

THE HAMILTON PROJECT AT BROOKINGS

FALK AUDITORIUM

ADDRESSING ECONOMIC CHALLENGES IN AN
EVOLVING HEALTH CARE MARKET

A HAMILTON PROJECT POLICY FORUM

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Framing Remarks:

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**Roundtable: Exploring a Tradable Credit System for
the Nonprofit Hospital Sector**

Moderator:

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**Roundtable: Improving Consumer Decision-Making and
Medical Technology Coverage in Health Insurance
Markets**

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P R O C E E D I N G S

MR. RUBIN: Good afternoon and welcome. On behalf of my colleagues, Hamilton Project, welcome to today's discussion which will be addressing Economic Challenges in the Evolving Health care Market.

Before turning to the program, let me just say a few words about the Hamilton Project. We started about ten years ago. We are not an institution. We are what I think is probably a unique organization in the policy world which is an assemblage of policy experts, academics, business people, former public officials, who have a strong interest in public policy and are banded together as an advisory council to provide governance and advice.

Our work has been motivated throughout by the belief that the objectives of economic policy should be growth, broad-based participation, benefits of growth, and economic security.

And we also believe that these objectives can be and, in fact, I think, probably almost

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necessarily are, mutually reinforcing rather than antithetical as is so often argued. For example, growth is essential if we're going to have widespread increased incomes both increased size of the pie and also to created upward pressure from tight labor markets. And similarly, growth requires broad-based participation in benefits of growth in order to generate demand, in order to bolster public support for growth-enhancing policies, and to give workers greater access to the inputs for productivity such as education, good nutrition, and the subject of today's discussion, health care.

Health care and its costs and its quality are obviously deeply important to each of us in our individual lives. But they're also central to our economy's competitiveness and efficiency to achieving sound intermediate and long-term fiscal conditions, and to creating the capacity, the fiscal capacity for robust public investment. And, of course, they are central to economic security.

We've had a long history at the Hamilton Project. focusing on health care in 2007, we had two programs or two events on health care under the leadership of Jason Furman who at that time was our director, one on the economic imperative of reducing the increase in the rate of health care costs, and the other on the imperative of achieving universal coverage which, of course, motivated the ACA.

Before turning to Jason for his framing remarks, I'm going to make three personal comments expressing some views I have on health care, and I'll freely acknowledge that these are my opinions and they may be right but they also may be wrong. And I think Jason and Peter are both prepared to say that they're wrong by any event.

First, it seems to me there's a great deal of uncertainty concerning the future trajectory of health care costs. Over several recent years, as you know, the Congressional Budget Office very substantially reduced the projection of the federal health care program costs largely because of projected

decreases in the rate of increase of the costs of our healthcare system.

Having said that, the societal rate of health care costs increases still exceeds our economy's projected growth rate. And more importantly, it seems to me, or at least equally important, it remains to be seen whether this slowdown is structural and long-lasting, or reflects more temporal factors, most particularly, the recession.

And it seems to me, at least, that a reasonable possibility, and sort of my instinct to think more than a reasonable possibility, that the rate of health care costs increases, the rate of health care cost increases could rise looking at our national's demographic future, the high-cost for conditions through the incidents increases amongst older people, that is to say, with age, and also the enormous cost of long-term care, and the proliferation of new technologies, and also of new drugs which can be a great boon to health care, but can also be very expensive.

And if, in fact, the rate of health care cost increases does rise whether as a consequence of inflation or of quantity used, or some combination of the two, that in turn poses serious questions with respect to our competitiveness, our physical conditions, and the sustainability of a federal of our federal health care programs.

Second, as you know, the ACA has moved us, or is in the process of moving us, away from fee-for-service model with all of its problems and toward what's sometimes referred to as a value-based model.

The fee-for-service model, as we all know, as I said a moment ago, had tremendous problems, but the new approach seems to me at least, present its own issues.

For examples, physicians have to balance their commitment, or all health care providers have to balance their commitment to diagnosis and treatment which requires adequate time with the patients versus the incentive to limit that time on each patient in the interest of seeing more patients.

The conceptual response to this is that the doctor has the incentive to set it right in order to avoid repeated visits without additional compensation. But it seems to me at least that there are real questions as to how that would actually work in practice.

For example, the system requires that prices be set in an appropriate fashion to create that set of incentives. And secondly and very importantly, it requires that health care providers, in fact, are going to act on the basis of long-term calculations rather than shorter-term incentives, and that seems to me at least, contrary to the behavior that we see in most political and economic arenas.

Finally, there is (inaudible) level between our desire to provide high-quality health care and the physical public investment public investment and economic ramifications of what that might cost.

We currently, as you know, spend about 17 percent of GDP on healthcare which is far more than any other developed economy. And if we fully vet

every need or every need for health care, even if we greatly improve the efficiency of the system, it seems to me that there's at the least the possibility that that number would become considerably higher, especially with the demographic technological and pharmaceutical factors that I mentioned a few moments ago.

The question of where to land on that spectrum between demand and cost, and I think at least, is going to receive increasing attention as time goes on for the very reasons I just mentioned, the factors that may, in fact, be pushing us or pressuring our system to higher health care costs. And that, it seems to me, is going to then create very difficult questions as it does already about how to allocate our nation's health care and economic resources.

And that context in addition, and as I said a moment ago, let me just repeat one comment I did make, and that takes into account what occurred seems to me even if we do accomplish the very substantial

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efficiencies in terms of cost to value that may lie ahead if we can properly manage the evolution of our health care system.

In that context, let me mention in addition to the thoughtful proposals we'll be discussing today, there is a paper that you received on your way in titled, "Six Economic Facts about Health Care and Health Insurance Markets after the ACA, which lays out many of the changes that have taken place and I would strongly commend to you as enormously worth reading. We are joined today by a group of highly-experienced, deeply thoughtful panelists who will help us think through the issues around health care. In accordance with Hamilton Project practices, I will not read to you or recite to you from their resumes, they're all, as you can see, truly distinguished, highly-respected, and deeply experienced in the field of health care.

Our program will begin with framing remarks from Jason Furman, Chairman of the Council of Economic Advisors, and former Director of the Hamilton Project. Jason, I think, is universally thought of, is

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universally seen as having done a really terrific job as CA director. Under his leadership, the CA has provided objective, thoughtful, and evidence-based analysis of a wide variety of economic issues, and in that way served both the professional economics community, but also helped improve public understanding, and with enormous credibility, I might say. We are, obviously, delighted to have Jason with us today.

Our first roundtable explores proposal by Craig Garthwaite, Professor of Strategy at Northwestern University's Kellogg School of Management, and his coauthors that calls for a tradeable credit system for the nonprofit hospital sector, an issue that is, I think, of far greater importance than is generally recognized and, unfortunately gets relatively little attention.

Professor Garthwaite will be joined by discussants Martin Gaynor, E.J. Barone Professor of Economics and Health Policy at Carnegie-Mellon University, Peter Orszag, Vice Chairman of Corporate

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Investment Banking at Citigroup, and Peter, as you know, is a former director of the Hamilton Project, a former director of the Office of Management and Budget, and a former director of the CBO, and Rick Pollock. President and CEO of the American Hospital Association.

The Moderator will be Julie Rovner, Robin Toner Distinguished Fellow and Senior Correspondent, Kaiser Health News.

After a short break, and we'll ask all of you to get back in your seats within ten minutes so that we can, as I say, make that a short break. Our second roundtable will deal with two separate but related topics in the health insurance markets: Improving consumer decisionmaking; and improving medical technology coverage.

The discussion will center around two proposals: One coauthored by Amitabh Chandra, Professor of Public Policy, the Harvard Kennedy School of Government, and coauthored by Benjamin Handel,

Assistant Professor of Economics, the University of California, Berkeley.

The discussants will be Niall Brennan, Chief Data Officer of the Centers for Medicare and Medicaid Services, Dan Durham, Executive Vice President of America's Health Insurance Plans, and Peter Orszag, who I've already introduced.

The Moderator for the second panel will be Diane Whitmore Schzenbach, who is the Director of the Hamilton Project.

Let me close by thanking the people who developed the electrical circuit for these discussions and brought it all together. Diane, who I have already mentioned, Kristen McIntosh, the terrific managing director of the Hamilton Project, and Jane Doko), who recently joined us and most welcome from the CEA, and is now policy director of the Hamilton Project.

We also thank our enormously talented staff without whom none of what we do could happen. Thank

you very much. And with that, Jason, the podium is yours.

(Applause.)

MR. FURMAN: Thank you, Bob, for that really kind introduction. And it's great be back at the Hamilton Project. And I'm particularly excited to be back on this topic. I have a really fond memory of working together with you on what I had remembered as a really extensive paper called "The Universal Affective and Affordable Health Insurance and Economic Imperative."

The reason I had remembered it as a really extensive paper is because I remembered just dozens and dozens of conference calls with you. And when I look at it again a few days ago, it's somewhat disappointing to find that it is only about a page and a half long, considerably shorter than the prepared remarks I have for today which are available on our website, and took considerably less negotiation even though it involved much of the federal government in that negotiation.

But I think that really did set out what we as a country have been trying to achieve over the last nearly decade. And I want to start by giving you, I think, a little bit more hope that some positive things have happened in the last five years. And I want to do that not because I want to guarantee you that everything is going to continue going well for the next five, ten or 20 years, but to tell you that have the tools to make sure things go better over those next number of years, and I want to point out three ways in which we can use those tools to make sure we're reshaping the health system for better in the future.

The really brief version is, terms of what's gone well is coverage, cost, and quality, and I'll go through of all of those at greater length. And going forward, I'm going to talk about what we need to expand coverage, what we need to do to continue to drive cost reductions and quality improvements, especially in Medicare, and then talk about the high-cost excise tax also known as the Cadillac Tax, which

is one of the most important tools we have to drive those changes in the private sector.

Lot of what I'm going to be talking about is not new legislation, not new things that we need Congress to do, it's tools that we already have, and making sure that we're implementing them, that governors are taking them up, that Congress is not changing them.

Expanding the boundaries of what's possible, thinking of new ideas, new legislation, building intellectual case in support, I guess very much what you are doing on the next two panels after this, and is a really important function, as well.

So let me start with the first one, which is coverage. The change here is truly phenomenal. The uninsured rate has fallen by 40 percent since the Affordable Care Act was passed. Today, fewer than one in ten people are uninsured. That's the first time that's happened in our history. The decline in uninsured is the largest decline we've had since the inception of Medicare and Medicaid. And economists

spend an awful lot of time trying to figure what caused what, how to disentangle different causal analysis.

This one is about as clear-cut case of that as you have in social science, and Health and Human Services has estimated that the economy contributed a small portion of that, but the lion's share, 17.6 million reduction in the uninsured was due to the Affordable Care Act, both the major coverage provisions, but also ones like allowing you to stay on your parents' plan through age 26.

This has happened at a time of exceptionally low growth in health costs as well. And I want to be very careful about what I'm saying and what I'm not saying. The slow growth in health costs started in the middle of the last decade before the Affordable Care Act was passed. But it's continued and deepened since its passage, and the causal link between the Affordable Care Act and cost is not nearly as direct and overwhelming as it is with coverage, but I think it's meaningful and important.

In terms of some of the facts on cost, if you look at the price of health care measured in the PCE deflator, you see that it has grown at 1.6 percent since the Affordable Act was passed. That's roughly the rate on inflation as compared to the previous 50 years when it grew at about 1.7 percent above inflation.

The pace we're growing at now for health prices is the slowest pace in 50 years. That pace some have attributed to the recession, but the slowdown only gets slower and slower so the past 12 months it actually grew at 1.1 percent, even slower than the rate over the previous four years even though we're increasingly far away from the recession.

Health premiums are a function both of the cost, the price of health care times the quantity, the utilization of it. And you see a slowdown in total health premiums. The latest Kaiser numbers 4.2 percent so that continues to slow.

And some people have raised the question as to whether that's translating for workers. As an

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economist, we tend to look at the total premium and think the incidence of that comes out of wages. But if you're worried about where the formal incidence is, the worker's contribution has slowed even more than the employer's contribution.

You also see the slowdown in Medicare and this is important because it's another proof point that this isn't just the recession at this stage. I think it has very little to do with the recession because Medicare isn't particularly cyclical, and right now, nominal Medicare spending for beneficiary is basically growing in line with GDP prices which is truly remarkable.

Some have also said that this is all happening just because deductibles are rising so you get lower premiums here but higher deductibles there. Deductibles are rising, but they're rising at basically about the same rate that they were, or almost exactly the same rate as they were rising in the years before the Affordable Care Act has passed. So there's not any uptick in deductibles.

Moreover, deductibles are only a partial measure of cost sharing because you pay costs in lots of different ways. So people might have a higher deductible, but they also have a lower out-of-pocket maximum, something that we have enacted into law now. And if you look at out-of-pocket spending as a share in employer coverage, that has pretty continuously trended down.

There is a lot of reasons for all of this. As I said, many of them predate the Affordable Care Act. Some of them are random fluctuations so drug prices were holding overall health costs down. Now that's going in the opposite direction over the last year or two, although I wouldn't overstate that one. Drug spend is about 10 percent of overall spending.

But I have no doubt that if you look at just simply the mechanical effects of changing the reimbursement rates and reducing the growth rate, adopting a set of ideas that Peter Orszag had pioneered at the CBO director, although then he presented this one option that policymakers may want

to consider and here was all the reason why it would be great for you to consider it.

That that spilling over from the public sector into the private sector explains by itself a meaningful factor, fraction of the slowdown when you then add in some of the delivery system reforms I'm talking about, that I expect will explain an even larger fraction going forward.

If all of this cost happened at the expense of quality, we would be concerned. Quality is harder to measure than costs, but some of the measures we do have show some pretty dramatic improvements that are coinciding with this expansion of coverage and slowdown in the cost growth of health care.

So the first set of numbers come from the Agency for Health Care Research and Quality, ARC, and it's the hospital acquired conditions are down 17 percent since 2010. That's the equivalent of 50,000 avoided deaths over this period.

Readmissions have also fallen quite sharply. The equivalent of 150,000 avoided additional

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readmissions from the beginning of 2012 through the end of 2013.

You can again draw a line between the incentives that we've put in place which involve building on fee-for-service to instead reward and create an incentive for quality through programs like the Hospital Value-Based Program, the Hospital Acquired Conditions Reduction Program, and the Hospital Readmission Reduction Program. So you put in place a penalty for excessive readmissions, and not surprisingly, shortly thereafter you see readmissions start to fall.

I dwell on all of this because this should give us all a cause for hope and for optimism that there actually are changes that we can make in the health system for the better. We're not anywhere close to all the way there yet. There's too many uninsured, costs are too high, and quality is still in substantial need of improvement.

