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## **CBO Releases Study on Rising Cost of Healthcare Congressional Budget Office and New America Foundation November 13, 2007**

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**MAYA MACGUINEAS:** Hi, can everybody hear me? I am sadly today the moderator who's recovering from laryngitis so I will be short and sweet in my remarks. I am Maya MacGuineas. I run the Committee for Responsible Federal Budget and I'm the Director of the Fiscal Policy Program here at New America Foundation. And today we are joined by Peter Orszag, the Director the Congressional Budget Office. And this is actually the third time that we have released or CBO has joined us to release one of their long-term budget projections.

What's really interesting today, and I think what's going to really have a huge mark on the whole discussion is that CBO is updating the way that they do their long-term healthcare projections, which obviously has a huge impact on all long-term budget projections. And that's the portion of what we're going to be talking about today. This is to report the long-term outlook for healthcare spending.

Just a few remarks before my voice does run out. On healthcare, one of the things I think many of you have probably experienced, I have experienced with regularity is we all know that healthcare is the biggest issue in terms of the long-term budget. There is pretty much not a budget or fiscal policy conference that I go to that somebody doesn't say knowingly, "Well, the real problem is healthcare." And we all nod and

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then we all kind of stop because nobody actually knows so much about what to do about healthcare.

One of what I think the most impressive things going on at the Congressional Budget Office, they are really taking a lead on developing the capacity for better understanding on healthcare, both short-term policy options and long-term projections. And this is going to give so many of the analysts who know that this is probably the single most important issue impacting long-term fiscal productions and the health of the budget much more substance with which to work and hopefully, I think, move the debate forward in a large way that we haven't seen recently.

Just a quick note about Congressional Budget Office for those of you, maybe you've heard the story before. But I am probably the single biggest fan of CBO out there. I feel like I should have started the fan club. In that about ten years ago when I was working on Wall Street I discovered a CBO report about the budget and just read it and it was so accessible, made me realize I wasn't interested in Wall Street, I was, in fact, interested in the budget. And this was before the Internet, or at least before I knew about the Internet, and I went to the Congressional Budget Office and I found out they give away the reports for free. And I thought this was just the neatest thing. I like loaded up on reports. I'm going to

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go there all the time. So I have long been a fan of the Congressional Budget Office and then since I started running the committee for responsible Federal budget, I've been very gratified that all the previous directors are on our Board of Directors, so I get to work closely with them.

There is one note of sympathy I have for the staff there, and that is that I have recently discovered that the directors of CBO are the biggest caffeine addicts of all time. And I say this because when Doug Holdzaken came here the past couple times to release the long-term budget projections he let me know that all he really lives on is Diet Coke and Twizzlers. So we would have Diet Coke and Twizzlers. Now anybody who's ever been in a conference with Peter or has watched him testify knows that Peter has this bizarre backpack that is sort of like the car that all the clowns come out of. He can pull out of his backpack sort of every economic report that's ever been written or is relevant to anything he's talked about and then five or six Diet Cokes on top of it. So I know for the staff that people are working at three in the morning to come with these new healthcare numbers, because anybody who's this caffeinated cannot sleep much so we've provided you with what we hope will be sufficient, Peter, there's more if you need them. And thank you so much for joining us today. I know this

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is going to be a really interesting discussion. Thanks everyone.

**PETER ORSZAG:** Thank you for having me, especially thank you for the Diet Coke. I do wish that -- I wonder if there's an ethics issue. I think we're all right. The reason I'm here today is that we are going to be releasing a long-term budget outlook as we have in the past next month. We are going to now start releasing our long-term budget outlook every year instead of every two years, which had been the norm before that. And a key part of our long-term budget outlook involves healthcare. Because we are presenting a new methodology for projecting healthcare costs and because healthcare costs are the key to our long-term fiscal picture, we're releasing this report separately today and then there will be an overall fiscal long-term outlook that's released in December.

We all know that healthcare costs have been increasing. If you look between 1960 and today, healthcare costs more than tripled as a share of the economy, from under 5-percent of GDP, or Gross Domestic Product, in 1960 to more than 15-percent today. And the key question we all expect that there will be further increases in the future. The key question for our purposes is how to project forward what will happen in the future under current Federal policy.

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And there are a variety of ways that that kind of analysis can be undertaken. A natural starting point is what growth rates we observed in the past. And the way that many analysts measure those growth rates is the so-called excess cost growth rate, and excess does not mean excessive, it means just the cost growth per beneficiary above and beyond growth in income per capita and above and beyond demographic effects.

So excess is just a technical term rather than a normative one and the bottom line highlighted in yellow shows you that the average excess cost-growth rates for Medicare, for Medicaid, for the rest of the health system and for total health spending between 1975 and 2005. We started that analysis in 1975 because that allowed sufficient time after the introduction of Medicare and Medicaid to not have the results affected by the startup of those programs.

Some people looking at this chart note that growth rates since 1990 have been lower than for the 1975 to 2005 period as a whole, which is correct. And therefore some people say, "Well you're starting off your jumping-off point for any future projections should not be the average over the past 30 years but should be the average since 1990." We wound up rejecting that approach because many of the things that appear to have reduced the rate of cost growth during the 1990s may well turn out to be one-time shifts in the level of cost rather

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than changes in the underlying growth trend and therefore you don't want to put too much emphasis on what happened since 1990. For example, the expansion of managed care in the private part of the health system, likely reduced costs relative to what would otherwise have been the case, but it's unclear whether that affects the growth rate or just a one-time shift. If you observe a one-time shift over some period of time, it will temporarily show up as a reduction in the growth rate and to some significant degree we believe that's what happened during the 1990s.

