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IMPROVING QUALITY, CONTROLLING COSTS, EXPANDING COVERAGE

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P R O C E E D I N G S

MR. COSGROVE: Good morning. I'm Toby Cosgrove, the CEO of the Cleveland Clinic, and it's my pleasure to welcome you all here. Please charge your coffee cups. And this is going to be a great day. This is something that we have looked forward to for a long time, because this is probably one of the most important topics that we could possibly be discussing in a health care arena.

Health care is something that effects every single individual in the United States. And we are now at a point where we need to have a national dialogue on health care and health care reform. Without this, we will not be able to come to consensus, come to a program that fits peoples needs. And it is my pleasure to have this particular colloquium here today that will -- to bring so many distinguished thought leaders together and to help stimulate the dialogue around health care reform.

It's our pleasure to be doing this with the Brookings Institute. And I'd like to introduce the President of the Brookings Institute, Strobe Talbott, who has graciously provided our additional partnering for this colloquium. Strobe.

MR. TALBOTT: Thank you, Toby, very much. I also want to thank, in addition to the Clinic, our other co-sponsors for today's event, the City Club, where I'm going to be speaking a little later in the day, the Council on

Small Enterprises, and the Greater Cleveland Partnership. Speaking of partnerships, all of us at Brookings, and there are a number of us here today, are delighted to be teaming up with you folks.

It's a special pleasure, I might add, and a personal pleasure for me as a Buckeye. I still think of this town as my home. The motto, "the best location in the nation", always occurs to me whenever I come back here, even though I didn't see the sign at the airport this morning. And I still root for the Brown's, even if it's on the principal of, there's always next year. I won't get into the issue of the Calves and the Wizards.

On a more serious note, like all Americans, and I might add, like all of the world, and I spend a lot of my time traveling around the world, Brookings is focused on the critical challenges facing our next President, and that's what our Opportunity 08 project is all about. More than most of our quadrennial election campaigns, this year's has become a kind of national brainstorming session, a brainstorming session on the nation's future, with the entire citizenry engaged to an extent that has not been the case for a very long time. For the first time in a long time, the candidates are writing on something close to a clean slate. That's, in part, because of who they are. And you'll notice that all three of the principal candidates are speaking on the theme of change.

But it's also because of a feature that makes this campaign quite different than any that we've had for a long time, and that is that for the first

time in 80 years, since 1928, there has been no incumbent President or Vice President running in the primaries in either party.

Another distinctive feature of the campaign this year is that all three candidates are putting a great deal of emphasis on the issue that Toby just addressed and that will be the focus today, which is the quality, the delivery in a reasonable and prompt way, and the affordability of decent health care for all American citizens. Therefore, that issue is very high on the Brookings Institution's agenda, and it will be for a long time.

We've got a team of world class experts at Brookings, and more than experts, real thought leaders in this field, and several of them are here with us today. You're going to hear a little bit later from Mark McClellan. Mark is bringing to bear his experience of high levels of the government on his current position, as the Founding Director of our Engelberg Center on Health Care Reform, and is the first holder of the Leonard D. Schaeffer Director's Chair in Health Policy at Brookings.

But it is now my distinct pleasure to introduce our first speaker, Alice Rivlin. Alice is a leading light of our Economic Studies Program, and in addition to being a world class scholar, she is a very distinguished public servant.

She was the first Director of the Congressional Budget Office, Director of the Office of Management and Budget, Vice Chair of the FED, and a senior official of the Department of Health and Human Services. She is also, I

might add, a good friend, a colleague, and a mentor of mine. So it's a double honor for me not only to be with you today, but to be able to turn the program over to Alice. Thank you very much.

MS. RIVLIN: Thank you very much, Strobe. I'm delighted to be here, and I have a mission. I was told, your job is to scare them, to scare them with the long run fiscal issues and the importance of getting control of the rate of growth of health care costs, an issue that, with all due respect, the candidates are not addressing. They are not talking about the fiscal future of the United States. Each of the candidates actually has a plan to increase the deficit modestly in the short run and is not talking about what we do to get it down in the long run.

I've been given the somewhat cumbersome title of reforming health care and addressing the nation's core fiscal challenge. That's not only cumbersome, but it sounds like two different subjects.

Reforming health care, which is a big subject in itself and which we will be spending much of today on. Everyone is for reform, but people have different views of the objectives of reform and different solutions. The common elements are usually more coverage, better care, lower cost; nice if you can do it all three at once.

And the second subject is the nation's core fiscal challenge, how to deal with the fact that federal spending is projected to rise much faster than federal revenues at any set of tax rate, creating unsustainable deficits and

agonizingly tough choices. I will talk about both, but my main point is that these two big issues turn out, in fact, to be the same issue. The future stress on the federal budget is all about health care, specifically about Medicare and Medicaid. But resolving the federal budget dilemmas turn on our success in reforming the delivery of health care generally, right here in Cleveland and everywhere else, to make it more efficient and effective.

Restraining Medicare and Medicaid by themselves at the federal level, without fundamental health reform, would just shift the rising costs to the states and to the private sector. Unless we succeed in making the health care system more efficient and effective, and slowing the rate of growth of spending, we will not have either a fiscally responsible budget or the resources to reverse the shrinking of health care coverage.

Now, let me start with the federal budget. We had a nice surplus in the budget in the late 1990's and through 2000. I feel I have to mention that because I'm very proud of it. It was the first significant budget surplus achieved in many, many years, it wasn't easy, but it's gone now.

We have had very significant deficits in the federal budget for the last eight years, not huge ones, but we're borrowing a lot of money. The deficit is currently rising because of the slowing economy and the continuing high military spending, and it'll probably be over 400 billion this year. Now, that's not trivial. We have been adding significantly to the national indebtedness over the last seven or eight years, and that's 400 billion more that we're borrowing.

We're borrowing heavily from foreigners, which makes us more vulnerable to their agendas. And we're passing the bill for government services on to future tax payers, our children and grandchildren, which is an immoral and selfish thing to do.

Nevertheless, recent deficits have actually not been very high by historical standards. And the current increase in borrowing will subside as the economy recovers and the war eventually winds down.

But now I come to the scary part. Look beyond the next couple of years, and what you see are projections of federal spending over the next several decades, which show federal outlays under existing programs, nothing new, just what we have promised already under Medicare and Medicaid, that spending rising substantially faster than revenue and opening up a widening and unsustainable gap between spending and revenue.

And those aren't very uncertain projections. We know pretty much what current programs cost and will cost. And we know a lot about the demographics. The people who are going to be eligible for Medicare and Medicaid and Social Security are already born, we know how many of them there are. So this isn't pie in the sky projecting. Now, the reason is clear, a promise is made under the major entitlement programs are getting far more expensive as the baby boom generation reaches retirement age, longevity increases, and health care continues to get both more effective and more expensive.

The cause of this rising projected federal spending is often called the entitlements program, and the entitlement that most people think of first and know most about is social security. Indeed, policy wants and politicians have put a lot of emphasis on the problem of paying for social security and make it sound a lot worse than it actually is.

Social security spending will accelerate over the next couple of decades, rising under current policies from about four percent of the gross domestic product of everything we spend, to about six percent, and the revenues currently dedicated to that program will fall short of paying for the full amount.

But this shortfall is actually relatively small and it wouldn't be very hard to fix. The fixes are well known: raise the retirement age, make the benefits slightly less generous, whatever combination you like. No really drastic reforms are necessary. However -- and this is the point that makes it different for Medicare and Medicaid -- by midcentury, the boomers will be passing from the scene, and spending for social security will level off. It will only grow slightly faster than the economy after that if longevity keeps increasing. Funding the social security program is a very manageable problem.

The future of federal spending increases is actually not an entitlement problem, it is a health care problem. The projected rise in Medicare and Medicaid accounts for more than all, slightly more than all of the projected

deficit.

