



*Highlights of a*  
**FORUM**

*Convened by the*  
**Comptroller General of  
the United States**

**Health Care 20 Years  
From Now**

**Taking Steps Today to Meet Tomorrow's  
Challenges**

**September 2007**  
**GAO-07-1155SP**



Highlights of [GAO-07-1155SP](#), a GAO forum.

## Why GAO Convened This Forum

“Unless we fix our health care system—in both the public and private sectors—rising health care costs will have severe, adverse consequences for the federal budget as well as the U.S. economy in the future.” This is one of the key messages that Comptroller General David M. Walker has been delivering across the country in town-hall style meetings, in speeches, and on radio and television programs.

Using another format to explore issues with health care experts, Mr. Walker convened a forum at GAO on May 17, 2007. Attendees included health policy experts, business leaders, and public officials selected for their subject matter knowledge and representation of various perspectives.

Participants examined health care cost, access, and quality challenges in discussion sessions led by distinguished economists Robert Reischauer and Mark Pauly and other leading health care authorities Carolyn Clancy and Suzanne Delbanco. Nationally known health insurance expert Leonard Schaeffer served as the keynote lunchtime speaker. At the conclusion of the forum, participants were polled for their views on points raised during the discussions. The poll was conducted using electronic voting technology that produced real-time, but confidential, results.

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# HEALTH CARE 20 YEARS FROM NOW

## Taking Steps Today to Meet Tomorrow’s Challenges

### What Participants Said

The discussion sessions focused on three interrelated topics: cost and personal responsibility; coverage of the uninsured; and quality, standards, and outcomes. The keynote speech focused on related policy challenges. The following are highlights from these discussions and the participant poll. The proceedings are not intended to reflect the views of GAO.

*Health care spending.* Participants did not reach agreement on whether the federal government should have an aggregate spending limit, such as a percentage of the federal budget, but supported other measures, such as federal value-based purchasing, reformed tax treatment of health care, and limits on direct-to-consumer advertising of prescription drugs.

*Health insurance coverage.* There was near unanimity that ensuring the provision of health care coverage for all Americans should be a federal responsibility. The group also strongly agreed that the federal government should assure the existence of a well-functioning health insurance market, whereas they did not agree on whether the nation should continue to rely on employer-provided insurance as the dominant method through which most Americans obtain their health insurance coverage.

*Performance measures.* Participants strongly supported the federal government’s taking the lead in developing new indicators of health system outcomes and performance. The group also strongly favored having a broad-based independent body develop national, evidence-based practice standards.

*Policy challenges.* The keynote speaker opined that a limited window of time—about 8 to 10 years—remains for the health care community to engage in effective reform. After that, he noted, budget and national security concerns will dominate. Because neither purely regulatory nor purely market-based approaches are politically viable, pragmatism rather than ideology should drive health policy. He concluded that we need a blended strategy, stating, “We have to shape our future now or be its victim.”

The figure below shows results for a sample of the 18 propositions that participants were polled on at the end of the forum.

**Selected Results of the Health Care Forum Participant Poll**

Propositions	Response				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The federal government should take the lead in developing indicators...to measure the U.S. health care system’s outcomes and performance.	71%	10%	16%	3%	0%
Steps should be taken to encourage individuals to assume more personal responsibility for their own health and wellness.	55%	23%	7%	16%	0%
The United States should balance its health care research investments between new discovery and assessing comparative and cost effectiveness for new and existing medical interventions.	65%	23%	3%	7%	3%

Source: GAO analysis of health care forum participant poll.

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## Preface to the Proceedings

As Comptroller General of the United States, I am afforded a mixed blessing. On the one hand, I am burdened with T.M.I. (“too much information”) regarding the future of this country’s federal fiscal condition and outlook. I live each day with the knowledge and certainty that unless we fix our health care system—in both the public and private sectors—rising health care costs will have severe, adverse consequences for the federal budget as well as the U.S. economy in the not too distant future. On the other hand, my position and long tenure at GAO allow me to bring the message to the public early and often. So far this year, I’ve appeared on a number of major radio and television programs, including NPR’s *Diane Rehm Show*, CBS’s *60 Minutes*, and Comedy Central’s *Colbert Report*. Also, since 2005, I have traveled the country with the nonpartisan Fiscal Wake-up Tour—a broad coalition of individuals and organizations led by the Concord Coalition and involving the Brookings Institution, the Heritage Foundation, and other organizations—to discuss the nation’s fiscal challenges in a series of town hall-style forums. Increasingly, and disturbingly, my fiscal message has become a health care spending message. In fact, health care costs represent the number one fiscal challenge for federal and state governments and a major challenge to the competitiveness of U.S. businesses.

I’ve used another format for shining a light on the challenge posed by rising health care costs on the nation as a whole—two forums on health care held at GAO, the most recent of which occurred on May 17, 2007. Our discussions this year confirmed that little in the health care system has changed since January 2004, when GAO held its first health care forum. Our longer-range federal fiscal outlook, owing significantly to federal health care entitlement spending, remains grim; Medicare and Medicaid spending threaten to consume an untenable share of the national economy in the coming decades. Health care spending systemwide continues to grow at an unsustainable pace, eroding the ability of employers to provide coverage to their workers and undercutting our competitive advantage. Finally, despite spending far more of our economy on health care than other nations, the United States has above average infant mortality, below average life expectancy, and the largest percentage of uninsured individuals. In short, our health care system is badly broken.

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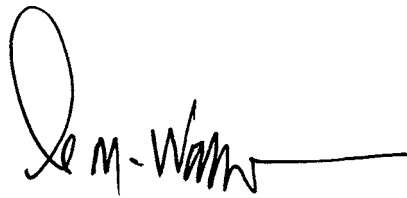
Nevertheless, I was encouraged to hear participants focus in a constructive manner on a range of possible initiatives for health care reform. Participants examined health care cost, access, and quality challenges in detail. (See app. I for an agenda of forum sessions.) The format was designed to maximize the opportunity for open, interactive dialogue without individual attribution. Forum attendees included health policy experts, business leaders, and public officials selected for their subject matter expertise and representation of various perspectives. (See app. II for a list of participants.) Distinguished economists and other leading health care authorities served as leaders of the forum's three discussion sessions and one served as the keynote lunchtime speaker. At the end of the day, participants were polled for their views on several key points raised during the forum regarding health care system challenges and reforms.

These proceedings summarize the ideas and themes that emerged at the forum, the collective discussion of participants, and comments received from participants based on a draft copy. As such, these proceedings are not intended to reflect the views of GAO. Their purpose is to serve as a small step toward elevating public understanding of the challenge and acceptance of the need for change. Ultimately, it will take the combined efforts of many groups and individuals over an extended period to successfully address the issue. Still, time is relatively short before budgetary pressures end the chance for health experts to decide deliberately and thoughtfully on the future of the nation's health care system.

I wish to thank all the forum participants for taking the time to share their knowledge, insights, and perspectives. These will be of value to the American people and to their representatives in Congress as they communicate with their constituents about the inability of our health care system to maintain the status quo. We at GAO will also benefit from these insights as we carry out our mission to help Congress examine federal health care spending and its implications for all health care payers. I am

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hopeful that the American people will become fully engaged in national debate on this topic as a means to facilitate serious, timely, and sustained action that can help save our fiscal future for the benefit of our country, children, and grandchildren.