So for that reason and also because if you look from year-to-year, there doesn't appear to be any significant trend over time and there's also a lot of volatility from year-to-year, which highlights the benefits of taking an average over a longer period. We decided to start with the average from 1975 forward. So the jumping-off point for our future projections will be that bottom row of excess cost growth. One point to note about that is that you can observe that the rates are fairly similar in Medicare, in Medicaid and the rest of the health system. That is to say costs have tended to track each other fairly closely on average over long periods of time.

We expect that that will indeed be the case in the future, but it is not a future of the scenarios that I'm going to present to you because in order for that to happen Federal

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policy will have to change. So the historical period that we observed for these data involved a series of policy changes that wound up resulting in healthcare costs in the different parts of the health system tracking each other fairly closely. That will likely occur in the future but it will require a change in Federal policy in order to make it happen.

The other thing to note about these excess cost growth rates, as you can see on this chart, is that they bounce around from year-to-year. IN some years Medicare and Medicaid are above the rest of the health system, in some years they're below. So there are periods when Medicare, say, is growing faster than the rest of the health system and periods in which it's not. And again on average the rates over the past three decades have tended to track each other fairly closely.

Okay, so we have something like 2 to 2.5-percent average growth rate over the past three decades and that can be a jumping-off point for future projections. If we simply just took those growth rates and said what happened in the past will happen in the future, you wind up with this chart. And there are two problems with this chart. One is that by the end of the period, healthcare is 100-percent of GDP and will soon exceed it and while we can illustrate the implications of current Federal policy, a mathematical impossibility like that is not generally a desirable feature of a scenario.

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The second observation which is related is that even in the absence of Federal policy changes, one would anticipate that as the share of healthcare spending and the economy reach 30, 40, 50, 60, 70-percent, there would be significant pressure at the level of employers, households, insurance plans, state governments to try to constrain the cost growth, even in the absence of Federal policy.

And so embedded in the scenarios that we present is an assumption that those other sectors of the health system will act to slow cost growth as the share of healthcare costs rise. And in particular, that they will adopt potentially painful steps like tighter utilization management, slower adoption of technology, higher cost sharing, more restrictive employer plans or less access to employer-sponsored coverage and other things that may ultimately reduce the rate of cost growth but that are not necessarily pleasant to live through.

In particular the assumption that we use to pin down the rate of growth in the rest of the health system is that households, employers and other entities will not allow more than 100-percent of productivity growth to go into healthcare. That is to say if the overall economy becomes more productive by \$100 so all of our income goes up by \$100, we will not allow \$150 to go into healthcare because that would require a

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reduction in cars, in houses and other things that we can sue [misspelled?].

By constraining non-health inflation-adjusted consumption to not decline, we then get a rate of growth in the rest of the health system that involves a slowing from those historical growth rates and that would be accomplished through many of the steps that I described. There would then be some spillover effects or other effects for Medicare and Medicaid even under current policy. In particular, Medicaid conceptually what we are trying to do in these scenarios is keep the Federal policy fixed, but that doesn't mean keeping state policy fixed. And since Medicaid is a mixed Federal/state program, state governments under these scenarios have the flexibility to respond to rising costs and we believe that they would and then even for Medicare the changes that the rest of the health system would adopt, whether in practice norms or in technological adoption or other things would likely have some effect on Medicare costs, because to some degree the health systems are integrated. Doctors see both kinds of patients, for example.

In addition to that, there is some scope under current regulation to adopt cost-saving approaches and the rising premiums and cost-sharing requirements for Medicare beneficiaries could also help to restrain cost growth in the

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system, even under current law. So in particular our assumption is that if for example, and as an illustration cost growth in the rest of the health system slowed from 2-percent a year to 1-percent a year, cost growth in Medicaid would slow from 2-percent to 1.25 percent, so basically a 75-percent spillover and cost growth in Medicare would slow from 2 to 1.75-percent, i.e. a 25-percent spillover.

Last, a fact on Medicare because the constraint that Federal policies fixed is more of a constraint for that program than for Medicaid. The result of all that is the following: these are our essential projections of healthcare spending. In terms of overall healthcare spending after the share of healthcare spending in the economy more than tripled between 1960 and today, we project that it would more than double again between today and 2035, rising to more than 30-percent by that year. In terms of Medicare and Medicaid we project that spending today, which is 4-percent of the economy, would more than triple by 2050, reaching 12-percent of the economy by that year and almost 19-percent of the economy or roughly 19-percent of the economy by the end of the projection window.