Now, these programs are also affected by the demographic shift. There will be more old people, old people spend more on medical care, and they will be living longer. But much more importantly, spending for each of those people is rising rapidly, greatly compounding, indeed, overwhelming the demographics.

Spending for Medicare and Medicaid goes up at about the same rate as health care spending for the economy as a whole. After all, why wouldn't it? Patients with a given diagnosis gets about the same treatment by hospitals and other providers no matter which payer or combination of payers is fitting the bill. Health care spending generally has been rising about two and a half percentage points faster than total spending, the total GDP, for about 40 years, that's a long time. And the federal portion, mostly Medicare and Medicaid, rises right along with it.

So what we're talking about is pressure on all budgets, federal, state, local, corporate, family budgets, you name it. We are now spending about seven -- almost 17 percent of the GDP on health care, and it's headed up. And everyone is making hard choices and will make more hard choices. Businesses, because health care is so expensive, are cutting back on coverage, and we are getting more and more uninsured people.

Now, you're all familiar with the reasons for this. Technology has advanced rapidly, drugs and procedures and equipment are more effective and

more useful than they used to be, we have higher incomes, and when you have higher incomes, you want more medical care. Some of the progress in medical care has been cost saving. There are certain things that are cheaper to do than they used to be, like cataract surgery. But when something is cheaper and better, people want more of it, so the number of procedures simply explodes. The upward march of health care spending, public and private, shows no sign of slowing. Now, why do we need to worry about that? I think two reasons; one is that everybody who works in the health care area and studies it knows, we're not really getting our money's worth now. There is lots of evidence, and we'll talk more about this today, of wasteful and ineffective and even harmful treatment that we are paying for.

But also, the increasing costs of medical care, whether to the federal government or to anybody else, is squeezing out other spending at all levels, and this will only get worse. Education, infrastructure, research, all the things that we need to grow our economy in the future are getting more and more squeezed.

So the federal budget is just a metaphor for the problem, it is where it is most obvious. But the problem is at state, local, and private levels, as well.

At the federal level, the projections are dramatic. If Medicare and Medicaid continue on their current course, this two and a half percent faster than the GDP is growing, Medicare and Medicaid spending will rise from about

four percent of the GDP, to about eight percent in 2030, to about 12 percent in 2050. That's three times what we're spending now. Those rates are simply not sustainable. We can't keep cutting back other spending to accommodate health. We could cut everything else, the government does, and not solve this problem in the long run because the health keeps going up.

We would cut, and we're already doing this, especially investment in future growth that most of us think we need. We think we need more infrastructure spending, more spending on skills and education, not less.

We can't keep raising taxes to solve this problem. A moderate rise in taxes probably wouldn't kill us, and actually seems quite inevitable. But continuous rises would eventually cut into growth. And we can't borrow all that money either. We're borrowed to the hilt, and nobody would lend it to us. So we need to get the rate of increase in our health spending down.

If health care spending were growing at one and a half percent faster than the GDP, or one percent, it would take a lot of the pressure off and give us more time to figure out what to do. I didn't say zero, because I don't think that's ever going to happen. We're going to continue over time to spend a larger portion of everything that we produce on health. And since we're lucky that we start with a fairly wasteful, inefficient system, so there's lots of opportunity to improve it, if we were a little more efficient, we wouldn't have this opportunity. Some moves would be one time reductions in spending that wouldn't be permanent reductions in the rate of growth, but don't knock it, we

need to do all the one time things that we can possibly think of.

There is no magic bullet, and we don't have to make a choice, as some politicians seem to sound like, between market approaches and regulation. We need to do both. We need to use the market better, and we need to regulate better.

There is a long list of things that we can do, which you will hear more about today. Aggressive shifts in the way providers are reimbursed. We need to collect and analyze the information coming out of our health system and restructure payments, reimbursement systems, to encourage cost effective treatment and stop paying for wasteful and excessive treatment.

Medicare can lead us there. It can't be the only place we do this. But we know from experience that when Medicare changes its reimbursement policy, everybody else follows. We need intelligent use of health information technology, we need incentives for adoption, but we can't stop there. We need to actually use the information to restructure how care is delivered. We need to reduce errors Medicare can leave there, too.

We need more prevention and disease management. We ought to do it to improve health, but we won't necessarily save money, certainly not in the short run. Tort reform could help a little, simplifying administration could help a lot, it's a long list. And federal programs can lead the way.

The Veterans Administration has made remarkable strides toward greater efficiency, so have some parts of the Defense establishment.

But the big payer is Medicare. And it also has the potential to gather a lot of the data on cost effective care. If Medicare makes aggressive, sustained effort to collect data and uses it to reward appropriate care and stops paying for wasteful, ineffective care, others will follow.

All of this is hard. It will take time, it will take patience, it will take effort. We must kindle the sense of urgency, both in the public and in the private sector. If we don't find ways to slow the growth of health care costs, we won't be able to do what most people associate with reform, namely, covering more people and covering them better. Indeed, we will find fewer people covered and employers cutting back. So my major message is, the federal budget problem is a health care problem, but it's not just a Medicare and Medicaid problem.

We can't slow the growth of those programs until we slow the growth of spending and improve the efficiency of the whole system. This is the context in which to consider proposals for broadening coverage and making coverage more secure. Thank you. And I think the schedule now calls for a few minutes of Q and A, right? And there is a mike right here.

SPEAKER: We talk about health care costs; there are two separate distinctions, there's health care costs and health care systems costs. As the system of running health care has increased since the '70's with the huge insurance industry, health care costs and health care systems costs, I would like to see addressed separately.

Every doctor's office, every clinic, every hospital has had a huge increase in the business office as the direct care to patients has been reduced somewhat. So I think it should be very careful that we don't mix those two up. The health care system is the thing that seems to be destroying our health care costs.

MS. RIVLIN: A good point, and I think we'll probably come back to that in our discussion later. When you look at the United States compared to some other countries, it is clear that there are a lot of reasons why we pay 17 percent of our GDP, and most of the continental Europeans who have quite good health care and universal coverage pay in the range of ten to 12 percent.

There are a lot of reasons, but one of them is the reason that you cite, that we have much higher administrative costs, we have a much more complicated system, public, private, lots of efforts to cut costs, which again are administrative costs. Our administrative costs are very high. We also pay our physicians more, we do other things less efficiently than some other places. But the administration is a big piece. Other questions? Yes.

SPEAKER: In previous times when the federal government reigned back Medicare, what the providers did was to shift costs, and that actually led to the crisis that led to the Clinton initiative back in the early '90's, after the Medicare administration changed how it reimbursed physicians, then the provider community and the insurers went in a different direction and hit the private sector more. How would, in the future, how would a Medicare reform

that is absolutely necessary prevent that scenario from repeating itself?

MS. RIVLIN: Well, you're making my point. Unless we engage in serious changes, we will only shift the cost. If you just said, okay, let's cut Medicare, you could do that, I mean you could find ways to do that. But if you don't do it in a way that changes the whole health system and the way it delivers care, it's just a cost shift.

But I do think that if we move toward reimbursement rates by public and private payers, whoever they are, we may change our system, but whoever they are, we have got to reimburse for performance and for effective care.

And what I said was, Medicare can lead that charge. It has -- potentially has a huge data base on which to base such judgements if it were using it effectively. And it has a history of when it does change reimbursement rates, as with prospective reimbursement in the 1970's, other payers follow. And so the potential for leadership is there. But you're absolutely right, the history has not been that, the history has been just cut reimbursement rates or something, and starve the provider community until they squeal, and then reverse it.

SPEAKER: My question has to do with your successor, the current CBO head, Peter Orzag, who has even scarier news along the line that you've mentioned in terms of our future if we don't get health care costs under control.

But he also has some stunningly good news, namely, he's collected Jack Winberg's work, an amazing collection of 30 years of work on the variation between how patients are not treated, but the costs, and he -- Orzag citing Winberg's work talks about a 30 percent potential savings and possible increased value from the Winberg variation analysis.

