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Getting to Universal Health Insurance Coverage Conference – Day 2
Luncheon: Point-Counterpoint: Is Medicare-for-All the Best Option?
National Academy of Social Insurance
February 1, 2008

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JOHN IGLEHART: I'm John Iglehart and I will moderate this discussion and make a few brief comments and we'll get going. I think everybody in this room agrees that the growth of health care expenditures at the historical rate that we heard Uwe is unsustainable over the long haul. In my estimation, all of the major stakeholders of the medical economy are managing their operations in a way that optimizes their own interests and at the same time, in that process, suboptimizes the broader interests of society.

To borrow from Charles Dickens, this might be the best of times and the worst of times to think about the pluses and minuses of a single payer system. I say the best of times only because I am of the belief that only in the long-term and who knows when we'll get there, only the blunt and full force of government has the potential in our society to tame the beast.

Perhaps this budget that will be released on Monday will be a shout out of a cannon. It focuses on Medicare. It won't happen but it's the next shot and I say the worst of times because obviously this administration that's finishing up in 08, perhaps despises more than any other administration the notion of a single payer be it Medicare or some other form of payment.

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I have the distinguished or the pleasure of really introducing two very distinguished colleagues who have long histories in the subject of social insurance and political science and health economics. Jim Morone is a professor of politics at Brown University, author of many books, countless articles, a senior student of the community, will lead off talking about Medicare-for-All, taking the pro side and he will be followed by Len Nichols, health economist and policy analyst, well known certainly in Washington who directs now the health policy program at the New America Foundation. Each of the panelists will speak for about 15 minutes and then we'll open it up to your questions and comments. Jim?

JAMES MORONE, PH.D.: Thank you, John. Thank you for inviting me. I feel a little bit like the ghost of Christmas yet to come, the problems of health care seem to be with us year in and year out. I believe I have a solution. It's not the solution for this week or next week but it's a solution I think that will work and if you guys with your mandates don't solve the problems that goes to Christmas yet to come will visit you.

Lets back up for a second and begin with the problems. I know you know them but lets just run through them one last time. If you're a health care analyst, you've got lots of synonyms for going up, right, rising costs. I remember the very first lecture I went to on health care policy. It was by Odin

Anderson who announced - the great old white haired sociologist at the University of Chicago - who announced that if we don't do something about health care costs, why it will take ten percent of GDP by 1990 and everybody laughed and they said we'll do something long before then. It will be a disaster. The idea of single payer began to insinuate itself as such as single payer in our policy discussions some time in the 70s and it came really out of a couple – you can't call it PowerPoint because we're 1970s but if you think back, those of you who were there at the time to the old overhead projectors, do you remember?

So gray your mind a little bit if you can, the overhead projector slide number one – the United States and Canada, percentage of health care – health care's percentage of GDP, World War II to 1971, can you picture it up here? Gray, it's hard to distinguish the lines – it actually is hard to distinguish the lines because they cross seven times – U.S., Canada – similar cost experience, then overhead number two – turn it around, flip it around, try to get it right, 1971 going forward – stunning. You know what it looks like, right? We go north, Canada flattens out – two percent depending on when you have the cut off date, two percent of GDP, three percent of GDP, four percent of GDP, five percent of GDP and the thought insinuates itself, maybe they know something we don't know and

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as you look around across national comparisons, it's stunning how other people seem to know something we don't know. Take the Bush era – Germany, health care is percentage of GDP, growth – zero. Japan – zero. It's 2001 to 2006. The English, Tony Blair tried to buy popularity. They spent like drunken sailors. They went wild. The English, both GDP, health care – up .7 – what a time they had. It's over now. U.S.A. – 2.1 percent in the Bush era. Uwe Reinhardt had a great – one of Uwe's great shticks was when we have it all, 100 percent of GDP going to health care, I think he meant it as a joke but somehow – so here we aren't 16 percent and there's two punch lines from this early statement of the problem – one, as John just said, we're in an unstable system.

Until this is solved, we've got a problem and the entire system is rickety and two, every other nation – it's dramatic – every other nation has solved the problem. It's hard. It's ugly. It's nasty, fur flies but none of them have a cost experience like our cost experience. Well that's problem one and let me just point briefly to problem number two because you all know it and that's the problem not just of uninsured people, not just the problems that uninsured people have but the crazy insurance system that the United States works with, one story rather than another imaginary PowerPoint slide. Judy Lave [misspelled?], many of you would know her, the economist

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from the University of Pittsburgh, used to tell about going to Europe and being nervous about those European health care systems so she thought it would be a good idea for her family to buy private health insurance before going abroad and that she did and the policy came back quite strangely. You see, her youngest son, everybody was insured except her youngest son's left leg. She did a little research on this and had discovered he had been to the hospital three years earlier after falling off his bike and had – had that leg x-rayed, no health insurance for the place where there might have been a problem. Somehow that got into the system. What a system, huh? What a system. Costs going through the roof and Judy Lave can't have her son's left leg insured all of which is to say is no matter how good you think your insurance is, it's rickety.