But we have the tools to deal with all this. And the first tool we have is just about one of the

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best deals the federal government has ever offered to any state in a public program which is you can expand Medicaid and we will cover, eventually, 90 percent, phasing down to 90 percent of the costs.

The evidence on what we've done in Medicare from the fact that 29 states and the District of Columbia have chosen to take the expansion, 21 states have not, is the uninsured rates have fallen more in the states that expanded Medicaid than didn't, again about as clear a causal evidence as you find in economics.

Moreover, that difference tends to understand the impact of the Medicaid expansion because in generally, the higher your uninsured rate the more your uninsured rate fell after the Affordable Care Act came into effect. The states that didn't expand Medicaid tended to have higher uninsured rates so they would on average be expected to get an even bigger benefit from expanding Medicaid than the states that have already done so.

Some of the best evidence for the consequences of Medicaid comes from the Oregon Health Insurance Experiment which took advantage of basically what is effectively a random trial and found that Medicaid as large benefits in terms of access to needed care, financial security, and bit effects on mental health.

And if you just quantify what it would mean for all the states that haven't taken it up to take it up, it'd be about 500,000 more people getting needed care, 600,000 facing better financial security, and 300,000 facing less depression.

Using quasi-experimental evidence, we can look at a broader range of outcomes and estimate that 5,000 premature deaths would be avoided each year if the remaining states took up Medicaid.

The benefits of Medicaid go beyond the health system to the degree it's reducing you for uncompensated care that actors within your state would have borne the cost of regardless of whether you expanded, then you're in effect being reimbursed at

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more than \$.90 on the dollar and potentially more than \$1.00 on the dollar, and the topic for another discussion, but I'm concerned about the future of macroeconomic stability when some of our policy tools are constrained going forward, Medicaid is one of the automatic stabilizers in enhancing that automatic stabilizer is good for the state and good for the country in terms of our overall macroeconomic resilience going forward.

The second step going forward is realizing the full potential of payment reform. We put in place a number of mechanisms for payment reform in the Affordable Care Act. We extended a number of those mechanisms to physicians in the bipartisan SGR reformed that passed earlier this year. We're already putting these in place but there's a lot more to do.

The economics of this is quite simple. Fee-for-service care is well known to suffer from three problems. First of all, it provides an incentive for excessive and not always high quality

care. Second of all, it doesn't provide any incentive for quality. And third it leads to poor coordination.

Alternative payment models, including bundled payments and accountable care organizations have the potential to help solve all three of those problems resulting in better quality at a lower cost.

One of the ways we're figuring out how to do all of that is through the Innovation Center, which doesn't just have a budget to conduct experiment, but also has the authority through the secretary to expand up those experiments if they're shown to either reduce costs without hurting quality, or improve quality without increasing costs.

And that's why it was particularly disappointing to see that there were proposals in the house for repealing the Innovation Center which would save on its budget, but according to the Congressional Budget Office ultimate add \$31 billion to the deficit because all of the reform we wouldn't get when, when it wasn't there anymore.

Going forward, alternative payment models have expanded from essentially zero a few years ago to 20 percent.

And Secretary Burwell has set the ambitious goal that they should be at least 30 percent in 2016 and 50 percent in 2018.

We're going to get there in a couple of different ways. One is bundled payments, and the hip and knee demo which we had done on a voluntary basis is going to be expanded on a mandatory basis to 76 randomly chosen places. And there's more we can do to continue to build on that type of bundle that gives you a fixed payment from the date of the surgery to the 90 days after discharge linked to quality.

Accountable care organizations have rapidly expanded and are now 20 percent of Medicare beneficiaries, 7.8 million people in total, and 424 accountable care organizations, and there's more we can do to build on that model.

And then finally, the physician reform is going, setting up a set of incentives to put more

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physicians into alternative payment as well, 60 percent by 2019, and effectively all physicians in the long run.

We can do these payment reforms for the federal government, but for them to work really well, we're going to need to see the private sector picking up all alternative models for payment as well.

We have a big advantage in terms of size. We have a lot of knowledge and you'll see, you know, the federal government help solve the coordination problem and the private sector following, but we're also trying to make an effort, collaborative efforts like the Payment Learning and action Network that roll up our sleeves and really work together with the private sector to make it happen.

The biggest tool we have for the private sector is the last topic I want to talk about in our agenda going forward, and that is implementing the excise tax on high-cost employer plans that is scheduled to begin in 2018 and is the most important tool we have for the private sector and one that

complements what I've been talking about in the public sector because it can help solve the adoption problems I've been talking about.

Repealing or delaying the high-cost excise tax would be deeply problematic in terms of all the goals and accomplishments I've been talking about in the context of the Affordable Care Act, although we're always willing to work on any aspect of the Affordable Care Act to improve it as long as we're improving health, the overall economy, and the deficit.

The basic economics are very simple, and it's why 101 economists recently signed a letter endorsing it and opposing the repeal if it which is that right now an employer has a choice between paying you \$.60 in cash or \$1.00 in health insurance. And even if that \$1.00 in health insurance isn't worth as much to you as \$.65 in cash because of the tax system, you'll have an incentive to do that.

What we've done to create a more level playing field s put in place a 40 percent excise tax on

very expensive plans. Plans that are \$10,200 for an individual or \$27,500 for a family.

To put some context on what \$27,500 for a family means, the average premium today is \$17,545. Even if it continued growing, you're talking about something set about 40 percent above the average in 2018.

This provision is going to have three benefits. The first benefit is a lower cost of health care. And CRS estimated that it would reduce the cost of healthcare by \$60 billion in 2024. That's 3.6 percent of health spending. And I don't know any other provision that anyone has that you can take off the shelf and have any degree of certainty of the type you have here that it will have that magnitude of reduction in health spending.

The reduction in health spending manifests itself in an increase in wages. And if you look at the CBO and JCT numbers, you can basically back out that they're consistent with wages going up by about \$45 billion in 2025.

To give you some sense of the magnitude of that, the proposal to raise the minimum wage from \$7.25 to \$10.10 which had been in Congress last year, \$45 billion a year is twice as large a wage increase as CBO estimated you would get under that minimum wage proposal. So again, it's about as large a tool as I'm aware of to raise wages.

And then the flip side of all of that is when your wages go up, that results in additional revenue, and that revenue will reduce the deficit according to CBO by \$90 billion over the ten-year window. We estimate it would be more than half a trillion dollar over the second ten-year window, and it's an important part of the reason why the 75-year fiscal gap looks so much smaller today than it looked five years ago.

There have been two general sets of issues raised about the high-cost of the excise tax. The first is how is it going to accomplish these reductions in costs leading to the increases in wages and reduction in the deficit?

Some have argued that it will entirely lead to cost shifting and higher deductible and co-payments. First of all, I've already showed you evidence that although people are making that claim today, it's not something that we're seeing in the data. And I suspect it's actually not going to be the major channel that it operates on going forward because, first of all, increased cost sharing has diminishing returned to scale. We know from evidence from Rand on forward, and because it actually affects FSAs and other tax preferred ways in which to help spend on health care which is a lot of where the out-of-pocket gets driving.

Instead, I think a lot of what the high-cost excise tax is going to do is drive the types of alternative payment models and reforms that I was talking about in the case of Medicare, as well as providing employers with a little bit more of an incentive to exercise their market power to slow the actual cost growth of health care as well.

I think it's important also to understand that these benefits aren't just for Cadillac plans because when Cadillac plans make a change, a lot of those changes spill out across the health system. So even people in less expensive plans would expect to see lower premium growth and more innovative care as a result of this.

Finally, there's the question of how many plans are actually affected by this. And there's a few different sets of numbers going around out there and I'm happy to talk about some of them in the Q & A.

The Department of the Treasury's Office of Tax Analysis has estimated that in 2018 4 percent of plan enrollees would be affected by it. This is similar, tiny bit lower than the CRS estimate. But notably, a lot of those plans are only affected to a very small degree. If your premium is \$27,000, \$27,600, you're only a 100 above the threshold and you're paying a tax that's very small relative to the size of your plan. So if you look at the percent of

plan costs that are affected the high-premium excise tax, it is 1 percent in 2018.

There have been issued raised about the indexation. I think that's something that one could have a discussion about, but it's notable that that percent of plan costs by 2025 only rises to 3 percent of plan costs.

In conclusion, I would say we've seen really exciting progress for the last five years. We have a lot of tools to have progress going forward. We certainly don't have all the answers ourselves. A lot of what we're trying to do is give the private sector a reward for quality and let them figure out how to improve quality.

Give the private sector more of an incentive to pay people in wages than they have today and let the private sector figure out how to reduce the cost of health care and create places like the Innovation Center that as we learn more, have the ability to scale those experiments up and use them to improve quality and reduce costs so that we can make the next

five or ten years as favorable for the health system as the last five years have been.

Thank you.

(Applause.)

MR. GARTHWAITE: Okay, what else is --

VOICE: (Indiscernible)

MR. GARTHWAITE: I believe it's a Brookings rule that you're not allowed to come here and not take questions. At least I've been told that in the past.

MR. FURMAN: Well, thank you, sir.

(Blank tape from 18:15:10 to 18:15:29.)

MR. GARTHWAITE: I mean, first of all, the labor market has outperformed economic forecasts consistently for the last five years and outperformed the labor market in other advanced economies. And I think you need to take a broader look at the impact of health reform on the labor market.

So slowing premium growth insofar as it's not fully passed on to workers in the short run helps employment. Workers that are less sick, missing fewer days, less disabled helps employment. Greater

mobility and not having the type of job lock we had in the past helps the labor market. So I think there are a lot of real important ways in which this is helping our labor market function better. So, thank you.

MR. FURMAN: Thank you. You were terrific.

(Applause.)

(Blank tape from 18:17:59 TO)

MS. ROVNER: While we're finishing up here, I'm Julie Rovner from Kaiser Health News. Thank you all for coming. I'm joined here by some of the best economic minds in health care to discuss what I think is a novel proposal for redistributing the availability of hospital charity care.

This is one of those little discussed but very critical pieces of the health care safety net, and one that will continue to be relevant despite the full implementation of the Affordable Care Act for reasons that we'll discuss.

Here's how we'll proceed. Our proposal today will be presented by Craig Garthwaite of Northwestern University's Kellogg School of

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Management. Craig's down at the end. After Craig lays out the plan, our other panelists will get to present their initial responses. First off will be Rick Pollack, President and CEO of the American Hospital Association. Rich will be followed by Martin Gaynor of Carnegie Mellon, and then Peter Orszag, Senior Fellow here at Brookings, who spends most of his time these days at Citigroup in New York.

After that, the four of us will have a discussion which will be followed by your questions. If you have a question, I think you were handed index cards as you came in. Could you please write legibly, if possible, and you can pass them over to one of the nice staffers, who will pass them up to me.

So without further ado, Craig, tell us what you got.

MR. GARTHWAITE: We're gonna wait one second while we (inaudible) which is why I'm not Jason Furman.

Well, I can start without that and then -- the first slide is not that important. So I'm Craig

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Garthwaite. Chris Ody, one of the coauthors, is in the audience, as well, as is David Dranov from my colleagues at Kellogg that couldn't join us today.

I'm going to talk a little about a (inaudible) trade system for uncompensated care in the United States.

And as Julie said, this is an issue somewhat that doesn't get discussed a lot in the sense that that, Jason's right, we have cured -- one second again.

Okay, here we go. So we going to explore a tradable system. Here's my paper. Okay. So uncompensated care is an issue that I think isn't getting as much attention these days partially because as Jason said we have somewhat solved, quote/unquote, the access to care issue by giving everyone health insurance under the Affordable Care Act.

And that is true. It's a different version of Jason's story which is showing the decline the share of uninsured and also how it varies by Medicaid state.

So overall, from 2013 to 2015, what we've seen is a marked change in the share of uninsured in the United States. It's been a meaningful decline. As Jason said, it's the biggest decline we've seen since the creation of the Great Society programs in the 1960s. And this is something we should all be very happy about.

There is variation here though. And some of it fairly systematic. States that did not expand medicaid. States that did not expand Medicaid had much smaller reductions in their share of uninsured. And so in those states we have more of a need for uncompensated care still because, for example, 14 percent of the population still lacks health insurance in those states.

But even in states that expanded Medicaid, even after those states eventually I would predict come in line and do expand Medicaid, we're still going to have a sizeable fraction of the United States population that lacks access to health insurance.

There are a variety of reasons for that. Some of those people are conditionally eligible for Medicaid so they're actually insured from the point of view of a hospital. If they get sick they can sign up. But other people are choosing not to sign up and still others have been expressly left out of the ACA. Undocumented immigrants, for example don't receive coverage under that.

In addition, what's going to change in the nature of what care is in the Affordable Care Act by making more high deductible plans in the insurance marketplaces. And while historically, as Jason showed, we haven't seen this big rise in deductibles in the employer market, we do know we have lots of high deductible plans in the Affordable Care Act.

We want to think about sort of the ability of low income patients who are primarily having their insurance paid for by subsidies whether they can actually bear the burden that comes with that deductible.

So we want to think a little bit about uncompensated care. So for a variety of reasons, hospitals provide care to individuals who don't have an ability to pay. Some of that is for various regulatory reason. When people show up at a hospital with an emergency, we treat them. Right? That's the way the United States works. We've enshrined that in law in the 1980s.

Some of that was because the majority of hospitals in the United States are nonprofits. In that sense, we expect them to provide some sense of community benefits. And that's been a widely defined term over time in the United States. We'd know that this community benefits standard though is in exchange for you not having pay taxes as a nonprofit hospital. And that nonprofit exemption costs about \$11 billion a year in 2011.

Now, when you do health economics, \$11 billion is nothing. Seems like a lot of money. But actually, that is a lot of money that we're spending. We'd like to figure sort of what we're getting in

return, particularly as we change the composition of the insured population. We can spend \$11 million in 2011, I'm sorry, \$25 billion. Not even 11. 25. \$25 billion in 2011, right, so that's double the cost of the nonprofit exemption at this point just in this talk.

But as we change the composition of the uninsured, all right, and we change the needs on hospitals, we ought to think carefully about how we want to require potentially hospitals to respond.

In addition, what we know is that the safety net we have to the extent that we see individuals able to get care at hospitals, this doesn't come without a cost for them as well. We see lots of individuals who have trouble paying for their medical care even in states that expanded Medicaid. We want to think about how we help those individuals.

So we're proposing, as our reason for this, is that we see in the United States while we have a nonprofit center, I think we're going to spend a bunch of time on this panel talking about what the nonprofit

community benefit standards is. One notable fact about it is that it's decentralized across the United States.