A handwritten signature in black ink, appearing to read "D. M. Walker", with a long horizontal line extending to the right.

David M. Walker  
Comptroller General  
of the United States

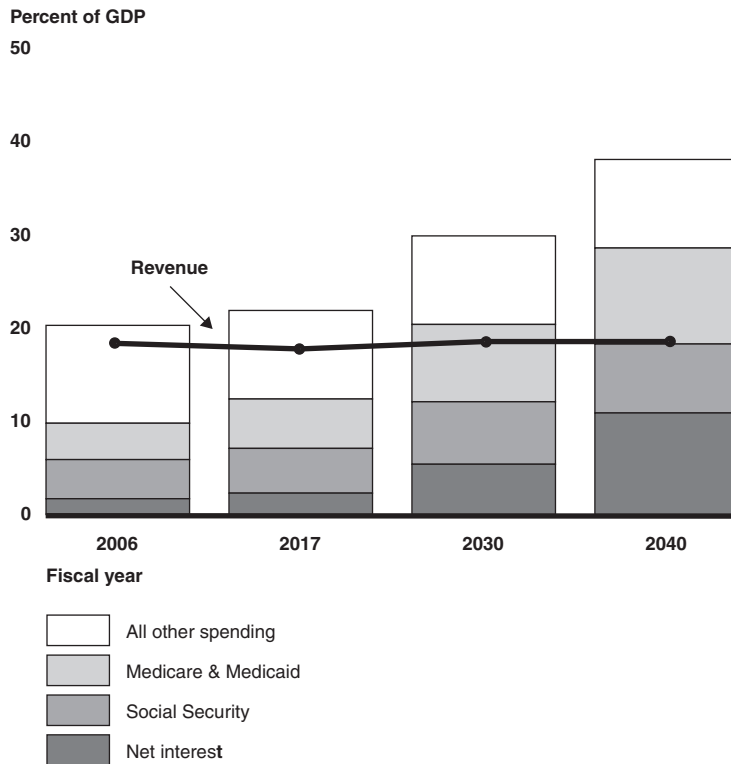
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## Comptroller General's Introductory Presentation

*Health Care Forum Introductory Presentation, led by David M. Walker, Comptroller General of the United States. Mr. Walker opened the forum with a presentation entitled "Health Care System Transformation Challenges: The Need for Leadership, Transparency, and Accountability." The following are highlights of Mr. Walker's presentation.*

The federal government is on a "burning platform" and the status quo way of doing business is unacceptable. Today is not the problem, tomorrow is. Mr. Walker noted that the present value of the federal government's major reported long-term "fiscal exposures"—the difference between what we have promised and what we have in dedicated revenues—totaled over \$50 trillion in 2006. This represents close to four times gross domestic product (GDP) in fiscal year 2006 and is up from about \$20 trillion, or two times GDP in 2000. If we wanted to put aside today enough money to cover these promises, it would take about \$440,000 per American household, up from \$190,000 in 2000. Clearly, we have been moving in the wrong direction in connection with our long-range imbalance in recent years. Equally troubling are the long-range fiscal simulations by GAO and others showing that, over the long term, the nation faces large and growing structural deficits in future years due primarily to rising health care costs and known demographic trends. (See fig. 1.)

**Figure 1: Revenues and Composition of Spending as a Share of GDP, Fiscal Years 2006-2040**



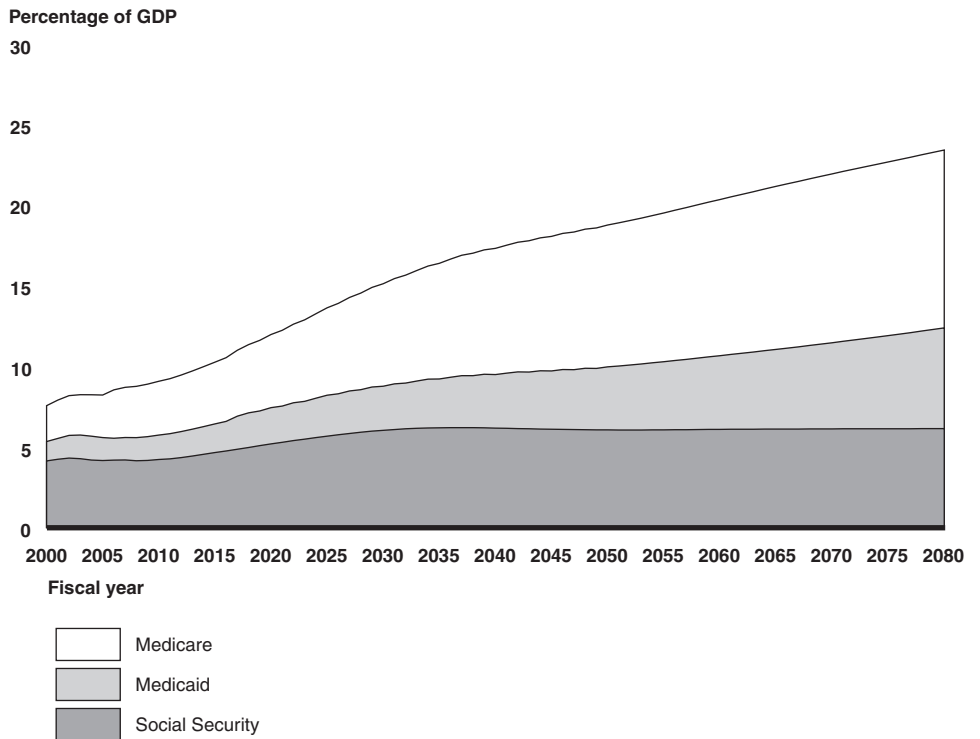
Source: GAO's January 2007 analysis.

Note: This simulation assumes that discretionary spending grows with GDP after 2007 and all expiring tax provisions are extended through 2017. Thereafter revenue returns to historical average of 18.3 percent of GDP plus deferred revenue.

Absent significant changes on the spending or revenue sides of the budget or both, these long-term deficits will encumber a growing share of federal resources and test the capacity of current and future generations to afford both today's and tomorrow's commitments. In particular, public entitlement program obligations will be unsustainable for future generations of Americans. As the baby-boom generation retires, federal spending on current retirement and health care programs—Social Security, Medicare, and Medicaid—will grow dramatically. A range of other federal fiscal commitments, some explicit and some representing implicit public expectations, also bind the nation's fiscal future. (See fig. 2.)



**Figure 2: Social Security, Medicare, and Medicaid Spending as a Percent of GDP, 2000-2080**



Source: GAO analysis based on data from the Office of the Chief Actuary, Social Security Administration, Office of the Actuary, Centers for Medicare & Medicaid Services, and the Congressional Budget Office (CBO).

Note: Social Security and Medicare projections based on the intermediate assumptions of the 2007 Trustees' Reports. Medicaid projections based on CBO's January 2007 short-term Medicaid estimates and CBO's December 2005 long-term Medicaid projections under midrange assumptions.

Absent policy changes, a growing imbalance between expected federal spending and tax revenues will mean escalating and ultimately unsustainable federal deficits and debt levels.