Finally, one last issue for us and I'm not sure it's been brought up a lot, our outcomes look awful. Life expectancy at birth, the most common way we measure population health among countries – U.S. – 31st, 31st among males in life expectancy at birth – oh there's another study that I know says 24th but we know we're behind Singapore, Croatia, Costa Rica, neck and neck with the Sultancy of Brunei – hello – but yes, I know. I hear you. I know what you're saying – the data's dirty. Yes, it is but by any way we measure population health, among industrial countries, the United States is either last or near

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to last. If our Summer Olympic team did this badly, can you imagine the congressional outcry?

The Japanese boy being born right now this minute can expect to live three and a half years longer than the American boy born right now this minute despite the fact that that Japanese kid is probably going to smoke cigarettes – sorry, Robert Wood Johnson there but there it is. Now we know that it’s complicated. There was a marvelous study that described the drive to work from Fairfax County, Virginia into Washington, DC and what life expectancy would be in the different counties you pass through and the variation is huge, which explains some of what’s going on in the United States.

So problems – cost, coverage, and real trouble, just in terms of how we do until, until, until you get to 65 years old and then our data starts to look very good indeed. By the time we’re 80, we’re number one in the world.

Now, I’m not supposed to be talking about problems, I just wanted to get them out there on the table once again to look at, lets shift to my solution, the solution I believe and that’s Medicare-for-All. We have experience. It’s a popular program and I believe it will solve the problems I just described. Now there’s lots of ways of thinking about single payer. I’ve got my own little plan and if you were to just e—mail me, I’ll zap you the plan. I might fund it with a vat tax.

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Michael Gratz at Yale University has worked out a very detailed vat tax proposal with tax credits for low income people, in fact, my version would have the vat tax pay for both health and education but that would be if I were czar of America and I know I won't talk about education in 15 minutes, The cost, if you talk to Bill Bradley, he will start negotiating with you on the telephone as if you're on the Senate Finance Committee, he says it's 250 billion dollar. Jacob Hacker says 350 billion, lets round it up to 400 billion dollars. I think that's probably an accurate statement of what it would cost.

There's a huge debate about whether or not people should be allowed to top out. Be serious, this is America – yes – we'll always have people who fly business class, that is, we'll look – huge debate among the single payer systems. The Canadians say no, no, no, no flying first class although that's a slightly simplistic view of Canada. The British – go ahead, top out all you want. The United States will have a top out system so there will be lots of private insurance on top of a Medicare-for-All but I want to push Medicare-for-All and not many of the other very well done elaborate single payer plans for the simple political reason that Medicare is an enormously popular program and I'd like people who oppose this form of national health insurance to be in the awkward position of

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arguing against Medicare, which is always a bit tricky if you're running for office.

Now why does Medicare-for-All or a single payer work? It works for cost, I believe, because you get a [inaudible] and buyers setting a price for all folks. No more cost shifting, no more administrative leviathan. The basic logic is simple. The irresistible force – we want more health care meets the immovable object – oh yeah, more health care? Your taxes are going to go up. It's not nice but you can't simply keep passing the cost on and that's why it works around the world - irresistible force, immovable object. If you want to know how it works in the United States, look at military spending, another highly technical area that has a lot to do with things we really, really need and somehow relates to people dying. The health care's percentage of GDP has never, never gone up more than five years in a row and by and large, it meets tax resistance very rapidly regardless of who's President.

Now, I think a Medicare-for-All, a single payer plan, deals with the cost explosion for the reason I just gave but at the heart of the single payer is something very different. It's a faith in social insurance and now you can sort yourselves out, fundamentally, about whether this appeals to you or not. Go back and read Truman's autobiography. The first thing he says is at page 15 is the biggest disappointment in my life was

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not winning national health insurance. It bugged him. He spent his life, the end of his life, sitting in the Truman library scribbling again and again it just makes me angry that we don't have national health insurance and that was true – this basic belief, Truman – L.B.J., Bob Ball – there was a generation of people who just believed their idea of a good society involved shared risk for health care so that people don't scrape and scheme and fight and push to assure their own health care. People can rely on a basic set of services.

Now if mandates just get you excited, this is not for you. I understand that but if deep down inside, you kind of believe what Bob Ball and L.B.J. and Harry Truman believed, let me say something to you. You've been [inaudible] since 1978, we've lived in a country where the politics has been dominated by movement conservatism, it's framed our politics. That era began in 1978 with proposition 13 and ended in 2006, at least that's what I would argue. All four presidential candidates – not a movement conservative among them - the media's trying to scratch its head, trying to figure out why. Perhaps we've moved passed the movement conservative era and if so, and even if not so, you social insurance advocates come on back out of the closet. Alright, smattering of applause – I see those of you not clapping, I feel like George Bush up here, half the room yes, half the room no. I hear it.