And I'm just -- one other thing, he just did a study of Medicare spending for chronic care, $290 billion, and he said, in effect, he, Winberg showed we could save $50 billion that Medicare would have saved, $50 billion, if all the patients received their chronic care at the Cleveland Clinic and the Mayo Clinic. Does that kind of quality and so on -- and I'm not paid by the Cleveland Clinic or Mayo Clinic.

My question is -- goes back to the point you made earlier, none of the candidates -- and I don't know any proposal that focuses on the potential value, savings, increased patient results from the Winberg savings -- Winberg variation analysis.

MS. RIVLIN: First, Peter may sound scarier than I, but we're using the same numbers. My remarks and the projections I gave you were based on CBO numbers, they are the gold standard of projections of the federal budget, and the administration doesn't differ from it.

Second, yes, the Winberg results are impressive, and they are based on Medicare data, they are part of the evidence that if you really use this data base, you can find out some pretty startling things. And as many of you

know, the differences between how a diagnosis is treated in one part of the country, the same diagnosis, and they're pretty careful about that, is treated in one part of the country very different from another.

If you have a heart attack of a specific type in Miami, you will see a lot more doctors. It will cost a lot more than if you have it in Minneapolis. But you won't be any better off, and the numbers show that very clearly.

The problem is the next step. How do you get people -- the medical community in Miami to act like the medical community in Minneapolis, how do you write the rules, how do you built that into the Medicare reimbursement rates, and how do you keep the doctors from saying, wait a minute, my patient is special, my patient is different from the one for whom this rule was written? It's very, very hard, and that's my message. We've got to start doing it. It's not just a question of saying, okay, let's cut $50 billion out by telling Minneapolis -- telling Miami to act like Minneapolis, ain't that simple.

However, your basic point is right, nobody is really talking about it. Worse than that, they aren't even really talking about the problem to which this is the partial solution. They're pretending it doesn't exist, that is the candidate. Yes. We'll have two there in any order.

MS. CHILL: Hi, my name is Peggy Chill and I work for a community health center here in Cleveland, Ohio called Neighborhood Family Practice. And I have -- so much of what you said is so true. I'm really proud actually of the way that the community health centers nationally have begun to

deal with chronic disease.

And I think it's wonderful that the Cleveland Clinic does such a good job, and the Mayo Clinic does. But I think there has to come a place where number one, prevention, is held at a very high, important level, and there has to be some kind of standardization across medical provider facilities where best practices are, you know, maybe even mandated at some point, I don't know. My other issue around the candidates is that nobody wants to talk about the elephant in the room, and the elephant in the room, in terms of high costs for health care, have been, to some degree, the insurance companies.

Now, I'm really not anymore, you know, dogmatic about having universal health care, I'm not sure that's the panacea either anymore. But I think that we have to come to a place where we talk about that elephant in the room, either regulate them or place standards on them where they don't drive those costs up. And we also need to cut out this huge, rich, big lobby that makes it so that none of the candidates are willing to even discuss the possibility of some form of universal health care. And so I wonder what your thinking is on that issue.

MS. RIVLIN: Well, several thoughts; one, you spoke of mandating best practice, let's try incenting it first, we aren't even doing that. And if the major payers, including the insurance companies, but also including the public programs, were on a solid basis of analysis paying for performance and effective practice, we would all be better off. Now, the fact that most of

everybody's bills are paid by a third party is part of our -- is a big part of our problem. I don't think we want to change that. I don't think we want to go to a system where everybody pays for health care out of their own pocket with no -- Americans don't want that. And so we've got to figure out how the payers incent the providers to do a more cost effective job.

And what I was suggesting was, let's start with Medicare, because it's a big payer, and if they start doing this and collecting the information and making it the norm, other payers will follow.

Now, there will be a lot of political opposition, including from the providers, and from the payers, because the system that we've got works for the people who are in it quite well; it doesn't work for the people who aren't. But I think, back to universal coverage, we shouldn't have the myth that if we just got universal coverage, even if we just had a single payer, the problem would go away, it wouldn't, it would change its form.

I spent four months last year in France; I wasn't studying the health care system, but I had some opportunity to watch what was going on. They do have a single payer, they do have a global budget, and their problem is, what do you do when you're running over your global budget, well, you talk about all the same things we talk about, higher co-pays, lower reimbursement, blah blah, all of the same stuff, and how to make the system more efficient. So we don't change the problem by just going to single payer or universal coverage.

SPEAKER: You said in the beginning that a number of the European systems with spending something like ten percent of GDP on health care provided, nevertheless, quite good health care. The conventional wisdom in this country seems to be usually that we offer the best standard of health care in the world, even though it's unequally distributed perhaps, and there are many inefficiencies connected with it.

Are you aware of any studies that have, on a non bias, non lobbying, non -- unfair way of studying that says what the qualities of the various health care systems are in the world, the quality of medical care that various countries are actually receiving?

MS. RIVLIN: There are studies, and there have been quite a lot of effort I think to look at this, and some other panelists may be more able to cite chapter and verse. But a simple way of looking at it is, what are the health outcomes of those systems in terms of longevity, in terms of infant mortality, in terms of other fairly easily measured items, and the answer is, they do better than we do. Now, in some of the very low cost systems, like the UK, they have had a lot of problem with waiting times for elective surgery and so forth, they're beginning to solve that, but at a price.

But the continental systems don't seem to have that waiting time problem. The very rich go outside the system, but the very rich are going to go outside any system. And so I think the quality of care is generally judged to be good. Melissa, you're standing there looking like it's time to move on. And

moving on means introducing my colleague, Henry Aaron, which is a great privilege, and I'm glad to see Henry here this morning.

Henry is a distinguished scholar at Brookings. He hasn't worked just on medical care and health care payments, he has worked on other things over a life time, as well. But he has written some very interesting and scary stuff, Henry can be scary, too, about health care. He has served in the government, he is a consultant to just about everything, and I am delighted to introduce Henry Aaron.

DOCTOR AARON: It's an honor to follow Alice, and I'm very glad to be here this morning. I'm going to start with a bit of entomology. On the east coast, we have an insect, it's called the periodical cicada. It emerges every 13 to 17 years, makes a terrible racket, mates, and then it dies. The larvae then burrow back into the ground, and the only thing that's left are some brittle casings. Nothing much is heard for another decade and a half.

Now, the reason I mention this is, I think it bears an uncanny resemblance to U.S. health care reform efforts, a distressing parallel. Another episode of noisy Washington based health care reform debate seems to be upon us. What a number of us fear is that this round, like so many in the past, is going to end up producing nothing but noise and the debris of dead proposals.

There are solid reasons to be pessimistic. The same obstacles to national reform that have doomed past proposals are alive and well.

Consensus on what to do remains elusive. Health care reform remains, when you cut through everything, largely an exercise in income redistribution, and that means that there are going to be losers, as well as winners.

It still takes 60 votes in the U.S. Senate to pass anything, and health care, let's not forget it, is really, really big. Alice mentioned she was in France; our health care system is as big as the entire economy of France. Against that background, the energy and the creativity evident in states around the nation is striking. Massachusetts has enacted and is implementing universal coverage, Vermont came close.

Governor Schwarzenegger in California did not come quite so close, but his proposal is still alive. Governors in Illinois and in Pennsylvania have pushed state based reforms to extend coverage and to improve quality. And right here in Ohio, Governor Strickland has set a goal of reducing the number of uninsured in Ohio by half.

So something really remarkable is going on at the state level. And it's distinguished by a phenomenon that has almost, but not quite, become extinct in Washington, and that is genuine bipartisanship. Both democratic and republican governors have been leading these efforts.

