

CONSUMER-DRIVEN HEALTH CARE

*A Cure for New York's
Health-Care Woes?*

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Edmund J. McMahon, Jr.

Speakers:

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INTRODUCTION

E. J. McMAHON: Let me begin by making a few depressing-familiar observations. The cost of health insurance is rising at double-digit rates, stressing employers and injuring job creation. Not surprisingly, the number of uninsured is also rising and is not limited to poor people. Meanwhile, Medicaid is fast becoming the bleeding ulcer of state government. These problems are not new or unique to New York. They have been occurring with increasing intensity in waves and cycles over the past several decades. Our policy response has tended to be the same: more government programs, more subsidies and cost shifts, and more top-down mandates, all of which have brought us more of the same.

There is indeed a better way: consumer-driven health care. This is not merely a theoretical or academic concept. The potential for a mass movement toward consumer-driven health care was greatly strengthened about eighteen months ago when Congress passed the Medicare Modernization Act (MMA) of 2003, which authorized the creation of tax-free

health-savings accounts, or HSAs, which put individuals and families in complete control of routine health-care expenditures and are affordable regardless of employment. These policies are rapidly becoming more popular all over the country, as some of our speakers will note.

What does this all mean for New York? Could expanded choice of control through innovations such as HSAs solve the twin problems of rising health-care costs and the growing ranks of uninsured? Could this concept be effectively integrated into programs such as Medicare? Or are we just talking about a niche product? If there are going to be real gains from consumer choice, when will we begin to notice them—in two, five, or ten years? Is there some tipping point at which we'll be able to measure the success of consumer-driven health care? Do consumers have access to sufficient information to push providers to compete on the basis of quality? If not, how do we get the information to consumers?

To explore these and many other questions, we're pleased to be joined by two of the nation's leading health-policy experts, followed by a seasoned state legislator who will provide us with his own comments and insights on their presentations.

Leading off our discussion today is the person who invented the term "consumer-driven health care." Regina E. Herzlinger is the Nancy R. McPherson Professor of Business Administration at the Harvard Business School. Professor Herzlinger was the first woman to be tenured and chaired at the Harvard Business School, and she also broke the gender barrier on a number of corporate boards. She is widely recognized for her innovative research in health care, including her early predictions of the unraveling of managed care, and in the rise of consumer-driven health care and "health-care-focused factories," another term she coined.

Her research, including two books that are on the subject of our forum, has been widely cited in major publications and journals. She is recognized as one of the most important voices in health care today and is frequently a key speaker at annual meetings of large health-care and business groups.

Professor Herzlinger's list of professional honors and distinctions is lengthy. I suspect that she especially prizes her election by students at the Harvard Business School as one of the outstanding instructors of the MBA program.

REGINA HERZLINGER: I am going to discuss consumer-driven health care. Consumer-driven industries are industries in which people buy things for themselves; in non-consumer-driven industries, someone else buys something on behalf of the consumer. Health care is clearly not consumer-driven. The rest of our economy is consumer-driven. In the automobile industry, which is—no pun intended—a consumer-driven industry, people buy their own cars. Over the past decade, cars have actually gone down in price: they've gone down 44% relative to income. In other words, the price of cars has increased much less than income has increased. The car industry is improving quality. Cars are much more stylish, fuel-efficient, and environment-friendly today, and people routinely drive their cars for more than 100,000 miles.

This consumer-driven industry has done what we'd like to do in health care: it has made the product better and cheaper. Nowadays, cars are made up of millions of microcircuits. The average consumer has no idea how a car works, but nevertheless, that average consumer has made it better and cheaper. When I go into a car showroom, I am a smart shopper; I actually know how much the dealer paid for that car. That is how informed I am, and I learned this excellent information in an easy way: I read *Consumer Reports*, which has a large

section on how the car works. But I pass over that; what I am interested in is safety, reliability, and cost.

The result of all this in the consumer-driven industry is widespread ownership. Seventy-percent of the poor own cars, and 30 percent of them own two or more cars. That is what happens in consumer-driven markets: cheaper, better, lots of information, and widespread ownership.

Let's consider the health-care industry. The United States leads the world in the rate of gain in productivity. Our rate of gain in productivity is about 2.9 percent in the past decade. The rate of gain in health-care costs is about 7.7 percent, which is an unsustainable situation.

We lack information. How good is the quality of health care? If I had breast cancer and needed a mastectomy, I would know nothing about the quality of the surgeon, the team, or the hospital in which this important activity would take place.

We have tremendous inflation and unknown quality. As a result, we have the tragedy that in this country, which is the wealthiest country in the world—probably the wealthiest country in history—there are 46 million people who don't have health insurance. The fastest-rising group of uninsured earns over \$75,000 a year. The mean per-capita income in the United States is \$44,000. So rich people cannot afford health insurance—that's how expensive it is. If you earn \$75,000, you take home, after taxes, about \$37,000. You're not going to spend \$15,000 of that money on health insurance. That's why we have high cost, unknown quality, and no information—and this tragedy of the uninsured.

What makes things get better and cheaper in consumer-driven industries? There are usually three kinds of entrepreneurs

who make it happen in the automobile industry. One type is the dirt-under-the-fingernails person who really understands how to make things better and cheaper. Henry Ford was one of those people when he started Ford Motor. At that time, it cost more to buy a car than to buy a house. The median price for a house is now \$206,000. So in Henry Ford's time, it cost over \$206,000 to buy a car. Ford came along and said: I'm going to make cars cheaper and better. People said that he was ridiculous. They always say to entrepreneurs, "You can't do it. You can't make it better and cheaper."

Ford did make cars better and cheaper in one decade. Automobile ownership went from the mid-thousands to the millions because he created a better, cheaper car. Ford developed mass production, so he fundamentally re-created how cars were made. This is what we need in health care. We need a Henry Ford, who fundamentally re-created how a product is delivered. But that is not all that Ford did. At the Ford River Ridge Plant, they made cars. They also made steel. Henry Ford was such a great entrepreneur that he made a new kind of steel to go into the cars. We have Japanese, German, and Korean versions of Henry Ford, and I hope that we will have new American versions of Henry Ford. This is one kind of entrepreneur that makes it better and cheaper."