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The final pitch on that part of the talk is to say what single payer advocates always say- look, we're not going to cover 47 million people plus reining in health care costs with an elaborate and to lay people, incomprehensible, series of complications, compromises, and concessions. Health reform is going to work only if you get a movement. Medicare-for-All at least has the promise of starting a movement.

Now Jonathan Cohen said last night and I agree with him – look, you take what you can get. Let me just say a word about the employer system and about market plans – just a word on each and then come to my conclusion.

Employer systems, yeah okay, employer systems – we've got it. It's been there for a long time. It's made a lot of sense and the question for those of you who say look don't mess with that – is whether or not the employer-based system will sustain itself in the new economic era. In a quicksilver economic era of global trade, contingent workers, and job shifting, will it come? Will it sustain itself? I remember once my dad came home – he was Vice President of an insurance company – he came home and announced to my mother that he'd been given a job offer by a rival company in which would double – double his salary – my mother said oh that's great and my dad looked at her shocked and said well I couldn't just jump companies. How would that look of the Vice President – jump to

another company? He didn't even negotiate a higher salary. In that era, I tell my students this story, they're like whoa – you're an old man – in that era, health insurance by employment made perfect sense but as you ask yourself does it still make sense, remember my dad. Market plans, they're so difficult to operate. They're so difficult to bring to scale because of something interesting – they require very nimble government, very nimble regulators, why? We have this endless chess match between entrepreneurs driven by the profit motive who know they win if they don't cover sick people and some form of oversight, it's constantly trying to shut the loopholes and keep one step ahead of the chess match.

So the question is who do you bet on? The entrepreneur driven by profits or the oversight, public or private? The great irony of market plans – do we go to the world – is our government might not be up to it.

Conclusion, those of us who believe in single payer always loved Winston Churchill. Do you remember the quote? Count on America to do the right thing after it's exhausted every other possibility. What's interesting about studying American history is if you're a complete glass half full optimist as I tend to be, you're always looking for how did those people make change in the past and I think the answer goes like this – a small group of crazy people take a cause

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they believe in while everybody laughs at them and they push and they push and they push and suddenly there's this moment where change becomes possible whether it's the abolition of slavery or the Civil Rights Movement or the Newt Gingrich revolution in Congress. Remember in the late 80s when Gingrich was running around, what a fool he seemed like? Doonesbury did a series of cartoons about what a silly character he was and yet he pushed, and he pushed, and he pushed and he believed and he won. Oscar Ewing went to Harry Truman in 1951 and said we're not going to win national [inaudible], lets do Medicare. Talk Truman into it. Truman hated the idea of backing down and they pushed from 1951 to 1965 before finally winning.

I'll give you one last piece of free advice. So the number one piece of advice is if single payer appeals to you, come out of the closet and remember all unusual changes in American history come because a small group of nuts push and push and push and then suddenly the moment occurs.

One last comment about that moment. The window of opportunity, when it opens in American politics, opens for just an instant and then it closes fast. We all tend to think of Medicare under Lyndon Johnson as inevitable. There was this huge landslide – Lyndon ruled the world for a little while but Lyndon knew better. He got a staff in a couple of days, this from recently released tapes in the Johnson library, and he

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told them, someone's going to hit me every day. I'm going to lose power every day so we got to move fast. The day, the ways, and needs committee finally, finally, finally passed Medicare through ways and needs after blocking it for six years or more – the story's in Ted Marmar's book – after blocking – there's a phone call we now have a tape of and the house leaders jubilantly call Lyndon Johnson – we did it and Johnson says this – he says, what about the Rules Committee. He doesn't say congratulations. What about the Rules Committee? He knows the head of the Rules Committee wants to stifle this thing and this is what he says. Now remember, nine times out of ten I get into trouble on this because a bill lays around and it stinks. It's just like a dead cat on the door. For God's sake, dead cat's standing on your porch – Mr. Rayburn, legendary Speaker of the House, he used to tell me they stink and they stink and they stink – the dead cats stink. When you get a bill out of your committee, you get that son of a bitch up before the opponents can get their letters written. The savvy health advisor, whatever you believe, the savvy health advisor tells her candidate the day after the election – hurry up, you're almost out of time. Thank you. [Applause]

LEN NICHOLS: Well yeah, thank you. We know it is true, it is true that I've followed some hard acts in my time but all I can think of it's a close analogy is if Jim is the ghost of

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Christmas future then I am John Anderson. Remember the 1980 campaign – standing in front of the NRA because he couldn't get on TV, he went to the NRA in order to advocate gun control to get attention, that's what I feel like today. I'm pretty sure I'm going to get attention but I also would just like to say I too am in a group of nuts and I will come back and tell you about my group at the end maybe but seriously, I am not here to bury single payer but to praise it but to talk about, in fact, how we might want to modify just a tad, if you wanted to pass in my personal lifetime – some of you know me well enough to know that I did devote a couple of years of my life there trying to make this happen with the last window opened for about an hour and a half, that's correct, and I will say I got one more shot in me and if we don't have it by Christmas 2010 then I'm going to do a productive thing, go coach high school football the rest of my life but given that time constraint, I think we've got to go a different way.