One of the implications of the projection methodology is that Medicare and Medicaid account for a larger share of the health system over time, precisely because Federal policy is held fixed. And I want to emphasize again, this is not a

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prediction of the future, because Federal policy will change, but Federal policy changes will be necessary to avoid that implication of an unchanged set of policies. I think you can even see from the chart that Medicare and Medicaid are consuming a larger share of the overall health system in these scenarios. Another way of calibrating the projections is to compare them to some previous scenarios that CBO has put out. In previous work, instead of picking essential tendency for healthcare spending, we tended to just use different scenarios for that rate of excess cost growth and in particular the 1-percent number, which is that second line from the bottom and then the 2.5-percent excess cost growth were commonly referred to in CBO publications -- and I think you can see that our new set of central projections lie in between those two -- in part because of the spillover effects and the activity that the rest of the health system would undertake in order to slow cost growth even again in absence of Federal policy changes.

Another calibration or another comparison that can be undertaken with our projections is to compare us to the intermediate estimates of the Medicare trustees. And what you see from that comparison is that over the next couple decades the two projections track each other fairly closely. One reason for that is that the first ten years of our projections are based on our baseline outlook, our budget baseline, and

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then the system that I described kicks in in 2018. Similarly the CMS actuarial projections are similar over the next decade and then you see a little bit of difference opening up thereafter. In the long run we are higher than the trustees by the end of the projection window; we are 50-percent higher than the intermediate estimates of the CMS actuaries or the trustees. And I will just briefly describe that the way that they do their projections involves from year 25 to year 75 an average excess cost growth rate of 1-percent, and that's an average over that 50 year period. They have slowing within the period. But we do not constrain our system to have that 1-percent average growth rate from year 25 to year 75. Instead, we adopt the methodology that I've already described, and the result is that we wind up higher than they are by the end of the 75th year. But I would also emphasize that the key message in both reports is quite similar, which is under current policy, spending on these two programs, Medicare and Medicaid will rise sharply, and furthermore over the next couple decades there isn't much difference at all in the precise magnitudes of that increase.

Another essential point to take away from the report is that we have been largely misdiagnosing the nation's fiscal problem. And I'm guilty of this as are many of my former colleagues in the think tank community and elsewhere. In the

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media, the nation's long-term fiscal problem is typically described as being driven mostly by the coming retirement of the baby boomers, the tidal wave of aging. And while that is a factor it is not even close to the most important factor. This chart shows you the pure effect of the aging distribution of the population, so that is that the population is growing older in that dark blue line, or the dark blue area. The light blue area is the effect of cost growth above and beyond aging and above and beyond GDP growth. And I think it's pretty obvious from the graph that while aging is there or the effect of aging population is present, it's not the dominant force. And in fact by the end of the projection window, the aging distribution, or sorry the aging population distribution accounts for only about 10-percent of the projected increase in Medicare and Medicaid costs.

So that is not where the money is. The money is in the light blue area. And we are paying far too little attention to what could help bend that curve in the light blue area, and far too much attention to, in effect, the impact of that dark blue area. And again I would say I am just as guilty as anyone is, but I'm hoping to change that. I'm reforming myself.

In terms of what could help bend that curve, it is also important to realize that imbedded in the central long-term fiscal challenge facing the United States, which is that light

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blue area, there is a substantial opportunity. And that opportunity is the ability to potentially take costs out of the healthcare system without harming quality. There is often described a medical effectiveness curve, which suggests that over some range of spending, as you spend more, health outcomes improve, but at some point that curve flattens out and might even turn down. I believe there's a substantial amount of evidence that in the United States we're either on the flat part or the downward-sloping part of that curve.

What is that evidence? I think the most compelling evidence, perhaps, is the very substantial variation in health care costs for beneficiary in Medicare, which by the way also occur in Medicaid and in the rest of the health system. Fact number one about the nation's healthcare system is substantial amounts of regional variation in Medicare in Medicaid and in the rest of the health system, for reasons that cannot be explained by the underlying riskiness of the patients or the cost of building a hospital or local wage rates or what have you. I like to say someone came up to me at a speech a couple of weeks ago and said, "I have the answer, it's cloud cover." In different parts of the United States. But a group up at Dartmouth has spent basically its entire professional career trying to explain this variation, and can reduce the variation

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perhaps by a third or so when you throw in the various control variables.

So a very substantial amount of variation in different parts of the United States that don't correspond to improvements in outcomes. And in fact if you look at the simple correlation across states, higher-spending states have, in anything, worse health outcomes than the lower spending states. Opening up the obvious question, why is this happening and how much money is there? Let's answer that second question first. I have a panel of health advisors that includes many of the top health economists from across the country. I asked them the question, "What share of healthcare costs do you believe could be removed from the healthcare system hypothetically at least? Leave apart the political economy of the difficulty of obtaining the savings, but just in terms of an opportunity, could we remove of the healthcare system without harming quality?"

And a few people said, "I cant' possibly answer that question," but the people who answered it gave answers that ranged between 5 and about 50-percent, with the most common answer being 30. Thirty percent of our nation's healthcare spending, which now is about 16-percent of GDP, is about 5-percent of the economy. Five percent of the economy for no adverse consequences to health is -- to say it's an incredible

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opportunity is an understatement. That is a huge amount of money for what many of the nation's leading health experts believe is no adverse consequences in terms of health outcomes.

So why is this happening? Let's try to get under the hood a little bit more in terms of this variation. Because if you look at -- this chart might be a little bit difficult to understand, but basically if the dot is right near the vertical line, that means there's not very much variation. And if the dot's pretty far from the vertical line there's a lot of variation. So one thing to note about this variation is in terms of the things we know that work, there's not that much variation across different parts of the United States. So it is best practice to administer aspirin upon admission to a hospital for a heart attack. Basically there's not a lot of variation in that kind of practice. Where there is a lot more variation is precisely in the more nebulous areas of say imaging or diagnostic tests, where it's not entirely clear what should happen.