States have different rules about it. Some states have no rules. We have a sense if we want hospitals to provide some community benefits with some guidelines from the IRS, but we don't ever require any part of the community benefits standard to have a certain minimum value.

Some of the things that we allow hospitals to do as community benefits, benefit the community. We all like research and teaching, but also benefits the hospital that does it. And even if they weren't a nonprofit hospital, they would probably do a large amount of the research and teaching because they get private benefits for it. And so we want to think about how much we want to reward them for that through the nonprofit standard.

Complicating matters further as a purely practical matter, even if hospitals in relatively wealthy areas want to provide benefits to low income

patients, they just don't have those patients showing up at their door. So if we did put sort of a blunt standards that says you have to provide 2 percent of your hospital revenues to uncompensated care, hospitals may have trouble finding charity care worth patients for that. And so we have to think about how the uneven distribution of income across the areas matters here.

Why they particularly matter, is that hospitals in the wealthiest areas who have probably the lowest ability to attract uncompensated care patients on average gain the most benefit from the nonprofit standard. And we'll talk on the panel a little about how that political economy works and we want to think about the transfer of resources across and within states.

So what we have proposed is a series of tradable charity care credits to solve the geographic mismatch, that mismatch being that we have hospitals in relatively wealthy areas who don't have lot of uncompensated care demand. We have hospitals in poor

areas that have excessive demand for their uncompensated care services.

And we propose three relatively simple steps. We want to set a charity care floor for all hospitals. You must provide a certain percentage of your hospital revenues in the form of charity care. We want to see an income threshold for charity care so people below a certain income threshold qualify for actual charity care. And we want to allow hospital to transfer resources to meet their obligations under one and two.

That's (inaudible) that we have. So if you're in an area that doesn't have many low income individuals who are uninsured looking for care, you can purchase credits from a hospital that has excess demand for those services.

For a variety of reasons, we believe this is best implemented at the state level. And what we mean by the state level is not just thinking about states individual, but at the sub national level. So states or regions of states might be a good way of

implementing this, particularly in areas, not that everything in the world should be centered around Washington, D.C., but this is an area we see lots of patient flows across borders. You might want to think about sort of the three states coming together to think about how to transfer resources across them.

I also want to note that our proposal will leave hospitals able to provide a meaningful amount of non charity care community benefits at their discretion. So we're not saying, and we don't even propose that a state should set this minimum floor. It's sort of something that's equal to the total nonprofit benefit that a hospital gets.

We think hospitals do lots of very important things to society be it community health clinics, be it research and teaching, and we would think that they should be allowed to continue to do that, but some portion of their nonprofit benefit should be carved out and dedicated to these low income patient, and each state or region could determine what that level's gonna be.

To give you a pretty easy sense of how this would work out, you can imagine sort of a rich and a poor hospital, Montgomery Burns Memorial and the Hospital for the poor, the average market income for one is obviously higher. Montgomery Burns Hospital happens to be bigger so they would face a great charity care floor obligation, but currently they provide less charity care than the Hospital for the poor, and they have charity care eligible patients of about \$1 million, but they're actually providing anything to low income individuals.

What you would see is that to meet our standard, currently they provide about \$1 million in charity to low income people, but they have to provide \$2.5 million. They (inaudible) provide \$1.5 million in more charity care. That's what our standard would require them to do.

They really don't have the ability to do that. Hospital for the poor though, they are a million dollars above the floor. They current have excess demand for charity care services, and so we

have is that hospital for the poor would be willing charity care for at least the current value of their charity bills which is about \$.1 million dollars. Think about what you could have sold those bills to in the outside market.

Effectively, what we want is we want to transfer the charity care services from hospital for the poor who has lots of patients who currently show up at their door and have insurance, we want to transfer resources to that hospital and transfer from hospitals that are currently receiving large nonprofit benefits but not serving much charity care.

Okay. Seven minutes.

MS. ROVNER: Very good. Thank you very much.

(Laughter.)

MS. ROVNER: Don't worry if you didn't get all that. We're going to talk about it. We're going to start, Rich, with your response.

I have a very broad question for you. Is charity care actually the correct matrix with which to

measure whether nonprofit hospitals are living up to their nonprofit status?

MR. POLLACK: You know, it's a piece of the matrix, and I think that's that's where the report of a study is somewhat troubling because from our perspective you need to look at the broader community benefits and every community is different and people have to meet that obligation of community benefit based upon the needs of the community.

If you went with just the charity care standard that the professor proposes, it also doesn't include the full range of uncompensated costs. It doesn't include the bad debt that's never collected. It doesn't include the underpayment for Medicaid, both of which the IRS acknowledges should be considered a part of how you count charity care as a part of uncompensated care.

But the more fundamental point goes to this broad definition of community benefit and the value and the accountability that we have for tax exemption

in a broad way. And this has been recognized that it ought be flexible.

And providing services that are never going to make money whether they're burn units and neonatal intensive units, is a community service. Doing wellness and prevention and screenings for poor pregnant woman that occur throughout the United States on a regular basis that is a community basis, benefit. You mentioned research and education. Certainly, that's a part of it.

You know, we do all sorts of things. Suicide prevention, poison control. Think about everything we have to do to maintain capacity for emergency readiness, to be ready for any accident, nuclear, biological, radiological, you name it. We had Ebola less than a year ago. The capacity to be ramped up to do that I kind of think that's a community benefit.

Food banks, violence prevention. I was just yesterday in Toledo, Ohio visiting with Crometica Healthcare, and they just built a grocery store in a

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food desert, meaning a high poverty area where you can't get fresh food. I think that's a community benefit and I don't know that they're doing that for any economic value in a poverty-stricken area.

And by the way, they built classroom on top of the grocery to counsel people on nutrition and to give them healthy cooking courses. I think that that's a community benefit.

You raised the issue of what revenue is foregone for this purpose of tax exemption. Yes, it's \$24.6 billion a year according to Health Affairs. But according to the IRS, we provide a total value of community benefit of \$62.4 billion. That's a pretty good return on that investment. And if you back out just the uncompensated care portion, it's \$35 million.

So I think that you have to ask the question of what's wrong with the current picture in terms of how to best serve communities.

Finally, the fixation on charity care as the best way to get coverage for the uninsured I think is really off base. Look, we supported the ACA. We

wanted to see coverage extended. We sacrificed reimbursement to extend coverage to what we hoped would be over 30 million people. That was a shared responsibility.

The notion that charity care is the way to get to universal coverage which we're not even close to as you acknowledged, you know, providing care on an episodic basis as opposed to giving people coverage, what's practical is to give people coverage.

And, in fact, I might add that we actually proposed to the government that we subsidize coverage for people to buy private plans on the exchanges rather than just taking care of people in the ED on an episodic basis so at least they have coverage and get the right care in the right place and the right time, and CMS was opposed to do that.

I also think it's not practical because it creates a very complicated system that's going to involve a new bureaucracy and I think the resources associated with all of this are better put to taking care of people that don't have coverage.

Finally, the other thing that's a little not practical to us is that if you look at where the whole health care system is going, a lot of it is moving out of the hospital. It's moving out of inpatient to outpatient and other settings.

So the question is when it comes to this obligation for society as a whole, aside from getting everybody covered eventually, we would hope, is where are the nursing home, where are the home health agencies, where are the health plans, where are the health plans? Why is it that it's the hospital that is being given the responsibility to solve this entire problem?

So that's kind of our take on it.

MS. ROVNER: Okay, Marty, we have sort of a pro and a con. Where do you come down on this whole idea?

MR. GAYNOR: Wow! So let me just give, start of with a little bit of background. Craig didn't have time to do this. But this idea has been used elsewhere to great success. In particular, we've

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recently been reading the Book of Ecclesiastes from which the saying, "There nothing new under the sun," comes and this idea of trading permits has been used very successfully for sulfur dioxide emissions. That's not to say that Craig and coauthors think that charity care is somehow like toxic emissions. Far from it.

But they're trying to build off that idea which has been used to reduce emissions and allocate them in a much more efficient cost-effective socially beneficial manner here. And I think it makes a lot of sense.

Look, of course I think most of us would agree universal coverage is the ideal. But we are where we are. I'm no expert on politics. I'm merely an economist. But I don't we're going to see major coverage expansions above and beyond what we have.

That means a larger number of people with no insurance coverage at all, particularly in states that have decided not to take up the ACA Medicaid expansion. And a lot of those states are very large

like Texas and have a lot of poor people that are going to fall in that gap between Medicaid eligibility and eligibility for the exchanges. So they will not have any insurance. That's a fact. I wish it were otherwise. But it's not.

This is not so much about the level of charity care. It's about the allocation. It's about the fact that some hospitals for some reason are in locations where there are not a lot of very, very poor folks and some hospitals are. And it's just trying to move resources around and match them better to where they would be used to the most effect.

So that I support. I think that makes a whole bunch of sense. There are a lot of details to be worked out. It's right, the first order it does not directly penalize other kinds of community benefit, but those are set off to the side.

And I think Rick has some points that one should pay attention to. What are broader effects of this for other kinds of benefits, but more broadly, on the kinds of things that hospitals do. But I think folks

without insurance that receive charity cards, such a first order important problem. And the fact that there is this mismatch is of first order importance that this makes a lot of sense to me.

MS. ROVNER: Peter what are some of the practical politics involved here, I guess, both for and against?

MR. ORSZAG: Well, first, before I get to the politics, I do want to just back up and make two points. One was the point that Martin made which is there are a lot of things that try to do through public policy that we can do more effectively even for the purpose that we're trying to pursue by using a market-driven approach like a cap-and-trade system or like a tradable permit system.

And for this piece of charity care, and I agree that it's not the totality of how we should be evaluating nonprofit hospitals, it strikes me as a, as the type of application that would fit the general category of we could probably do it more efficiently.

There are some hospitals that will fulfill their community benefit by providing more food banks and more psychiatric emergency wards and what have you. And there are some that are better equipped and more efficient at serving very low income uninsured patients, or not very low income, moderately low income uninsured patients, and they should be able to specialize in those two things while both continuing to enjoy the same tax benefit. That's the basic concept. That's point one.

Point two, I do think, and this is not specific to the hospital sector, but I do think it is time for a broader review of nonprofit status writ large. Nonprofits now account for more than 10 percent of the U.S. labor market, a substantial amount of tax expenditure, and it is, people should not be attacked for just raising the question of are we getting our money's worth out of that tax expenditure. It's a significant amount of money and there are legitimate questions that I think should be asked about whether that's worth it or not.

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I don't really view that as core to this proposal. This is saying we have that. How do we go about making one piece of this more efficient recognizing that nonprofit hospitals do lots of other things?

Now, on the specific of the proposal, my own suggestion would be that we -- the authors sort of started with the national, a national standard as being the baseline and the said, well, we should do a level below that.

I would actually go a level below their level to a much more localized area below the level of a state just to try this out and see how it works. Do it across a few hospitals in a city. Do it across a few hospitals in a local area that's not as broad as even in a hospital referral region.

The example in the paper where you're comparing an income level in Bridgeport to an income level in Greenwich, well, I don't know. I think someone who's got \$40,000 income in Greenwich is not, does not have the same opportunities and standard of

living as someone who has \$40,000 in Bridgeport. The cost of many services and what have you are different now they choosing to live there, but it's complicated and I'd rather just look you know, Bridgeport/Fairfield or other areas where it's, the socioeconomic dimensions are a little bit closer, try this out, see how it works, see what kind of effects it has, and then go from there.

Now, on the politics of actually doing this, we live in, as you know, a highly polarized political environment and so the chances of doing anything immediately I think are exceedingly small to zero, so I don't want to hold out the false promise here that this would happen.

But what's interesting about taking it to the state and lower level is whether the state's themselves, again, separating this from the federal nonprofit status because that's subject to federal law and what have you, is whether the states themselves in evaluating nonprofit status at the state level, could start a pilot to try this in one or two areas and just

see how it works. It can't be such a bad idea that we're not willing to try it somewhere and just see what the results are.

MS. ROVNER: We're going to chat here. While we do that. I'll remind you if you have questions, please write them on the cards and hand them to one of the nice people in the room and they will bring them up to me.

I want to step back a little bit though and talk about this whole issue of nonprofit versus for profit because that's becoming a bigger issue even in the campaign. You know, there's been this look at are nonprofits doing enough to offset the tax break that they get.

On the other side, you have people saying why on earth do we even have for profit health care in the United States? Why should people be making a profit off of other people's illness, basically? I mean, I get there's the innovation part of it that if you don't have some incentive to do things, you might not.

But in terms of hospitals and doctors in particular, where does that sort of fall into this whole category of how we get care to the people who can't afford it?

MR. GAYNOR: Well, one thing to think about here and I think Peter touched on this in terms of the political economy is there has been a lot of push back against the tax exemption. A lot of it state or local property tax exemptions right or wrong. But one thing to think about the economy is this in a sense is sort of a political trading card on that.

Now, broadly speaking, does it make sense to have a nonprofit tax exemption. I think charity care is the one area where you can say that we are deriving some non trivial benefits. Exactly how large is the subject of some debate. Look, you have an industry that shifted to being largely sales revenue driven organizations, higher education, by the way, the industry in which I live, is also like that. Don't tell my president or provost I said this.

MR. GARTHWAITE: Not Northwestern.

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MR. GAYNOR: But, yeah, we take, Carnegie Mello we taken not for profit very seriously. But there's a question of whether the not for profit form makes sense when you started as a charitable organization with most of your revenues from donations or whatever to very large organizations that live and die on sales revenues.

MR. POLLOCK: You know, one of the things, and I just want to be clear, we have to earn our tax exemption. There is no question that we have to be accountable for it, and we think that the numbers show that we are and we need to maintain that accountability. And, in fact, the Affordable Care Act had new requirements that actually enhanced those accountabilities that we were fine and we're working with. So I think that's something that has to be stated.

You know, one of the things that Marty said that I think has to be important if you go back to the construct here, you raise the issue of who gets penalized. Okay. think about this. High Medicaid

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hospitals get penalized in this construct because Medicaid underpayment is not counted toward uncompensated care in this construct notwithstanding the fact that the IRS recognizes it.

So if you're a hospital that serves a high Medicaid population, admittedly service a lot of poor people, many uninsured, you're going to be disadvantaged by this because you're going to be given an even additional responsibility when, if you buy into this construct. You're already doing an awful lot in this area.

MR. ORSZAK: Couple thing. I mean first, I'm not going to speak for the authors --

MR. ROVNER: I think the author can speak for himself.