Anyway, the theory is nice. I'll talk a little bit about that. Technically it could work, let it be clear, I think it could, politically and I think in fact, there is a better alternative for the United States now and John has promised that I will have a bullet proof vest completely encasing me before we go too long.

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Theory is nice. There's no question about it and obviously Jim knows all the theories and has written most of them and indeed there are many variants and there is sort of a caricature out there of this vision of single payer, that is often maligned but I will say before you get very far into any theory, you've got to be pretty clear that finance is not what it's about. Finance is actually easy. Finance is algebra and a little bit of redistribution around the edges but what's hard is how to think about delivery system of change because you go back to the cost facts that both John and Jim laid out. If we don't get that big cost battleship turned, if we don't get fundamentally less of our GDP to be claimed extra every year or figure out how to get a whole lot more value of what we are spending because that's really what it's about. It's about values, not about cost per say. If we don't get a value proposition far better developed, then I do, as an economist, worry a great deal about our international competitiveness and I'd love to talk to Mark about – I think employers do bear a bit of this in the short run and that's causing a lot of consternation.

So it's about the linear system reform and that means we're going to have to figure out how to align the interests of patients, providers, and ultimately tax payers and we'll come back to the immovable object and the irresistible force and I

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will just suggest this is hard to achieve and it's going to be hard to achieve if what you do in that gray, I would just say, orgasm of moment where we pass it, it's not going to be – better be a damn good cigarette because let me tell you, what's going to happen is suddenly we're going to realize and now we've got to pay for 47 million more, how are we going to do this and if all you do is put them in Medicare, then suddenly the debates in Senate finance get even more intense. So you've got to deal with provider payment and that's why I was attracted to and suggested to [inaudible] that they make sure to make it available. The Colorado conversation, by the way, I just spent the last four days in Colorado and they are talking very seriously about moving forward with universal coverage approach and they have a number of different folks suggest the plans and the single payer plan that came out of the Colorado bunch, I would say, is the best one I personally have read. I'm not [inaudible] but I will say what impressed me about it was how much incredible attention they paid to exactly these delivery system issues. You've got to think about provider payment reform. You've got to think about information asymmetries. You've got to deal with innovation and incentives – sorry – and all things that indeed make our system work but let me make it clear just for the record and for any lingering assassins that may still be aiming, it could work. We could put

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everyone into Medicare, in fact, I would go so far as to say we could enroll people quicker in Medicare than any other way we could imagine going forward, even those that I will advocate in about four more minutes.

However, I think it's also fair to say that if you look at the cost and quality performance of the Medicare program over whatever time period you would like, you would have to conclude it has not been stellar and I've talked about single payer.

So, let me just go on. I would say the real issue though is politically and we'll talk – maybe I should skip to this one and talk about the costs. Somehow these got misordered, it's my fault.

This is the classic picture, I take it from Peter Orzack because he's smarter than I am and he has people who can make these things with four different lines at the same time and the fundamental point, of course, is very simple and that is the Medicare programs cost performance over time is pretty much like the private market's cost performance over time and for those of you who actually pay attention, all of you do, this shouldn't be shocking, they're buying health care in the United States health care system so of course it's the same – duh but that's kind of the point. It is the closest thing we have to the monophony [misspelled?] power that a single payer

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feature would reflect and yet it manages not to achieve any better performance than we achieve elsewhere and that's why I think the real questions here are politically and, to me, comes down to and this is a very, I would say, amateur political science interpretation but this is the question.

Do the people trust the elites enough and my simple observation based upon countless frequent flyer miles is that between Philadelphia and Las Vegas, the answer is no. Between Philadelphia and the ocean, in between Las Vegas and the other ocean, the answer is probably yes. Certainly it is in the latter. There's no question California would vote for this in an hour and a half but do the people trust the elites enough and I would simply say well the Medicare program is unambiguously popular. Arguably I think it still is the most single popular program in the history of civilization. It is still the case that there are going to be ads against politicians who advocate single payer saying one size does not fit all.

Now Jim, very deftly and intellectually says well of course, we're going to let Americans top it off and of course, we would to which I ask the question if you allow Americans to top it off, as Americans really like to top it off, how different is that really from having a mandated benefit package

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that you say everyone has to have and then you let people buy what they want above it. It is the same thing.

