. One was at the time there was not a stand-alone risk-bearing insurance product that covered only drugs, and so I think that there was a legitimate question among the policymakers as to whether this would actually happen even with all the rules in place. And so to have an entitlement program where you wanted to have some way of making sure that the benefits you promised were actually delivered I think was a little bit more of a question. Whereas, now, you do have insurers who were playing by some of these kinds of rules in the states; I think it's a little different.

Second, it was triggered in the different regions. It wasn't a national plan.

Third, and I think one of the more important distinctions is that government wasn't going to come in and at that point negotiate. It was going to be -- if it -- wherever triggered it was going to be essentially PBMs. The government would bear the risks because what it would show is that there weren't more than two plans that could actually bear risk and do it, but

they were going to go out and negotiate their own rates. It wasn't going to be the kind of, I think, more robust government plan that's envisioned here. So I think at least to me that's a couple of distinctions worth highlighting.

Bill Gradison: With the risk of total cynicism, my view of the public plan, politically, has been that it's been a stalking horse and the general idea is that the more attention that's been given to it, the easier it will be once it is off the table to say, "Okay, we got rid of that; now you can support the rest of the bill."

Robert Reischauer: There's one aspect of to have a public plan or not to have a public plan which people haven't focused on, and that is under some constructs it saves money and if you don't have it you got to come up with some other form of paying for this. And what we've spent the summer doing is crossing all of our pay-fors off the list and we've been arguing either for or against this public plan but you have to remember it has a cost component to it, too.

Joseph Antos: That's a very good point. I mean in essence it either works in that regard or it doesn't and, of course, we don't actually know. Let's see there was a question back there. Oftentimes, there's a bias against seeing the people at the back -- the person right back there.

Peter Levin: Hi, Peter Levin [phonetic]. James Capretta has raised some major issues that would impact on any plan and I wonder what Len and Bob Reischauer think about that. We are going to be forcing more people into the fee for service world. We have no idea how to control or improve quality. We're going to hammer hospitals without respect to whether they're efficient or inefficient, and I mean this will happen if you put more money out there in the insurance system.

I wish I could say something good about trying to save Medicare Advantage but at least it was an attempt at having a structure to do this. And the crazy idea about having a medical home and paying a doctor \$3 a month or something to manage the care of people is just plain wacky. They don't want to do it in the first place and that's not going to motivate them. But what do we do about these issues of just pumping more money into the fee for service sector where there is a shortage of family medicine and primary care?

Len Nichols: Well, it's a great question. I would say two things. One, let's be careful about Medicare Advantage. Some of it is indeed delivering high quality coordinated care that would not be the private fee per service piece of it, which is basically just a sheer overpayment for no good reason other than ideology, which is expensive. So what I would say is you could go to of system like I believe will be the final

proposal out of the Finance Committee and I think therefore it will win in conference, and that is a competitive bidding where you allow them to bid, they bid market, they bid what they bid and they offer services and we actually have a market - what a concept - and you indeed allow this to go forward. I will point out we are trying to do competitive bidding in the '90s and John Kyle killed it all by his self. It was impressive; Bob remembers all these because he didn't want competition in his town 'cause his health plans didn't want competition. They preferred to be overpaid by formula. I would, too, if I could get it; it's a good deal. But it doesn't actually promote competition. So first you got to agree you got to have competition.

Second, you were correct. We do not have a payment formula that is going to fundamentally alter the incentives to deliver high quality care tomorrow. I did not believe we're going to create one in Baltimore. I do believe we have a pretty good sense of payment structures that we want to move toward. They include, ultimately, integrated health systems, accountable whatever you want to call it. I will call integrated health systems where you literally would pay a full global fee. When you say capitation, you can say it again if you like and they take accountability and they actually show

what they do. There are very good systems out there doing very well.

Also, you could do bundling where you go across hospital, physician, post-acute and create incentives to coordinate. And there are lots of places without integrated systems. A concrete example that I've written about lately is Grand Junction, Colorado where they achieve outstanding results at very low cost just by sharing information and building incentives on their own at the moment.