MR. ORSZAK: But I would say, look, separate the idea here from the particular choices they made whether the uncompensated part of Medicaid care counts or not. You could have the same system with Medicaid uncompensated care counted, and then that dramatically changes -- in fact, one of the benefits again of

trying different things is to allow the rules to be different --

MR. GARTHWAITE: In fact, the report addresses that and says you might want to include Medicaid under payments as part of it.

MR. ORSZAK: But I want to come back to the broader question here which is the evidence does suggest that nonprofit hospitals behave differently than for profit hospitals a little bit. Yeah, maximizing somewhat different things, but even if that's that the case, it doesn't prove that the tax exemption is worth it.

And I'll just repeat myself again, I agree that, I think any entity that is enjoying this large tax expenditure needs to kind of prove its meetle and prove its worth. And we have been from a policy perspective, frankly, pretty lazy about really forcing that kind of analysis on an ongoing basis. And a lot of what's happened is inertia which might turn out well. Maybe it's justified.

But the political polarization means we put in place a tax expenditure and it persists regardless of whether it remains to be justified, it remain justified or not.

VOICE: And the other interesting this for an analysis purposes if you did away with the tax exemption, how are you going to get those services done? I suspect government will have to do it and that involves tax revenue, government revenue. You know, who's going to do --

VOICE: That might be --

VOICE: That might be a more efficient way of doing it, Rick.

VOICE: I think that's a really important point. So that we sort of lead with getting care for people who don't have insurance and aren't likely to get it in the immediate term. We have to think about how we want to get that done. And I think Peter's point is right. We have a system in place that we're at least giving lip service to doing that. We have to think much harder about if we're going to use the

current system which is costing us a lot in certain unbudget ways, how do we get what we want as a society from that?

The alternative is, and I agree with you, if we're going to say, sorry, not sorry, just, okay, you're no longer not for profit. You're for profit. We can't just take away. We have to say how are we going to provide care for --

VOICE: And just in the event of emergency readiness.

VOICE: -- those folks. We can't ask hospitals to finance that in the same way that we would if they had not for profit status.

VOICE: And, again, just look at one aspect of it, emergency readiness. You're in New York. I mean, you know what the hospitals had to do to ramp up. Now, it's significant. And we spend a lot of resources on our own to do that. You know, where is that going to come from?

VOICE: I think it's important --

MS. ROVNER: Let Rick respond.

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MR. VOICE: It is important, I appreciate sort of what Rick has done here was just sort of pivot the debate to talk about the other things that hospitals do which is good, and I think in most settings when you're around a bunch of economists I'm the one who gets beat up for being too pro hospital. So it's sort of nice to be on the other side of this for a second.

(Laughter.)

MR. GERTHWAITE: But I think we're pretty clear about setting aside the revenue you're currently spending on that still exist and you can allocate it how you want. And the revenue you're currently spending on charity care, we want a more efficiently allocated across the hospitals in a state, in NSA, in a HSA, you can pick what you want.

But a lot of what you should have pivoted to is like emergency readiness, which is important, emergency departments which are important, poison control, all the things that we think we want, suicide prevention, food banks, food deserts, every buzz word

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in the room that people care about. And we thank those should continue, and we're very clear and went through great pains in the paper to be very clear those should continue.

What we would want is to reallocate the rest of it. And if we wanted, and we say in the end of the paper, if we want to put Medicaid underpayment in, we think that's perfectly fine.

I don't think there are a ton of hospitals, you actually might have the data better than I do in some ways, where you have lots of Medicaid underpayment and very low levels of charity care just given how income tends to be distributed across the country.

If that hospital does exist, then that person would be really supportive of the part of the policy where we fold the Medicaid underpayment in. In fact, that hospital that (inaudible) does all of this Medicaid services, they're going to, they should be (inaudible) most supportive of it because they're

going to be getting payments from all the other hospitals that aren't doing a lot of Medicaid.

VOICE: Let's go back to this fundamental issue. You know, you talk about practicality. I raised it in passing, but it's really important, okay. Hospitals that want to basically provide care to people that are constantly showing up in ER because they're uninsured and are willing to actually buy a plan for them on an exchange so that they can get access to health insurance and get the preventative care in advance so they don't have to go through this awkward charity care approach where you show up at the ED.

That seems to me something that isn't in this discussion. And again, we have begged CMS to allow us to do that on numerous occasions. Seems to me, again, my point is that if you want to provide the right care to people, we need to look broader to achieve the objective as opposed to just trading around on this charity case notion.

And that's all I'm trying to get at because what we want to accomplish here is expand the coverage to the uninsured, and we want to do it in the right way. And that's the objective. And I realize that may not be the total scope of the paper, but I think for all of us that's got to be the political objective. And while we may not be able to get to universal coverage overnight, there are these kinds of things that just make a lot more sense than taking care of --

MR. GERTHWAITE: There's two really important points about what you said. So I understand why a hospital wants to buy insurance for people that's (inaudible) because that's going to be a much more financially lucrative way for you to do that. And that's fine. I have no problem with hospitals (indiscernible). But what you want is insurance to pay for those ED visits.

I think it is important though that what we note is that the bulk of the evidence that we have on insurance expansions for (inaudible) in Oregon and

other places, is that it doesn't reduce ED utilization. Those people are not going to stop coming to the ED. They're going to keep coming, but they're going to be reimbursed and so that's good for the ED.

But, I mean, we all know why. We want to believe that's what's gonna happen. We want to believe we give people insurance and they find these primary care providers and they get things in the normal way that we would want for the most efficient care. It just doesn't appear to be to date what we want.

That is a much broader conversation I think most (inaudible) and we would like to solve how we do that, but let's not pretend that you're buying an insurance on the exchange is going to shift them to this sort of very efficient way of getting care. We haven't seen that to date. We haven't see it with the ACA for sure. Right? I mean, any of your members will talk about either for profit and nonprofit,

increases in ED utilization since the expansion of Medicaid (indiscernible). That's what we've seen.

VOICE: Well, if we would have had universal coverage, the question then arises again that you really raise, what's the justification for the nonprofit tax exemption at the state, local, and federal level.

MR. POLLACK: And there again, even if you fully implemented the Affordable Care Act according to CBO, there's still going to be 30 million people uninsured. And we're still going to end up providing care to an awful lot of those people. About a third of them are illegal immigrants. We take care of everyone that comes through the emergency room door. About a third of them are the young invincibles, and then there are a third of the folks that kind of that's kind of slipped through the cracks.

So the whole notion of uninsured or charity case is unfortunately not going to go away.

MR. GERTHWAITE: I agree with you. And that's (indiscernible).

MR. POLLACK: But you raised the question of if you got that point, why do you need the tax exemption?

VOICE: He said universal.

VOICE: I said if we were to get to universal.

VOICE: And I'm saying --

VOICE: Which I don't think we're going to get --

MS. ROVNER: I want to add yet another layer of complexity to this maybe at my peril. It seems that you have service (indiscernible). You're either insured or you're low income and uninsured. And, in fact, we've seen despite what Peter and Jason were saying, we seem to be at the place where we're getting increasing numbers of underinsured people who are showing up at the hospital and they do have insurance, but they may have \$1,000 deductible and \$6,000 out-of-pocket cap and there's no way they're ever going to be able to pay that.

What do you do about those people in this sort of situation? I mean, right now hospitals are spending a lot of money trying to chase them down for money they don't have.

MR. POLLOCK: Well, first of all, there are a lot of rules that we abide by and we make collection agencies abide by under federal law to make sure that any of that is appropriate. And, in fact, sometimes people are critical of us like GAO for medical reimbursement that we don't do that in a vigilant way.

But put that aside. The question that you're raising is a very important one, and we always kind of accept that we didn't have (inaudible) package. Of course, you'd expect that from us, right? But, you know, the reality is, yeah, charity care may go down as covered expansions increase, but bad debt goes up because people are not able to pay some of those out-of-pocket expenses that they simply can't afford and that's the hydraulic that we have seen occur.

MR. GERTHWAITE: Not that you're saying it's sort of in the report, but this is the issue we deal with directly in the report because what we're worried about is this idea that's what we're going to have now, we're going to expand insurance to more people. (inaudible) is actually going to be a pretty good plan it may change. You not going to see that. You're going to see a 6,000 deductible for a family. And what is going to change the composition of uncompensated care that's more bad debt now from insured people and less sort of pure charity care and we think that should be a counter force some way.

It's actually pretty hard to do though because the bad debt you're getting there does involve a payment you're getting from the insurance company as well. And so if you just simply forgive that the insurance is going to be upset because you've effectively unwound their cost sharing mechanism that they have for how they set their premium, and that's more, I mean, my wife is the lawyer in the family now, I mean, that's a contractual question, how you deal

with that because that's going to effect your reimbursement rate.

But we think that shift in the nature of bad debt is going to be really important. I mean people who are insured but can't afford, particularly low income people who aren't paying anything for the insurance because we paid for their entire subsidy, those are the people where we see this bad debt coming from. I know your members are seeing this right now.

And so we would welcome the idea of how we could efficiently and legally fold that into that concept of a tradable credit.

MS. ROVNER: But it's not now.

MR. GERTHWAITE: Well, I mean, bad debt exists in all businesses so hospitals I talk a lot about bad debt. Lots of other places we call this accounts receivable. Right? And you don't always collect on it. Some fraction of your bad debt is going to be there. The hospitals are a (inaudible) organization in the sense that when someone shows up and doesn't pay and he has a business where I teach a

course (inaudible) Kellogg, the first thing I would tell a student is don't sell to that person anymore. Cut them off. You can't do that. You don't have the option of doing that.

Someone shows up in the ED, just for the ED, they're just for emergent care, I mean, you have other systems that you show up at the ED for non emergent care, you cannot treat them. And so it is a more complicated conversation then because of that.

MS. ROVNER: Peter.

MR. ROSZAK: I was just going to say just coming back to the data, I'm not denying that this is a significant issue, but to the extent that they people who are showing up on the exchanges are not disproportionately coming from dropped employer plans, and evidence to date suggests that that's not where they're coming from, and they are coming from being uninsured, then even if there is a high deductible, it's still better than infinite deductible, so there's more coverage there.

And I think the chart that Jason put up that many people might not have noticed, it was on the right in gray, showing that for employer sponsored insurance the share of out-of-pocket spending as a share of the total firm provides insurance is going down not up. It's so contrary to all the media and all the --

MS. ROVNER: You should see my mail.

MR. ORSZAK: Right. That is it worth, I mean, we often will have discussions that are driving by chitchat instead of actual data, and I think that is an example where it is very important to, first, acknowledge that for many people, out-of-pocket spending is a huge burden. But in terms of how, where it kind of rests on the priority scale, it is important to figure whether Jason's chart was right or whether all the media hoopla is right, and right now I'm betting on Jason.

MS. ROVNER: Well, I'm thinking (inaudible) right because so many people don't have any out-of-

pocket costs. So I would think that the few, what is it, the 5 percent --

MR. ORSZAK: Yeah, this is something that people often have forgotten while deductibles have been going up, which is true, is that we now have out-of-pocket limits that are also in general tighter than they were ten years ago and so --

MR. ROVNER: Yeah, but they're \$6,000, they're \$10,000.

MS. ORSZAK: I understand. But if you look at the trend, that's important. And so what he was showing me was the total out-of-pocket spend, and if you read the newspaper, you'd think that was skyrocketing as share of employer-sponsored insurance and that certainly didn't look like it was skyrocketing to me.

MR. GERTHWAITE: But in terms of a trend post ACA, (inaudible) one data point.

MS. ROVNER: Yeah, I understand.

MR. GERTHWAITE: Post 2014, and we had something happen in 2014 that we that we think should change it.

MR. ORSZAK: Let me make another point about the bad debt. I have some sympathy for this. Nonetheless, I think it is tricky. And consider out-of-net work bills. So those are very, very difficult for consumers absolutely, and it can mean that the institution has a lot of difficulty getting paid.

On the other hand, networks and the negotiations between payers and providers is a very, very important way in which health care markets work. In which prices are kept down or at least grow as little as possible. There's lots of research evidence on this. I'll put a plug in for the Federal Trade Commission, my former home here on that. And so if you systematically start to forgive that and pay providers, their incentive to negotiate with plans that are putting these networks together has diminished considerably. And that can lead to a very bad dynamic that actually could ultimately affect the

affordability of care and insurance and work through the system in a way that we have even more people without insurance.

Now, I'm not saying that would happen, but it's something to think about. This is actually a very tricky area.

VOICE: So all bad debt is not equal I think is important.

MR. ORSZAK: Absolutely. Absolutely. I'm certainly not saying that.

MS. ROVNER: All right, I'm going to questions from the audience here and thank you for whoever wrote this question for writing it big enough. I don't have to put my glasses on.

"How would academic medical centers treatment different from community hospitals with the teaching mission compared to simple community missions?"

MR. GERTHWAITE: Different under the proposal, you mean? I think what we'd see is the academic medical centers, they're the type of organization we think are, they do a lot of community

benefit in terms of, say, research and teaching. Some of that is a community benefit. Some of that is really a benefit for themselves as well. So my home institution, Northwestern Memorial Hospital, really likes to be a sort of brand name institution. They like it because in those networks it gives them purchasing power. It's also keeping them out of some narrow networks so they're dealing with that.

But they make a point every year we put up our sign, "U.S. News & World Report Top 100," and that goes up (inaudible) you walk through the hallway, it's a huge banner that says that.

They're not doing that just to benefit society. There's personal benefits too, and they're probably going to do more research that is socially beneficial because there's some benefit.

And so do we think that should be part of their nonprofit credit? I think that probably if I have to make a decision between things that personally benefit them and things that would give low income,

care to low income people on the margin, I would prefer low income care.

MR. POLLOCK: Oh, no, I think the question, there's a follow-up question. I mean, their mission is training and research. That is what they are established to do. In some ways, the patient that come are simply to further the mission of teaching and research.

MR. GERTHWAITE: But let's also remember that an awful lot of our teaching hospitals are located in inner cities and they do a lot of Medicaid work and they do a lot of uncompensated care work. And they have really high reimbursement rates for the insurers.

MR. POLLACK: And some of them are frozen out by these narrow works --

MR. GERTHWAITE: Well, (inaudible) person works.

MR. POLLOCK: Because their prices are too high.

MR. GERTHWAITE: You see your prices
(indiscernible).

MR. ORSZAK: Academic medical centers are, I mean, they're great things, but they get a whole variety of additional benefits beyond being a nonprofit hospital. So if we're sort of focused here on a subset of of the subset, they get a lot of benefits beyond being nonprofit, you know, for payments for medical education and IH funding, blah, blah, blah, blah. The list goes on and one. Okay.