So I submit to you in many ways, we're talking about matters of degree about who has control over what and who has responsibility over what and I submit to you there is a fair bit of latent and powerful fear of granting the authority that would be entailed in having the elites in charge of most of what people would transact in the health care sector and that reel is powerful.

I would also say you might have noticed this, Congress has a little trouble delegating authority in programs that affect all payer constituents who vote and the fundamental issue here, I'll simply say what I always say, is you now if you really want to see how single payer would work in addressing this immovable object and so forth, come and – come with me to a Senate finance mark-up. Come and sit next to me and let us take notes, let us share and reason together as we observe this process, go forward and what you will see, I submit, is you will see where we have taken an insurance program for the most vulnerable among us, the ones for whom we do indeed share collective affection and we don't even say the deserving old, we say all the old, although you have to have ten [inaudible] and all that but my point is even that insurance program for the most vulnerable among us in the

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Senate Finance Committee has turned into an income support program for mediocre providers. That's what it is.

Now as it turns out, providers are constituents too and if you live in Indiana or Iowa or Montana or any other place, sometimes I think it's the rural Senate Finance Committee but you know the bottom line – those guys are always going to respond to the pressures upon them and what we're talking about in a single payer framework is putting even more authority in the hands of that Committee and I submit if you could get that out of that committee and have them do what the Roman Senate did for another hour and a half back there in one of those centuries and delegate, okay – fine but somehow I just can't see that delegation being efficient and going forward in that way. So that's what makes me worry.

We talked about cost performance being fairly mixed so I'll just go on to there. So here's what I would submit to you is indeed a better alternative and I submit to you and I can argue about it and we can debate it in the bar then I'd be more fun, I share your goals. I share your dreams. I share where we want to be and that is a place where every American has access to the health care that we know would make them better off if they could get access to it in a way they could afford it and I submit to you simply you can get there in at least two ways.

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One is single payer around finance committee and the other is what I call a sustainable system and to me, in this environment, at least in my timeframe before I start coaching high school football, the only way I can see making it sustainable is to make it bipartisan and contrary to perhaps some rumors, there are good Republicans in the world. There's one of them sitting at that table but there's a lot in the Congress as well and I submit to you sustainable means bipartisan for the simple political science reason you want it to sustain the switch and the momentum, which will happen and bipartisan in today's context means private markets have to be important. It is not a negotiable item. They have to be important.

Now there's lots of ways to make private markets work I would submit in a single payer context but there are many other ways to make private markets work that are going to attract far more support and I submit to you sustainable also has an economic dimension and that is it must be an efficient delivery system and that means we're going to have to work really hard on information infrastructure, really hard on smarter incentives, really hard on comparative effectiveness, and I submit to you we're going to get that in a much more likely way, much more palatable way to the folks we need to bring on board if we let private markets play a much stronger role.

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So I submit to you think about sustainable as nurturing the political will to cover all and to enhance our value per dollar simultaneously. I submit to you it is a movement. I am clearly a member of a small group of nuts because I get attacked from right and left almost daily, some days more than others, some side more than others but that's the deal but the deal is this, we're working to get 60 votes. It's not about a fantastic speech, which Jim just gave and others could give as well. It is about 60 votes and in my humble and battle-scarred opinion, 60 votes does not actually mean 60. Sixty votes means 70 people in that Senate have to believe it's a tolerable idea because otherwise, you will not get 60 to top off what you need to ride over the filibuster threat and that's why it's got to be centered in a way that more of us can live with it and then you know what, we're not going to pass one bill even in this incredible window of opportunity, which I agree is opening and it will close very soon.

We're not going to do that and then go away for 20 years. We're going to revisit it and fix it just like they are in Massachusetts and just like we will as a nation if you listen to me. Thank you very much. [Applause]

JOHN IGLEHART: We have a few minutes for questions, comments to the panelists. Jonathan?

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JONATHAN: Let me just say as a co-chair of this meeting, I think that was just a fantastic debate. I think you guys should take it on the road. I think [applause] the cap was – that was really just incredibly illuminating and wonderful and I just want to ask a question, Jim, which is one thing that Len – neither of you talked about enough but at least Len mentioned, you didn't, we have – I don't know – a 500, 700 billion dollar a year private insurance industry that you would make go away, we don't nationalize 500, 700 billion dollar industries in America – how does that window ever get opened when you're talking about putting the city of Hartford out of business? How do you – that to me, is itself - is the biggest strength of all and I didn't hear you even talk about – I don't know – don't solve it but address it for me because that to me is the biggest issue.

JAMES MORONE, PH.D.: Of course, it's a huge issue. We talk about the cost problem as if it's a problem though every dollar goes to someone who wants that dollar, right, it's not a problem. The Canadians discovered when they went – now it was a smaller insurance industry at the time but they discovered there were so many ways both to use the insurance industry, to use it for ancillary services, to use it in secondary ways, that they brought a lot of business into their Medicare system using private insurance companies.