And then third, you could do some kind of bundling of chronic conditions which is after all where we spend most of our money. Yes, some versions of medical home make no sense but having a common, shared, if you will, incentive structure between primary care clinicians who should be managing the basic care, specialists who are going to be needed to be called in given the condition, and hospitals occasionally having a shared savings kind of bundle might be a smart way to move toward -- in fact, there's a lot of private insurers that are experimenting with this kind of arrangements right now.

So what I think we have here is a system where you want to, as Joe said, get some savings upfront by taking away from private fee for service and making everybody else bid. Rationalize some of the more egregious price distortions in our current payment structure like some of what we do for - in-

office equipment, and build incentive, if you will, experiments, pilots, whatever you want to call them, and I would predict that if you do the incentives and you make it clear that we are going to make fee for service as it is less profitable to you than moving in a world where there's far more accountability and far more coordination of care, I predict most providers will go there and there are a lot of them who are ready to teach the rest of them how.

Bill Gradison: I'd like to comment just on the context in which I see this recent part of our discussion. When Medicare and Medicaid went on the books, there was an extraordinary inflation of healthcare cost. I worry what happens now; it isn't that uninsured are getting no care but they would certainly get more care and should get more care than they have been getting, which in itself could be a significant inflationary element. Beyond that, a lot of the fundraising payment systems that are being talked about are increasing cost for the providers. They're going to try to pass those things on; they can't eat them, which is a separate inflationary impact in addition to just having more people able to pay the bill.

I think many of the things that are being discussed have great promise - longer term - for producing savings, but I don't think that necessarily should be thought of in terms of

where we've been the last few years on cost but ought to be thought of in the context of how do you deal with the substantial increase in the inflation rate beyond what we've had in recent years. And I think that's really scary but a real possibility.

Robert Reischauer: Just a comment on the language that's been used which is we're going to force people into fee for service. What we do right now has brought them to participate in Medicare Advantage when we have no substantial evidence that the quality of care is significantly better than those in unmanaged fee for service. In the long run, what we want to do is pay for performance here and have the pay for performance across three food groups: the Medicare Advantage component; those who are in fee for service but have joined an accountable care organization or something like that; and those who remain on the open range eating grass wherever they want in the unmanaged fee for service world and transfer resources across those three buckets in a way that doesn't increase the costs over where the baseline is right now and that would help create the incentives that will make the system that I'm talking about work better. This is not something that's going to happen in the next five years I mean we're talking about starting down a path that's going to take a decade or two to fully develop if you want to go this way.

Joseph Antos: Just to be clear then Jim is going to speak but Bob's proposal is not in any bill right now.

James C. Capretta: Just a word on the competitive bidding and Medicare advantage. There's two options in the CBO book. There is one right next to each other back to back. One would be competitive bidding just among the private plans and that saves money essentially by having less people in Medicare Advantage and more people in fee for service. That's essentially how it saves money and that's what is going to be presumably in the Finance Committee bill. By my lights, that's not really competitive bidding because 80 percent of the beneficiaries are in fee for service and that program is not part of the bidding. That was why the demonstration was killed in the '90s, right?

Bob Reischauer proposed in the past - I don't know if he's still for it - some versions of competitive bidding where everybody in Medicare would get the same essentially voucher and they would pick whether they would go into a private plan or the public government run plan. For those who are advocating the public option and are against competitive bidding and Medicare it makes you wonder how the public option for everybody else would evolve over time. If you really want competitive bidding, do it for the whole program.

Joseph Antos: Let me put a plug for a book, that's coming out pretty soon and then we are going to ask Chip Conda [phonetic] ask his question. I don't remember the title but it's making this point, a book by Roger Feldman, Brian Dowd and Bob Coulam coming out sometime this fall.