In health care, the Henry Ford variety are the doctors, the hospitals, the nurses, the kidney dialysist, the radiologists—the ones who actually understand how to make it better and cheaper, but that's not all it takes. Henry Ford was a genius. Like many entrepreneurs, he was also filled with the hubris of the entrepreneur, and we have many people like that in health care. ("I know what you need. You don't know what you need.") He is alleged to have said that you can have it in any color as long as it's black. I telephoned the Henry Ford museum to confirm that, and was told, "No, he didn't say that." Ford was not po-

litically correct. But if he didn't say it, he really meant it, because there really was only one type of car.

The second type of entrepreneur is very different: the Alfred Sloan kind. Sloan was also an engineer who graduated from MIT. He is what they call an industrial engineer—meaning a businessman. He looked at a market and said, I'm going to clean Ford's clock, and I'm going to do it by introducing choice. Sloan started General Motors and introduced a variety of brands of automobiles, ranging from the proletarian Chevrolet to the top-of-the-line Cadillac. He understood that Americans wanted choice. He nearly bankrupted Henry Ford, who simply didn't get it.

Why does choice make things better and cheaper? Choice means competition, and competition means productivity. So Alfred Sloan, a marketing type, came along and introduced many new products. Health insurance is the natural place for the Alfred Sloans of the world to emerge in health care.

The third type of entrepreneur is the information entrepreneur, who gives people what they want. You get this information only in consumer-driven industries, because when consumers buy things, they want to be well-informed. Entrepreneurs present them with the information that they need. *Consumer Reports*, for example, is an entrepreneurial nonprofit. If I were a hot-rodder, I'd go to *Car and Driver*. J. D. Powers gave power to consumers. He rates automobiles. He's not infallible, but he's an example of a third type of entrepreneur who appears in a consumer-driven market. This type understands how to give ordinary people important information that they can use to become better informed.

If you're a Henry Ford in health care, you're going to get punished. The way the system is structured right now, if you make

health care better and cheaper, you are going to have your tail handed to you.

If you're an Alfred Sloan, there is one choice toward health-insurance policy; no choice, no competition. No competition, no productivity. That health-insurance policy is so consumer-unfriendly that it's called a "PPO." Would anyone who brands consumer products call something a "PPO" or a "POS"? People ask, "What is that?" So we need Alfred Sloan.

And we don't know anything about quality. In New York State, there are measures that tell you such things as how many mammograms you get in a certain health plan. I am not interested in such data. I am going to get my mammogram. What I am interested in is: how good is that doctor, how good is the hospital, and how many surgeries of this kind has he or she performed? What's the infection rate, and how many people have been readmitted? I don't have access to that sort of information.

The way to fix health care, or make it consumer-driven, is to let the Henry Fords loose. Let the Alfred Sloans loose so that we can have more choice. We have 240 models of automobiles, we have 195,000 new book titles, and we have one choice of insurance policy. Why are health-care costs so high? Let these people loose and liberate the J. D. Powers and other consumer-driven kind of entrepreneurs who can present consumer-friendly, useful information.

What would the Henry Fords do? You know the 80/20 rule: 80 percent of anything is caused by 20 percent of the population. When businesspeople talk about low-hanging fruit, they are talking about 80/20. They are talking about focusing on the 80 percent of the market that is caused by 20 percent of the possible causes. If you don't believe me, go home and

look in your closet. You will find that 80 percent of what you wear comes from 20 percent of what's hanging in your closet.

This concept of 80/20 has everything to do with health care, since 80 percent of health-care costs are utilized by 20 percent of the users. Our health-care costs are larger than the entire GDP of China. So 80 percent of that is a great deal of money spent on 20 percent of the users. Who are these people? They are people who have chronic diseases or disabilities, or they are underserved populations like African Americans with sickle cell anemia.

What kind of health-care system do they confront? Let's consider chronic diseases—heart disease, for example, which cost the U.S. approximately \$350 billion in 2003. We don't know what causes heart disease, and it has many manifestations. The best way to manage heart disease is for you to manage yourself, which is very hard to do. Do we have a team of organized providers who focus on everything about you and your heart disease, and who don't just say, "Do this and that and get out of my office"? We do not have that.

What the Henry Fords would do in a consumer-driven system is integrate care for chronic diseases and for disabilities for underserved populations. They would make it better and cheaper, because there is a great deal of money there. That is the 80/20; they keep the low-hanging fruit in the health-care system. Why would they do it in a consumer-driven system? If I had HIV/AIDS and were offered access to today's "everything for everybody" system, or to an integrated team that dealt with my HIV/AIDS, I wouldn't have to think about it for a second: I'd go to that team.

What would Sloan do? Health insurance is a tremendously standardized product. One of the ways it's standardized is in

benefits, and there's a requirement here for standardized benefits. Does that give people what they want? I really want long-term-care insurance at my age, because the average American woman spends \$144,000 on a nursing home, if she hasn't given away her assets already. She's then broke and qualifies for Medicaid. I don't want that to happen.

I talk about women when it comes to nursing homes because right now, most of the people in nursing homes are women. This will change with my generation, which was the first generation of women that entered the workforce in large numbers. The age of death differential is narrowing. I also want very different coverage. How many of you know how much the lifetime maximum is in your health insurance? It is probably a \$1 million, which sounds like a great deal of money.

Next to the Harvard Business School is a company called Genzyme, which makes personalized medicine drugs. We all have mutations in our genetic codes that likely cause diseases. Personalized medicine drugs are being designed to respond directly to that mutation, which is called the SNP – single nucleotide polymorphism – a mutation in the normal gene. Genzyme has such a drug, called Cerezyme, for people who have a condition called Gaucher's disease. You take Cerezyme and you live; if you don't take it, you die. This is a real life-saving drug. Genzyme has yearly revenues of \$1.2 billion, \$800 million of which comes from Cerezyme. The annual cost per person for this drug is up to \$400,000. Two and a half years' worth costs up to \$1 million, which breaks right through my lifetime coverage. How many insurers want to pick up someone with a guaranteed take of \$400,000 a year? I want my lifetime coverage of \$10–15 million, if I have a good chance of needing one of these drugs, and I'll scrimp on something else in order to get what I want.