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Now I'm not going to sit here and tell you this is an easy thing to do. That's why it's not going to happen this year but there are about ten conversation stoppers for single payer despite the fact that lots of people think well it kind of makes sense and lots of countries do it. That's one and I'm sure we'll hear the other nine.

They get it on the table and get the private insurance industries thinking when they go to the Senate Finance Committee – how can we work with this? How can we profit from this? How can we use this? Are they going to win everything they want? No. Are we going to keep the private insurance industry running the health system and cut costs? I don't know but we start the conversation and we begin to think of ways of how to negotiate, bring in the insurance industry and that's something that we'll see as the conversation takes place. It happened in Canada.

There is an old cliché, last point, old cliché that you never get a medical system that doctors opposed. It's historically. Americans are re-writing that to say we never get the health insurance system that the insurers propose. If that's true – if that's true, if they've got an absolute veto and there's not any negotiating, then you're right and I'm wrong.

JOHN IGLEHART: Jed?

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JED: First, I want to second Jonathan's statement about I think this is terrific and I think we should have started this way and had the rest of the conversation about it because it engaged core conceptions of social insurance with different conceptions of the politics of getting to those goals and I appreciate Len's clarity about that point.

I've got two smaller questions for you Len about the way in which you reasoned to your support for this particular mechanism. Question number one – you used the term [inaudible] to describe the Medicare position x-anti, not x-post – now Jim did not describe that. The Canadian example is an example of the government, at least for hospitals and doctors, being in a [inaudible] position – so I don't think you can have it both ways. Maybe the question is why did you try to have it both ways on that? Medicare has done roughly as well but it's not been in the [inaudible] vis-a-vi the market as a whole and I think it's misleading and maybe that was just an innocent matter but the more important question I've got is about how history gets interpreted and bipartisanship gets brought into it. I'm very much impressed by your point about 70 rather than 60. I mean the story of Medicare is not the window of opportunity opening when JFK won. They lost year after year after year. The window of opportunity that emerged was after the election of 64 in which the 70 standard was met both in the

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Senate and in the House and while I think – and I'll leave you this – I think maybe put it this way, the most I think unassaulted way, what set of political conditions would persuade you that you could take Jim's road? That's the question I got for you and the question I got for Jim is what step in Len's plan would you think would maximize the probability to get to your road?

LEN NICHOLS: Should we take a bunch of questions then…

MALE SPEAKER: Why don't you do this…

LEN NICHOLS: That was an amazing set. I think we should start there. Let me just say if you thought the panel was good – I thought your questions outstanding – and on the [inaudible] let me clarify that because it is very quick, what I meant to say was it would be a [inaudible] if it became single payer. Medicare, right now, is a big oligopolous. It's a [inaudible] for some specialties and some hospitals but it is an oligopolous.

On the – essentially what would make it feasible? What are the things that would make it feasible? I would submit it would. I mean this is not original to me or new, I would say it really would require a consensus that our fundamental system was so unacceptable that we have to move extremely quickly. What I see is 47 million uninsured. We now know, thanks to the Institute of Medicine, roughly 18,000, 20,000 or so at a

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minimum die every year. To me, that's a crisis. I noticed, however, for all of my fellow human beings, it is not and so we're not at the point where because still it is true, I give talks all over the country as does Jim as do all of you, I know and you stand up in places and people say well we have universal coverage in America, it's called Entala and I have patiently explain that Entala is not universal coverage. It doesn't matter. [Inaudible] well I engage the beast but I would say they do indeed still believe.

So I think you've got to have a real sense of this is unacceptable and this is therefore the quickest way to get everybody covered tomorrow.

MALE SPEAKER: Something like blueprint.

LEN NICHOLS: Yes. Exactly.

JAMES MORONE, PH.D.: On the second part – great questions, lets be direct about this. If you think marketers are the answer, you're going to get your turn before the Medicare-for-All people get their turn. I think most people in this, many people in this room believe markets are currently broke but if you're a market guy and there's some great market reformers in this room, you're going to get a crack at it. Medicare has, as Len point out, has real problems. There are mandates of problems but the mandate people are going to get their crack as well. I was only half kidding when I talked

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about the ghost of Christmas yet to come, it seems to me single payer is a solution out there in the distance but that if for other solutions, for other ways to get to 70 people, there will be opportunities before Medicare-for-All comes up.

Let me just make two more very quick points and one is if you study history, as I know many of you do, you have to be really impressed not at the discussion around narrow proposals over time because, of course, those change but have the framing of the Washington discussion, it's self—changes. We live very much in eras and all the assumptions and expectations shift from time to time.