And in Congress, there are bipartisan teams, as well. Ohio's Senator Voinovich has teamed up with New Mexico's democratic, Senator Bingaman, to co-sponsor a federal bill to have the federal government assist states in moving health care reform efforts ahead called the Health Partnership

Act. Wisconsin's democratic, Senator Feingold, and South Carolina's republic, Senator Lindsey Graham, have joined to co-sponsor a similar bill. And in the House, representative, democratic and quite liberal representative, Tammy Baldwin, from Wisconsin, and very conservative representative Tom Price, a physician from Georgia, have teamed up, along with more than 80 co-sponsors to push similar legislation.

Now, I'm mentioning them partly because I'm kind of proud. I consulted on the drafting of all three of those bills, and I know first hand that a goodly number of democrats and republicans are solidly committed to promoting just the sorts of state based efforts that are now underway in Ohio.

And I think that with some back-up from a sympathetic president, we could have legislation that helps states do what they clearly want to do, and that is, give them some financial support, some regulatory and legislative flexibility to help them move ahead.

Alice Rivlin talked about the importance of controlling the growth of health care spending, because the pressure it will put on public and private budgets, I agree completely with what she said. Right now, unfortunately, controlling health care costs is a bit like the weather, something that people love to talk about, but over which they really don't have any effective control. Our payment system is bewilderingly fragmented. Patients have little financial incentive to economize, and providers have a financial incentive typically to do a bit more.

Until we change the way we pay for health care, I believe that prospects for significantly slowing the rate of growth of health care spending are very close to non-existent.

That's why I think the agenda for health care reform now should focus on how to extend coverage to as many of the uninsured as can be reached, and simultaneously to improve the quality of care that all patients have every right to expect, and that's just what we're going to be doing here this morning in the next two sessions.

We have two panels for you. In the second, which Mark McClellan is going to chair, a panel will report on the efforts underway in Ohio to cover as many as 500,000 currently uninsured Ohioans. In this panel, right now, you're going to hear from three experts who are going to focus on how to improve the quality of care. And there is, as Alice noted, and as you will hear, vast room for improvement. The IOM has documented that tens of thousands of people die needlessly every year in American hospitals. Nearly half of all patients do not receive all recommended care in a typical contact with a physician or a hospital. For $2.4 trillion a year, we can do better than that. Our first panelist is going to be Michael McMillan. He is the Executive Director of Managed Care right here at the Cleveland Clinic. And I want to thank him for his emergency room which I visited this morning.

In that capacity, he directs development of the Cleveland Clinic Community Partners, a provider panel with more than 2,000 physicians, ten

hospitals, and 20 other organizations.

Our second panelist is going to be Alan Rovner, a physician working in one of, what I think is one of the most exciting and pivotal specialties in modern medicine, radiology. He practices medicine at Radiology Associates, directs quality assurance at the Ultima Hospital, and teaches at the Northeastern Ohio University College of Medicine.

Finally, our third panelist will be Doctor Bill Winkerwerder. He's board certified in internal medicine, so at least we have a couple of doctors here to keep us honest. He chairs a health care consulting and strategy company that he started after leaving the Department of Defense, where he was Assistant Secretary for Health Affairs and oversaw a pretty good sized enterprise, $40 billion worth of the military health system. Each of them has about eight minutes. I shouldn't say about, has eight minutes, for some introductory comments. After that, we'll have a little bit of discussion back and forth on the dais here, but then we're going to open it up for questions, and so I hope you will participate actively in that discussion. Thank you very much.

MR. McMILLAN: Well, good morning, I'm the lead off batter, so I would like to start by thanking the Brookings Institution for this opportunity. And I want to tell you a little bit about what I do, a little bit about my world.

So I'm the guy on the other side of the table from United, Aetna, Medical Mutual, representing hospitals and physicians, and so I really work with our business relationships in the wholesale market place and folks who buy our

services and price our services. And sometimes that's straight forward, and sometimes it's the shootout at the OK Corral, but increasingly we're getting tough questions from the folks who pay for health care around a number of issues. And I'm just going to give you some real life examples of questions from the other side of the table. Why is it that Apollo Hospital came to our location and told us that heart surgery can be performed in India for a third of what it is done for here with similar outcomes? Why is it that I have to shove off more costs onto my employees because my premiums keep rising, or have to reduce my benefits?

The burden of health care, of an international manufacturer in this region said, makes us less competitive in the world market place. And finally, the entire region is less competitive because folks are less likely to come here because of high health care costs.

So the challenge I think around reform, at least from where I sit, has to do with, how can we tap into the innovation and energy and creativity to try to address and answer some of those questions?

By the way, you know, the last question I did is, what are you putting in place to make sure that that tragic situation that happened in Las Vegas, where needles were being reused, doesn't happen to one of my employees, what are you doing about patient safety, these are now explicit concerns from the employer community. So how can we tap into that innovation and entrepreneurship? Well, let me give you a few examples at the

Cleveland Clinic. I think one of the underlying themes is that health care isn't a commodity, and outcomes matter. And, you know, if you take a lead from Michael Porter's book, Competition at the Level of Disease Ought to be the Engine to Drive Reform, it does make a difference where you end up and which physician treats you or which hospital you find yourself in.

Chuck mentioned the Jack Winberg data, I think it's an ample demonstration of driving toward outcomes. And yet at the moment our payment system is designed to really come out of health care. Physicians are all paid the same way, hospitals generally are paid the same way. There are few opportunities to stand out, to get paid more for better results, better outcomes, and innovation.

What other things are we doing that can impact the reform efforts? Wellness; it's an undeniable fact that more things are going to happen to patients, more technologies are going to emerge, health care costs are going to continue to rise. So one tech that's absolutely critical is reducing the disease burden, getting people healthier, and moving in a direction where there are fewer admissions to the hospital and less utilization of health care services. So at the Cleveland Clinic, we don't hire smokers, we moved to a trans fat free cafeterias and restaurants, you know, I have searched in vain over the entire vast expanse of the Cleveland Clinic for a candy bar at a vending machine, or a donut, and so moving employees -- and obviously being smoke free. Moving employees into a wellness mode is increasingly attractive to employers and I

think a critical part of the longer term solution.

We've organized them to institute. So physicians who naturally work together around a body system or a disease entity can work together, improve communication, improve efficiency, drive lower costs, and drive better outcomes. And so that is a Toby Cosgrove innovation that's in place in our organization and moving forward very aggressively.

Expansion of services, not only here, a state-of-the-art building that will be opening up very soon, but services across the country and around the world, so that access has improved and more patients can take advantage of superior outcomes they might find in this organization.

The advent and development of a whole suite of E products, so one of the ways to improve efficiency is to have -- physicians having access to data and information about the patient, wherever they might find themselves. So if you go to one of our family health centers, the same imaging information, test information, lab results is all available to you there, just as you might find down at the main campus, that improves efficiency, that reduces the duplication of testing, a key element in managing costs and improving quality better.

And we've got a whole range of things for physicians, for patients. And you've just seen the announcement of the relationship with Google, which moves this whole idea of consumerism to another level. So eventually patients will own their records, own all of their data, make it

completely transportable wherever they might go to an internet based interface so that they can use their data, it's theirs, their information, wherever they might need to seek health care in the country or the region.

Focus on patient experience, because from a patient point of view, it's not just the money, it's the outcome, and it's how you were treated while you were in the hospital. And this organization has put in place a number of initiatives including a chief patient experience officer to manage and improve patient experience and outcomes related to that. And then we have worked very closely, lastly, with health plans to try to reduce administrative costs. So there is a burden in the health care system unrelated to better outcomes, unrelated to improving patient care that we can simply reduce, and we call it waste and a process improvement mode, and we have put in place initiatives with major health plans, in fact, are insisting now that we look for ways to reduce the administrative burden, simplify the processes for patients and physicians, so that every dollar that can be made available for patient care is actually made available for patient care.

So there are -- and finally, changing in a payment system; I heard mentioned before the need to reform payment is absolutely critical, because at the end of the day, you can't have a commodity based health care system, you have to have a system based on outcomes, and where there are superior outcomes, physicians and hospitals ought to be rewarded for that, and if you're not where you need to be from an outcome point of view, you've got a real

incentive to improve either through additional payments or access to patients. So it's an exciting time, and I think there's an opportunity to tap into what's best in the American spirit, which is innovation and experimentation to try to create a better system for patients and the folks who pay the bill.