Mr. Walker observed that many of the federal government's current policies, programs, functions, and activities are based on conditions that existed decades ago, are not results-based, and are not well aligned with 21st century realities. Policymakers need to engage in a fundamental review, reprioritization, and reengineering of the base of government.<sup>1</sup>

<sup>1</sup>See GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: Feb. 16, 2005).

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With regard to our health care system, specifically, the public needs to be educated about the differences between wants, needs, affordability, and sustainability at both the individual and aggregate level.

Mr. Walker concluded that comprehensive health care reform will probably need to occur in installments over a number of years. Our goals should be fourfold:

- Provide universal access to basic and essential health care.
- Impose limits on federal spending for health care.
- Implement national, evidence-based medical practice standards to improve quality, control costs, and reduce litigation risks.
- Take steps to ensure that all Americans assume more personal responsibility and accountability for their own health and wellness.

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## Discussion by Forum Participants

After the presentation, forum participants asked questions related to Mr. Walker's illustrations of the long-term fiscal picture. Then the discussion broadened to participants' observations on the appropriate focus of health care reform efforts.

## More on Long-Term Fiscal Picture

Some participants raised the following questions about the various assumptions underlying GAO's simulation in figure 1: How would allowing the tax cuts to expire affect the long-term fiscal picture? Would preventing an expansion of entitlements have a greater or lesser effect than eliminating the tax cuts?

Mr. Walker responded that the recent tax cuts comprise only about 1 percent of GDP; in a GAO simulation under which the tax provisions expire, the long-term fiscal imbalance remains largely unchanged. Not surprisingly, the entitlement programs are the bigger fiscal problem. In addition, not only must the federal government reform Social Security, Medicare, and Medicaid and institute tough budget controls, it must also engage in comprehensive tax reform that will not undercut our economic growth and must reprioritize and constrain other federal spending. Maintaining federal revenues at their historical average of 18.3 percent of GDP will not be enough to cover the growth in the entitlement programs. We must do all of these things, and the sooner the better because time is working against us and our debt clock is ticking.

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Another participant asked whether GAO has created a scenario that assumes the growth rate for Medicare spending is kept to the growth rate of GDP or GDP plus 1 percent. Mr. Walker noted that GAO's simulations are based on data from the Medicare Trustees' "best estimate" (intermediate) projections, which assume that Medicare spending grows at a rate of GDP plus 1 percent. He added that that this growth rate pushes the fiscal imbalance problem further into the future but does not solve it.

Yet another participant wondered how this message, which has been heard for several decades, might be different today. Mr. Walker explained the difference as follows: the traditional measures of fiscal health—economic growth, inflation, interest rates, unemployment, and capital markets' performance—may not point to a current fiscal crisis. Nevertheless, the long-range structural deficit is worse today than it was in the 1980s and closer to becoming a reality. Furthermore, the political and social circumstances today are quite different from the 1990s. At that time, the United States was mostly borrowing from itself. Today our debt is increasingly held by foreign creditors who may put political pressure on the United States to change its policies in their favor. Another difference relates to the baby boom generation's impending retirements, which will result in an unprecedented strain on U.S. entitlement programs and therefore the federal budget. Finally, the geopolitical climate has changed such that there are new emerging superpowers, including China, India, and the European Union, competing with the United States in world markets.

#### Observations on Appropriate Focus of Health Care Reform Efforts

Several participants agreed that addressing problems in the health care system cannot be limited to the federal government's role. According to one participant, framing the issue is the most important factor in finding a solution. He contended that patients' experiences with the health care system should be the highest priority. Another participant countered that the federal role was most important, as Medicare, Medicaid, and the federal employees' health insurance program make government the largest payer in the health care system and federal payment models have had a strong influence on private payers. For example, in the 1980s the movement in Medicare to pay hospitals prospectively based on groups of related services—that is, DRGs—rather than reimbursing them their charges was adopted eventually by payers systemwide.

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Several participants commented on elements they believed should be the focus of health care system reform, offering a diversity of views:

- We are not getting good value for our dollars spent; health care quality needs improvement, as demonstrated by studies finding evidence of both overuse and underuse of services.
- The problem with discussions about “reforming the system” is that we do not have a system to reform. Ours is a disaggregated model in which providers operate as individual self-interested entities seeking to maximize their revenue.
- We should focus on the rate of health care spending growth and its driver, medical technology, rather than on system reforms.
- Looking at individuals’ out-of-pocket costs—that is, copayments, coinsurance, and deductibles—is highly misleading as a focus for reform. Under our third-party payer system, the true cost of health care remains hidden from view. In the private sector, prices are neither transparent nor uniform, as negotiations between payers and purchasers occur under cover. Therefore, the extent to which public and private payers are subsidizing one another remains unknown. We need to examine health care costs in their totality.

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Following Mr. Walker’s remarks and group discussion, participants engaged in discussions on three major topics: health care costs and the role of personal responsibility; access to and coverage for health care services; and health care quality, standards, and outcomes. Session leaders began with a presentation of key points, after which discussion was opened to all participants.

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## Session 1

***Cost and Personal Responsibility, led by Robert Reischauer, Urban Institute.*** *To what extent or in what ways can federal health care spending be controlled? Should there be absolute spending limits, spending triggers, or spending targets? Should tax preferences be reformed and insurance incentives structured to foster personal responsibility? Dr. Reischauer developed several of these topics for discussion, as paraphrased here:*

Health care is the monster in the federal budget. Under certain, not unreasonable, assumptions about the rate at which health care costs are projected to grow, spending on Medicare and Medicaid will soar to

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unsustainable heights. However, “trends which are unsustainable will not continue.” What can or should be done? Will policymakers address the health care spending trend in a timely and incremental fashion or will more drastic change be forced on us by crisis?

Some argue for controlling federal health care entitlement spending—that is, spending on Medicare and Medicaid. The question is, can federal spending be controlled in isolation of spending in general? The American public will not tolerate separate health care systems for services provided through entitlement programs and those provided through the private sector.

Proposals to control spending with absolute limits come with an array of policy questions. For example:

- What would be the measure used to set a spending limit: a percent of GDP? a percentage growth rate? a percentage of the federal budget? a per capita dollar value?
- How do you decide on the threshold number? What factors should affect the threshold—for example, population size? the population’s health status? the general inflation rate?
- How could you have a national limit when levels of spending, growth rates of spending, and quality of care vary across geographic areas? If Medicare spending in Minnesota is half of what Miami spends, why should the same steps be taken to control spending in both areas?
- How do you enforce exceeded limits: reduce provider payment updates? increase beneficiary premiums? tighten program eligibility rules?

Another way to control spending relies on incentives to slow growth—ranging from revising tax exclusions for insurance premiums and out-of-pocket costs to achieving greater price transparency. A third way involves discouraging unhealthy behaviors, by penalizing smokers and drinkers, for example, with higher insurance premiums.

At the end of the day, however, can incentives to slow growth and penalties for unhealthy actions result in anything more than rearranging the Titanic’s deck chairs? In particular, can federal health care spending really be controlled without fundamentally restructuring the nation’s delivery and financing systems?