Let me give you an example of an MRI. MRIs have generated huge benefits in terms of being able to diagnose things that we weren't able to do before. However, that MRI then gets applied in lots of settings where it has a very, very small, if any, probability of affecting the diagnosis. That drives up costs without improving anyone's quality. And I'm

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sure you may have experienced this; I have experienced this personally where doctors were urging MRIs on me for no discernible probability of changing a pretty clear diagnosis. Replicate that thousands and thousands and thousands of times and you get the kind of variation that we see in that chart for no discernible improvement in quality.

Another perspective on the same point, if you look at hip fracture cases, if you fracture your hip you're going to be hospitalized. The cost of hip fracture cases doesn't vary that much across parts of the United States because it is clear what should happen. In other cases like back surgery where it's not so clear what the medical benefits are or what should happen, there's a lot more variation. Furthermore, if you look at the follow-up costs to hip fracture hospitalization, there's very little evidence if any on whether you should go and see the doctor four times a month or twice a month or three times a month and there's again more variation where there's less certainty on what works and what doesn't.

It leads to the obvious conclusion that if we had a much larger share of healthcare costs that were delivered based on direct evidence, this variation might be much less substantial, and I'll come back to that in a moment. But before I do, the other thing that people note about that chart is they say, "Well, yeah, that's great. But those dark red

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areas, they have a lot of academic medical centers, and we all know that the academic medical centers in the United States are the best in the world in terms of the healthcare that they deliver." So I want to just explore that for a second and courtesy of a colleague at Dartmouth, refer to the cost per beneficiary in the last six months of life at three top medical centers in the United States, whose names will undoubtedly be familiar to you if you follow healthcare.

And again last six months of life, so it's fairly clear that all of these cases are serious and potentially high-cost. The quality measures that we have for these three centers don't vary that much, which is the top row. Cost per beneficiary at one of the medical centers is slightly more than \$50,000 on average. At another center it's about half that. It leads to the obvious question of how can the best medical care in the world cost twice as much as the best medical care in the world? And one of the reasons is that if you start to look at physician visits or medical specialists or hospital days, where again it is not clear that we're getting anything more in terms of outcomes, these are sort of more discretionary kind of things, there's a lot more of that activity at the higher-cost center than at the lower-cost center, again for no discernable improvement in quality.

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I believe, therefore, that the reason that we have this variation in practice norms in the United States is that too small a share of the healthcare delivered in the United States is backed by specific evidence on what works and what doesn't. In the absence of that evidence social norms among practitioners and physicians vary across different parts of the United States. WE have more interventionists and less interventionist norms. The more interventionist norms are not backed by solid scientific evidence and therefore they drive up costs without improving quality. And we have a payment system that facilitates that, by being largely a fee-for-service system in which it doesn't really matter whether that MRI has any value; as long as you do it you get paid for it.

One obvious approach to addressing that, then, involves building out the information base on what works and what doesn't and we can talk more about that if people are interested. And then tying financial incentives both for providers and to consumers to the evidence on what works. And I'll talk briefly about the consumer side and then I want to come back to the provider side at the end.

One of the other little-remarked things in healthcare is that if you look at out-of-pocket expenses, so co-payments and things like that, for example, the share of total health expenditures in that forum has plummeted over the past few

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decades. From about a third in 1975 to about 15-percent today. And all of the evidence suggests that that lower out-of-pocket share drives up costs, either a little bit, if you believe the results from the Rand experiment, or a lot if you believe the results of that Amy Finklestein [misspelled?] and others have done with regard to the introduction to Medicare. But directionally, when we each pay somewhat less out of pocket for that additional MRI, we drive up costs for all of us and overall costs are therefore increased.

One obvious approach, therefore, is to introduce more cost-sharing on the consumer side, and there are many proposals floating around to do that in various different forms. There is, however, an inherent limit to the capability of consumer cost-sharing to reduce costs. It's there but limited. And the limitation comes from the fact, this is the second big fact of healthcare, which you see in Medicare, Medicaid and the rest of the health system, healthcare costs are very concentrated among a small number of beneficiaries. In Medicare the top 25-percent of beneficiaries account for 85-percent of costs. That kind of concentration you also see in Medicaid and in the rest of the health system. So again, I think the two key facts that you see replicated across different sectors of the health system are lots of variation that you don't see associated with improvements in outcomes and significant concentration of total

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costs from a small share of beneficiaries. This second fact limits the ability of consumer cost-sharing to reduce costs because we are very likely as a nation to provide very generous insurance against catastrophic cases. Even the design of a health savings account, which sort of embodies the notion that we should have more cost-sharing on the consumer side, provides catastrophic insurance.

And therefore there is an inherent limit to the traction you get from consumer cost-sharing, because such a large share of costs are accounted for in this sort of catastrophic range. There's some affect -- and I would not even the Rand experiment suggests that cost-sharing on the non-catastrophic part of spending could have some effect on the catastrophic part, so there's some spillover there. But nonetheless, that limits the degree to which consumer-led cost-sharing approach will capture the full opportunity to reduce costs at minimal adverse consequences for health outcomes.