MR. TALBOTT: Thank you very much, and that was eight minutes.

MR. McMILLAN: Was that eight minutes?

MR. TALBOTT: Yes.

MR. McMILLAN: Okay. I timed that earlier.

MR. ROVNER: Thank you very much for having me here. It's really quite an honor to be on such a -- a member of a distinguished panel. I just want to give you my sound bite in 30 seconds, which is that health care plans that are local can work, and they can be a benefit to both the providers, the employers, and the employees.

I just want to assure the audience that, as a radiologist, I'm not here to push cat scans as the leading edge for health care financing reform. What I am here to do is to share with you my 25 years of experience in managed care, both as a provider and as an administrator.

And that experience coincides with the development of a local star county initiative we call Alt Care, which began in 1985. And it began, as we said, sort of déjà vu, when there was an earlier recognition of a health care financing crisis with rising health care costs, and that led, of course, to the

development of managed care. Alt Care is a joint venture between Altman Health Foundation, which is the parent organization of Altna Hospital, and Star Quality Care Physicians, Inc., which is a group of diverse physicians with a common interest. Some of you would know it as a medical staff. And it would seem like a paradox that a community, a market where we have numerous loosely affiliated medical practices, could actually get together and join forces with a hospital, because you know administrators and physicians are natural enemies, and yet we did make it happen, and we made it happen because our business coalition came to us and said, we can't afford this anymore, we're calling a halt to it, and that's when we knew we had to take it seriously, and I think the same situation is here now.

In addition to developing a health plan, what we also found that we had developed was a communication plan, because now we were able to sit down with business leaders, employers, both large and small, with providers, with employees, and talk very openly about health care costs, health care delivery systems, plan design, and of course, quality of care, and that was a real revelation to us.

The employers taught us how to create value in our system. They were manufacturers; we felt that health care was kind of a -- sort of a micro brew kind of a system. But they taught us how to save money in our processes. We, in turn, taught them how to create health care value in their businesses. Just as the Cleveland Clinic has gone into wellness, we taught

them how to recognize wellness and embrace it so that they could avoid health care costs, which is probably the greatest way to save the costs of medical care.

And finally, the providers became intimately aware of what the businesses were facing in terms of their operating budgets. At first they were kind of ignorant about it, secondly, they tried to deny it, and then finally they came to accept this.

The lessons that we've learned locally is that one size does not fit all. We started out with a PPO because that was a model that fit the independence of our medical staff. We realized we needed an HMO, we got into Medicare managed care, Medicaid managed care, HSA's, and also individual products.

And so we have learned that you can slide and dice this product a number of ways to suit your community. And the community is the front line for us. That's where we practice, we live, and that's what we have to protect. And one of our decisions was, and it was quite conscience, that we would rather be the architects of our own fate than have somebody come in from outside and do something to us, but not necessarily for us as a community. What we've learned is that with rising health care costs, businesses have to stop paying for health care. If we don't do something about it, they will, in fact, stop it. It will be easier to outsource it to the government, and I don't think any of us really wants to see that.

The other dilemma for them is that they need healthy workers. If people are sick, they don't show up for work, so regardless of who's paying for the health care bill, they have nobody in their shop to produce what they're doing.

In terms of health care reform issues, as they impact local plans, and actually local is probably a lot bigger than we imagine, we know that size does matter, but perhaps in an inverse way. We have learned that small local plans can be more nimble, they are more responsive to the community, versus a governmental wide perspective of a one size fits all.

We also need a level playing field. If there are state wide reforms and certainly national reforms, we need to know that we can be allowed to deal with the problems at our level in an appropriate fashion that best suits the community. We also know that we need an equitable distribution of the funding. We know that large cities have huge problems, we have them, as well, perhaps on a smaller scale, but we all need an equitable distribution of the money to solve our local problems.

And as a physician and being heavily involved in the development of our managed care program, we also feel very strongly that there does need to be a safety net, we acknowledge that. We're already taking care of these patients, we're compensated for some, but for many we are not compensated, but we have to protect the people with catastrophic illnesses or chronic illnesses that lead to episodic, chronic problems which bankrupt them,

and neither they nor actually the community can afford.

We also need transparency in our costs. The community needs to know what they're paying for with their premium dollar. They need to know what the administrative costs are, how much of what they pay actually goes into the health care they receive. That's very important and that's not something that's always readily available.

Quality is, of course, another issue, that goes without saying. And just to conclude, I want to encourage all of you to become involved in your health plans, I think it's something that you can do. Certainly, the Cleveland Clinic has the resources to do it. And I think it's only by accepting the personal responsibility, not only for our own health care and our own wellness, but for the health care and delivery systems of our community will the reform every be successful. Thank you.

MR. TALBOTT: Thank you.

MR. WINKERWERDER: Henry, thank you, and thank you all for the invitation to be here, I appreciate the opportunity to participate in this interesting discussion. Let me also thank Alice Rivlin for her comments. I agree completely with her perspective about the central problem of health care costs and the impact on the federal budget.

My comments, and I'm going to try to keep it to eight minutes, as well, are based upon my experience, what I have come to know about human behavior, as well as my experience with politics, especially these last several

years, as well as sort of an understanding of macro economic policy and decision making, and then finally, a perspective as a physician with regard to how decisions are made when doctors sit across from patients, as I have done many times, and you have to make those choices about care. And all of those dynamics enter into the equation here. Let me say up front, I'm going to label myself pretty much a hard eyed realist at this point, after more than 20 years in the private sector, not just as a provider, a practicing physician, but as an executive with two major health plans, and also experience on the delivery side with Emery University.

I've been an advocate for reform, for payment reform, financing reform, and for reform in the way that we deliver health care for more than 20 years. But I've come to experience first hand just how difficult it is, and I think I have some sense for what things work and what things don't.

So let me jump to the conclusion as I see it, and that is that the rising health care costs that we're experiencing are our main problem in terms of health policy reform.

There was an introductory statement about this panel that said, if I can read it, that the need for health care -- that we would examine the need for health care reform to improve care while controlling costs. I would put it a little bit differently. I would say we need to control costs so that we can improve care. We are not getting the value for the money that we're spending, as Doctor Rivlin pointed out. And rising costs, I think we're seeing more and more,

do have a great deal to do with the disparities in our health care system. They certainly have a lot to do with the unaffordability of insurance, and therefore, the rising number of uninsured.

So rising costs are the main problem. Therefore, our main policy goals, it seems to me as we look sort of at the big picture without getting into the various solutions, must be, one, the affordability of coverage, especially for those who are covered in the private sector, and then on the public sector side, the sustainability of our public sector programs, whether it's Medicare, Medicaid, VA, or the Department of Defense.

Now, for those who obtain coverage through their employers or in the private market place, I believe, I've come to believe that you cannot tackle the problem of health care costs unless you deal with a tax code. And I don't want to go into the details of that, but I think that's fundamental.

Secondly, the costly weight of regulation in 50 different states is a big part of that issue. And then finally, and I want to speak to the employers here, the active involvement of employers. We have an employer based system largely, it's certainly under great stress right now, but without the active leadership of employers to influence behaviors, as you're doing here, and let me commend what the Cleveland Clinic is doing, I think that's fantastic, more employers need to do that to emphasize wellness, and to put your money where your mouth is on that issue, and then also to shape benefits, and the two go together.

So secondly, for those health benefit programs that are essentially controlled by Congress, Medicare, Medicaid, VA, and DOD, and I had the responsibility for the Department of Defense health program, some of you might not appreciate that, it's a huge program buried within DOD, but we were a $40 billion a year program. Combined with the VA, the cost of veterans and defense health care alone are approaching $100 billion a year.