“Term” is a financial word that means the length of the contract. Health insurance is written in one-year policies. What’s the problem with that? Suppose I smoke. Would a health insurer have any incentive to help me stop smoking? No, because if I stop smoking right now, the benefits from my smoking cessation are not going to appear until a long time, maybe ten years from now, when I am likely to have switched insurers. I want to be in a relationship with my health insurer, and I want a ten-year contract so if I change my behavior and become healthier, the insurer will reward me. Switzerland, which is the only consumer-driven country in the world, has a five-year insurance policy. They measure the insured’s health status in the beginning. If at the end of those five years, you’re healthier than would have been predicted, you receive half your money back. You would receive \$25,000 back for improving your health status. That is a major incentive to improve your health. But you need a five-year term, and you need a change. J. D. Powers would give us the information we want. He would give us risk-suggested outcomes, for our particular levels of risk, age, kind of patient, and physician.

Dr. Ralph Snyderman, head of a medical center, understands the 80/20 rule. He knows that one of the things that can happen to a heart is that it can grow weak. The muscles are flaccid, and, you can get congestive heart failure as a result. No one knows why this occurs, and it has cost us about \$56 billion per year. Dr. Snyderman decides to solve this problem by organizing a team of providers who will focus on knowing everything about you and your congestive heart failure. The team jointly decides how to treat congestive heart failure. This is the Henry Ford kind of innovation; they decide we’re going to increase visits to cardiologists, which is contrary to managed care, which typically opposes resists visits to specialists. In just one year, they improve health status enormously. Visits to hospitals drop, and once people go to

hospitals—they go to have the liquid taken out of their body—they stay for far shorter periods of time. Altogether, Schneiderman reduced total costs in one year by 40 percent. Nationally, that would be more than \$20 billion per year.

This is what the Henry Fords of the health-care industry can do. You would think that health care's Henry Ford would have become rich, but he lost a ton of money. He gets paid to keep people in the hospital. The healthier he makes people, the more money he loses. If you are a Henry Ford in this system, you are likely to be destroyed because of the way we pay. In a consumer-driven system, we're going to ensure that these innovators profit if they do good. We want them to do well.

The consumer-driven system will give you a choice of insurance policies. HMOs, PPOs, and high deductible policies that are incorrectly called consumer-driven. Consumer-driven is not one thing. Consumer-driven will give you a choice of a high-deductible, multiyear policy, a five-year policy, or a bundle of disease focused providers, so if I had AIDS, diabetes, heart disease, I'd go there. Customized plans and lots of information will also typify the variety of insurance policies that a consumer-driven system will make available. One of my students started a company called Health ShareTechnology. It was just bought by Web MD, which is doing an IPO on a health portal. It will give you risk-adjusted outcomes by procedure for each hospital in the United States. Health Allies is another company started by a student of mine. I'll give you an example of what it does.

As I mentioned, the uninsured are growing among rich people. As a hypothetical, but illustrative case, a Los Angeles woman who is an uninsured entrepreneur—she earns about \$75,000 a year—doesn't think health insurance is a good buy. She needs a hip replacement. She goes to Cedars-Sinai Medi-

cal Center and asks how much it would charge her for the hip replacement. The hospital has no idea, since it is not consumer-driven. So it comes up with the rack rate—which is its charges, a price no one pays except for an uninsured patient who happens to wander in naively—totaling \$40,000. She goes to Health Allies, a consumer-driven health-care provider. Health Allies holds an auction on her behalf, selling a hip replacement in accordance with her criteria. She wants the surgery done at an academic health center, at most thirty miles from her home, by a team of surgeons that does sixty or more of these operations per year. They hold this auction, she goes to Cedars-Sinai, and the price is \$17,500. Why would the hospital agree to this? Because if you run a hospital, it is a fixed-cost machine: your costs are going to stay the same if she comes in there, and that \$17,500 goes to the bottom line. Some people say that with consumer-driven health care, the consumer is still powerless. Health Allies makes consumers very powerful. In fact, Health Allies was recently purchased by United Health Care, which is the second-largest health insurer.

What do we know about consumer-driven health care so far? According to information from United Health Care, costs went down, and information seeking went way up. Health status was not impaired.

South Africa has a very long history of high-deductible accounts. An analysis of what happened there appears in my book *Consumer-Driven Health Care*. Essentially what happened is costs went down and health status remained the same. People are not going to sacrifice their health status; they are simply going to be much better informed about what they buy when they spend money at their home.

The triple-tier pharmaceutical plan—you pay more for branded products than for generics — best illustrates what

happened in the United States when consumers were exposed to costs. When people see the cost, they go to the best value for the money, and generics now account for 50 percent of all prescriptions and are the fastest growing part of the drug industry.

What happens when you contract with consumer-driven systems and with the Henry Fords of the health-care industry? There was one experiment on this, called Buyer's Health Care Action Group, in Minneapolis. They put together about 20 care teams and said that they were not going to micromanage your providers care or tell your physicians how to deliver health care. They said to the groups of providers — you give us your best value for the money. Here is what happened: the consumers who used this system left very expensive teams and went to the most cost-effective teams. Second, the Henry Fords in the consumer-driven system became much more cost-effective. The Park Nicollet Hospital, which used to be a very expensive hospital in Minneapolis, became a much lower-cost, but still great, hospital.

What happens when you give people information about health care? I haven't got a clue because there is little information out there about health care. But I can tell you what happens in the financial markets. The movement to consumer-driven health care is just like the movement that occurred in the pension market when pension management was changed from management by experts to management by consumers. Most people said, "This is going to be a disaster because the consumer is as thick as a brick." Most consumers don't know a debit from a credit. However, consumers who invested for themselves did better than someone else investing on their behalf. Have any of you read the Morningstar report? Morningstar is very consumer-friendly and provides excellent information, so even if you don't know a

debit from a credit, you can still be a very smart investor. That is how many people did well in this stock market. People change their behavior quite dramatically when they have information on health care.

Consumer-driven health care is going to increase because payers want it, state government and businesses want it, consumers want it, and providers want it.

Consumers all over the world want control of choice and information, and when they get these things, they actually make industries more productive. Some people believe that people will destroy the industry if they get what they want. The most productive industry in the United States is the retailing industry, a consumer-driven service industry. What happened in that industry? The retailing industry, like the health-care industry, used to be run by self-referential kings of merchandising who liked to shop. They thought that you liked to shop, but they never bothered to ask you what you wanted. These department store owners all went bankrupt, and then had a novel idea: let's ask the consumers what they want from their shopping experience. American consumers are the hardest-working in the world. The consumers said that they didn't want a shopping experience and wanted shopping made more efficient for them. So in response to this, retailing opened Office Max, Staples, and many other lifestyle-oriented stores. It is easier to run a lifestyle-oriented store than an everything-for-everybody department store. That is why retailing became more efficient.