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## Discussion by Forum Participants

In response to Dr. Reischauer's presentation on taming health care spending growth, participants discussed the nature of the U.S. health care delivery system and efforts to address certain of its flaws. They also made observations about, among other things, the price of medical care in the United States relative to other countries and the role of medical technology in driving spending growth.

### Fragmented Delivery System, Acute-Care Focus

The group generally agreed that our disconnected health care delivery system is not designed to treat, with efficiency, individuals with chronic conditions (e.g., diabetes, hypertension, asthma)—the population that accounts for most of health care spending. As one participant noted, “the entire system works fine in terms of short-term care, such as colds or broken arms, but works terribly in treating chronic conditions.” Another noted that Medicare in particular was built around paying for a disease or injured body part. Payment under this approach has not fostered efficiency nor is it conducive to disease management or prevention. For example, physicians are financially rewarded for the number of services they provide while financially discouraged from time spent on care management and prevention. Related to that idea, some participants noted the importance of integration, meaning that doctors, hospitals, and other health care providers should be organized to provide care and receive reimbursement as integrated units. Without such integration, another participant pointed out, current pay-for-performance initiatives aimed at a single provider type will not achieve desired savings and will remain superficial; incentives to be efficient need to be aligned across all providers to foster cooperation. Pay-for-performance efforts aimed solely at hospitals, he continued, will not work while physicians are ordering 80 percent of health care services.

Some in the group cited integrated care delivery, longitudinal care (as opposed to episodic, illness-oriented, complaint-based care), and built-in accountability for care as key factors needed to reform the current health care delivery system. Participants pointed to recent models that embody these factors, including:

- the British and German health care models, where all specialists are employees of the hospitals, while primary care practitioners are out in the community.
- provider-sponsored organizations (PSOs), which work much like a managed care HMO, except that they are formed by a group of hospitals and doctors who assume the financial risk of providing care to patients.

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- the medical home model, in which patients have direct access to one physician (“my personal physician”) who accepts responsibility for managing their care, makes arrangements with teams of additional health professionals to provide services outside the practice’s expertise, and is paid under a reimbursement system that rewards physicians and patients financially for choosing medical practices that foster quality and efficiency.
  - bundled payment systems, in which flat fees are paid for major procedures, such as coronary artery bypass surgery; these fees include some months of follow-up treatment and cover additional treatment if the patient suffers complications or is readmitted to the hospital.
  - Medicare’s physician group practice demonstration, which tests a hybrid payment methodology that combines Medicare fee-for-service payments with a bonus that participating physicians can earn by demonstrating savings through better management of patient care and services and meeting quality performance targets.

At various points in this discussion, several participants asserted that efforts to contain health care spending by federal payers—particularly Medicare—could not be effective if conducted in isolation from health care spending by private payers.

#### Additional Observations on Health Care Spending Growth

Some participants indicated that constraining capacity is a strategy that should be added to the list of reforms Dr. Reischauer presented. One explained that there has been a push to increase the number of physicians educated in our country, which, in leading to an increased number of physicians, could result in increased costs ranging from an estimated \$5 billion to \$50 billion a year.

Taking a different tack, another participant noted that the United States does not differ markedly from other countries in health care utilization, capacity, or technology. For example, she observed that the United States does not have more physicians per capita nor more hospital beds per capita than other countries and that Germany and Switzerland are also on the cutting edge of medical technology. The difference between our nation and others, she contended, is in price: in the United States, the payment level for services and for providers is higher than in other countries.

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With regard to health information technology (IT), one participant saw it as an important part of the solution to health care cost control. She gave an example of small businesses that have not had their health insurance premiums go up for 5 years because of their ability to use health IT to control costs. Several other participants noted the potential for health IT to improve the quality of care but believed that on a wide scale it would have little effect on cost, given the nature of major health care cost drivers.

Several participants noted the major contribution of medical technology advances to rapid health care cost growth. The dilemma for society, contended one, was to balance the seemingly limitless potential to improve technology against the cost of doing so. The participant observed that technology could be vastly improved for automobiles, but people would not be willing to pay for it. He concluded that work needs to be done in the area of comparative effectiveness—that is, comparing the relative benefits and costs of drugs, medical devices, and medical procedures designed to achieve the same outcome.

One participant suggested that a more fundamental problem existed than could be addressed by imposing spending limits, changing the health care tax exclusions, or encouraging better health habits nationwide. Citing noted economist Professor Uwe Reinhardt of Princeton University, he observed that our health care delivery system is like an elephant walking over trees and policy makers are tiny people hitting the elephant with sticks. In other words, the real problem—provider oligopolies (such as specialty hospitals that can self-refer) and unsavory relationships between physicians and drug companies and physicians and the research community—is massive and reforms to bring down health care spending do not address these complex and destructive relationships.

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## Relevant Propositions and Electronic Poll Results

The electronic poll conducted at the end of the forum asked for participants' views on points raised in session leaders' presentations or in the discussions following. Participants could *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree* with 18 propositions presented. Below are the poll results for the propositions related to points made in session 1. Using a two-part test for statistical significance, we sought to determine the extent to which participants agreed with each of 18 propositions. For a comprehensive look at the poll results, see pages 27-29.



A spending limit—such as a percentage of the federal budget—should be used as a policy tool to control federal health care spending.	No agreement
Certain federal tax preferences for health care should be revised to encourage more efficient use of health care products and services.	Strong agreement
The federal government should impose constraints on the development and diffusion of medical technology.	Agreement
Steps should be taken to encourage individuals to assume more personal responsibility for their own health and wellness.	Strong agreement

## Session 2

***Covering the Uninsured, led by Mark Pauly, Wharton Business School, University of Pennsylvania.*** *Should every American have at least some health insurance? If yes, why and how much? What, if any, federal role is there in ensuring some basic level of coverage to all Americans? Should the minimum coverage for different people be uniform for everyone or different for people at different income or health status levels? Dr. Pauly developed several of these topics for discussion, as paraphrased here:*

What do we know for sure about the uninsured population? Dr. Pauly identified some facts and conditions that health care experts generally agree on.

- The uninsured population is a very heterogeneous group. Compared with the insured population, the uninsured population has a higher share of those who are nonworking, poor or near poor, or at high risk for health problems. However, many of the uninsured are working, not poor, and not at risk for serious health problems.
- People are uninsured for different reasons: some because the cost of insurance is high relative to their total income and other basic needs, and others because the cost is high relative to the benefits they expect to receive, even though they may be able to “afford” it. This latter category includes young adults who do not expect to be in ill health.
- From a policy standpoint, one of the most controversial uninsured subpopulations is the “Tweeners”—those individuals with incomes above the poverty level (up to 150 percent of poverty) but below the median income (about 325 to 350 percent of poverty). Three-fourths of the nation’s Tweener population is insured, mostly through private insurance. Nevertheless, Tweeners make up about half of the uninsured population.

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With this blend of insured and uninsured in the Tweener population, policymakers are concerned with “crowd out”—which occurs when a public program attracts individuals who might otherwise obtain health insurance through the existing private market, thereby shifting health care costs to the public sector.