Which brings me back to a key point. In healthcare, to a first approximation, I think we get what we provide financial incentives for providers to provide. So we have strong incentives for high-end technology, we get a lot of that. We don't have strong incentives for preventative medicine, we don't get a lot of that. So therefore a key design mechanism for the health system is how to use the power of incentives for

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providers and physicians and others to deliver higher-value care than we currently obtain. And I think to do that we'll require more information on what works and what doesn't, and that it will also require a sophisticated approach to aligning incentives to deliver higher value care rather than just more care. Thank you.

**MAYA MACGUINEAS:** Thank you so much. I truly think that was an excellent overview of healthcare both of the picture looking forward, if we do nothing and of the possibilities where there probably are the most hope for making changes to the system. It does, from hearing this dawn on me that perhaps the two MRIs I got for carpel tunnel were unnecessary, but that was in the past. I would like to start with a question and then I know that we're going to have a robust question and answer session.

One of the most interesting things about healthcare in my mind is that when we talk about healthcare, probably everybody in this room thinks about it from a slightly different perspective. For me most often I think about it as a part of the long-term fiscal challenges and part of the budget picture. So I'm going to ask you a question on that, and then I know we'll get more in-depth in actual healthcare policy. So the possibility of a savings of 5-percent of GDP for basically healthcare, the low hanging fruit of healthcare reform is

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astronomical. The promises there are truly amazing and I almost feel like everyone should stop working on other things and work solely on that. And in some ways that's the argument these days in fiscal policy, but I guess I'm not convinced that that's where the solution will be. So my question is, do you ultimately think that what we will need to do to close the long-term fiscal gap in this country, which is quite large over time, not so problematic in the short-term but very problematic in the long-term, will that come, do you believe, primarily from healthcare reform or will it come from a mix of healthcare, revenues, other entitlement policy programs, other budget roles, where do you see the solution?

**PETER ORSZAG:** Well, there are lots of different ways of structuring. I think it's very likely that ultimately there will be a mixture of steps taken, but I guess what I would say is if you did everything else and you didn't tackle this, you wouldn't get that far. This is the central long-term fiscal challenge facing the United States. So look between today and 2050 in our projections. Medicare and Medicaid costs go up by 8-percent of GDP. That is four times as large as the increase in Social Security costs, that is four times as large as the size of the 2001 and 2003 tax legislation, assuming that the ANT is reformed so that it doesn't take back the effects of that tax legislation over time.

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So just looking where the money is, while those other policy options are clearly relevant and could help, by far the most important thing is whether we can bend this curve. And again, I believe that we are given that observation way under investing in analysis and options that could help policy-makers identify specific things they could do and I am trying to augment CBO's ability to do that, but we need the help of think tanks in the foundation world and the academic world. We are seriously misaligned in terms of our investment of resources and significantly over invested in writing books about Social Security reform and significantly under -- and me too -- significantly underinvested in writing books about bending the curve.

**MAYA MACGUINEAS:** I should have put Peter's book on Social Security reform for sale outside -- Okay. Can I open it up for questions please? Yes, here in the front.

**VICTOR BESS:** I'm Victor Bess, a consultant in national security policy. About a year ago I published an article on this subject and my conclusion that the costs of healthcare are killing the viability of the country. Just looking into the future. It is killing our military projects, killing programs that are necessary for the development of the country. Now, my conclusion was that one means -- and this is not the principle means and it was very interesting what you said the fact of

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excess costs, which has to be reviewed -- one of the principle means for reducing cost in healthcare is paradoxically increasing human longevity by a gerantological means. And I underline this. By our gerantological means. I attended conferences and associated with Medicaid biogerantologists over the past six or seven years and they are saying now that if they have adequate funding and they can increase human longevity by up to 20 years free of aging-related diseases. I stress this, free of aging-related diseases, free of cancer, free of cardiac diseases and so on so forth. So if we get this we will significantly reduce the cost of healthcare. Also we will increase the cost of Social Security, obviously, too. But on balance the cost reduction will be so much greater. The problem with this is that after the 20 years--

**MAYA MACGUINEAS:** Let me make sure that there is a question here.

**VICTOR BESS:** Okay. I'll -- a couple more sentences. After the 20 years, these aging-related diseases will come back, so my solution is I'll take the 20 years free of aging-related diseases, as soon as I exhausted that I commit suicide and that's it.

**PETER ORSZAG:** Maybe he should have ended before this. Let me make a couple remarks.

**MAYA MACGUINEAS:** I promised you a provocative Q&A.

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**PETER ORSZAG:** There we go. The first thing is to -- this allows me to flush out a little bit more of why the demographic affect, that is in specifically the aging, the share of the population in different age categories doesn't have that big of an effect on the projections. And I'm going to give you a very simplified example, which is an exaggeration but I want to just for pedagogical purposes make the point that consider a world in which basically you're healthy, you're healthy, you're healthy, and so your healthcare costs are very low and then you get really sick and die. If we're adding more years of life in the healthy years, which the evidence suggest is indeed the case. That is as mortality rates have come down, morbidity rates have also. So we're adding more healthy years. You're adding more of those low-cost years to the system and the pure effect of aging is still, you're going have the high costs at the end of life, that's always going to occur regardless of whether you live to 80 or 85 or 90, so the pure effect of longer life expectancies is not as large as you would think because you're disproportionately adding low cost years.