Consumers want this. People might say, "Consumer-driven—that's only for the elite," but the workers at Whole Foods Market—the cashiers, baggers, and meat cutters—were given a choice. They voted for consumer-driven health insurance, and

they have had fabulous results — better cost control and higher employee retention.

So why is this going to happen. Because the iron triangle that motivates all change in the US wants it: consumers, payers, and suppliers.

Eighty percent of health-care costs are consumed by people in their late fifties, the baby boomers. Payers also want this because the costs are killing them – even Medicaid is going to consumer-driven health care in South Carolina and Florida. Providers want it—because it will return the right to practice medicine to them. It is going to happen soon because of these pressures. It is going to start under an employer's umbrella and then become consumer-driven.

Some people believe that others are not intelligent enough for consumer-driven health care, or that all the health insurers are going to be venal and corrupt. Some say the sick are going to suffer more. It's all nonsense.

To your health.

E. J. McMAHON: The book to which Professor Herzlinger referred, *Consumer-Driven Health Care*, contains everything you ever wanted to know about this subject. The first eight chapters are by Professor Herzlinger herself.

Our next speaker, Scott Gottlieb, M.D., is a senior fellow at the American Enterprise Institute and a former senior policy advisor to the commissioner of the Food and Drug Administration and to the administrator of the Centers for Medicaid and Medicare Services (CMS) of the Department of Health and Human Services. Besides researching FDA and CMS regulatory policies at the American Enterprise Institute, Dr. Got-

tlieb is a staff writer for the *British Medical Journal* and the author of the new *Forbes/Gottlieb Medical Technology Investor*, an investment newsletter. Last, but far from least, he somehow finds time to be a practicing physician.

SCOTT GOTTLIEB: I want to address some of the implications of Medicare implementation on the drug marketplace, but also with respect to state Medicaid programs. I'm going to talk about a few topics. First, how the drug market is changing the results of Medicare benefits. Second, how programs can be positioned to take advantage of some of these changes and where other opportunities may be found to build on the trend that the Medicare program is going to start. Some of the sleeper issues are going to potentially bite parts of the state when they look at their own Medicaid programs after implementation takes place. I will also talk about the New York state initiative with the prescription drug list, which will lead to a two-tiered system in this state. I trained in New York State, practiced here for many years, and worked in a Medicaid clinic. I am familiar with the services offered, and, in some respects, Medicaid is already headed in the direction of a two-tiered system, if it is not already there. Having this kind of a drug list is going to move us further in that direction.

Regarding the implications for drugs and drug manufacturers and the implementation of the Medicare drug benefit: the benefits will lead to a bifurcation in the drug market between low-cost drugs and high-cost drugs—or, more precisely, between primary-care drugs (the kind we take for allergies, pain, high cholesterol, or high blood pressure, particularly the things we take for chronic conditions that we don't feel every day, such as high blood pressure) and very high-cost drugs (which include cancer drugs and the drugs that are for catastrophic conditions).

If you look at the structure of the Medicare drug benefit—from zero to \$3,000 of drug spending per year—the consumer is bearing a significant portion of that amount through such things as co-pays and tiers. From \$3,000 to about \$5,000 is the famous doughnut hole, and above \$5,000, all the costs are really being picked up by the federal government through reinsurance. The government is going to pay about 90 percent of those costs. So above the \$5,000 cap, the prescription drug firms are not going to care much about the spending, because it's being paid for by the government. Just as most HMOs ignore what's going on in the intensive-care units of hospitals because it's being picked up by a reinsurer, many of the prescription drug plans aren't going to care that much about the decisions being made in the catastrophic realm. So once the patient costs a certain amount of money, the government is paying for it. We don't care if they take Iressa, and Tarceva, or whatever it might be because it will cost over \$5,000, anyway. So what is the difference, from a financial standpoint?

Below the \$3,000 cap, they care because that is where they are going to try to manage costs very aggressively, causing greater competition in the market for primary-care drugs. The pharmaceutical companies themselves are already realizing this. If you look at the pipelines of many of the big performers, they are starting to move up into more catastrophic disease areas and out of primary-care drugs. They are trying to move into diseases such as cancer, Alzheimer's, and multiple sclerosis. For consumers in the prescription drug plans right now, this means that they will be exposed to much of the cost of primary-care drugs. So, for example, they are going to have to decide whether a brand of cholesterol-lowering drug is really worth the extra co-pay over the generic alternative, which is free on the prescription drug plan. Companies themselves are going to have to price those drugs in a margin that makes

sense for consumers to pay the incremental cost out of pocket after they are convinced by marketing material or literature that the drug actually has incremental benefits. But that margin will be very slim, so it is going to drive overall cost down on the primary-care drugs, and the primary-care market is going to become very competitive. We are going to have increased competition in the market for routine drugs. This is where Medicare comes into focus and contention with the market for routine drugs. Even the initial discussion around the prescription drug list that has been put forth is focusing on some of those routine drugs. That market is going to become very competitive once the Medicare benefit comes on line. Plans are going to try to put patients on lower-cost alternatives of generic drugs and then put tiers of co-pays in when it comes to more expensive drugs, exposing patients to the incremental cost of their expensive decision making.

From a market perspective, the pharmaceutical companies face two risks going forward. First, the risk below the cap is a risk of market competition. Can they price themselves effectively enough to make the drugs still cheap enough relative to the generic alternative, but get enough literature out there and brand them enough? Procter and Gamble sold over-the-counter drugs in a very consumer-oriented fashion, in a way that doesn't cost much, causing the selling costs to go down.

Second, there is risk above the cap, the catastrophic range. Initially, there is no risk, but long term there is certainly a risk that if the cost continues to grow significantly and the government is picking up a significant percentage of the cost, the government is going to become interested in trying to control those risks. So there could be regulatory risks above the cap.