So the focus on the nonprofits that, now we're focused on a piece of a nonprofit status which is just focused on charity care. There I don't know frankly that there's any significant difference that I should have in mind when I'm think about, you know, whether a academic medical center is treating a Medicaid patient or a community hospital is treating a Medicaid patient for the same kind of condition.

And by the way, there are lots of other things that I think are worth considering that would

provide a lot of benefits to the hospitals that are disproportionately treating those kind of patients.

One example is in my opinion the evidence shows pretty clearly that there is a large socioeconomic status impact or effect on things like readmission lists. We don't currently adjust the readmission rate penalty for socioeconomic factors. That would provide a very substantial benefit to the hospitals that are disproportionately serving low income households, and by the way, it's in my opinion the right thing to do because the data suggests that it absolutely influencing readmission rates.

So rather than kind of thinking we can solve all problems with one thing which we're not going to do, it strikes me again if we just focus on the provision of charity care and again acknowledging that the first best outcome by far is to get people covered, but recognizing as we all do we're not going to get there immediately, I think the immediate question is do we think that even within a local

hospital market there are some hospitals that are going to wind up doing certain kinds of charity care more efficiently than others. And if so, then this proposal can make a lot of sense.

And if you don't think so, then it's not (indiscernible)

VOICE: But on the flip side to your whole point, everybody (inaudible) every community is different. And every academic medical center may be different.

The other thing is that, you know, you raised another good point. You know, the need for a socioeconomic adjustment on readmissions. Absolutely. We've been arguing that for some time and there's bipartisan legislation in the House and Senate to do that. We wish it would get done as quickly as possible.

But that raises another point too which is what are the other public policy levers that are out there that try to achieve the objective that is inherent in your proposal, and that is sort of evening

out or making it easier for those that provide high amounts of charity care to better able to maintain their financial viability.

So you can't rule out the other levers that ought to be a part of this discussion. So there's this thing called Medicaid Dish. There's this thing called the Medicare Dish, and there's thing, police levers things called 340B that require pharmaceutical companies to provide discounts to hospitals that serve high numbers of poor people.

So to your point, there are a lot of levers here that get to the objective that you're trying to seek of --

MS. GERTHWAITE: Or they try to get the objective --

MS. ROVNER: But not very efficiently apparently.

MR. GERTHWAITE: (Indiscernible).

MR. POLLOCK: But they're in place. And practical.

MR. GERTHWAITE: In the interest of precision, I think that's good to know.

MR. GAYNOR: But, unfortunately, we have the mismatch they document. So I think this is, this is, again, this is not one thing that will solve all problems, but first order folks who have no insurance at all that are going to come to hospital charity care, the whole thing is to try and sort of reallocate resources in a way that you get the most bang for the buck. It's that simple. And I think it's an idea that is very worthy of consideration. I think it has to conform to local realities and norms just like Peter has been saying. But I think it makes a whole bunch of sense.

MR. GERTHWAITE: Two point for precision. One, Medicaid Dish is dedicated or is the target of hospitals that have lots of Medicaid patients with the hope that we hit places that have lots of charity care. And state level decisions on that vary. Some states give it to everyone. Some states give it to a very small number of hospitals.

The other thing, if you are an academic medical center that has lots of uncompensated care patient, you're going to win under this proposal. If that's who you are, you get a chance (inaudible) from all the rest of the hospital so we shouldn't be worried about those individuals or those firms. They'll be taken care of.

MS. ROVNER: All right, here's a question from clearly one of the economists in the audience. "Does this create an even greater incentive to inflate the cost of charity care?"

MR. ORSZAK: Well, you know, in terms of how you count charity care, you know, now forget about whether you include bad debt or what, it ought be a cost. There was a debate at one time whether it ought to be charges and we always said, no, cost is the way it ought to be and that is the factor. There's a bit gap there. Cost is lower and that's been the standard.

MS. ROVNER: Yeah, you address in the paper, yeah, tell us.

MR. GERTHWAITE: I think the idea is what is cost in the hospitals is a nebulous term at times. We have very specific accounting rules as to what cost is.

MR. ORSZAK: We follow the government rules.

MR. GERTHWAITE: Well, there's lots of government rules that are pretty crappy and this might be one of them. I'm not saying you guys, no one is saying you guys do anything wrong.

MR. ORSZAK: What other standard is there?

MR. GERTHWAITE: Most businesses give a better sense of what cost is. In the hospitals we don't have as good of sense, and then we also we get into a conversation which I'm the economist, whoever wrote that, I'm looking in this direction, about what (inaudible) versus what's accounting cost, but there's conversation we should have and we do have to worry about that, I agree.

But we say it cost, but we don't have a good way of defining cost. I think you'd have to agree we follow the rules but the rules aren't that good.

MS. ROVNER: All right. Here's sort of a related questions. "Why would this proposal be much more efficient than the current use of hospital provider taxes and related mechanisms like the Massachusetts safety net care pool?"

MR. GERTHWAITE: So, I mean, one, I think it's all what you called that, the Massachusetts Uncompensated Safety Care Pool. That's not a foundation wide program that we have.

MS. ROVNER: No, but it's an example.

MR. GERTHWAITE: And I think what we want to do, we don't want to do this based on hospital revenues. We want to do this based on hospital revenues. We want to do this based on targeting a hospital that is best able to provide cost to low income individuals the most efficient way. That's sort of the goal. And the goal is not to sort of have a sector specific tax or anything like that. The goal is to try and use the market in the way we do with sulfur dioxide and the way we try to do with other

systems and cap and trade to try and target the, to have the hospitals who are best able to provide this care to be the ones who do it, and to be compensated for it by the hospitals who are less able to do that who do other viable things we want them to do.

MS. ROVNER: And then another state-specific, doesn't say but I assume this person is from Maryland, wants to know, "How does this (inaudible) trade system for charity care compare to all payer rate setting systems that incorporates the cost of uncompensated care into the hospital-specific rates?"

MR. GERTHWAITE: So, I think all payer rates I think is a pretty bad idea. I don't like to say this in the scope of Maryland where I got my Ph.D and I spent many fine years, so I don't think that, I don't think that we should think of those as competing ideas. I think we should have all payer rate setting solving one issue and this is solving another. I think if we think that we have difficulty implementing pilot programs for ACOs and the ACA, trying to put (inaudible) or anyone else trying to put all payer

rates in (inaudible) probably would have been even more difficult. We haven't seen many states other than Maryland put in place either.

MS. ROVNER: Maryland has had it for a long time.

MR. ORSZAK: But most states that had it dropped it.

MR. GERTHWAITE: Yeah.

MS. ROVNER: Maybe it just worked on the Chesapeake Bay. All right, I think we have time for one more question. This is very existential. "Would universal coverage impair the ability of hospitals to provide their charity care?" I think that goes back to my question about people who might have coverage but maybe not the best coverage. I mean, would there --

MR. GERTHWAITE: Depends what you mean by universal coverage I guess is the idea.

MS. ROVNER: And depends on what you mean, and it also depends on what you mean by charity care.

MR. ORSZAK: Would still be bad debt, yes. So would some of that bad debt still occur in populations that are vulnerable, yes. So if you want to define that as the charity care problem at that point, but it would just be much less severe than exists today. The size of it would be much smaller.

VOICE: We'd love to be able to face that question (indiscernible).

VOICE: I think that depends in large part on what the universal coverage looks like which is what other people are saying. If you set up cost sharing in appropriate ways, so that there was sort of a sliding scale based on people's income, their assets and ability to pay, then I think you'd sort of have a minimal amount of that. It wouldn't go away completely, but I think you'd minimize that.

MR. GERTHWAITE: But in that world, and I think Marty's point about this sort of (inaudible) discipline prices and we want to be very careful not to undermine that in the sense that health spending is easy to control. We have to either spend less than

what we can assume at a price level or assume less care. (inaudible) to help on price and if we start to unwind that by (inaudible) bad debt as charity care in any reimbursement system, that's not the goal of our proposal.

VOICE: No, I mean, on the narrow networks, you know, we need to be careful that they do provide appropriate access within the structure whenever we move into it.

MS. ROVNER: And I was just going to point out that the narrow networks also create this problem of inability to pay because you may live and not be able to get to any hospital except one that's outside your network. So once again, you have insurance but it's not helping with bill.

VOICE: It's a well define --

MR. ORSZAK: Possibly, Yeah, I think that's key. Just because it's a narrow network does not mean you run into that problem even in terms of access or in terms of quality. But I think we have to be very careful in thinking about this and that's a whole

nother conversation both at state and federal level about network adequacy. But if we're not careful, we can get a backlash like we got in the (inaudible) against managed care that can undo a lot of things a lot of things that benefitted everybody.

MR. GERTHWAITE: I believe the next panel is actually going to talk about sort of how we efficiently pitch which insurance plan we want which is going to be something about the generosity we want, but also about these network plans. We have tools that people are developing to try and help with that as well.

MS. ROVNER: What a segue. Thank you very much. Thank you, panel.

(Applause.)

MS. SCHANZENBACH: So in the second half we're going to cover two proposals. Both look at different ways to improve the functioning of healthcare markets. One, by improving consumer information and their ability to choose across increasingly complex choices, and the other one which

is a proposal to increase transparency in the cost and values, and enable choice across these in a more transparent way.

So my name is Diane Whitemore Schanzenbach. I'm the Director of the Hamilton Project. And let me briefly introduce the panel. I'll start with Amitabh Chandra on the end. Amitabh is the Malcolm Weiner Professor of public Policy at the Harvard Kennedy School of Government. And among his many distinguished roles he is also a member of the Congressional Budget Office's panel of Health Advisors and he's a Research Associate at the National Bureau of Economic Research. Together with his co-authors, Nick Bagley from Michigan and Austin Frakt from the Department of Veterans Affairs, Boston University, and Harvard, he wrote one of our proposals in this panel, Correcting Signals for Innovation in Healthcare. Next to him sits Ben Handel. Ben is an Assistant Professor of Economics at the University of California at Berkeley and he is also a Faculty Research Fellow at the National Bureau of Economic Research. He is our

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other author, and together with his co-author, John Kolstad, also at Berkeley, wrote Getting the Most From Marketplaces: Smart Policies on Health Insurance Choice.

The two authors will be joined by our discussants, Peter Orszag, again a Non Resident Senior Fellow here at Brookings and the Vice Chairman of Corporate and Investment Banking at Citigroup, Niall Brennan, who is the Chief Data Officer and Director of the Office of Enterprise Data and Analytics in the Centers for Medicare and Medicaid Services, and Dan Durham, the Executive Vice President of America's Health Insurance Plans.

Each of the authors is going to start with a brief presentation, first Amitabh and then Ben. And of course I'll remind you, as we did in the first session, we will have note cards and if you'd like to write questions, you know, write them on your note cards and pass them in and we'll open it up to questions and answers at the end.

So, Amitabh.

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MR. CHANDRA: Thank you, Diane. And I walked into Brookings this morning and kind of made my way into the back and somehow it was a panel you guys were running on Indian politics and someone asked me what I was going to talk about and I said, you know, medical technology coverage (laughter). And then I made my way -- I thought I was in the wrong think tank, so I actually walked all the way out of the building. So thank you for not having me talk about politics in India.

So this is joint work with Nick Bagley and Austin Frakt. And here is how we think about -- let me just motivate this the way we got into it. We've known (inaudible) for a very long time that innovation in healthcare has always responded to market size. So the best estimates come from people like Daron Acemoglu and Josh Orlin , and they would say something like, look, if you were to increase market size by one percent -- and there's a variety of different ways you could increase market size in healthcare, you expand access, you could increase prices -- but if you were

to increase market size by one percent the number of new molecules that will show up 20 years later is about four percent. So one percent increase in market size will be like a four percent increase in the number of new molecules. So innovation is responding to market size. Now our point in this piece is to note that for a variety of reasons we may be inaccurately signaling market size to manufacturers, to manufacturers in bio pharma, to manufacturers of devices. We think that we're probably signaling market size to be larger than it actually, but there are other reasons to think that we might be sending signals saying that it's actually smaller than it actually is. The reason we think that we're signaling market size, we're over stating market size, is because we have no cap on our willingness to pay. So this is just another way of saying we don't do cost effectiveness analysis. So essentially, regardless of our incomes, if we're earning as a country an average income of \$50,000 a year, if you don't do cost effectiveness analysis, well, you're going to be

sending -- you're telling manufacturers, you know, it's like just assume we earn \$500,000 a year on average, or \$1 million on average, because if you build it we will pay for it.

Another reason for why we may be overstating market size is we have fee for service healthcare in the United States. And so what that does is it increases the diffusion of technologies regardless of values. So if you are the manufacturer of a dubious medical technology, you're not getting a signal from the marketplace saying, uh-uh, this is a dubious technology, there is not demand for it. There is the tax preference for employer provided health insurance which privileges high earning employees like myself. So as Peter pointed out at the start of the discussion this afternoon I have an incentive to get more of my compensation in the form of health insurance benefits. And so again that's distorting the market size signal.

And then finally there are coverage spillovers. And in particular we're thinking about coverage spillovers from Medicare and Medicaid onto

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the private health insurance plans. Medicaid and Medicare are required to cover a number of technologies on label and off label, and when they cover those technologies it becomes very hard for private insurers to say no. So again, a number of reasons why we think we're overstating market size, and we'll tell you a little bit about the proposal.

But first just let me lay out the problems. So what I've got for you on the Y axis is sort of the dollars per life year gain. Think of this, if you're an economist, as life price. What are you willing to pay for a life year gained. And then on the X axis is the number of years of life produced. Now there's probably a demand curve. Each of us would have a demand curve. Different societies, different countries will have different demand curves. And if you remember your Ec 101 lesson, you know that those demand curves. But what we want to talk about today is actually the supply curve. The supply curve for new innovations probably looks something like this. Now I just made this up out of -- it slopes upwards

because that's economics (laughter), and it's basically saying, you know, if you give me a stronger, bigger price signal I am going to innovate more. Okay. So that's basically the set up. The reason it's very, very steep is because those innovations that essentially add just, you know, a little bit of life are often extremely expensive to produce. As you think about just innovation and cancer. As we go from chemotherapy to targeted therapy, from targeted therapy to immunotherapy, from immunotherapy to gene therapy, that marginal innovation becomes extremely hard to produce, which is why I've just, like all economists, just assumed that the curve is very steep over there.