Now that's different from saying that longer life expectancy actually reduces costs. The way I would say it instead is if we add more years of life and the cost impact is not significant, but those are years of, productive years, we either can better afford the overall costs because more people

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are working, or at the very least we're all enjoying the fruits of life for a longer period of time and that's a good thing also. And I guess I wouldn't sort of leave it at that. It's clear that there are many exciting possibilities in biological sciences and elsewhere in terms of the effects of innovations on life expectancy and one of the reasons that the demographics or at least the age-distribution part of these projections is not as large as you might otherwise think is that, is precisely that you're adding more years of relatively healthy living.

**MAYA MACGUINEAS:** Yes?

**FEMALE SPEAKER:** Hi, I'm Barbara Spin [misspelled?] and I'm [inaudible]. I wanted to ask you a more technical question about scoring and venna [misspelled?] services, because you talk about the last investment in venna services but I think that in the past it's been difficult in CBO methodology to capture the returns on prevention and make those a scorable game that makes those investments possible. And just as an aside to that in terms of higher co-payments and co sharing, there have been some studies done by large companies that it may actually reduce cost-sharing for certain types of chronic illnesses. The compliance improves dramatically in overall cost of [inaudible]. So I guess my question is how do you wrap all of that into the scoring and get a return within the five

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or ten year window that's required to make those investments possible?

**PETER ORSZAG:** Good question. First let me deal with cost-sharing, because I think the evidence suggests that both providers and consumers do respond to the financial incentive that they face and so if you reduce cost-sharing requirements on a certain subset of interventions, you are more likely to get consumers, say, to follow those interventions. The trick or the difficulty is right now we are not doing a very good job, partly because we don't have the evidence on encouraging the higher value interventions. So one of the things that I would hope would ultimately come about is that we have enough information to design a system so both on the provider side and on the consumer side we're encouraging the valuable care through financial incentives for providers and the cost-sharing and other requirements for consumers and not adopting as blunt an approach as is typical today where partly because we don't have the information the financial incentives are not aligned to delivering and receiving high-value care.

In terms of CBO scoring, let me make a couple points. One is that a lot of the things that people believe will save money over time are slow acting and take time to mature and we do not choose the budget window. The Congress has chosen the budget window for scoring purposes and I am often blamed for

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that but it's not my fault. So that's the first observation. The second observation is even within the 10-year window, in many cases the evidence in favor of something that we all believe must work is not as compelling or is not even present to the degree that would be necessary to score saving. I'll come back to that in a second but the third thing, and I want to get this quickly, when we have evidence that something reduces costs, we will score cost savings. I think there has been a perceptions that CBO is sort of philosophically opposed to anything that would save money in the healthcare system on the theory that nothing could possibly work. And what I want to make clear is to the extent that there is specific evidence that this or that will reduce costs, we will and we have started and we have in the past but I'm just making it very clear that we will score savings.

Let's talk about some of the specific examples, though. Prevention, for example, the specific policy interventions that have been demonstrated to reduce costs over a five or ten-year window are not as robust, to use Maya's word, as many of us would like. And I guess what I would say is we are open to evidence, and I have actually gone out of my way to request data from -- a lot of health insurance plans, for example, are experimenting with lots of definitely things, and I think that's terrific. And to the extent that we can -- I can't go

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by some CEO walks in and says, "Well we did this and it worked," I can't go by that. So to the extent that we obtain reliable analytical information showing that an intervention whether it's on prevention or disease management or care coordination or what have you, it works, we will score it. So we are open for information, basically, open for evidence.

**MAYA MACGUINEAS:** Yes, please.

**MALE SPEAKER:** Hi, I'm Charles Rurig [misspelled?] of health care economist in Ann Arbor, Michigan. When you plot those charts in the current law, that's assuming there's no government spending being allocated to people who were currently uninsured and would become uninsured over time, I presume. So if you had another chart counting the number of likely uninsured through 2050 or 2082, it would be going up dramatically, I would bet. And so let's suppose we do something about that [inaudible] individual mandate or something like that with subsidized premiums, government subsidizing premiums for those who can't afford it, over time you're going to find more people who can't afford it because the wages are not going to be rising as quickly as healthcare costs. Have you -- I just wonder what that would look like as another strip of government spending, what the growth rate would look like for that, because I think that would grow faster than Medicare and Medicaid because the numbers falling

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into the need of subsidy category would be increasing fairly dramatically.

**PETER ORSZAG:** Let me tell you what we assume. In particular, we assume that the share of non-Medicare, non-Medicaid spending in the form of employer-sponsored spending on healthcare, would remain constant at just under 60-percent. I believe the figure is 58-percent. That could come about through various mechanisms whether you had higher cost being offset by some employer dropping and therefore more uninsured, or it could be slower growth and then more people being added to those roles. We didn't break out all the various different configurations of the evolution of the employer-sponsored system, which will have a very significant affect on the number of uninsured people in the projections, but instead took this sort of aggregate approach, in part because it's so difficult to predict how the rest of the health system will respond in terms of the specific interventions, again, whether it's utilization management or various different cost-containment techniques or increased cost-sharing for employees or simply employer dropping and what that will do. We didn't attempt in this analysis to break that all out.