- The current tax exclusion for employer-sponsored health benefits is inequitable and inefficient. Under this exclusion, an employee’s health insurance benefits are not considered income and therefore not subject to income tax. Generally, people who can get health insurance through their employer thus get favorable tax treatment not available to others.
- Being uninsured harms the health of those who are poor and near poor.

Despite this general agreement regarding the uninsured population, Dr. Pauly continued, certain facts are in dispute. For one thing, research cannot quantify the existence or magnitude of harm to Tweeners of not being insured. There are correlations between insurance and health status, but correlation does not translate neatly into causation. Moreover, it is not clear that extensive coverage results in better health. While catastrophic coverage for the uninsured appears to be a good idea, research has not shown whether more generous coverage would have a significant positive effect on health.

Similarly, the “distributional effect” of eliminating the tax exclusion of employment-based insurance is unknown. Specifically, to what extent would dropping the health insurance tax exclusion affect different population subgroups—the currently insured and uninsured—in terms of health coverage and health status? In a related point, Dr. Pauly noted that some proponents of coverage expansion advocate for uniform coverage for all Americans. However, uniform benefits for all is inefficient for producing equal access to care. Policies based on tax subsidy incentives, for example, should be targeted to low-income individuals if equity is to be achieved.

Dr. Pauly concluded his presentation by noting that insurance coverage reform decisions will likely reflect societal and individual values, some of which are moral; others, more self-interested. Regardless of these differences, it appears that much of society is willing to incur costs to increase Americans’ access to medical services, improve their health status, and reduce their chances of financial distress.

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## Discussion by Forum Participants

Following Dr. Pauly's presentation, participants examined issues associated with expanding health insurance coverage.

### Observations on Universal Coverage

One participant called attention to the findings of a survey of the Citizen's Health Care Working Group—a 14-member body created by Congress and appointed by the Comptroller General. According to the survey, most citizens believe that all Americans should have access to health care coverage. The survey also found that most people are willing to share financial responsibility for extending coverage to the uninsured and providing financial security to protect individuals from medical bankruptcy.

In reaction to the idea of universal coverage, participants made several points:

- Caring for the uninsured now is costly; one participant put the cost at \$126 billion annually, contending that an additional several billion dollars is spent in lost productivity because of uninsured workers' delay in treating health problems.
- It is important to consider whether dollars spent now on the uninsured population's costs could be reinvested so that everyone had access to a core set of services and coverage for catastrophic health events.
- The lack of political will to achieve universal coverage exists because of the absence of consensus on how to expand coverage and the peril politicians face when specifying the cost and details of a coverage expansion plan.

### Defining Basic Benefits

A number of participants agreed that in considering policies to broaden health insurance coverage, it is not feasible to identify a "basic" or "minimum" benefit package. For example, one participant noted that "the search for a basic benefit package is akin to the search for the Holy Grail." Others pointed out that a consensus exists for considering only a small number of services, such as certain cosmetic surgery, as "luxury" medical care. Importantly, what is basic for someone with asthma or other chronic health condition may not be basic for a healthy individual. Further, one participant noted, regardless of what services are included, budget constraints are the most important factor in shaping any benefit package.

### Potential Models for Expanding Coverage

Several participants noted that there are ways to proceed without trying to tackle the definition of a basic benefits package. One example is to expand catastrophic health insurance. Another participant noted existing

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programs that can serve as models for expanding health insurance, although with some qualifications:

- Medicare is the most popular insurance program in the United States and should be considered as a potential model. At the same time, the benefit package is considered to be limited, lacking in stop-loss provisions, and most beneficiaries have additional insurance to supplement Medicare.
- State Medicaid benefit packages often include a broad range of services and might be described as “generous,” but because provider reimbursement levels are often very low, access to care often can be limited.
- The Federal Employees Health Benefit Program (FEHBP) offers an array of options and choice to a sizable population across the United States. However, the population covered under FEHBP is employed and has reasonably good purchasing power. The cost-sharing requirements that are manageable for this population may not be equitable or affordable for the poor or near-poor populations.
- The state of Oregon experimented with defining a core set of services as part of proposals to expand coverage statewide; but under public pressure, the core set broadened over time, which added to the proposals’ cost.

## Coverage Solutions for a Heterogeneous Population

Several participants noted that because the uninsured population is heterogeneous, there should be different solutions to increasing coverage for the different subpopulations. For example, one participant felt that public sector programs could be used to expand coverage for the poor and near poor while private sector plans could play more of a role in attracting those uninsured who have higher incomes. Another participant pointed out that requiring uniform health insurance coverage is inefficient because people have different preferences for the amount of coverage they are willing to pay for.

Even under a pluralistic approach to expanding coverage, several participants noted that a dominant health care payer, such as Medicare, needs to be a larger player in the market. Otherwise, achievements in access to care, control of system costs, and widespread use of information technology and quality will likely be limited.

## Relevant Propositions and Electronic Poll Results

The electronic poll conducted at the end of the forum asked for participants' views on points raised in session leaders' presentations or in the discussions following. Participants could *strongly agree, agree, neither agree nor disagree, disagree, or strongly disagree* with 18 propositions presented. Below are the poll results for the propositions related to points made in session 2. Using a two-part test for statistical significance, we sought to determine the extent to which participants agreed with each of 18 propositions. For a comprehensive look at the poll results, see pages 27-29.

The federal government should ensure that all Americans are covered for basic and essential health care services.	Strong agreement
States, rather than the federal government, should take the lead in expanding access to health insurance to all residents.	No agreement
The United States should continue to rely on employer-sponsored health care coverage as the backbone of the U.S. system of coverage.	No agreement
The federal government should assure that a health insurance market exists that adequately pools risk and offers alternative levels of coverage.	Agreement

## Lunch Session

***“Breaking the Policy Impasse to Secure America’s Future,” led by Leonard Schaeffer, founding chairman and CEO of WellPoint and former administrator of the Health Care Financing Administration. Mr. Schaeffer currently serves as Senior Advisor to TPG Capital.***

Mr. Schaeffer recapped several themes that emerged in two earlier sessions: the unsustainability of federal health entitlement spending, the demographic shift to an aging society that will consume more health care than ever, the lack of standard medical practices and evidence-based care, and the increasing burden on employers to finance health care. He followed with a discussion of barriers to implementing good policy, noting, among other things, that

- physicians are not trained to manage the health care system; they function as individual contributors whose defense of their professional autonomy contributes significantly to a system lacking leadership and accountability;
- consumers, spurred by advertising and the Internet, demand access to new medical technology, without knowledge of its value, safety, or efficacy;

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- information on price and quality, needed for the marketplace to work more effectively, is lacking on the major drivers of health care spending; and
  - advocating rational health policy is a “third rail” for politicians, as constituencies in health care are multiple and each has objectives that conflict with one another.

Mr. Schaeffer contended that pragmatism rather than ideology should drive health policy. For example, proponents of a market-based strategy want to reform the insurance market and tax policies, rely on competition and consumer choice, and solve problems through increased use of information technology and greater price transparency. Alternatively, proponents of a regulatory strategy want to rely on government control of costs and spending, leverage federal programs, and establish best practices. Mr. Schaeffer argued for a blended strategy—one that coherently combines the best elements of the marketplace and regulation—to increase access, contain costs, and improve quality.