Now let's put some data onto this curve. And this is data that we took from Peter Bach's JAMA paper, and Peter is not responsible for this graph or these data, and it's just kind of making the point that like if you look at a drug like Herceptin and you look at the use of Herceptin in and adjuvant therapy setting for breast cancer, what you see is that

something like Herceptin generates about two years of life and it costs a little less than \$100,000. Move up, you've got Herceptin being used for metastatic breast cancer. Here it generates about six months of life. Now look at the drug, Abraxane in the context of metastatic breast cancer, even less benefit, so it generates about two months of life. But when I think about using Abraxane for non small cell lung cancer, I'm essentially generating only one month of life at that point. And at the very top, and this is just because it was something interesting in Peter's table, is Tarceva. Tarceva, when used for pancreatic cancer generates two weeks of life and costs about \$650,000. And so what we're doing as a society is we're telling manufacturers, look, it doesn't matter where you show up on the supply curve, we will pay for it. So we're sending them a very unambiguous market signal saying whether you produce Tarceva or Herceptin, we're going to pay for it. So by the way, this is not a way of kind of going after bio pharma manufacturers, I think the problem is even worse in the device industry,

where we're not even able to really measure the incremental value of some of these technologies.

There is a spillover from Medicare and Medicaid because Medicare and Medicaid are required by law to cover these technologies even for off label use. And like I said earlier, everyone has to cover this.

Now the conventional solution to this from economists has been well we just need more differentiation in plans. We need Cadillac healthcare plans that essentially cover drugs like Tarceva for pancreatic cancer and Abraxane for lung cancer. And then need like sort of Civic plans, Honda Civic plans that cover Herceptin in adjuvant therapy setting for breast cancer. That's been the standard thing -- Austin Frakt and I actually wrote a *New York Times* piece advocating for that kind of plan heterogeneity. And what we do in the piece for Brookings is to actually point out that we were wrong. That market is not a viable market because of adverse selection. If you actually allow for those plans to exist, what will

happen is people will pick the Honda Civic plan, but as soon as they realize they have pancreatic cancer they're going to want to buy the plan that covers Tarceva for pancreatic cancer. So unless you're willing to tell people you have to buy a plan at 18 and live with it for 60 years, unless you're willing to do something like that, or essentially risk adjust on the disease itself, which is effectively uninsuring people, that market is not viable. So what can we do?

We have three solutions and they all start with the motivation for the paper is we want to send the right signals to manufacturers about our willingness to pay for healthcare. So the first solution is I think the simplest and most elegant one, which is let's just start to think about healthcare spending, let's just try to pay for healthcare at a parity level as everything else. So, you know, we support the Cadillac tax, but I think if there's once criticism of the Cadillac tax, our criticism is that it probably doesn't do enough in some sense. And so what we want to do is we want to tax income and health

benefits at parity. And so what we would like to do is replace the current exclusion with the tax credit that phases out as income increases, so that someone like me doesn't benefit from the current exclusion.

Now this might be viewed as extremely radical. So a less radical solution is to say we could just phase out the exclusion with the income. So just keep the current exclusion, but someone like me or someone like my co-authors, especially my co-authors don't benefit from it. (Laughter) either way, whichever way you do it, you know, high income employees would no longer be able to purchase insurance on a tax referred basis. Now why are we going after high income employees? One reason we're thinking about high income employees is because high income employees' willingness to pay for some of those technologies high up the supply curve is much greater. But it's when I purchase that technology that it starts to spill over onto everybody else which is fine if I'm subsidizing the coverage of everybody else, but if they're not they're paying for it in the form of

lower wages or paying for it in the form of higher taxes. That seems like an externality.

Alternatively, Congress could give Medicare the authority to decline treatments whose costs dwarf their benefits. As you all know the coverage determination processes in Medicare have been becoming more and more rigorous over the past decade. But the program has really got tiny resources to make these kinds of decisions. And so better data about comparative effectiveness of treatments I think could help over there. So this is all we're saying, Medicare could say look, we'll over anything that exceeds -- you know, we'll cover things as long as they don't exceed a cost of something like \$150,000 per life year, or \$200,000 per life year. We've already got PCORI but we could strengthen PCORI because what PCORI tends to do is compare treatment A to placebo when what you really want PCORI to compare treatment A to treatment B, and then if treatment A is better you go for treatment A. So that's already out there.

And then finally I think what's most exciting for us is getting Medicare to think about reference pricing. Now you've heard about reference pricing in the context of CalPERS, but we'll tell you about why our reference pricing is different. CalPERS is essentially doing what we call horizontal reference pricing. So it will give you money and encourage you to go and get your care at the cheaper, lower cost provider. So you have to do a lot of shopping. Patients hate to shop, I hate to shop. We think that most of the waste and inefficiency actually lies within delivery systems, not between. So we're not saying that there isn't waste between delivery systems, there is tremendous waste, it's just that there is a lot of gray area decision making within.

And so what we want to do is we want to say look, let's take this proposal that Pearson and Bach put together in health affairs and add some teeth to it. So let's just start with the Pearson and Bach proposal. Let's classify new treatments as being superior to existing therapies, equivalent to them, or

of uncertain benefit. Just using clinical effectiveness and we're not doing anything about costs. If your technology is superior to what we have then you get paid just the way Medicare is currently paying you. So all the problems of the cost based reimbursement and all, we're not taking those on, we're saying let Medicare -- we'll just use the current formulas. On the other hand, if your treatment is essentially equivalent to another payment then the payment would be the same as the equally effective reference therapy. And then for the technologies of uncertain benefit, and this most of healthcare. Most of healthcare is not where we know the thing is inferior, it's just that we don't know. Our proposal is just like Pearson and Bach where we say Medicare should pay you as if the technology was effective and then reevaluate that decision after three years or four years or five years. We just picked three years because we think that's a long enough time.

Now the way we've been cross into this is to

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say what Medicare should do is that it should have a predetermined cost effectiveness threshold and therefore allow for balanced billing. And let me tell you how all of this works. Here's an example. You've got three hospitals, A, B, C, and they're treating men with prostate cancer. The ways you can treat men with prostate cancer -- there's a bunch of different ways, but just for argument's sake assume that there are three ways -- we could use proton therapy, there's IMRT, there's brachytherapy, and you can see the average bundle across these three hospitals. If I was doing CalPERS style reference pricing, CalPERS style reference pricing is all about getting me to pick hospital C. Why? Because the cost of getting prostate cancer treated at hospital C is \$13,000. In CalPERS I'm still free to go to hospital B, but then I pay that \$4,000 out of pocket. I could also go to hospital A and pay \$9,000 out of pocket. That's terrific, and we have no problem with that. But what we're proposing is vertical reference pricing. So we're saying do reference pricing not across the

hospitals, but across the different technologies. So if you actually did the comparative effectiveness analysis you might find that IMRT is there reference therapy. In that case it's not that we should what NICE is doing, we shouldn't say we're only going to cover IMRT and not cover proton. What we should say is you're free to -- we will always pay for the IMRT therapy and if you want proton at hospital A then you pay the \$20,000 out of pocket. If you want proton at hospital C, then you pay the \$15,000 out of pocket. This has two benefits. The first benefit is we think it's going to increase a lot of innovation around the area of the reference therapy, not above it, which is really great. The second thing that we think it will do is it's going to say to the proton manufacturers keep producing protons, but lower the cost. So it introduces a bunch of price pressure to lower the cost of proton to the cost of IMRT. So that's innovation on two dimensions, both in terms of what appears, but also how it's priced.

Thank you very much. (Applause)

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MR. HANDEL: Okay. So my proposal is joint with Jonathan Kolstad who is sitting in the audience over there. No one asked me to be on the panel on Indian politics (laughter), so I guess I'll just jump into the proposal.

As many of you know the private based provision of insurance through markets is a major underpinning of most major recent U.S. health reforms, so both of the state exchanges in the Affordable Care Act and with Medicare Part D in the Medicare Modernization Act. One of the key motivating issues in this managed competition paradigm is that consumers should be active, consumers should be well informed, and given the information they have, hopefully consumers are going to make sophisticated choices. If that's the environment consumers are shopping in, they're going to have immediate benefits from picking the best insurance plan in the market. There's going to be immediate government fiscal benefits since regulators are providing a lot of the subsidies in these markets. And importantly there's going to be

medium to long run benefits from insurer value creation and insurer innovation in the market.

So our proposal is built on a substantial body of economic research that shows that unfortunately consumers have difficulties both in active decision making, so decision making even when they're forced to choose a new plan, as well as passive situations or situations where inertia is a problem. So across the range of context, large employer context, the Medicare Part D context, these studies show that consumers are losing hundreds or even thousands of dollars in the insurance choice process. And there is a couple of foundations that these studies cite including obviously the complexity of the product, limited information, et cetera, and just the fact that as many of you probably know from personal experience, people don't really like shopping for insurance.

So to deal with these problems that the literature has found, we propose two policies. The first is personalized decision support that uses

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individualized and forward looking tools to make recommendations to individuals about what they should choose. And the second policy takes the models and the data that are used in the personalized decision support and has the regulator opt consumers into policies subject to the fact that these policies constitute a clear and substantial increase in value for the consumer. So the policy goals are actually essentially to kind of to make the market function as the ACA founders intended. So the goals are to enhance consumer welfare given the choice set of options that are available in the market. That's a short run goal. In the medium to long run to create this incentive for insurers to innovate either through things like value based insurance design or through creation of value driving narrow network plans. And then most importantly -- and this is especially true for the smart default policy -- this is a budgetary problem as well, and implementing these policies will help reduce the subsidies paid in the market, both through kind of the short run impact of improving

consumer choices, but also through this long run value creation mechanism.

So part one with personalized decision report, this builds on the general ACA requirement that the web based provision helps consumers make choices in these markets. Our proposal has a couple of components. First we propose that these market implement an individualized forward looking cost calculator for consumers purchasing plans. This essentially means that for each consumer we have an assessment of your health risk based on data which I'll talk about in a minute, and that we have a model that basically maps that data with the insurance plan designs into a personalized and targeted prediction for what you can expect to spend in all of the different options in the market. In addition, we propose as part of this personalized recommendation a planned specific assessment of downside risks. So what's the maximum amount of money you can lose in a given plan for kind of reasonable types of expenses. And finally, and this is the place where I think that

data infrastructure is most lacking, there needs to be clear and detailed information on provider networks, both targeted to a specific consumer in terms of the providers they've been using as well as in terms of telling you about what the breadth or quality of a general network is in this context.

So this policy has a number of enabling conditions. The first is obviously plan specific data on the financial characteristics of plans and the provider networks of plans. That should be manageable. The second enabling condition is individual specific data on health. And that can come in a number of formats depending on feasibility. That could be basic information like age and demographics. Hopefully we would at least achieve a medium level of information so some health related information potentially through user inputs. And finally the gold standard we're thinking about here is an all payer claims data base. Finally, with those data we're going to have a simple model that brings these data together and makes these recommendations.

So obviously there's been some progress on these kind of apps and these kind of policies, but we think there is still quite a way to go, especially in terms of a focus on implementation for these policies.

Our second part takes this data infrastructure and the model kind of making plan recommendations and tries to deal with the issue of consumer inertia. So research shows that even if you do kind of as good a job as you can providing recommendations to consumers, still you might only get 20 or 30 percent of consumers to switch plans, whereas research in 401K and other sectors has shown that if you set default options for consumers you can ultimately kind of impact the market and switch a much larger market share for consumers. So in our policy a smart default here is basically a consumer specific default where the regulator opts the consumer into a plan where that plan constitutes a clear and substantial increase in value over what the consumer is already enrolled in. Importantly, consumers can opt out of this plan, okay. So this is a libertarian,

paternalism type of strategy where they're defaulted into this plan but they can actively opt out of they want to. There is a successful example of this. This kind of smart default has been applied successfully to personal investments in the 401K literature. And recent examples, for example, in the low income subsidy enrollees in Part D show the need for policies like this since in that context consumers are randomly defaulted into plans below a premium threshold in that market.

So we expect these kinds of policies to have a bigger impact than the personalized decisions to policies because they help overcome inertia as well as active choices or decision making issue. And as a result they can have a much bigger impact in achieving the policy goals that we've talked about.

So let me quickly walk you through an example. If you look at the right of this chart, what we're thinking about and what we included in the proposal for the proposed default policies is something with three prongs. So the first prong is

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that to smart default a consumer into an alternative option, the expected financial benefit from this option based on their risk data and based on the model is greater than some dollar amount. In the paper we kind of run some simulations with different dollar amounts, \$200, \$400, \$800 in expected benefits, which can depend on regulator preferences. The second component is that the individual is that the individual is not switched into a plan that doesn't contain their primary providers. And the third component is that they're not switched into a plan that exposes them to substantially more downside risk. A key facet of the proposal is that these three levers can be changed to reflect regulator preferences on kind of the distribution of outcomes with these policies, as well as kind of how aggressive or conservative they are. So if you're a regulator and you wanted to implement this in a conservative way you could think about cases where consumers are in dominated options or options where they're clearly losing money.

So lastly, I just wanted to touch briefly on the potential downstream implications of these policies. So it's pretty clear to us that this kind of smart default policy will have a positive impact on the market and on welfare given the current market structure. But we want to make clear that we think people need to be cognizant of the downstream implications of this. So what are the market equilibrium or the market downstream impacts of these policies? First, you have to cognizant of the potential for driving adverse selection in the marketplace. Second, you have to worry about regulatory capture, because now smart defaults in an algorithm set up by the regulator is driving traffic towards certain insurers. Third, you need to make sure that there is no favoritism in the algorithm. And finally, and maybe most importantly there is this notion where by implementing smart defaults you're making consumers choose what you think is the best option for them or what clearly is a better option for them, what they're actually choosing. But that might

not actually be consumer agency in the sense that the kind of ACA founders intended in terms of the market provision of health insurance. As a result you could see insurers kind of responding through innovation in the market by kind of tailoring products specifically to what you see in the algorithm rather than some kind of organic component of value.

And so even despite these potential downsides we think that the policies really have the potential to drive clear value, and especially in certain cases.

Thank you. (Applause)

MS. SCHANZENBACH: Thank you very much to both of you. And I'll take this opportunity to remind you about your index cards for questions.

So I was going to open it up to the panel and start with a question for Niall Brennan. So, Niall, I know that CMS is working to provide better information to consumers also and build new data infrastructures. So I thought you could start by describing recent and coming efforts in this area and

how that might interact with the Handel and Kolstad proposal.

MR. BRENNAN: Yes, absolutely. So I want to congratulate Ben and his co-authors on the paper. I thought it was extremely interesting.