**MAYA MACGUINEAS:** Yes, right there.

**MALE SPEAKER:** [Inaudible]. Bruce [inaudible], DAO.

You mentioned the need to build the evidence base on the

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footworks of my cousin. My two-part question is whose job should that be and second, what mechanisms, if any, are needed for new evidence to [inaudible]?

**PETER ORSZAG:** Okay. We're going to be coming out with a report on this topic before the end of the year, so there will be a much more elaborate answer to your question, which is a good one. And let me say a couple things. First, there is some of this kind of activity that's already being undertaken, both by insurance plans and by a small agency within the Department of Health and Human Services, but I believe most observers think that the scale is nowhere near what be warranted or beneficial. And in fact, a question many people ask is, "Well, why aren't insurance companies doing more of this?" And I think the answer is there are several answers to that. One is that a lot of this information is essentially a public good. If you find out that intervention A is more effective than Intervention B that has implications for lots of people beyond your beneficiary roles. In addition, the insurance companies do face a variety of just simple kind of data limitations, insurance claims databases, for example, typically don't have health outcomes tagged onto them, so combining the spending with the outcome can be difficult. Because we have an employer-based system, there's turnover and so you lose part of your sample. And that also reduces your

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incentive to undertake the research in the first place because if you find out that intervention A pays off over three or four years, what's the point of doing it if you're going to lose a lot of the people that you are investing in up front, for example.

All of which leads many observers to believe that increased Federal support for this kind of activity will be necessary if it is to be undertaken at the scale that many observers believe would be warranted. How that Federal support, though, is channeled, is an open question. There are different models for whether we need to be undertaken by a Federal agency or whether a quasi-governmental thing or entity or entities, even, could undertake it and our report will go through many of the different models for expanding this kind of research. And then you also asked about how the results of the research then get embodied in practice, and I think that's an absolutely essential question and by the way should feed into the design of the effort in the first place because it does no good to come out with this study or that study that doesn't have credibility with the medical profession because you're not then going to drive behavior.

And there are two ways in which you could effect -- I think the sociology of the medical profession is very fascinating, but there are two ways of affecting that behavior.

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One is the simple provision of information I believe does affect behavior. And knowing that -- the reports, for example, I put up aspirin upon admission -- the simple reporting of those statistics has significantly expanded simple steps like that but when it comes down to it, the biggest return will come if you tie financial incentives to the results of the research. So I think it's very unlikely in the United States that we'll ever had on/off switches so we -- if Intervention A is proven to be more effective than Intervention B we simply don't do Intervention B, but we are already all used to formularies and other things on drug plans where you pay more, you pay less for generic or a preferred brand. And you can imagine systems of payments where financial incentives for providers are such that if they do Intervention A they're paid more than if they do the less-effective Intervention B, or other systems where you still allow some degree of individual physician flexibility but try to provide incentives for what the evidence suggests is more effective.

And again, I'll just come back to I believe that this is an absolutely essential thing to understand because many people believe that healthcare is just different and healthcare is different but it's also affected by economic incentives. And I do believe that if you look across a whole variety of aspects of the health system, we wind up with what we provide

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strong financial incentives to providers to provide. And therefore if you want a higher-value healthcare system, you need to change the structure of incentives for providers.

**MAYA MACGUINEAS:** Just to stay on that topic for one more moment, because I think the whole question of developing the perfect incentive system is so fascinating. One, is there sort of a proposal out there for a mix of incentives that you think would be most effective? And two, do you have a preference for incentives on the provider versus the consumer side or will it definitely be a blend of both?

**PETER ORSZAG:** Let me answer the second question first. There's often this sort of divide in the health world between the sort of consumer types and the provider types. And it's like you can only operate on one side of the equation. I see no reason why both sides of the scissors can't be doing some work and financial incentives affect both providers and consumers. And they need not be mutually exclusive. If you force me into a mutually exclusive world I would say that coming back to the comments I made about the consumer side, if we are going to provide insurance against catastrophic costs, there's an inherent limit to how much traction we get out of consumer cost-sharing because we're only going to be applying that cost-sharing to a small share of overall cost.

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On the different financial incentives, there are -- I don't believe that we actually have the information base yet to design an appropriate system. We have infrastructure building that we need to do. We need to build out electronic health records which can then serve as an information source for this kind of analysis. You need an entity or entities that can undertake the analysis. You need changes in Federal law so that Medicare can be transformed from a fee-for-service to a fee-for-value system. There are lots of things that people are playing with but are not in place yet, so the typical adage that all we need to do is lock policy-makers in a room and not let them out until they've solved the problem just doesn't apply because no one knows specifically what to do. I have not seen a credible long-term plan to restore solvency to Medicare and Medicaid, period. There are tons on Social Security, some small share of which I've written. There are none on Medicare and Medicaid. And that is a stunning, yeah.

**MAYA MACGUINEAS:** I'd like to call my colleague Shannon Brownlye [misspelled?]. I also just wanted to mention that Shannon is the recent author of a new book called Overtreated. And we also from New America Foundation have another book by Phil Longman called Best Care Anywhere, which chronicles the successes and kind of analyzed the VA Healthcare System.