The Medicare benefit will drive more of a consumer-oriented health care when it comes to drug spending, because of the

intense competition that's going to take place, particularly in the primary-care-drug market. There is already evidence that exposing consumers to these kinds of choices as well as seeing incremental cost and expensive decision making when it comes to primary-care drugs lowers overall drug spending and makes for intelligent consumers. There is evidence that the Medicare beneficiaries who are on the famous drug cards are making more reasonable decisions to use generic drugs on a wider scale. I testified recently before a Congressional Committee, when they were discussing how to increase generic utilization. Generic drug utilization is increased by exposing people to the cost of the alternative, which is the branded drug. If they have to pay an incremental portion of that, relative to their own income, they're usually going to opt for the generic drug where it makes sense.

Information we have through the drug cards keeps consumers better informed and is also helping them make more rational choices. An important caveat here, and one I made before the House when I testified, is that it's important to allow patients to opt around these sorts of restrictions to use generic drugs. That is why these kinds of alternatives make much more sense than things like lists, where you take the decision making out of the hands of the physician and the patient, which seems to be the direction of some of the state Medicaid programs.

Co-pays and tiering are two of the existing or emerging tools that are being employed aggressively by the private marketplace right now. There is every expectation that prescription drug plans will employ these tools extremely aggressively. That is certainly the indication I was getting from these plans when I was in CMS and hearing from them.

Such things as co-insurance and health-savings accounts expose consumers to the incremental cost of expensive decision-

making when it comes to drugs and drive better decisions when economics are taken into consideration. When you think of co-pays and tiering, that's more derivative than buying a contract that Pharmacy Benefits Manager negotiated. How good a deal did they get? So they will put a co-pay or a higher tier on a drug that you could not find a good deal on. That is neither value-based nor economic-based; it is business-negotiated-based. But co-insurance—charging a consumer an incremental portion of a decision relative to his income—is truly consumer-based. That is going to be a value-based economic decision, not tied to whatever business decision the PBM happens to have.

Information technology becomes very important here because consumers need information when they are making a decision, and doctors need to know at the point of care what the alternatives are and how much they will cost. When I write a prescription for a patient, very often I'll get a call back later that day that the patient went to the pharmacy and found out that there is a \$50 co-pay since I switched to something else. If I as well as the patient had that information at the point of care, we could take into consideration the economic factors right there while we were making a decision and see if the economic factor would affect our decision about one or the other, where there was really no medical difference between two choices. The information tools are very important to that process.

To extend the notion of consumer-driven health care that Professor Herzlinger was discussing, we need opportunities for greater flexibility and choice. Waivers provide the flexibility to offer tailored coverage. New York State, for example, offers a very expensive drug package in its Medicaid program—well beyond what it needs to provide from a statutory standpoint. Certainly, the poorer patients might need the gen-

erous benefits that New York State offers, but as people move up the income scale, we probably do not need to offer the same package of benefits to patients who make more money. Maybe we can offer tailored benefit packages, but the law doesn't allow us to do it. We also need flexibility to make ramifications on long-term care. We talk about drugs as an expense item. The real explosion in cost is in long-term care and the services side. It's harder to grapple with that because the unions are very powerful. Many of the families of my patients are forced to use nursing homes because they can't afford to take care of their loved one at home. That is another thing that is discussed at the federal level: allowing states to have the flexibility to provide a grant to the family to keep the patient at home.

We need to consider health literacy and disease management programs. Medicare's new chronic-care improvement initiative, which I encourage you to look at, is a very large disease-management program. There have been proven savings from those kinds of initiatives, which should not be undervalued, either in the immediate impact or the long-term impact that they can have.

What will Medicaid look like after they allow the dual-eligible to back out of the program? I don't think anyone is really thinking about that, but it's going to be a very interesting manifestation. If you look at eight of the top ten drugs used by the Medicaid population—once you back out the dual-eligible after the Medicare drug benefit comes into fruition—it's all mental health drugs—atypical anti-psychotics—and HIV medications. So you're dealing with a very particular patient population with very special needs. The kinds of things that are being contemplated right now to try to save money on the drug side are not going to be relevant to that population. I don't know the specials on them, and I don't presume to—

people here might as well be thinking about that—but states that I have visited have not considered that.

The net effect of MMA is that 50 percent of New York State's prescription drugs will be converted to Medicaid and Medicare. If you look at what's left of that spending, it's not patients who are currently being contemplated being affected by prescription drug lists. Again, will the existing initiatives make sense for the population that's left? I don't think so. From what I understand, the state is already contemplating carving out mental health medications from the prescription drug list, so there's not much left there. Certainly, some of the primary-care drugs are still taken by those patients, but the real spending is going to be on the medications that you're not going to want to touch because you find it to be such an issue. With that patient population, you don't want to do any unnecessary switching.

Much research is available on the issue of things like prescription drug lists or mandatory formularies. They are not necessarily achieving all the savings, especially long-term, that we aim to achieve with them. Certainly in the short term, we can have an immediate savings if we can get people off expensive medications. But in the long term, some of the unintended side effects of such a program could actually lead to higher costs, worse outcomes from a medical standpoint, and an increased health disparity among patients who are already vulnerable. The Medicaid population isn't only vulnerable because they don't have a lot of other means to work around the system; Medicaid becomes a very important determinant to what gets done in the clinics that service the inner cities and populations that might not be on Medicaid, but are certainly challenged and underserved and don't have a lot of economic needs. It is a big wheel that influences that market, just as Medicare was a very big wheel that influenced the

entire private market. We had to be very conscious of what we did to Medicare programs because what we did had all kinds of ramifications in the private market. When I was at CMS, it was hard for us to anticipate all of it. Medicaid does cause many reverberations in the community.

As a practicing physician, I would be concerned that it would further erode the kinds of opportunities that the Medicaid beneficiaries have. It already exists having practiced where I did. The services that would have been available for private patients weren't available to the Medicaid beneficiaries, and the types of settings that the patients were seen in didn't provide as many opportunities. That is not a big secret. Patients are seen in very busy clinics, and certain drugs weren't available because they took too much time to administer—too much teaching was involved. Procedures weren't as readily available, and, in many cases, physicians who were accessible weren't equivalent to what you would have had if you were in a private system. Putting patients on a formulary—depending on how it's done, but in any circumstances—is going to lead to further erosion.