We have now perhaps gone through, perhaps I'm being overly optimistic from my perspective but we've been through an era where a conversation about single payers really off the table. It's not part of a set of expectations. It's very interesting – go back and read Time Magazine from the 1960s. You'll be shocked because the kinds of assumptions in Time's coverage of political events is entirely different. Some guy commits a crime and they talk about underprivileged. Well today we snicker thanks to Ronald Reagan but I bring that up only to suggest how the frame of policy making changes. What happened in 1963-64, was the frame changed. We are moving, I believe, into a possible frame-changing era. Joe White says it's very hard to change big frames and it is but they do change.

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Perhaps we're moving into a more post-partisan era, perhaps we're moving into something else. What I want to suggest is people who are very engaged in policy, tend to miss the big changes in the political framing. So be ready for it and make it part of your conversation.

JOHN IGLEHART: Okay. Briefly please because we're running out of time.

FEMALE SPEAKER: I'm sort of surprised Len that you didn't talk about the administrative cost, infrastructure in the current system that really will just be perpetuated and important, it's not just on the insurance level. It's across the entire system. It's doctors' offices. It's hospitals. It's trying to administer these multiple programs. The other thing that you did mention, I appreciated it, is the need for an electronic kind of interoperable data information. I believe you said it'll happen. Well I don't think it's happened yet partly because there's no sustainable business model for it because there's no sustainable model for the health care system and so why would they do IT? Well the only good tech databases in the country on health care right now – nationally are the VA system and the Medicare system and that's because everything else is fragmented so I wonder how you would address that.

LEN NICHOLS: Okay. Well first let me just say that you're right. I didn't talk about administrative costs and I

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would say it this way. It is unambiguously true that having a single payer would reduce all of the administrative burden, the providers themselves having to do – follow the different insurers and all that stuff and it's pretty clear that we could administer the Medicare program for all at a lower rate than private insurance has between the premium and the claims, which we call the load but I would also say you could accomplish the former efficiency if you had standard claims and standard billing and all that stuff, which one could impose. I'm not saying no regulation. I'm not a laissez-faire guy. I'm trying to make the market work in ways that are more palatable to a larger swath of the American public until Jim gets them all fired up and we got a crash at the gates. So if until then, I got to get 70 guys to say it's okay and until then, I think you can get there in this way.

The second point is – well [inaudible], two more points – is the second issue though is if you had individual mandate, you had a market that worked, that had been reformed and worked for people and you outlawed rating on risk and you said we're going to let you go ahead and do age rating because that makes sense and it reduces the burden you impose on young immortals but it actually means it's pretty simple to calculate, then all the stuff that goes into the excessive underwriting, a big chunk of that load, would be nonprofitable anymore. What I want

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to do is align incentives. What I want to do is have incentives of the social good actually fit the business model. So you change what you get paid for and suddenly – and that's the way I think you change everything. You change what you pay for and you'll change culture.

JOHN IGLEHART: Briefly please now.

HELEN HALPAN: I'm Helen Halpen [misspelled?] from the University of California-Berkeley. I would like to posit that we are in fact in the middle of a paradigm shift and I don't think anyone has really made that much note of it yet but in the past, all of the proposals were one size fit all. So if it was an employer-payer-pay, everyone was going to get their insurance for their employer. If you had a link otherwise there would be other public options or single payer, everyone in the whole country has to go on to single payer.

My sense is we've rejected those one size fits all models and in fact, if we look at the democratic candidates' proposals, what they do is actually provide a choice of systems so that you can – if you get employer and you like it, you can keep it. If you have Medicare or S-CHIP. If you buy in the private market, you can keep it but what they've done is created a pool and given people options in those pools, FAHBP options and the single payer option. They don't call it single payer. They call it public plan like Medicare but it is a

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single payer and I developed this idea in California in 2002 and modeled it, give people a choice of a single payer system that operates alongside the existing system, no one has to go in it – only those who want to go in it, go in it and the Lewin group modeled it and within one year, they estimated that 60 to 70- percent of the population would move into the single payer system. It doesn't put the insurance companies out of business. They'll still have about 20 percent or so – maybe less – of the total market but I think Medicare is the example, Jim, for how we use the insurance industry. From the very beginning, Medicare has relied almost exclusively on Blue Cross and other private insurers for claims processing and other administrative functions. They've had a very lucrative business in the Medi-gap policies, which needed to be regulated but could be and they can still sell to those who want to. So I really think we need to think about letting people keep what they have, give them a choice of single payer and I think what we'll see is a voluntary transition with most of the population very quickly into that system.

JOHN IGLEHART: Go ahead.