Mr. Schaeffer concluded that a limited window of time—about 8 to 10 years—remains for the health care community to engage in effective reform. After that, if nothing is done, federal health care spending will be at the mercy of budget hawks eager to lower the deficit. If the budgeteers are not successful, the national security experts will intervene, seeking to significantly reduce our debt to foreign nations whose interests and values may be contrary to ours. “We have to shape our future now or,” he forecasted, “be its victim.”

Mr. Schaeffer sprinkled his presentation with candid commentary, some of which is highlighted below:

*Regarding reliance on consumerism to lower costs:*

- “American consumers don’t have enough information in the health care market as opposed to other markets. To ask them to behave as good consumers is not reasonable.”
- “In the few cases where consumers have price information, they don’t seem to comparison shop. If consumers don’t price shop when it’s entirely their health care dollar, why would they do it with other payers’ money?”

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- “Do YOU have restless leg syndrome?” Who ever heard of it before the ad for the new drug? Consumers see ads, self-diagnose, and then go see their doctor.”

*Regarding unmoderated growth in medical technology:*

- “Health care is one sector of the economy where the introduction of new technology does not replace the old, but adds to it.”
- “Health care technology diffuses on the 5 o’clock news. Every news station has a doctor now. Patients hear about new medicines before their doctors get a chance to read about them.”

*Regarding health care reform solutions:*

- “This is an area of the American economy that is a significant risk to our economic future. Everyone who pays a bill is desperate for savings.”
- “Health information technology won’t solve the problem. Health IT is required to collect data—then we have to turn data into information for decisionmaking and then make sane decisions.”
- “The best hope is to leverage federal Medicare and Medicaid by fiat, because the government can do things that other payers are afraid to do. It is not an easy position but the private sector will follow.”
- “It is not the market vs. government. We need a hybrid solution.”

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## Session 3

***Quality, Standards, and Outcomes, co-led by Carolyn Clancy, M.D., Agency for Healthcare Research and Quality, and Suzanne Delbanco, The Leapfrog Group.*** *How can national practice standards be developed to measure provider performance and what should be the federal role? How can IT facilitate quality measurement and improved outcomes? What do international comparisons of health outcomes and other such measures tell us about quality? The two session leaders discussed these and other issues in their respective presentations, which are merged here for purposes of exposition.*

The presenters raised several interrelated points on developing quality measures and addressing structural challenges. They noted that the need for improvement in health care quality is widely recognized. Studies confirm that a substantial gap exists between the best possible care and

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actual care. To illustrate that gap, experts estimate that providers do not “do the right thing” between 40 and 50 percent of the time. Not surprisingly, health care purchasers are increasingly monitoring the performance of their network providers. However, these monitoring initiatives are disparate and uncoordinated, lacking in an alignment of goals and consistency of measures nationwide. Part of the problem is structural, in that health plans, providers, consumers, and purchasers are all responsible, but no one is accountable. For example, about two-thirds of outpatient visits are to small group practices of fewer than five physicians. Because of their small size, there is not likely any one individual who is responsible for monitoring quality, while the infrastructure in small group practices—that is, the administrative resources to measure and monitor quality—is likely weak.

What can be done in a system in which different stakeholders have diverse goals—that is, one seeks to reduce costs, another aims at ensuring error-free care, and others want to minimize administrative burden? The presenters offered these ideas and challenges:

- The science of measurement is still evolving. Today’s measures are tightly linked to site of care—for example, the physician’s office, the hospital, or the rehabilitation center. This means that providers are blind to what happens when a patient leaves their enterprise. To date, measures that encompass episodes of care are not available, although researchers are working toward developing these measures.
- With regard to the relevance of international comparisons, the Organization for Economic Cooperation and Development (OECD), which reports on health care quality indicators, concludes that no country does the best or worst on all measures, but some countries do better than others, and every country has areas of improvement. Similarly, within the United States, health care spending and outcomes can vary dramatically by geographic area. Although benchmarks should be set nationally, it is important to observe differences at the local level, since change is driven locally.
- Finding a cohesive set of quality measures is a challenge. Some purchasers seek measures that can lead to improved quality care and reduced costs. The measures do not have to be perfect, as long as they improve on the current low level of information. To date, public agencies and private companies have organized under the National Quality Forum (NQF), a body created to promote a common approach to measuring health care quality.



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- In 2002, NQF sought to standardize adverse reporting by compiling a list of “never events”—safety errors that should never happen in a clinical setting but should be reported when they do. Since then, the list has been adopted or modified by other governmental entities and organizations. For example, the Leapfrog Group, an organization whose members include large public and private sector health care purchasers, asks hospitals to adopt the Group’s own never events policy. This policy entails telling patients of errors, not billing the patient for care associated with the error, reporting the error as appropriate, and conducting a root cause analysis. Leapfrog is interested in the never events policy because it addresses cost and quality simultaneously.
  - In their search for standards, some purchasers are seeking health plans that, in their measurement initiatives, address the Institute of Medicine’s six key traits of high-quality care—safe, timely, effective, equitable, efficient, and patient-centered.
  - How measurement information should be used—to reward performance or improvement—is another factor needing deliberation. One answer is to have incentives that not only reward “leading edge” providers but also bring along providers that are not at the top in performance.
  - Reporting to the public on physician and hospital performance matters. In fact, public reporting has been shown to lead to improvement in care. Whether the reporting should be voluntary or mandatory remains problematic, as drawbacks exist with both. Voluntary reporting may attract only those with nothing to hide, but mandatory reporting may suffer from trying to meet the needs of the lowest common denominator, which may not be sufficient to illuminate differences in quality among providers.
  - Public reporting is a “messy business.” Purchasers are not consistent in the metrics they use to assess providers’ performance, resulting in challenges in aggregating data across providers. The lack of uniformity adds to the difficulty of achieving transparency—making public the basis for reporting and the algorithms used.
  - Health IT is not a magic bullet to improve health care quality on its own. Rather, it can make the right thing to do the easy thing to do. The evidence that health IT saves money or results in improved quality is thin, as a substantial number of studies on health IT effectiveness are concentrated in four large institutions that had a strong champion inside the organization, ran home-grown health IT systems, and had lengthy

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experience with health IT. Less is known about the success of currently available commercial products.

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## Discussion by Forum Participants

Following the presentations by Dr. Clancy and Ms. Delbanco, participants elaborated on points the presenters raised, including national goal-setting, cost impact, public reporting, and health IT.

## Setting National Goals

Participants reiterated the points raised by the presenters, noting in particular the importance of having national goals and benchmarks to define the performance expected from the health system. For example, some participants thought the collection and analysis of data should be done nationally; in deciding how to change practices, however, the scope of data analysis should be local to account for area differences: what works in one place may not in another. Others noted that no means exists for coordinating a national focus on quality. One participant thought the NQF could serve that coordinating function, but to do so would require more financial support, including federal resources. Another participant concurred that the efforts of NQF were good but questioned whether its consensus-driven model was bold enough for the level of reform needed.

## Impact of Quality Improvements on Cost

Several participants were skeptical that quality improvements, desirable in and of themselves, would also save money. They argued that there was at best a weak relationship between quality and cost and that other actions would need to be taken to achieve cost savings. To illustrate, one participant noted that hospitals were unlikely to agree to forgo payments for certain never events, such as surgery on the wrong body part or a mismatched blood transfusion. As a result, while reducing avoidable never events could improve quality, different incentives would be needed to contain costs.