I want to mention the issue of prior authorization on certain catastrophic drugs. It's safe to assume most Medicaid beneficiaries aren't going to get those drugs once you put a prior authorization on it. When I worked in a Medicaid clinic, I did everything: booked my own appointments; followed up with patients; wrote my own prescriptions; and did all the paperwork. In a Medicaid clinic, there is no support. Whatever support was there was purely to pick up the phone, and they barely did that. If I had to get on the phone and do a prior authorization, I couldn't give that to a nurse because I didn't have a nurse. I had to see a dozen patients in an hour, so there was no time for giving prior authorizations. Putting that prior authorization onto the drugs in a Medicaid clinic is going

to eliminate access to the drug altogether. In the same way, some of the things that the FDA is doing now in terms of risk-management programs around certain drugs disadvantages an already disadvantaged population because people who practice in these kinds of Medicaid settings don't have the resources to comply with these things.

E. J. McMAHON: Our last speaker, Senator Raymond A. Meier, brings extensive pride to the public-sector experience for his service in the state senate. He's well known for his intense focus on reform in the welfare and Medicaid systems in particular, which was inspired by his service as Oneida County's county executive. In Albany, he's widely respected for the force of his intellect and his command of substandard issues. He was co-chair of the Bi-Partisan Senate Task Force on Medicaid Reform and was chairman of the Senate Committee on Social Services and Children and Families. Senator Meier's role here today is at once simple and challenging. We asked him to tell us briefly what he thinks about what he has just heard.

RAYMOND MEIER: Years ago, when I was practicing law full-time, one of my favorite observations of the law was an observation of Oliver Wendell Holmes, who once famously said that the life of the law has not been logic. This is doubly so for politics. As I've dug into the issues in many human-services programs—in welfare, on which I've worked extensively, and publicly sponsored health-care programs, principally Medicaid—it strikes me that many of the difficulties that we encounter are because of a continuing tendency of most politicians, which is to think that by passing a law, you can repeal a much more important and deeply influential body of laws, those being the laws of economics and human nature.

What we have heard today is a dramatic case. What amounts to a version of a command-style company in the health-care

system in this country is what causes many of the problems that many of us in government then try to grapple with and, some would say, frequently exacerbate. If you look at the transformation of health care in this country over the last, say, six decades, one of the most transformational events—beyond, of course, the dramatic advances in science and technology—was the dramatic takeover of this economy by third-party payers. On the government side, those are principally Medicaid and Medicare. Many people don't know this, but in the federal budget, Medicaid has now surpassed Medicare in terms of the dollars consumed. That should be of concern to my colleagues at the New York State Legislature, because when everyone finishes running away from the president's proposal to rationalize and put some private influence into the Social Security system, they're going to turn their attention to Medicaid. New York State has not even started preparing for the day when that happens.

But government has a huge role in producing so much of what we see in the health-care system because we are many times the primary payer for services, and not just in terms of Medicaid and Medicare. We're also one of the largest purchasers and providers of group health-care insurance. We are also a regulator, not just of health care itself but of providers of health insurance. One thing that this legislature loves to do is to tell health-insurance companies what they must cover—chiropractic services, prostate screenings, and fertility treatments, which are covered by every health-insurance policy in the state. Never mind your intent or ability, you're covered. We're now engaged in a debate that's been going on for two or three years. It is heart-wrenching debate for many people, and one that has great implications for the portability of health insurance in the state over so-called parity mental health coverage. Some of these mandates are the product of having placed the state on a well-constructed rail to take us over the cliff. As far as being wor-

ried about whether we can extract any more money from taxpayers, there's a greater formulation that Mark Twain used about that: he said that the role of the politician is to try to extract money from taxpayers without disturbing the voters.

We've now turned our attention to trying to confer benefits, not by doing it through the public till but by mandating to health-insurance carriers. As I said earlier, the concept here is somehow that we repeal the laws of economics. One law that we repeatedly seem to be trying to repeal is the relationship of how people utilize services depending upon who is paying for them. We embarked on quite an adventure in the state senate over the last couple of years with the Medicaid Task Force. We spent a lot of time traveling around the state talking to all the stakeholders, providers, insurers, health-care professionals at every level, and consumers. A hospital administrator up in the Adirondacks, in the rural north of New York State, made one of the most insightful comments. She said that we are never going to get Medicaid under control until patients have a direct economic stake behind the Medicaid services that they receive.

We found that it is quite to the contrary with Medicaid. As the cost of Medicaid has expanded explosively in many instances—particularly in this state—government has dealt with Medicaid in ways that have exacerbated the problem. If you compare Medicaid with a conventional insurance company, you find several elements that comprise the cost. The elements are simple: Who are we covering? What do we provide for them? What services, and if they're able to access someone, who will give them those services? How much do we pay the provider?

This is where politics comes in. No self-respecting politician wants to throw large numbers of people off a public program

or take significant services away from them and treat the providers as victims. Instead, you cut or cap reimbursement rates and you institute co-payments—which everyone on Medicaid in New York knows you don't have to pay—so it in effect becomes a cut to the provider. Every time you try to control prices in a command economy, you create shortages and get inferior services for the cut in price.

We fight this war every year in New York over Medicaid, and many of the issues that we deal with parallel the ones that you talked about with customers. For this covered population, how do you provide medical care that is necessary—life-saving in some instances—and how do you prevent this continued hemorrhaging of taxpayer dollars? Many of the problems go back to this conceited notion you can somehow make the command economy work. The notion that government can plan and run an economy just collapsed all over the world. It has probably become one of the most discredited notions in the history of mankind.

It calls to mind the story about how Nikita Khrushchev, who was reputed once to have one of his commissars run in and say, "Nikita, the peasants are starving." Khrushchev consulted the latest five-year plan and said, "Too bad. This year, the peasants get shoes, and next year they get bread." It reminds me of when we did a hearing in Binghamton where there was a group of people from a disability-rights organization. They were for the most part younger people who, for one reason or another—traumatic injury or birth defects—had some type of physical disability. We talked at the hearing, and afterward and I found that even though they may be young and have some physical disability, they have the desire to go to school, to work, and to participate in the community. They are confronted, in many instances, with a Medicaid system that says this year, next year, for the rest of your life, you get nursing-home care.

The nursing-home industry, on the other hand, in this state is not to blame for this situation because in command economies you get consumer demands, but the people commanding the economy say you can't get what you want. So you are going to get nursing-home care because that is what we are paying for; we make the market for the disabled by disregarding their demand for independence. At the same time, we toss away possible creative, contributing efforts for this population and we interfere with a whole industry that wants and waits to be creative and responsive. Most people in the industry want to do that as we try to transform the system, because the payers are going to have to be active in transforming the system.