Chip Conda: Actually, I just want to make a point of clarification. I'll start off by saying that I am with Len and a supporter of reform, but I think in the House bill and in the coming Senate bills we need to be more careful about our numbers. I don't have them committed to memory but the hospital number in the House bill is about a 155 in terms of savings and, frankly, they're the old-fashioned kind of savings with some exceptions maybe for readmissions we can talk about. In the Senate bill they're going to be about the same and in the House bill the number for managed care for Medicare Advantage was I think 158 or 160 so - which have been discussed - and then the numbers obviously on pharma will vary between the two bills.

So I only want to point out that -- just as a point of clarification that the hospitals aren't sitting by - as a representative of the hospitals - and not contributing and also say that I think it is unfortunate that we have to go through the same process of trying to get savings the old fashioned way. But those are the only savings CBO is going to count, and

hopefully we will get some reform out of the bills but I don't think there's that much in there if we actually analyze it.

And part of the problem is that so much of this is unproven. I mean the idea about these accountable health organizations, they may be great. I remember back in 1997, in BVA [phonetic] '97 we had something called PSOs, provider-sponsored organizations and they were going to change the world and there were two of them. They didn't change the world.

And so I think we have to very modest and humble about the potential for Medicare as a change agent. I mean I've been involved in Medicare policy for many years and I think DRG has served an incredible function over time. I think we could look at physician payment and other payment experiments and they don't always work and sometimes they cause bigger problems than we would have had otherwise. So I think we have to be still modest and humble about what we can achieve. And that's the only part of the president's speech that bothered me a bit is it sets an expectation that we're going to be able to change the world with dramatically dealing with fraud and abuse and delivery reform and sort of been there, done that and we ought to keep at it, but I don't think there's necessarily any given answers here that can solve all our problems.

Len Nichols: Chip, I agree. Thanks for clarification about the numbers. I would just say let us not forget the cost

of doing nothing is going up every day. I know you are with me, but to say that therefore - we don't know therefore we should do nothing is a pretty extreme conclusion.

Joseph Antos: Okay, but that was not Chip's [cross-talking]. Yeah, okay. Actually we have a television schedule to keep. I think we probably have to close off the discussion right now. Oh, Norm, do you have a -- yeah, Norm, quickly. I didn't see him.

Norm: The question is this: How much of a cost driver really is defensive medicine and how much prospect is there? If you had a set of best practices that provided some cover for doctors if they're sued, if they followed those best practices, is that realistically something that could work as a major part of malpractice reform and could bring the cost down? Is there a lot there?

Bill Gradison: Well, I am going to say quickly there may be some. But doctors, in my opinion, tend to develop certain practice patterns as a result of their training and their experience. I'd be very surprised if they would dramatically change that as a result of what you are talking about. A new generation of doctors coming into the field might have a different view just as I think we are seeing some differences in many ways, in new physicians' approach to the practice than we've seen or those that have been out there for some time.

I'm not saying there are no savings but I sure it wouldn't count on a lot of them.

Robert Reischauer: I think that's the general consensus that this is small but it could grow over time, but you threw in a few bells and whistles which are quite controversial, which is what if we had practice guidelines, if you followed them, you would have a safe harbor. Over the long run, that could have I think a very significant impact, but once again we don't have the information we need to develop these at this point. We're talking 10 to 15 years.

Joseph Antos: Actually, there already is something like that safe harbor. If you deviate greatly from the standard practice, wherever it came from in your community, you are going to have trouble in court; whereas, if you can say, in essence this is what all the gastroenterologists do, we can't do anymore. In that local court, that's going to fly. So we're really already there. I don't think that is going to have a gigantic impact until you get some better idea about what to do. That's the hard part.

We really have run out of time for formal questions. We have solved every health reform problem and I appreciate that because I had my doubts about this, but we're there now. The only problem is I don't think any member of Congress probably heard this telecast.

Male Voice: They've got all weekend.

Joseph Antos: They've got all weekend. That's right.

Please join me in thanking our panel.

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