JAMES MORONE, PH.D.: That's a nice point. Let me just add one more thing. It would be great to have federalism in the United States. That is to say there are so many barriers – the state experimentation – on the federal level. It's really

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something to focus on and think about – how to promote lots of different state efforts and you guys know as well as I do though, the long list of difficulties and waivers and so forth that need to be gotten through. The next – one place where I think we might get 70 votes is an agreement to let states try a whole lot of options and just open up the possibilities. I think that would be an exciting moment with things just like that coming down the line…

MALE SPEAKER: But to support Helen's point if I could just point out, it's interesting to me, you described the model that way, of parallel systems, every major democratic candidate and the two remaining ones have a public plan in their vision competing and I think the challenge will be, I mean it makes me nervous about holding my 70 but the challenge will be how can we define the rules so that the competition among those two sets is actually level and we have smart people to help us but I think that is the difficult thing.

JOHN IGLEHART: Yes sir?

MALE SPEAKER: By way of background to the question, we asked over 50 companies to attend a conference to get exposure to the economic ideas for reforming the health care system and very few accepted and I knew everyone I wrote to. So I called and asked a few about why and they said because reducing the trend rate is not on the agenda. So I learned something about

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how to make an agenda from my colleagues and I take responsibility for that but with that in mind and also keeping in mind that the two trillion dollars doesn't just go to the people administrating the health care system, it goes to GE and IBM and Kodak and so forth, what is your plan for reducing the trend rate in a single payer system given that some of the countries you alluded to very effectively control the costs by setting a budget from the top down? Is that your plan or would you favor another approach and I would ask the same question of the sustainable model as well.

JAMES MORONE, PH.D.: What strikes me most about a lot of companies, particularly if you're the big companies – you're talking about is how sick and tired I – they may tell you it's not on the agenda but one thing that strikes me is how sick and tired they are of talking about health care. They don't want to be in the conversation anymore. I remember giving a single payer discussion and someone from Ford, from the Ford benefits office was there and the idea was he was supposed to blast me and he got up and said fine with me. Get us out of this business. Sign me up and it was a big disappointment in the room. It's – he doesn't want to pay for it anymore. You guys pay for it was his essential line.

I had a second thought – oh how do you do it.

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LEN NICHOLS: How do you do it – yes. Yeah, that would be the key thing yeah and I'm glad you're going first.

JAMES MORONE, PH.D.: The way a political scientist thinks about this, thank God I'm not an economist, is – and I know this is going to sound crazy – is to make it a political process. It's not that there's some procedure, some budget, some super duper equation that solves the problem of health care costs.

We believe if you believe the single payer, you believe ultimately, you're not going to hide it in some technical gizmo in a DRG in a formula. You're going to make it part of a national discussion every year. It'll be messy and it will be ugly but what happens in a Germany, in a France is that every year there's a discussion, there's a process. There's a communal decision about health care costs. That's the underlying truth about single payer plans. If you think oh God, bring politics into it. I can't stand it, single payer's not going to be for you because we're really making it a collective decision, a process by which we fight about this in public. I believe it's the only way really to make the kinds of hard choices we have to make if we're going to stop the ever—rising set of health care costs but that is exactly the kind of thing the political scientists would love.

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LEN NICHOLS: Well since my goal in life is to make Jim happy, I would say that fundamentally, we're not that different. The aggregate discussion about what we will spend as a nation toward our fellow human beings' access to health care is a political thing in my system or his. The difference, I would say, in my system is that I'm afraid a lot of people, again between Philadelphia and Las Vegas, will be very nervous about having the major and only decision being made in Washington.

The fundamental reality of health care, I think as a phenomenon in our society is that it's personal. It is between the individual and the clinician and the family and the community and so forth and therefore there has to be a great deal of room for breathing before our population as individualistic as we always will be, will accept these kinds of limits, cut offs, whatever. It's got to be there's got to be room to breathe at the bottom. That's why what I want is lots of different ways of having different payers make those opportunities available. You need a heck of a lot of public investment because it's public good, to have information pumped out there about what is and is not most effective for the subpopulation. You've got to have incentives tinkered with by lots of different payers because none of us are great at figuring out at how to set those incentives right and you've

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got to have a heck of a lot though of actual physical discretion on the ground where a patient and a clinician decide together to follow those incentives or not. If you don't have that my friend, we will not have a system that's sustainable.

JAMES MORONE, PH.D.: Can I just make one last point and I just want to underscore what Len just said and that is I live actually in New Hampshire and that is very much not on the coasts. I live in a very conservative town and I'll tell you, people could care less about health insurance and health insurance markets. They want to be able to go to the doctor and they want to be able to go to their doctor and all the fancy stuff that I – we all spend our time talking about doesn't touch them in any way, shape, or form. They want a connection with their physicians and their hospitals and that's the bottom line for them and I think what Len just said is absolutely right – we ought to just bear that in mind because most of the stuff we talk about, they don't care about. They want to be able to go to the doctor.

JOHN IGLEHART: Okay. Two announcements – one, we're going to clear this room for about 15 minutes and then rejoin for our next session but two and more importantly, terrific panel guys. Thank you so much. [Applause]

[END RECORDING]

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