There is a phenomenon that occurs among people who are taken hostage: they start identifying with their captors. There are some providers and some health insurance carriers who identify with their carriers. At one point, we worked on a bill with many in the long-term care industry and disability-rights movement to reform—under a federal waiver—those Medicaid funding streams and make them more individualized. I was visited by one of the longest long-term-care providers in the Capital district, who told me that I was jeopardizing the program. I told her that I thought she would be entrepreneurial enough to survive and to do much better.

The challenge in New York State is shifting the debate about health care away from politics and away from the notion that health care is primarily a jobs program rather than about health care. But it is a movement that needs consumers—consumers who are also the taxpayers and voters. If we ever make that connection, we can get movement on the issues we have talked about here.

REGINA HERZLINGER: It is going to start with business because business can most readily do this. If businesses were

to start the innovation, the government would then adopt it. When Medicare tried to pass the Catastrophic Reform Act and the seniors marched en masse on Washington, D.C., the lesson became clear: don't mess around with this. So to begin, the private sector will embrace it and make it work. Then Medicaid/Medicare will work on it. But the big change is to get rid of the micromanagement that the senator talked about so eloquently. How can you have this brilliant group of people know how a doctor ought to practice medicine, what drugs he or she ought to use, or exactly what price for the drugs to choose? Ultimately, a much bigger revolution will have to come with dismantling the command-and-control apparatus that the senator spoke about.

E. J. McMAHON: Dr. Gottlieb spoke extensively about choice and changing regulations and laws in the area of prescription drug benefits and policy. Among other things, he was critical of, in fact, the PDL that was just done here, which is something many people tout as a major accomplishment.

SCOTT GOTTLIEB: The data from CMS (preliminary data that are probably going to be released in a more cohesive form) showed that patients on the drug card were opting more often for generic alternatives where they existed. Therefore it was giving an incentive to patients to become more cognizant about therapeutic alternatives and to opt for lower-cost options. Their conclusion was made in part because of the education and tools they had available to find therapeutic alternatives—things like the drug-compare website—for the first time. It is the first time that patients are actually being educated about options.

The PDL presumes that all Medicaid beneficiaries are of a certain ilk, which is not true. There is a cohort of patients who cannot actively participate in their own care—for whatever

reason, whether it is education or initiative, whether they just don't have the time, or they are disadvantaged in some other way. The percentage of that, the population that falls into that category, with absolutely no data to support this, is rather small. Many patients would like to have broader participation in health care. Medicaid certainly doesn't allow for that. It challenges us in a program that is very limited and regimented in what patients can and cannot get. So they lose the ability to make choices. Maybe over time, whatever incentive or desire they had to participate starts to get eroded, but it can be built back fairly quickly. Most patients want to be active in their own health care. So that is not an absolute impediment to trying to bring some of these ideas into Medicare. There will always be a percentage of the population for which it won't work. That is why we need safety nets, but there are many more people for whom it would work.

RAYMOND MEIER: We will spend \$45 billion in this state on Medicaid this year, so someone is blowing through it quite nicely without having it. Some consumers may need help making decisions about health care. Professor Herzlinger talked about purchasing a car. I talk to my brother when I go to buy a car because he knows more about cars than I do. There is a way to structure these programs so that there is a counseling element for people to get assistance. They could go to what amounts to a broker to help them assemble what makes sense for them. There are ways to get around this. But every time someone wants government to control people's lives, what he really means is that he thinks that most people are not intelligent enough to make their own decisions.

REGINA HERZLINGER: The Swiss have a consumer-driven program, and everyone has to buy his or her own health insurance. When it comes to buying things, most people aren't very intelligent. Nevertheless, the market gets better, because

of people like the senator's brother—people who really like cars and who know a lot about them question the car manufacturers. These consumers make it better, so that everyone else can just tag along on what they do. For a market to work, everyone need not be a genius. If that were a requirement, we couldn't buy anything, because most of us—competent as we are—aren't very smart about most of the things we buy. But the smart ones make it good for the rest of us.

In the Swiss system of acquired benefits, you must buy a counselor whether you want a counselor or not. I'm not so sure I like that; but that is a required benefit that comes along with the plan. You cannot buy health insurance unless you go through a counselor.

E. J. McMAHON: Joanne Laing is here with us and is a font of information on the HSA market in particular. If you want to talk to someone locally who is involved in this, Dr. Joseph Gulyas, director of the Northeast Spine and Wellness Center in Schenectady is also here. He uses HSAs in his own company and has knowledge from his own experience. John Rodat, also with us, is the health consultant who is head of Signal Health Firm. He has graciously put a discussion form on the Signal Health website regarding this subject.

REGINA HERZLINGER: The HSA, as I mentioned, is one choice. It is not consumer-driven. Two hundred forty models of cars, 195,000 new books each year—we have a tremendous amount of choice in the rest of our economy, and we will have many choices among insurance policies. So the HSA is one choice, and it's not a bad one. It's attractive for some people because they think more about using their own money. But when they get into the catastrophic portion, they're back in the same old system. Once we get done with the innovations in health insurance and give consumers a lot of choice, we

will gain in productivity. But then the hard part is going to begin, and that is permitting the Henry Fords of the health-care world to innovate and make it better and cheaper. That will require dismantling of this command-and-control system. So your point is very well taken, and it continues to be, in my view, a barrier to achieving the great economies, the greater consumer responsiveness and productivity that we can have in the health-care system. As I said, if you are Henry Ford or a Ralph Schneiderman right now, and you make things better and cheaper, you get bashed in the teeth. That cannot be right, and it cannot persist.

Some people say that if you have a consumer-driven market, people who are ill will get priced out of the market. People who are ill would be priced out of the *current* market. But the current market is primarily a group market. In the group market, the payer pays for the actual costs of the people for whom it provides coverage. So the New York State Employees Plan pays for the actual cost of the employees. Right now, it's paying for the people who are ill. What the consumer-driven, HSA version—which is not the end-all, though it is good—will do is likely pay for the people who are healthy. I have a twenty-seven-year-old son who is a captain in the U.S. Infantry and in good shape. But for his choice of occupation, there is great risk. He's going to go right to an HSA. I'm not so sure I would go to an HSA at my age. What's going to happen to the employer of my son and me? My son is going to cost them much less than he used to, and I'm going to cost them just the same. This point is much more important for the individual market than for the group market. When someone like me goes out in that market, I'm going to pay more than my son will. If I were ill, I would pay a fortune.