## Public Reporting

Some participants identified the need to present quality information differently for consumers and professionals. For example, one noted, if we report that Hospital A has a 1 percent error rate and Hospital B has a 0.1 percent error rate, consumers shrug. But if we report that Hospital A's error rate is 10 times that of Hospital B, consumers react. We don't want to scare consumers, but we need to dramatize the issue for them. Another participant agreed that public reporting is not yet "consumer friendly." However, she also noted that consumers want information on quality and want the information when they actually get the care, according to survey findings released by The Commonwealth Fund. She reported that consumers have not had much impact on health care quality to date and need to get more involved. At the same time, health care systems must get better at making information more "actionable" for consumers.

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One participant cautioned that although we have some reasonable quality measures now (such as care for diabetes) and are developing more, some aspects of care may never be conducive to measurement or public reporting; instead, the attention should be placed on structural, payment, and organizational issues, including the need to create appropriate financial incentives and encourage stronger health IT to manage risk. Other participants countered that, although the current measures are not sufficient to drive change, improvements can happen as more measures are developed and reporting becomes more routine.

In the end, one participant concluded, quality measures need to be driven by the “real world” of physicians practicing in their offices and doing what needs to be done medically, not just because the government is measuring it. Another participant suggested that Congress create a model system in each state that the local physicians could observe in operation to see how it could work for them. A third observed that most physicians view quality initiatives as “background noise,” pointing to a key cultural challenge that needs to be met.

## Limits of Health IT

Participants noted that if health IT is to be successful in affecting cost, quality, or both, a strong cultural change is needed systemwide, as well as alignment between the entity making the health IT investment and the savings achieved. Part of the cultural change includes assuring that the smallest unit in the health system has health IT capability. For example, Medicare’s quality improvement organizations are working with small physician groups to implement health IT. Additionally, health IT investment may be more likely when cost savings accrue to the entity making the investment. For example, VA applied health IT to support the use of its cost-saving formulary. This positive impact was supported by an underlying structure of accountability within a closed system.

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## Relevant Propositions and Electronic Poll Results

The electronic poll conducted at the end of the forum asked for participants’ views on points raised in session leaders’ presentations or in the discussions following. Participants could *strongly agree*, *agree*, *neither agree nor disagree*, *disagree*, or *strongly disagree* with 18 propositions presented. Below are the poll results for the propositions related to points made in session 3. Using a two-part test for statistical significance, we sought to determine the extent to which participants agreed with each of 18 propositions. For a comprehensive look at the poll results, see pages 27-29.

A public-private entity should be created to assess and disseminate its findings on comparative and cost effectiveness of health care products and services.	Strong agreement
OECD health care measures (population-based, resource, and spending) are a valid gauge of U.S. health care system performance.	Agreement
The federal government should take the lead in developing indicators (such as comparisons across regions, trends over time) to measure the U.S. health care system's outcomes and performance.	Strong agreement
The federal government should create financial incentives to expedite the use of information technology in health care, ensuring it interoperability and wide adoption.	Strong agreement

## Wrap-Up

In the forum's final session, Mr. Walker polled participants on their views regarding the health care system challenges and reform options that surfaced in the preceding sessions. Through the use of interactive voting technology, participants registered, on a 5-point scale, the extent of their agreement or disagreement with 18 propositions. (See table 1 at the end of this section listing each proposition and the polling results.) The technology allowed for the voting to be real-time but confidential.

The poll was not intended to be scientific: our participant sample was neither random nor large enough to be statistically representative. However, forum managers, through careful development of the participant list, sought to ensure that the forum presentations, discussions, and poll results would not be biased in favor of any particular view of health system maladies or directions for reform.

Taken as a whole, the poll results suggest several themes from participants' collective views on likely avenues for effective reform. The discussion below seeks to capture these themes, referring to the numbers of relevant propositions shown in table 1.

## Health Care Spending

The session discussions made it clear that nearly all participants felt some urgency about gaining control of health care spending in the United States. The group did not reach agreement about whether an aggregate spending limit, such as a percentage of the federal budget, should be used as a tool to control spending (#1) but strongly supported other measures, such as instituting value-based purchasing in federal health care programs (#5), changing the tax treatment of health care to encourage greater efficiency (#3), and limiting direct-to-consumer advertising of prescription drugs

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(#6). The group strongly supported encouraging individuals to assume greater responsibility for their health (#7) and generally agreed with permitting further importation of prescription drugs (#8) and aiming efficiency incentives at the individual patient (#2).

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## Health Insurance Coverage

Several of the themes emerging from the forum discussions and participant poll related to the role of the federal government in addressing health care challenges. In particular, despite the efforts of several states to reduce the ranks of the uninsured (#10), there was near unanimity among participants that ensuring the provision of health care coverage for all Americans should be a federal responsibility (#9). Further, the group agreed that the federal government should assure the existence of a well-functioning health insurance market (#12), whereas they reached no agreement on whether the nation should continue to rely on employer-provided insurance as the dominant method through which most Americans obtain their health insurance coverage (#11).

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## Technology

In forum discussions and the participants' poll, participants generally favored constraining the development and diffusion of medical technology (#4). They strongly supported balancing the nation's research investments between new discovery and assessing the value of new and existing technologies (#18) and strongly favored the creation of a public-private entity to assess the comparative and cost effectiveness of health care products and services (#13). While discussions indicated that the diffusion of health IT was no panacea, there was strong support for government subsidy in this area (#16).

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## Performance Measures

Forum discussions generally supported the notion that reforms should be accompanied by the development of performance measures to gauge success or failure at meeting reform objectives. In the participants' poll, two-thirds of participants supported the view that OECD measures, which compare health system performance measures across countries, are a valid gauge of U.S. health system performance (#14), and four-fifths supported the federal government's taking the lead in developing new indicators of health system outcomes and performance (#15). Consistent with this view, the group also strongly favored the development of national practice standards by an independent body that includes key stakeholders (#17).

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## Poll Results

In conducting the participant poll, we sought to determine the extent to which participants agreed with each of 18 propositions, using a two-part test. First, we tested for the existence of a statistical difference (significance) between the responses of two groups—participants who said they agreed or strongly agreed and participants who said they disagreed or strongly disagreed. If the test did not find the difference to be statistically significant, we characterized the result as “no agreement.” If the test found the difference to be significant, we conducted a further test to determine whether a statistically significant difference existed between the proportion of participants who agreed and the proportion of those who strongly agreed. If the test found a statistical difference, we characterized the result as “strong agreement.” Otherwise, we characterized the result as “agreement.” (See table 1.)