If you add the disability costs, it's over $100 billion. We're making comparisons of health care spending with respect to the country of France, and those two being roughly equal. Our defense health budget in the U.S., defense health, my budget, is greater than the entire budget of the Ministry of Defense for Germany and France, not the two combined, but each of them. So that just gives you an idea. It felt odd to go to a country like that and realize you were managing a bigger budget than they were for the entire defense. They need to spend more in defense, for sure. But I believe that you can't control these programs and their trajectory of growth without changing the budget process.

And I know that Brookings and others have looked at that and talked about that and written about that. But the way that Congress goes about setting budgets and the mechanisms and really even the term entitlement implies that things are untouchable, and I think we've got to challenge that. They cannot be untouchable because they are squeezing out other spending.

And then the other thing that's intertwined with that is the structure of the benefits themselves, eligibility, who's covered, cost sharing,

premiums, all of those things.

I'll tell you a brief story about my experience in the Department of Defense. We had a growing problem with expenditures. I spent a great deal of time bringing to light that issue within the Department. When your budget keeps going up, if you're not careful about the way you define it, what the problem is, you can get hammered, and it's your fault. I tried to explain, and I think was successful in doing so, what were the real drivers of our costs, and with a lot of discussions with the Joint Chief and the Secretary and so forth, they all came to understand, hey, we got it, we need to reform and change our benefit for our retirees. This was not an active duty problem. Our budget, less than 40 percent, was for all the active duty. It was a retiree health problem. And once they got that, they were willing to go to Congress to propose some reforms, very monitored reforms. We got killed, no interest.

Privately people would say, yeah, I agree with you, we really need to do something about this, but this is not the time. It wasn't the time for republicans to be courageous, and it certainly wasn't the time for democrats to agree that there needed to be more, you know, cost sharing and more adjustments in such a visible program.

So let me just say, in the military we use a term called major muscle movements when we talk about big operations. I think that's what we need in health care, if I can use that analogy. You cannot stand up from lying down without moving your major muscles, your hips, your torso, we need major

muscle movement to reform care. And before you can start moving your muscles and get up off the ground, you know, from being tied down, I'm thinking about Gulliver's Travels, you need the intention to act and the will. So as a country, we absolutely have to have the will to act, and to bring that before our leaders. I agree, our leaders currently and those that are running have not made this the visible problem that it needs to be. I also believe that once those major muscle movements are called into action, then it becomes a lot easier for other reforms to take place.

I'm not saying that you have to have those first, you can pursue the others, but the payment reforms that we've talked about, the emphasis and wellness, better chronic care coordination, lower admin costs, reducing variation.

Let me just close by saying a word or two about competition. What might a more competitive market be able to achieve? I'm going to reflect on my own experience during the 1990's, from about late -- well, actually late '80's up until 2001.

I worked as a senior executive at two large health plans, and also, as I mentioned, a delivery -- and a great delivery system. When it comes to the competition, I believe, looking back, we had some very intense competition for about a four year period, about 1994 to 1998, both in the health plan sector and in the provider sector. And there was certainly a competition among and between providers. The word I heard you use, Michael, about what

could happen like, for example, with the competition from India was something that U.S. providers felt -- it was my perception they did among and between themselves and markets as employers and health plans reflects in their muscles.

For better, for worse, I think the result of that time period and that experiment, if you will, was that providers want that sort of stand-off, and what we've had since that time is a great deal of consolidation in the market place. In some cases that certainly makes sense to do things more effectively. But most providers are in all networks, and the pricing power has been maintained.

So to the extent that there could be real competition in the provider market place, I see that as being difficult under the current structure of things, unless there is true engagement of consumers, and that they themselves use their power to make changes.

So I think that's required, and it is beginning to happen, but to accelerate it, I think there need to be different benefit structures, more cost sharing, more engagement, more incentives, as you talk about here for staying healthy, maybe even a few penalties for unhealthy behaviors and life styles, and it requires information and transparency at the end of the day. I've come to believe that Daloit who I work with is a senior advisor, had some very interesting data about surveying consumers, a large survey, and what that survey showed was that there's a real hunger for more information, and even

among, and this was sort of a cross section, include low income groups, Medicaid beneficiaries, and so forth, is that they wanted more information about their health care. That's not a common assumption that we have about some of those groups.

So one area that's kind of interesting in this regard is pharmaceuticals, I think. And there seems to be some fairly interesting downward pressure on prices and competition in that segment. And what are the features of that market?

Well, they're generic, they're benefit designs that differentiate the underlying cost structure of the product, they're large retail outlets that move these products, now Walmart, Target, and the big chains are into the pharmaceutical business, there's international competition, and there's visible and transparent prices. So that's an interesting one, I think, to look at. There are a couple of other trends that I'll mention, we sort of touched on them, that I think could have an impact, one is this notion of retail clinics. I bring that out because there's a projection that over 2,000 such small primary care based clinics will be installed and in operation in the Walmart's, in the CVS's, and the Walgreen's of the world, and that could have a real impact at least on the primary care front end.

And then medical tourism, what we're coming to call medical tourism, of going to get these procedures, major procedures in overseas locations at much lower prices, could also have a competitive effect. So it will

be interesting to see those.

At the end of the day, the solutions in Washington are going to require a lot of leadership, broad public buy-in, bipartisan support, and a real understanding of the American public. I'm hopeful, this is a big issue.

I continue to remain an optimist, believing like, whatever Winston Churchill's quote was, that the Americans will work around for the longest time until we get to the right solution, we'll finally get it, but we sure need to stay at it. Thank you.

MR. TALBOTT: Thank you very much. I'm going to ask just two questions and then we're going to open it up to you, so please be getting ready for it. I'd like to go back, and for the first question, to the last question of the previous session, which concerned the relative quality of U.S. health care compared to that in other countries.

There's one area where there is no question that we are not at the forefront, and that is in the use of information technology. A lot of other countries are way ahead of us.

President Bush created an agency or an activity within the Department of Health and Human Services headed by a very energetic person, David Brailer, but there was just one problem with David Brailer's charge, he was given no money, none. He had to operate within current budgets and persuade other people.

So I would like to put to all three of you a specific question.

There's going to be a new President next January 20th; you are asked to give advice to that President on how to bring the United States up to the front line with respect to the use of information technology; what would you tell them?

SPEAKER: Well, at the moment, there aren't adequate incentives to get folks who are comfortable in the current situation to move to adopting electronic medical record, automating their office. And so one of the things that the new President ought to do to the Medicare program is figure out how we can create some incentives to make that movement.

So if you go into the community setting, independent physicians, the uptake on adoption of electronic medical record, even at very low prices, has been very, very slow. And so you've got to tie some more benefit to it in order to speed that adoption amongst physicians. So I think incentivizing as quickly as possible is going to be a critical thing.

By the way, I believe Mrs. Clinton has significant savings in her plan associated with the adoption of the electronic medical record, but it's not clear how she's going to get everybody on it. And so without those incentives or without some way of strong encouragement to get folks to sign up, it's going to be tough.

SPEAKER: Also, it's important to keep in mind that it's easy for a candidate to claim savings. Getting the Congressional Budget Office to actually score them as savings is very much harder. The Chair of the next session, Mark McClellan, holds the Leonard Schaeffer Chair at Brookings.

Leonard Schaeffer is fond of saying free is not cheap enough with respect -- but do you --

SPEAKER: Yes, I agree with Michael. At the Department of Defense, we invested heavily in information technology, and along with the VA, I think it's fair to say we're leading, are leading the country with a handful of others, like the Cleveland Clinic, like Kaiser Permanente, and so for us it was a pure matter of necessity.

There was no practical way, and I realized this early on, in 2001, we had already done some investment, we had not made the big decision to move forward until about 2003, but we could not track people all over the world, especially those deploying, and know what the heck was going on with them when they got back without electronic records, it just was not possible.

And we'd had such a bad experience during the first go for with people losing records. So we moved forward, we spent a lot of money, and there's a lot of progress.