Here's how the Swiss handle this situation: they retroactively risk-adjust the insurer. So the insurer has wound up with many

older, ill people. They take money away from the insurer who wound up with many healthy people, and they give it to the insurer who has wound up with many people who are ill. Switzerland has seven million people. It's much smaller than the state of New York, but it has 100 insurance companies. They are all profitable. So it shows that you can have many small insurers flourishing in the market, and they are not affected by the very real problem you talked about.

I look to Switzerland, where, again, it is consumer-driven, and the largest single-selling policy is a variant of an HSA, and the second and third largest are also deductible, but not so high deductible. I become angry when people talking about health care in the U.S. compare us with Canada. How many blacks and Latinos does Canada have? We are a great melting pot. How can we be compared with homogenous countries? I compared the health status of Switzerland not with the U.S. but with a state in the United States that is the most like Switzerland: very white, very highly educated, very high-income, very urbanized. That state was not Massachusetts, which was Number Two, it was Connecticut. The Swiss spend 10 percent of their GDP on health care, as compared with the 15 percent that we spend. They have excellent health status. Are people so stupid that they would let their health deteriorate because they are spending out of their own pockets? The Swiss system would tell you absolutely not. They really take care of themselves; they just spend less because they are much less concerned about the cost. There are more data on that subject.

E. J. McMAHON: South Carolina has applied for a waiver that would essentially convert its Medicaid system, or a large portion of it, into a consumer-driven system. Dr. Gottlieb, do you have any particular views on what the outlook for that was?

SCOTT GOTTLIEB: I'm not that familiar with what South Carolina is doing in particular. There is much interest inside CMS, and inside the federal government generally, to try to give the states more flexibility and try to implement more creative ideas to help improve the quality of care that patients are receiving under Medicaid. That doesn't necessarily mean formulated lists for drugs, but things like the ideas and concepts that Professor Herzlinger referred to.

Consider what Professor Herzlinger referred to as the employers leading on some of the thinking about health care (Pitney Bowes, in particular, has been in the lead talking about this) when it comes to prescription drugs—in particular, on the primary-care side. Think of the prescription drug market as two markets right now: the catastrophic market and the primary-care market, because that's what we're going to be seeing a year from now. On the primary-care side, they're not cutting back on benefits. In fact, they are overmedicating patients because they're realizing that by providing more benefits, the savings are always realized on the ledger of the workplace through fewer missed days at work—for example, patients who don't have allergies, who don't have to go home early, who can deal with chronic pain. They're realizing the actual savings from providing more generous benefits on the primary-care-drug side. This is where most of the state Medicaid plans have tried to aggressively manage benefits—not on the catastrophic portion, but on the primary-care portion.

There is at least the possibility here to take care of a population such as the Medicaid population, which has much chronic illness. It might cost a great deal of money. In order to achieve the kinds of long-term, good health-care outcomes that we want, it might be a significant investment up front. Talking only about the cost going up and the quality going down ig-

nores the fact that by undermedicating and undertreating this population, or presenting barriers to certain care, we're possibly causing worse health outcomes in the end.

REGINA HERZLINGER: Jeb Bush in Florida also has a plan for consumer-driven health care in Medicaid. One element of that plan is that providers can organize themselves and say, "Here's a package that I want Medicaid recipients to look at." It is not going to be mandated benefits; no one is going to micromanage what we do. Here is how Medicaid recipients should be managed. It's a noble experiment. I wonder whether the provider community is ready to step up to that plate, because as the senator very wisely said, the Stockholm syndrome takes place and people who are naturally entrepreneurial get used to looking to the state for providing guidance. But we are going to get there. Governor Sanford from South Carolina has a plan with three parts. First is making normal Medicaid consumer-driven. The second part is using the cash and counsel idea, which you have here for the disabled. The third part, which is really wild, is the Health Allies concept that I talked about: the woman with the hip, where there's an auction. Sanford is going to have the long-term care providers bid for Medicaid patients. He's going to set up an auction process. People sometimes say that that's crazy. But the way we get innovation is from crazy ideas. So my hat's off to both Bush and Sanford [ok?].

RAYMOND MEIER: What is revealing about that decision is the way that it was presented and the fact that it was compared with the BRAC, the Base Realignment and Closure Commission. If you remember when Congress set up that concept, it had to do with the fact that the iron curtain had come down. It was time to scale back the defense establishment and to right-size it and use some other buzzwords. They were faced with the political fact that in communities in many parts of

the country, military installations had become economic-development and jobs programs. The theory behind the BRAC is that it is the only way you get it done, by setting up the so-called independent commission. We are going to see if that happens because there is the possibility for the legislature to go up or down the whole list, at the end. This is somewhat of a departure from what we heard when we were going to deregulate the system, that the market was going to speak. We know that as a practical manner, in many parts of the state, you can't completely let the market not work because you can't leave people in rural communities without health care. I have my own reservations, but I do stand by what I've said all along: health care in this state is too much about politics and not enough about patients.

SCOTT GOTTLIEB: I was always critical of the estimates that were made about how much the drug benefit was going to cost, not because of what was said in the media, but because there was no accounting made about how behavior would change for the Medicaid dual-eligible.

The Medicare drug benefit would cost, once the Medicaid dual-eligibles were put into that benefit, would their behavior change? Would they know that they were in the same plans as private paying patients? Would their taste change for drugs? Would their mix change on drugs that they requested? Would they begin getting access to medications that previously might not have been offered to them? It will be important to look not only at how their behavior changes but how their outcome has changed, because it will be a harbinger of what happens when we introduce some kind of a consumer element into Medicaid. They will suddenly have access to broader formularies and to programs that perhaps provide them with information about drug choice and about outcomes for using various medications. It would be a much more consumer-ori-

ented health plan than what they are used to on Medicaid right now—certainly not the ideal vision for what consumer-directed health care should look like, but moving in that direction. We hope that the outcomes will improve and the types of choice that patients make will be more intelligent choices, getting back to the choice of whether Medicaid patients are capable, if you will, of being involved in their own health care. We'll get a good sense that they are from this grand experiment that Medicare is doing.

E. J. McMAHON: There are several ways to follow up on these topics. You can enter the online forum at John Rodat's website. You can also write me at ejm@empirecenter.org.

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