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**SHANNON BROWNLIE:** I want to thank Peter for a really terrific talk, an incredibly clear talk on this very complicated issue. And I'm completely in agreement with you on the problem of needing to build the evidence base and the need for comparative [inaudible] and the fact that that is a public good and therefore there has to be some kind of role, a greater public role in doing it. My question, though, is that I don't think comparative effectiveness is going to reduce spending in the short term enough, and it also can't really address, even when we have all the evidence, how are we going to address the fundamental problem of overcapacity in various places in the country and the problem of supply of medical resources is driving a great deal of what's delivered.

**PETER ORSZAG:** I think it's a very good question. I view the supply side of -- many people look at that map that I put up and they know correctly that hospital beds per capita and specialists per capita are higher in the darker regions, which is correct. But again I come back to the payment system. I believe that our payment system facilitates that outcome and that in a sense the supply side aspect is a mechanism through which the lack of evidence and the financial incentives we provide is delivered. So I know that many other people believe -- and there are options out there that can be evaluated -- that we should adopt a more command-and-control regulatory

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approach to only allowing a certain number of specialist or what have you in different areas. I think those can be debated and they're important topics. The political economy of that kind of approach seems to me quite difficult. So I guess I would come back to I agree with you that comparative effectiveness research as just one example, is unlikely to significantly reduce costs in the near term, and just underscore that therefore there are many things we need to be doing starting now and trying different things. And at that point I would also highlight, coming back to the question about that I got about CBO scoring. To CMS's credit, CMS is conducting a whole variety of pilot projects on different things, care coordination, disease management, pay-for-performance, which are exactly the kind of activities that we need to be undertaking to see what the evidence suggests on whether there's a return to that. And I'd also note, by the way, just on scoring, that some of the things that we intuitively believe will help reduce costs, including care coordination, the pilot projects thus far are not providing very significant evidence of any cost-savings. If anything, actually the care coordination demonstration project, for example, suggesting if anything it may go in the other direction.

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So my view is that there is a lot of kind of infrastructure building and research and laying the groundwork that can be done. But that we're not in a position today to make the hard decisions that will actually reduce costs without harming quality. And we need to be investing a lot more in that effort, because the longer we wait -- we're losing time. We needed to start to this, say it's yesterday as a cliché, we needed to start on this 15, 20 years ago, yeah.

**MAYA MACGUINEAS:** Yes, in the back.

**MALE SPEAKER:** I'm Roger [inaudible] technology industry association. And the question I have has to do with the use of information technology in healthcare. Not medical technology but information technology. For at least two decades the theory has been that the greater use of information technology could significantly reduce the rate of growth in healthcare and actually it can improve the quality of services, both on the consumer side like digitizing medical records and permitting the physician to pull up all the records instantaneously and on the supply side by digitizing medical information and permitting the physician to look at MRIs taken over the whole world in the last ten years and what works and what doesn't work. So the theory is that for a modest up-front investment, you can have a significant, perhaps enormous, but significant impact on costs and at the same time, by

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coincidence ,both improve quality and improve the security of medical records. Have you -- my two questions are first, obviously you've looked at this. You've mentioned it already; it's a dominant theme in both the democratic and republican approaches to healthcare. What are your views on the role of information technology and how did you take that into account in the projections that you developed?

**PETER ORSZAG:** First let me just say on health information technology itself, I believe the biggest return to health information will be to provide a source of information that can be utilized to explore many of the opportunities we've been discussing. And in fact on that point I believe that the medical profession will out of necessity be forced to deal with imperfections of penal data econometrics where you're following lots of people over time and trying to tease out causation from observed correlations when you're controlling for everything you can possible control for at exactly the same time that economists, having growth frustrated with the imperfections of that approach are yearning for randomized control trials that have dominated the health profession.

The second thing, though, is if all you did was put in an advanced HIT system in the absence of some structure to use that information, it's high financial incentives to it, I believe that many of the estimates that are floating around

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with regard to the cost-savings that would accrue just from putting in an HIT system, are very substantially exaggerated and would not show up in any way in a CBO score of that kind of approach. So HIT as part of a broader system of changes that may help to arrest cost growth or slow cost growth, something that seems--many analysts believe is promising. By itself not clear.

**MALE SPEAKER:** [Inaudible] the size of the public interest, but also you'll have freelance writing and a [inaudible] blog on healthcare issues. That [inaudible] can spoke [misspelled?] a second opinion basically says we have to scratch beneath the surfaces and it's a way to fundamental reform. I'm curious to see if it is going to be at least leaning in that direction or talking about that or what you think about that as an issue when you lean -

**PETER ORSZAG:** You don't lean.

**MALE SPEAKER:** I had a separate question about just get it out on the table and it had to do with the statistic that I found intriguing in your report. Individuals paid 33-percent of GDP, of healthcare costs, rather, back in 1975 and now it's down to 13-percent so that leads to one logical conclusion that consumers ought to pay more in order to get more skin in the game in order to reduce costs but if you actually do the math, overall healthcare costs, it was 6-percent of GDP then, it's

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15-percent now. That means consumers are still paying about 2-percent of GDP in healthcare. So therefore the time when we have basically stagnant household budgets ask them if they can pay more it has [inaudible] questions.

**PETER ORSZAG:** Let me first- [AUDIO CUTS OUT]

[END RECORDING - 1:01:38]

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