**Table 1: Results of the Health Care Forum Participant Poll**

Propositions	Percentages					Summary result <sup>a</sup>
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
1. A spending limit—such as a percentage of the federal budget—should be used as a policy tool to control federal health care spending.	26	19	13	23	19	No agreement
2. Fostering efficiency incentives at the individual patient level is an appropriate and effective way to moderate health care spending increases.	23	29	13	19	16	Agreement
3. Certain federal tax preferences for health care should be revised to encourage more efficient use of health care products and services.	58	39	3	0	0	Strong agreement
4. The federal government should impose constraints on the development and diffusion of medical technology.	36	39	7	7	13	Agreement
5. The federal government should revise its payment systems and leverage its purchasing authority to foster value-based purchasing for health care products and services.	77	13	3	3	3	Strong agreement
6. Direct-to-consumer advertising of prescription drugs should be limited.	52	26	13	10	0	Strong agreement
7. Steps should be taken to encourage individuals to assume more personal responsibility for their own health and wellness.	55	23	7	16	0	Strong agreement
8. Further importation of prescription drugs (beyond current levels) should be allowed.	39	32	23	3	3	Agreement
9. The federal government should ensure that all Americans are covered for basic and essential health care services.	73	23	3	0	0	Strong agreement
10. States, rather than the federal government, should take the lead in expanding access to health insurance to all residents.	3	17	17	33	30	No agreement
11. The United States should continue to rely on employer-sponsored health care coverage as the backbone of the U.S. system of coverage.	16	26	19	26	13	No agreement

Propositions	Percentages					Summary result <sup>a</sup>
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
12. The federal government should assure that a health insurance market exists that adequately pools risk and offers alternative levels of coverage.	48	36	10	7	0	Agreement
13. A public-private entity should be created to assess and disseminate its findings on comparative and cost effectiveness of health care products and services.	87	10	3	0	0	Strong agreement
14. OECD health care measures (population-based, resource, and spending) are a valid gauge of U.S. health care system performance.	13	53	10	7	17	Agreement
15. The federal government should take the lead in developing indicators (such as comparisons across regions, trends over time) to measure the U.S. health care system's outcomes and performance.	71	10	16	3	0	Strong agreement
16. The federal government should create financial incentives to expedite the use of information technology in health care, ensuring its interoperability and wide adoption.	48	32	10	7	3	Strong agreement
17. National practice standards should be established by an independent body that includes key stakeholders.	58	26	10	7	0	Strong agreement
18. The United States should balance its health care research investments between new discovery and assessing comparative and cost effectiveness for new and existing medical interventions.	65	23	3	7	3	Strong agreement

Source: GAO analysis of health care forum participant poll.

Notes: Percentages may not add to 100 due to rounding.

<sup>a</sup>Significance is at the .05 level (using a one-tailed test).



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# Appendix I: Forum Agenda

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8:45	Welcome and Introduction: <i>Bruce Steinwald—Director, Health Care Team, GAO</i>
8:50	<u>Introductory Presentation and Group Discussion</u> : <i>David M. Walker—Comptroller General of the United States</i>
9:45	<u>Session 1: Cost and Personal Responsibility</u> : <i>Robert Reischauer—President, Urban Institute</i>  To what extent or in what ways can federal health care spending be controlled? Should there be absolute spending limits, spending triggers, or spending targets? Should tax preferences be reformed and insurance incentives structured to foster personal responsibility?
10:45	Break
11:00	<u>Session 2: Access and Coverage</u> : <i>Mark Pauly—Professor of Health Care Systems, Business and Public Policy, Wharton Business School</i>  Should every American have at least some health insurance? If yes, why and how much? What, if any, federal role is there in ensuring some basic level of coverage to all Americans? Should the minimum coverage for different people be uniform for everyone or different for people at different income or health status levels?
12:00	Break
12:15	<u>Luncheon</u> : <i>Leonard Schaeffer—Senior Advisor, TPG Capital; Founding Chairman and CEO, WellPoint; Former Administrator, Health Care Financing Administration</i>
1:00	<u>Session 3: Quality, Standards, and Outcomes</u> : <i>Carolyn Clancy—Director, Agency for Healthcare Research and Quality—and Suzanne Delbanco—CEO, The Leapfrog Group</i>  How can national practice standards be developed to measure provider performance and what should be the federal role? How can IT facilitate quality measurement and improved outcomes? What do international comparisons of health outcomes and other such measures tell us about quality?

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2:00	<u>Session 4: Real-Time Poll of Forum Participants.</u>  Use of interactive voting technology to assess the group's views on long-term goals and promising first steps.
2:45	<u>Wrap-up and Concluding Comments: David M. Walker—Comptroller General of the United States</u>
3:00	Adjourn

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# Appendix II: Forum Presenters and Participants

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## Forum Presenters

Carolyn Clancy	Director, Agency for Healthcare Research and Quality
Suzanne Delbanco	CEO, The Leapfrog Group
Mark Pauly	Bendheim Professor of Health Care Systems, Wharton Business School, University of Pennsylvania
Robert Reischauer	President, The Urban Institute
Leonard Schaeffer	Senior Advisor, TPG Capital; founding chairman and CEO of WellPoint; former administrator of the Health Care Financing Administration
David M. Walker	Comptroller General of the United States

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## Forum Participants

Henry Aaron	Senior Fellow, Economic Studies, The Brookings Institution
Robert Berenson	Senior Fellow, The Urban Institute
Nancy Chockley	President, National Institute for Health Care Management Foundation
Nancy-Ann DeParle	Managing Director, Healthcare, CCMP Capital
Elizabeth Docteur	Deputy Head, Health Division, Organisation for Economic Cooperation and Development
Elliott Fisher	Professor of Medicine and Community and Family Medicine, Dartmouth Medical School, Dartmouth College
Richard Frank	Margaret T. Morris Professor of Health Economics, Harvard Medical School, Harvard University
Anne Gauthier	Senior Policy Director, Commission on a High Performance Health System, The Commonwealth Fund
Gail Graham	Director of Health Data and Informatics, Veterans Health Administration, Department of Veterans Affairs

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**Appendix II: Forum Presenters and  
Participants**

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Robert Greenstein	Executive Director, Center on Budget and Policy Priorities
Mary Kay Henry	International Executive Vice President, Service Employees International Union
John Iglehart	Founding Editor, Health Affairs
Karen Ignagni	President and CEO, America's Health Insurance Plans
The Honorable Nancy Johnson	Fellow, Institute of Politics, John F. Kennedy School of Government, Harvard University
Randy Johnson	Director of Human Resources Strategic Initiatives, Motorola, Inc.
Charles "Chip" Kahn	President, Federation of American Hospitals
Marjorie Kanof	Managing Director, Health Care Team, GAO
Herb Kuhn	Acting Deputy Administrator, Centers for Medicare & Medicaid Services
Patricia Maryland	Chair, Citizens' Health Care Working Group
Mark Miller	Executive Director, Medicare Payment Advisory Commission
Ron Pollack	Executive Director, Families USA
John Rother	Group Executive Officer of Policy and Strategy, AARP
Dallas Salisbury	President and CEO, Employee Benefit Research Institute
Henry Simmons	President, National Coalition on Health Care
Bruce Steinwald	Director, Health Care Team, GAO
Richard Umbdenstock	President and CEO, American Hospital Association
Bruce Vavrichek	Assistant Director for Health and Human Resources, Congressional Budget Office
Alan Weil	Executive Director, National Academy for State Health Policy
David Wennberg	President and Chief Operating Officer, Health Dialog Analytic Solutions

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**GAO Forum Managers**

Jessica Farb

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Bruce Steinwald

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