I think one of the big hurdles is that large organizations on the provider side have the capital or they should make the capital available. The problem is the smaller mid sized groups and individuals. And what should be done, I think, is to provide more money, yes, I don't know that it needs to be an overwhelming amount, and it ought to be time limited for people to get the necessary funds to invest. There ought to be some -- probably some stick along with it.

And then the other road block is the interoperability standards, and Mark knows this. We've worked together on the commission, the American Health Information Community, that Secretary Levitt chaired, and that's a tough, technical set of issues. But we've got to work at it, and maybe some pressure to meet certain standards by certain time lines with health.

SPEAKER: I'd like to ask Doctor Rovner a question, but with an anecdote at my way of introduction. It happens to be a personal anecdote, we all have them. This one concerns research that I did in connection with a book comparing British and U.S. health care, and one of the areas I compared was diagnostic radiology.

So I had a whole bunch of phone calls, transatlantic phone calls with British radiologists, who said, you know, we don't do enough and you do too much. That was the standard reply. One of them said, you know, he said, if you're over 65 and you go in to have your hearing tested, you're going to have some hearing loss, and the first thing the doctor is going to tell you is, you need an MRI, and why is that, because once in maybe 10,000 cases, there will be something called an acoustic neuroma, a slow growing cancer that is treatable.

Fast forward about a year, I come back from vacation, I have hearing loss in my left ear. I go to see an audiologist, he tests me, he confirms I have hearing loss, he said, you should have an MRI, I said, could it wait, he said, sure.

Now, my question is, how do you write rules for radiologists, and by inference, other physicians, that skims off the low benefit, I'm not saying no benefit, the low benefit use of high technology that costs a lot of money here and goes some distance toward explaining why we spend twice as much per capita as the average of the next ten richest countries in the world on health care?

MR. ROVNER: Well, I have a short answer for that. And although I make my living reading these things, it's astounding to me at how many studies are done for the one percent. I think a lot of that is done for medical legal reasons, especially from an emergency room. Last week I worked on our night shift, 12:00 at night until 8:00 in the morning, and knowing that I was going to come here to speak, every time I read another cat scan on somebody who had a headache last week, I should have, you know, cleaned my little mental register and said, okay, there's another couple hundred dollars down the drain.

I think the rules are out there. And, in fact, the American College of Radiology has put together appropriate miss criteria, and they've done this in concert with other specialty groups, so it's not just the radiologist telling you what to do, because God forbid if we ever did that.

The issue is, when you're on the front line taking care of a patient, and the patient says, I need an explanation for the symptom, doctor, and I happen to know that there's all this technology out there, you know, I

really appreciate your opinion and I'm really glad that you were able to get me in today so quickly, so could you just schedule me for a cat scan.

In fact, I think if you could do it online, patients would bypass -- would schedule themselves and walk into the doctor and say, okay, I have a hearing problem and the MRI was negative, now what do you think, and really speed up the process. In fact, many specialists do that now, too, they say get these studies and show up at our office and then we'll tell you what the problem is. I think if the medical societies were incented, and I don't know whether it's with a carrot or a stick or a combination of both, to come up with agreements that say these are reasonable standards of care, this is the percentage yield if you do this study in this kind of clinical scenario, and that, no, it is not malpractice, if you had the acoustic -- in a few months, you're not likely to sue somebody, but it may be somebody else who will file the lawsuit.

And I think that knowledge is out there, I think it's just getting everybody to have the will to get together, agree upon the standards, and not have a penalty for following the standards. And I think that's what I see in common every day practice.

SPEAKER: Getting there is going to be a problem. Incidentally, in connection with MRI, the former head of the Medical School at Washington University quipped that he thought it might be -- just be very economical if you put the MRI machine at the entrance of the emergency room. But we now have time for a number of questions from you. They can be addressed to any

of the three participants. Don't be bashful. There is a microphone here, and somebody will raise it to a higher level.

MR. SEBUL: Thanks, Randy Sebul. I have a question for Doctor Winkerwerder and for Doctor Aaron. I actually direct a transparency collaborative, essentially a collaborative that's funded by the Johnson Foundation and others to do performance reporting and so forth, and we're going to come out with our first report in the near future.

A quick couple of comments on that, but it leads to my question. We are really blessed in Cleveland with an enormous number of -- enormous penetration of electronic medical records.

We're able to essentially capture data related to half of all the patients in the region on electronic medical records and those data are being shared. We're using national quality forum standards to report, and it's evidence based guidelines and so forth and so on, and so it's a terrific and remarkable partnership here in Cleveland to be able to do that.

The question for Doctor Aaron and Doctor Winkerwerder really has to do with where reform should be focused and what the future of reform at a regional level or at a state level is. Doctor Aaron, you talked about state level activities. Bill, you talked about sort of the need for the will at every level. But the issues with regard to sort of what are the hurdles to regional reform are things that I'm focusing on, because we're doing sort of a regional reform initiative.

And the challenges are, at the employer level, that while they are wonderful things going on such as incentivizing your employees to do better, increasingly, with outsourcing and downsizing of local presence, you know, so we'll have Eaton and we had TRW and we have some big companies, or had some big companies here, but the local presence is smaller, so their investment in the community I think has diminished. They may have larger companies generally, but they're present elsewhere.

So the question is, how much incentive do they have to invest in, performance incentives or that sort of thing? The second is, related to that is, I actually wasn't aware that you were -- that you had been an executive in a national health plan, so the national health plans basically have regional offices, but if you want to do something novel at the regional level, you're basically fighting a bureaucracy that goes up from Ohio to the mid west to Retuxin in Minneapolis, and so the issue then becomes, how do you do outside the box kind of regional reform when you're faced with challenges of this sort?

DOCTOR WINKERWERDER: Let me take the last part of your question first. I think that's, you know, the health plans continue to consolidate on a national level, and it appears that more of the decision making is concentrated at the national level, less interest in variation or experimentation. I think that's a mistake.

I think they need to experiment and be willing to engage in projects, shared risk projects or penny for performance projects, and how else

can they move forward to something better unless they try it.

And so I don't know how to suggest to you what you should do, but whoever the employment community is, the Cleveland Clinic itself, you know, you could go forward and get some agreement about what you think would make sense to try, and I would encourage you to try it.

You've got to experiment. And, you know, I'm a big believer that some of the best ideas come from local levels. I know that some of our innovation in military health and technology came absolutely from the battle field and the local level. If we were trying to control that all from the Pentagon, it would never have happened, never, so that's my take.

DOCTOR AARON: The question is a vast one. I'm just going to answer two little tiny fragments of it. The first plays off of a comment that Bill made earlier about the centrality of tax reform and health care reform. And I'm going to use it. The Cleveland Clinic has been getting a lot of plugs this morning; I'm going to give one for the Brookings Institution.

Please stay tuned, we commissioned a number of studies of the way in which the taxes should be included as part of health care reform. Those are going to appear in -- well, actually they are now on the web site of the American Tax Policy Institute, the sponsor of the event, and Brookings will be publishing them collectively sometime in late August or early September. I think that point deserves emphasis.

The second point I'd call attention to goes a bit in the opposite

direction. Lately, the one organization whose health care system has been getting the best press, maybe it should have been shared more broadly with defense, but the organization getting the best press is the VA. And I want you to think about what the VA is. It's a organization with a fixed budget, operated by a government agency, and for a long time it was a disaster case. The care was abysmal and it was a shame. What happened was, it got taken over by aggressive administrators who were given a measure of flexibility to apply sound management principals to the operation of that system. I mention that because it indicates that efficient operations is not inconsistent with a government agency running a system with a fixed budget.

That same quality study that I mentioned earlier that said on the average, about 55 percent of people get all recommended care when they have contact with a physician or a hospital found that the VA was about 65, and put it significantly ahead, not too far, but it was the best single purveyor compared to any broad aggregate of health care providers in the United States.