We've been committed to providing consumers with better tools for some time now dating back to the evolution and emergence of the various hospital compare websites. Obviously we feel that while the marketplace may not have got off to the most auspicious start in 2013 we did a lot to improve and enhance the consumer experience last year and we're certainly looking to build in more improvements. This year we've included requirements for health plans to provide links to provider directories and the like. And I think, you know, giving consumers information, you know, to ensure that if they switch plans they can still see their doctor is very important. Also formula information is very important, but beyond that we believe we actually need to take it to the next level, is their doctor any good. And, you know, we've

also been active in that area releasing a lot of data, primary Medicare focused because that's the easiest for us to control from a data perspective, but over the past few years we've released millions and millions of lines of data that for the first time actually show people how their physicians practice in Medicare, how their physicians prescribe in Medicare. Just this week we augmented that physician data set, not only with the physician specific information, but with aggregate information on what the physician's beneficiary panel looks like. So again from a consumer perspective does that physician see patients who look like me, does that -- you know, I'm a diabetic, what proportion of my physician's practice is accounted for by diabetics. And I think a lot of these tools are really working. I mean one thing we can say about healthcare.gov and the health insurance marketplaces is that these are very active consumers. If you look at the plan selection experience for the 2014 open enrollment period, we had about four and a half million new consumers and about four million

returning consumers. Of that four million, two million were auto enrolled, and two million actively came back, shopped around, compared their options, and one million of those actually switched plans. So that's a level of consumer and patient activation that really we haven't seen before. It's certainly way more active than I am with my plan selection choices for health insurance.

And so I think we really are very committed to this and we are always striving to improve.

MS. SCHANZENBACH: Thanks. Dan, I was going to turn over to you also. Can you describe what the health insurance plans are doing on their own to provide better information to consumers, and how could policies help support this better?

MR. DURHAM: Sure. And first I'd like to say, two excellent papers. I learned a great deal reading them and I just wanted to congratulate the authors. I think it will really help move the debate in the right direction.

Health plans are clearly focused on consumer
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information. This is a consumer driven marketplace and consumers are demanding value, quality care at a low cost. And so our plans have developed tools that are consumer friendly and provide them with actionable data in terms of what their out of pocket costs are for particular services. That type of data is critical and it has to be linked with quality data as well. And, you know, we're moving in the right direction there. There's a long way to go and we're working collaboratively with our colleagues at CMS in terms of healthcare.gov. And our experience has been you've got to walk before you run and what Ben has proposed is an all out sprint. So I think there is still a lot to be done on the back end of healthcare.gov. Health plans are still working a lot on manual work-arounds. And so I think clearly the front end is much better. And we're coming up on open enrollment here and I think it will be a much better consumer experience, but let's get the back end issues straightened out and let's focus on good information for consumers to make value based decisions.

MS. SCHANZENBACH: Thank. And, Peter, to you, stepping back I wondered if you wanted to comment on both proposals and their possibilities of improving efficiency in the healthcare sector more broadly?

MR. ORSZAG: Sure. So I like both proposals. On the first one a couple of points. One is that the first proposal to move the tax exclusion towards a credit I think can be motivated beyond the motivation that was given by the authors, which was about changing the incentives for innovation and for unnecessary costs, and just step back and make the broader point which Lilly Batchelder and Fred Goldberg and I made in a Stanford Law Review article a decade ago, and like most Law Review articles the ratio of footnotes to the actual point was very high (laughter) -- the actual point was just simply, there are lots of things that we do through the tax code that shouldn't really vary depending on your marginal tax rate. A dollar of health insurance that a high income person gets is no more socially beneficial than a dollar of health insurance that a moderate or low income person

gets, and yet the tax approach, the exclusion gives a \$.40 on the dollar tax benefit to the higher earner and a \$.15 on the dollar per dollar of health insurance benefit to the middle income worker, and that doesn't make any sense. So from an economic efficiency perspective there is no reason to be doing this in the form of a deduction or exclusion and it should be done in the form of a credit. And I think that's true across a whole variety of tax expenditures for healthcare, for retirement saving, for home ownership where we're trying to produce social goods through the tax code. There is basically no reason to link that to your marginal tax rate. So the first proposal, double thumbs up for reasons even beyond health policy.

On the second and third, I'll just make one very brief point which is we in health policy continue to view Medicare as the primary driver of the overall market, and that historically was absolutely true. One caveat that I just think is important to take into account, Medicare Advantage, the private insurance

part of Medicare, is already 30 percent of coverage. The CBO projects that by the end of this decade it will be in the low 40s. I think that may turn out to be too low. And so you're quickly going to find yourself in a position in which the majority of Medicare is not the traditional form of Medicare, it's a privately insured kind of Medicare, and that changes all of the kind of historical ways of thinking about what Medicare does, doesn't do because it's a fundamentally different structure. And CMS is already moving towards allowing more innovation in those Medicare Advantage plans by moving towards, for example, trying out a value based insurance plan as part of Medicare Advantage. So just a caveat, I'm supportive of the directionality of the second and third proposals, that there may not be that much gas left in that tank by the time you got to it.

Then on the second proposal clearly consumers don't make great choices when there is complexity and, you know, their lives are busy and the evidence is overwhelmingly suggesting that. So just a

couple of comments though on the specific proposal. The first is we are far away from even getting to claims as being the basis for these predictions or for sort of allocations in terms of which plan people should be in. And I'd say even that raises the possibility that there are going to be a bunch of people who are misallocated after the fact. If you look at the claims based risk adjusters that Medicare uses, in terms of the relevant question not how much of the past variation they explain, but how much of the future variation they explain, the answer is like 15 percent, 10-20 percent maybe, and that's not very high. That suggests that there's going to be a lot of variation you allocate based on some pattern of claims and then even on year out the reality in terms of what conditions people have and so on and so forth is much different. You can do a lot better than that using clinical data, lab tests, socioeconomic status, et cetera, but then we're really getting into a different realm in terms of the information being provided to this algorithm. So all of that is just to suggest if

you're prompting people this might be a good idea, here's why. Check the box yes, that's one thing. If you're switching them into that plan and check the box if you don't like it, and then the next year they're \$5,000 out of pocket because you switched them into a plan that looked good at the time, but didn't make a lot of sense ex post. That will generate a huge amount of political backlash. And so that depends on how good the models are, how much data are fed into them. But it's also worth -- and it's also -- the backlash will depend on whether it's active decision making, you have to check the box to accept the recommendation and here's why we're recommending this, which might build support for it, or you're automatically opted in. But regardless, it might also be worth thinking about whether there's some kind of back end insurance protection that if we moved -- especially if you do the opt out approach, the harder approach -- we moved you into this plan and, oops, didn't look like that was the right choice for you after the fact, that there's some sort of reinsurance

that you can kind of cushion the blow for that person because by the way if the algorithms are so great that should be free. It should basically almost never kick in and it would take away a lot of the political backlash to say if we moved you and that was a mistake, it's on us.

MS. SCHANZENBACH: Ben, want to go to you for a response to that? The smart default is such an important part of your proposal. What are some of the parameters that the policy makers should be thinking about?

MR. HANDEL: Yes. I really like the idea of reinsurance. We hadn't thought of that and I think that that could really help mitigate the downside.

In terms of Peter's comment on the predictiveness of claims and how well we can do with claims. I think we might actually be able to do a little better with claims than he was saying. You know, some companies are working on this and I think we can get up to, you know, r-squared of 30 percent, not to get too technical. And more importantly I

think -- and we talked about this a lot in our proposal, there's baby steps here than can be taken, it doesn't have to be a huge jump. So I mean if you look a lot of research in Part D or in employer markets, I mean there's really low hanging fruit there. You know, there are people losing thousands of dollars. I have studies where people are choosing dominated plans where they can't possibly be better off in the option they're in. And so I agree with him that, you know, the more data they better, and integrating clinical data would be fantastic in the long run, though that comes with other privacy issues and things like that. But I think the key point I want to get across here is that the policies we're proposing, we think of them as flexible in the sense that they can just shift people who clearly are going to gain from the policy. And then as you get more confidence in the models and more confidence in the data, you can then become a little more aggressive with those policies.

MS. SCHANZENBACH: I want to bring Amitabh
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back in. I think we've talked a lot about the Handel and Kolstad paper. I think the most newsworthy piece that I've heard so far is that, you know, Jason Furman gave a very eloquent defense of the Cadillac tax. You seem to say, no, no, we shouldn't be taxing Cadillacs, we should be taxing Cadillac drivers. Now Peter Orszag seemed to just agree with you. So should we call Jason back and say no, no? (Laughter)

MR. CHANDRA: I think what we want to do is -- by the way, you know, my view is we just want at the end of the day be sending the right signals for innovation. There are a number of reasons that -- I think that running with the Cadillac analogy gets us into a little bit of trouble because there are reasons to think, for example, that we don't innovate enough on prevention for example. Anytime you have un-insurance in a country or under insurance in a country, that actually understates the market size signal because those people have a willingness to pay for innovation and manufacturers aren't able to tap into it. So un-insurance, under insurance understate

the market size signal. So that's the reason I'm sort of hesitant to draw that analogy to Cadillacs. But I think the larger point is connecting back to Jason's comments, what the ACA leads on is it leads on the challenge of reforming the delivery system to slow the diffusion of low value care. I think it leads on that. I think ACOs are going to struggle as long as they're on a fee for service chassis, but we've known that, you know. I think we'll get it right eventually. What the ACOs are not able to do is they can deal with diffusion at best. They're just not able to deal with innovation. So if something new comes along, the ACO is going to be like, whoa, now what do we do. You see this with Kaiser, you see this in the NHS. Those guys are completely capitated, but when something new comes along, proton therapy, they don't know what to do because a lot of these technologies have some incremental benefit, but they don't have the ability to say -- even NICE doesn't really have the ability to say, you know, we're not going to completely step away from it.

So what our proposal tries to do is it tries to say look, create a system for innovation where we send the right signals from the social insurance programs and then the private insurance programs for really risk averse patients, or patients who really value these dubious technologies, they can have it, right, they just have to pay for it.

MR. ORSZAG: I just wanted to piggyback on the comments about the Cadillac tax and this proposal and what have you. First, I think it is -- we have to be very careful in discussions that, you know, the Cadillac tax is not perfect and this other approach might be even better, to not lose the point that virtually no one who is proposing repealing the Cadillac tax is then saying oh, we should do this better thing instead. (Laughter) So I want to just come down forcefully in the same camp that Jason did which is unless you can step up to the plate and say I have another proposal that's going to reduce health spend in 2024 by \$40-60 billion through my other tax proposal, it's not really the -- a lot of people who

have come out in favor of repealing the Cadillac tax have said oh, I'll make it up on the deficit front. It will be deficit neutral. That's nice but that's not really the point. The point is make it up on total health spend and then let's have the discussion. There are no proposals out there to do that and so until that happens I think we should just be cautious about doing anything significant to the Cadillac tax.

Now, that having been said, there's also no reason why you can't have combinations of different things. I think the paper is right that a lot of the focus is on the distribution or diffusion of existing technology. I would put a caveat that in an ACO structure there might be more -- you may wind up in a situation in which the decision about whether to cover or pay for a new technology is the medical director at the accountable care organization structure's responsibility. And so that person would be deciding whether or not to adopt or cover the new technology. And by the way, that strikes me as not a bad outcome. I actually would be fine with a diffuse number of

medical directors at different health systems making decisions on behalf of the patients that they're covering when they're financially responsible for whether the new technology is worth it or not. In fact I would rather that, you know -- I get my care at Mt. Sinai, I'd rather have some doctor there deciding whether this new thing is worth it or not rather than my having to read, you know, is this new thing worth it or not.

So there are ways of I think combining the various different incentives. You could, for example, do everything in this paper and still move to ACO, still move toward bundled payment, and have all of the different dimensions operating at the same time. And given how complicated the problem is, it's probably likely that we're going to want to have all of that happening at the same time. There's no one magic bullet here.

MS. SCHANZENBACH: Yeah, Amitabh.

MR. CHANDRA: Can I respond?

MS. SCHANZENBACH: Yes, please.

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MR. CHANDRA: So I agree with everything you're saying. You know, our proposal doesn't run contrary to the current efforts to slow the diffusion of gray area technologies. You know, I think if it were the case that the medical directors were really able to walk away from the dubious technologies, that would be wonderful. I mean I'm thinking of the famous Zaltrap case that happened at Memorial Sloan where they decided to not cover Zaltrap. And there was this terrific op-ed by Peter Bach in the *New York Times* about it. And I congratulated him on it, and he said, you know, the sad thing is we'll never be able to do it again because it's so hard. And I said why is it so hard, and he said that was a very unique situation. It was unique for two reasons. One is it was very clear that it conferred absolutely no benefit over Bevacizumab, over Avastin. It was like there were identical. But there was a huge pricing error by the manufacturer. So that allowed them to come in. The challenge with medical technology is often that you've got something that adds a little bit of benefit, and

that's when the medical director finds it awfully hard because of litigation. I mean we've seen again and again that when -- you see this even with Medicaid -- even when they -- you know, anytime you try to say no to something, as long as Medicare covers it, the Courts have historically ruled on the side of Plaintiffs. And that makes comparative effectiveness rulings by Medicaid directors extraordinarily difficult. So it's another way of saying I think we're going to need Medicare to do more here. And maybe it's Medicare Advantage, but even with Medicare Advantage and its growth the challenge is you'll still have the sickest patients in fee for service Medicare.

So unless we're totally able to shrink that program I don't think the Medicare advantage solution is sufficient. But it's certainly one that I think all three of us would welcome and agree with.

MR. ORSZAG: So I think the really interesting question is whether the medical director job and dynamic changes when the full financial liability for the new technology rests with that

hospital or that health system or that because then the trade offs are different. And we don't know the answer to that, but that's the direction in which we're heading. And relatedly, this very interesting question of to your point about, you know, blow back on coverage decisions, hospital systems and doctors have not experienced that. They are able to basically say it was the insurance company's fault, go blame them. As we move towards the shifting risk onto the providers, they're going to be the fulcrum, they're going to be that kind of point of deciding yes, no, maybe, what have you. And it's probably more politically sustainable for the doctor to be saying I don't think you need that than the insurance company saying no, you can't have it or no, we won't pay for it. But a lot of the same pressures, to your point about litigation and what have you, ultimately will likely be shifted to the hospital and doctor if they're ultimately put at financial risk for the total cost of care and they're there for deciding more of is this worth it or not.

MR. BRENNAN: And even though I mean we may still be -- I agree, Peter, we may still be, you know, crawling from a delivery system or form perspective so to speak, we have I think fundamentally shifted the incentives through the Affordable Care Act on things like ACOs away from unconstrained use of medical technology and towards changing the incentives for providers and, you know, making them consider and engage the patients more on what works for them at the right price and right outcome.

MR. CHANDRA: Well, you know, the skeptic in me would say well, you know -- I mean if you look at the current -- and I realize it's early days -- the ACOs -- I mean I'm thinking of the *Journal* papers and all, and *New England Journal* have not really shown us the kinds of savings that we thought they would show us. I think one reason is what I was saying earlier, they're built on a fee for service chassis, we're giving the ACO the right financial incentives. But if I was an ED doctor working at an ACO and I figured out a way to save on a \$900 CT scan of the abdomen and

this ACO was even in a 30 percent risk sharing contract, and there are 100 doctors in my ACO, I would get only \$3 by saving \$900, right. And so I save \$900, I got \$3. Well, it's a lot easier just to do the cardiac CT for \$900, right. That's Ec 101. And I think that is the challenge deep in the bowels of the ACOs that will sort of always hamstring them, unless we're able to change the way doctors are paid and incent it at the individual level. Simply giving the delivery system the right financial incentives doesn't mean that it knows how to actually get those incentives to trickle down to the level of individual doctors. I mean I'm still a believer. You know, I'm out there. I'm batting for you, Peter, here (laughter), but, you know, I look at those papers and I look at my economics textbooks and it doesn't -- you know, it's sort of like this is not what I would teach my undergraduates.

MR. ORSZAG And yet the one outlier that is positive on this dimension comes from your home state of the alternative quality contract where the effects

have been larger than --

SPEAKER: Which is a private initiative.

(Laughter)

MR. ORSZAG: Same as one before. No, no, I understand. But one of the reasons is that Blue Cross Blue Shield of Massachusetts is a much larger payer for most of those hospitals than even Medicare is for most hospitals. So if you're doing a Medicare ACO and it's 20 percent of the patient flow and then it's, you know, not that high powered an incentive even within that, it's not very much. If it's 50 or 60 percent of your patients and it's a stronger incentive, that gets your attention.

MR. CHANDRA: But back to the Blue Cross Blue Shield example, I'm a big fan, but the problem is at the MGH Hospital in Boston we have a proton center. This is like Exhibit A for wasteful healthcare. The alternative quality contract has not been able to turn off the lights on that proton center for prostate cancer, right. That's the challenge we're up against. And it's way too easier to let that proton center run

every day under the current regime, and that's what we're hoping to change is if Medicare said this thing is uncertain, we'll give you three years to develop evidence, which is what our proposal is all about, maybe the innovation in things like proton would slow.

MS. SCHANZENBACH: I'm not sure if everybody knows about the proton beam (laughter). Just briefly, briefly.

MR. CHANDRA: Okay, so proton -- where do I start. (Laughter) Now I'm really excited. So the fixed cost of building the technology are anywhere between \$100 million to \$150 million just to build the technology. Why? Because you have to build a cyclotron the size of a football field to accelerate a beam of protons which you can then use to zap the cancerous cells in a child's brain if they have brain cancer, or in a man's prostate. Now there are many more men with prostate cancer than there are kids with brain cancer. Medicare reimburses for proton therapy, extraordinarily generously, about \$32,000 for a full course of treatment. That's essentially the -- you

could insure five people or six people on the exchanges for that kind of cost, right. We're willing to pay for it, we're sending a signal to proton manufacturers, if you build it, we'll adopt it. Guess what, the United States has 27 proton centers. And, you know, the proton manufacturers tell me -- or the hospitals tell me, we only use it in kids with pediatric blastoma. But I'm a patient at the MGH and I love going there, you know, once a month and picking up the -- when you walk into the proton center all the brochures are about how to get zapped for your prostate cancer, right. That's where we don't have care, and that's the kind of innovation we have to slow.

MS. SCHANZENBACH: Dan, you had wanted in?

MR. DURHAM: Well, I was going to jump in earlier on the ACO discussion, but I'll just say, you know, health plans pioneered the accountable care model before the Medicare Shared Savings Program. The problem with ACOs under the Medicare Savings Program, it's kind of a one size or maybe a two size fits all.

With the models that healthcare plans have advanced, you have much more collaboration with providers and the shared savings can be much greater. And it's much more flexible because not all providers are in the same place and health plans have a lot of data. And depending on how much data the providers can use in terms of meeting specific value based targets, you know, we can adjust in terms of the incentives. And it's all about the incentives here. How do we get the right incentives in the system to drive value. That's what health plans are doing. You know, we collaborate with providers on quality and we negotiate on price, but the challenge is when the market where we buy healthcare services and products is not a competitive market. We see that with provider consolidation where a hospital system owns the market. We see that with single source drugs where there are no competitors. Well, then health plans are price takers and consumers wind up paying in terms of higher premiums.

So I think Amitabh has put his finger on it.

We have to deal with innovation on the diffusion side

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as well in terms of innovation. And I like the work that Steve Pearson is doing at ICER, right. He's focused on let's look at these new drugs coming on the market and let's sit down and focus on what the value here is. And do it in a very collaborative way. You know, you've got pharmaceutical manufacturers there, you've got health plans there, you've got other stakeholders. That's how we're going to drive value and we need more of that kind of evidence to move this forward.

MS. SCHANZENBACH: Amitabh, I was going to go back to you one more time to flesh out your reference pricing proposal a little bit more. We haven't talked about that in great detail yet. How narrow are we talking about? What kind of information is needed, what kind of information supports do we need for consumers, and how do we get there?

MR. CHANDRA: You know, I think to start with the example that I used would be a guaranteed way for the proposal to fail. I motivated using an example from oncology and even though the evidence

base in oncology is rich, you know, there are pathways and I don't know exactly how we would do the reference pricing in oncology. But I think one place to experiment is on something like treatment of -- well, durable medical equipment for example would be a great place to start a small experiment in reference pricing. You could start a reference pricing experiment in Medicare with a waive on say imaging, on advanced imaging for certain conditions where we're not saying you can't have it, we're still insuring patients, but if we have no evidence, no evidence at all, as determined by professional societies, you know, we're going to say you pay the extra cost. And I'd like to see how that sort of approach helps us understand. Because we want to understand how well patients respond to reference pricing. Now one of the things we do know from British Columbia, from Spain, from France, from Germany, is that when you do reference pricing for drugs you can save 15 or 20 percent. Now drugs are about 15 percent of all of healthcare savings, but if you could knock the price

of that down by 20 percent, in addition to everything else that we're doing, those are real savings given that that's a big source of innovation.

MS. SCHANZENBACH: You want to respond? You look like you want to respond. So I've got a couple of questions from audience and some of them are too difficult to read, so I'm sorry, you lose. (Laughter) So, Ben, your proposal relies on the accuracy of the plan's provider network data which are currently extremely inaccurate. Do you have any policy proposals to improve the quality of this network data? My data gurus over here might have some things to say about that too.

MR. HANDEL: Yeah, I mean generally speaking, in the proposal we think that having the provider data at least kind of being able to allow consumers to search whether specific providers are in the network, we think that's an important part of the proposal and we recognize that that's something which really, you know, isn't true in practice. You don't see that much in practice right now. In the proposal

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we kind of on purpose steer clear of kind of making the paper about building out data infrastructure. And the reason is we think that that, you know, could have -- you know, you could have one or two or three additional papers just probably on that topic. And so we kind of view the policies as contingent on at least kind of medium data infrastructure, but I'll let Naill and Dan speak to it more because they're working on this on a day to day basis.

MR. BRENNAN: So we are working on it on a day to day basis. (Laughter)

MS. SCHANZENBACH: Flesh out one or two or three of those papers that he said.

MR. BRENNAN: I think, you know, from a data quality perspective I think the important thing to note is the one way to improve data quality is to actually start using the data in a much more widespread form. You know, the data is not set in stone, it will change and evolve and get better as we start using it. And that applies not just to provider directories, but really, you know, any type of data

that any of us use in our projects. If it's not used, if there are no eyes on it, you know, there's nobody cross checking it and saying well that should be this or that's wrong and it needs to improve. I don't know, what do you think, Dan?

MR. DURHAM: You put your finger on it. It's the quality of the data that matters. Health plans are focused on making sure the provider directories are as accurate as possible. That's just basic good information for consumers. The challenge that we have is with some providers. Even though it's in the contract when we negotiate that you must provide us with updated data on a regular basis, not all of them do that. They don't tell us when they stop seeing new patients in their practice, they don't tell us if they've changed address or something like that. So it's a two way street. The providers have to cooperate here as well. And we look at things like the requirement in MA where starting January 1 the requirement is plans have to do monthly outreach to providers. So if you're a large physician group and

you're in 10 plans, you're getting 120 emails or phone calls a year. And they're just going to ignore that. So the question is how can we make this -- where is the incentive to get the providers to insure that data is up to date. And we're working on pilot programs to try to work where you could centralize this, there's a one stop shop where providers can go and update it so they're not getting deluged by calls and emails and, believe it or not, faxes seem to be one thing they respond to more than anything, you know. So let's try to make this -- let's focus on the quality and not just put up the machine readable where the quality is still in question.

MS. SCHANZENBACH: Another audience question is I think very good. Comparative effectiveness research is powerful, but it's often been manipulated. So something that's been shown to be clinically beneficial for a small targeted population is often applied more broadly. I think for anyone on the panel, certainly you, Amitabh, how do we strengthen the decision making by providers to rely on the best

evidence?

MR. CHANDRA: I think you're exactly right, which is why the example -- I couldn't agree more with whoever asked that question. It's such a good question I think one of my co-authors must have set me up for this one. You know, the graph I put up was sort of highlighting the problem of off label use, because the same drug in different settings has very different cost effectiveness ratios. And we often do trials -- I don't think this is a general rule, but a lot of manufacturers are probably going to do trials where the cost effectiveness and comparative effectiveness looks really good and then there's a bunch of off label use that follows. One advantage of reference pricing is that you're actually taking that head on and you're saying look, a drug like Herceptin is covered in an adjuvant therapy setting for breast cancer. And it's covered for metastatic breast cancer, but it's not covered in this completely different tumor type, because in that different tumor type it's not just off label it doesn't meet the

evidence base.

MS. SCHANZENBACH: Peter?

MR. ORSZAG: So one other thing is it's enormously expensive and probably not practical to do randomized control trials on each subset of people to test whether X works or X doesn't work. Luckily there is this thing called the data revolution going on (laughter) and the data resources that are available if we were willing to kind of lower the standard a little bit and look at observational cross sectional data or even panel data instead of just RCTs to evaluate what's working or what's not, you can get a lot more granular a lot faster. And so more effort being put into building up those data bases would be helpful. And we're kind of shooting ourselves in the foot too frequently. So the most recent example in my opinion involves medical devices where the FDA has for high risk medical devices required a unique device identifier. Those UDIs are not currently linked to insurance claims. It's like you put a bar code on a FedEx package and you don't know what address it's

going to, it's totally useless, so it's sitting out there. If those two were connected you could then be studying whether that specific device for that specific subset of people worked or didn't work, had problems or didn't have problems, without having to set up separate registries, separate data bases basically, for each type of person. So there is a lot we could be doing to better target what interventions and what procedures and what drugs and what devices worked for subsets of the population if we (a) invest in building out the data that are rapidly expanding and the analytics surrounding them, and (b) accept the fact that we're going to have to kind of lower the standard a little bit and deal with just looking across populations instead of RCTs.

MS. SCHANZENBACH: That would introduce a really interesting line of research to try to compare what we learn from RCT to what we learn from big data. And I think that that's an open question across a lot of dimensions right now.

Sort of a summarizing question. These are
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both great proposals, but are the second order given the magnitude of the challenges facing us? Do we have better first order --

MR. CHANDRA: I have a slide on why it's first order.

MS. SCHANZENBACH: Excellent. (Laughter)

MR. CHANDRA: All right. So here's why we think it's --

MS. SCHANZENBACH: Another question from your co-authors.

MR. CHANDRA: Yeah, this is why we think it's first -- can we get that slide up by any chance? So what I'm going to show you is a time trend of Medicare spending from 1997 to now, to 2011. And what we did was, in dark green we just coded up for you all the spending on stuff that wasn't around in 1997. So one in three Medicare dollars today gets spent on something that wasn't around a decade ago. That is innovation. Some of that stuff is extraordinarily valuable and we should be paying perhaps even more for it than we are. Some of it is junk and we're paying,

you know, full freight for that. So innovation is a first order problem. I think the ACOs will do an excellent job of thinking about the light green area, which is the diffusion of all the gray area stuff. But the dark green stuff, which is the new stuff that's just sort of coming in because of the market signals we're sending innovators is I think a first order challenge just because of this one in three fact.

MR. HANDEL: Sorry, I --

MS. SCHANZENBACH: No, absolutely, Ben, I hope you'll give me a spirited defense of why yours is not second order also.

MR. HANDEL: I don't have a slide on it, but I think it's -- I mean there's thousands of dollars at stake here for consumers. Not only are there thousands of dollars at stake for consumers, but also there are billions of dollars at stake in government budgets. So there is a recent study that shows if Medicare Part D switched the low income subsidy program from random default to a smart default, that

could save \$5 billion immediately, and that's not even counting the medium to long run downstream effects on the market and innovation. So there are many, many pressing issues in healthcare like we've talked about today, but I think it's one of the first order issues.

MS. SCHANZENBACH: Yes. And even though you don't have a slide, I might point people to the Hamilton Project's Six Excellent Facts on the Economics of Healthcare reform where we highlight this as I think fact number three -- somebody help me out. Peter.

MR. ORSZAG: Look, the problem here is not that if we did this it would be second or third order in terms of its effects. I think both of these proposals would have fairly large and beneficial effects. The problem is we're not going to do either of these proposals in the short term, so. (Laughter)

MR. ORSZAG: The fundamental difficulty is expanding what's politically possible in the direction of allowing these sorts of innovative proposals to be done. And if we were in a world in which we could

actually do them, I think you'd see large effects.

MR. BRENNAN: So first of all I think Ben is actually positing that he may have an alternative to the Cadillac tax in terms of revenue saved if he's saving \$5 billion a year (laughter). So somebody should let Jason know. But I think more seriously and to build on Peter's points, I don't think that every aspect of either proposal, you know, is going to become a reality anytime in the immediate future, but I do think that there are some aspects of Ben's proposal around better decision support tools for consumers that are, you know, literally happening right now. We have an open enrollment season beginning in less than four weeks for the marketplaces and we're definitely trying to improve and strengthen the tools and information people have in order to make the important decision of which plan to choose for 2016.

MR. DURHAM: I think all stakeholders need to focus on driving value in our healthcare system to make sure it's sustainable. That goes across the

board. Innovation is critical, but we need sustainable pricing in order to keep things moving in the right direction. That's where health plans are focused, we're collaborating with providers, we're working on providing consumers with the best data, actionable data, so they can make value based decisions. That is how we're going to move forward towards a better healthcare system.

MS. SCHANZENBACH: Thank you very much for joining us today. As you know, the healthcare sector is 18 percent of our economy and we think that these three proposals that the Hamilton Project put out today will help us get better value for those dollars.
(Applause)

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