Of course, there are local areas of great excellence, Cleveland, Mayo. But I just want to mention, as something to keep in mind, that an agency that embodies a strategy to reform that may serve localities around the United States. We're much too big, as Doctor Winkerwerder stressed, for a single set of decisions to govern all health care in the United States. Our tastes differ, our needs are various. But for the VA, that system has been arguable the most successful model we have going currently in the United States.

SPEAKER: More questions, please, yes.

SPEAKER: If I can just make a comment. I would agree that VA has been able to do some very good things. I thought we were able to do similarly some very good things within DOD. As a former administrator of a program that was not just a financing program, we were a delivery and financing program, and very large, I would say the main thing I would have wanted was more flexibility to make decision.

Congress, bless their hearts, you know, love to get in and micro manage, and it just is maddening, because you knew as, you know, I wasn't trying to do anything bad, I was trying to do good things, you know, more efficient, better quality, lower cost, but, you know, that's my concern about a health care system that's so politically controlled, is it really inhibits sound decision making.

SPEAKER: Yes, ma'am.

SPEAKER: Hello; I -- there are a couple of comments that have been made that I've been listening to. I certainly know, as a worker at a federally qualified community health center, that a couple of mandates came out of the presidential office, one for more community health centers, which was funded, and one for going to electronic health records, which was an unfunded mandate. And I know very truly that cost is the -- we have the incentive, we are taking care of people on the lowest level of the poverty line and who -- and I believe who poverty and chronic disease are very linked, and

we are doing some really cutting edge chronic disease management programs that came out of Pursa and we are unable to collect the data because we can't afford the electronic health records.

One of the solutions that we have considered, and actually there's been talk around -- on a local level about, is partnering with our hospitals on the usage of -- on the sharing of an electronic health record system, maybe even being hosted by a hospital, informing a network, because we see patients that go to -- that we refer to these hospitals, and we would be able to -- we would be able to have -- to share those records and to take better care and reduce redundancy and all of that stuff.

And I also hate the idea of retail clinics, I'm worried about the level of -- quality of health care. I think that we should not dismiss our health centers, and I want to know what people think about the idea of creating health center hospital networks and sharing some of that.

SPEAKER: It could be possible. I think you'd have to understand a little bit more about the model and how it would work. And like a lot of things, it comes back to ultimately how it gets paid for. And, you know, you can't get away I think from the idea that, if you're going to extend the electronic medical record, you're going to have to create some incentives to do so, and there will have to be funding that's going to be made available to make that happen.

SPEAKER: I'm a family physician here in Cleveland, working for

Metro Health, our county hospital system. But I'm a single pair national health care advocate, and I think that it would answer all the problems you mentioned if we had a single pair universal health care. Everyone would be covered, it would end disparity, it would help our companies be more economically viable, because health care would be paid for by taxes. It just seems like it would be the simplest solution, decrease your cost, your administrative cost, and plus, you could do more quality work because you could -- everybody would have the same insurance, we could all be connected to our electronic medical records. So I just think that it should be paid for by taxes.

SPEAKER: Is your question why this idea --

SPEAKER: Why doesn't it happen?

SPEAKER: -- has not persuaded the other 85 percent of the American population?

SPEAKER: Well, I mean -- and the studies have shown that like close to 70 percent of Americans would rather pay increased tax money so everyone could be covered. I mean, you know, I've seen polls that say that. So I don't really understand why it hasn't even been mentioned, and it's been kind of ridiculed by some of you and talked about.

SPEAKER: I don't think anybody has ridiculed it. Let me just say that this is an idea that has been around for a great many years, its popularity has ebbed and flowed, but the ebbs have never come close to commanding a

majority of the population, for good reasons or bad. I'm simply reporting what I think is the historical record.

And so my own view is that the practical question now is how to persuade each of us who has his or her own favorite plan to stop behaving the way we have for a long time, which is to say, if it's not our plan, the status quo is what we prefer. The goal now is to get us to find a way of moving forward that can commend a majority support. That happens to be the reason why, I think, a state based approach is not the final answer, but it may be the next step in moving toward ultimate reform, and that may --

(Interruption)

MR. O'HANLON: I'm Mike O'Hanlon, Senior Fellow at Brookings, and Director, along with some colleagues, of the Opportunity 08 project, just delighted to be here. I'm going to introduce Mark McClellan, who will then introduce the panel in just a moment.

I want to quickly, on a personal note, to thank Pochankle and all the folks here at the Cleveland Clinic who have been a joy to work with. I know I speak on behalf of Melissa Skolfield and Aaron McGaffin and everyone at Brookings in saying this.

Very briefly, I also, as Henry Aaron mentioned, we all think about health care reform from the point of view of personal stories and anecdotes, and I just want to very briefly thank the Cleveland Clinic for its work on autism, which is an interest -- a particular concern to me.

And now I want to introduce Mark McClellan, who is the Leonard Schaeffer Chair in health policy at the Al Engelberg Center for Health Care Reform at Brookings. Mark has been with us now for a couple of years after a distinguished career in government, which I'll mention in just a second. But before that, I should quickly go over his educational track record. Like many of us children of the '60's and '70's, he spent a lot of years floundering through school figuring out what to do with his life. Thankfully, in his case, he actually managed to get a Bachelor's from Texas, an MPA from the Kennedy School, and MD from Harvard, and a PhD in Economics from NIT in the process, so it wasn't a completely lost cause, and it wasn't all spent on the Frisbee course or the concert hall.

But, in any event, after that time, he's also taught at Stanford in both the fields of economics and medicine, served in the Clinton Administration, in the Department of the Treasury, and has had several important jobs in the Bush Administration, including the Director of the Food and Drug Administration, and then the Centers for Medicare and Medicaid. So it's a great honor and pleasure to introduce my friend, Mark McClellan from Brookings. Thank you.

MR. McCLELLAN: Thank you. Thanks very much, Mike, and thanks for all your leadership on the Opportunity 08 project. And it's a real pleasure to be back here in Cleveland at the Cleveland Clinic to talk with you all about these very important issues. I've had a chance to work over the years

with the Clinic, with Alt Care, with many of the other provider groups represented here, and it reminds me about why this panel is so important. A lot of the very good ideas for finding better ways to actually reform health care, to actually change the way health care works, have come from organizations like this, from providers, from communities working together to change the delivery of care.

And you heard a lot of pessimism in some of the numbers earlier this morning, in fact, a little bit of fighting about who's actually more scary, about the future of fiscal outlook for the nation. But I wanted to highlight -- you also heard some optimism.

Henry ended the last panel, Henry Aaron ended the last panel by talking about his optimism for state and regional and locally led reform efforts. I would also point out that that's built into some of those CBO projections that you heard so much about this morning.

For all the gloom and doom of our GDP going from 17 percent of -- related to health care, this year up to 31 percent over the next couple of decades built into that is actually an expectation that states are going to find ways to help slow the growth of health care costs, that's actually built into those assumptions. And so what we want to do with this panel was talk a little bit more about some of the steps that are happening now, particularly right here in Ohio, to help provide a basis for broader reform nationally, something that the presidential candidates definitely need to pay attention to, something that will

definitely be part of the national debate and discussion this fall and in the next year for health care reform more broadly.

State and local leadership is very important. As you heard, all of the proposals for major reform that have actually been implemented or close to being implemented have started out with ideas at the state level.

There was a big debate at the federal government last year, not about major health care reform, but about dealing with the problem of uninsured children. Remember, there wasn't a broad bipartisan agreement including the administration and democrats and republicans and Congress on that issue.

It ended up getting stuck between, on the one hand, proposals for expanding government programs, like S Chip and Medicaid, in kind of the ways that they had been done at low income levels up to higher income levels, and on the other hand, trying to -- other hand arguing that those programs were meant for low income individuals, and that we couldn't afford to pay very high subsidy rates up at 250 -- 300 percent of poverty, 400 percent of poverty or so. In many states, the debate hasn't stopped there. There's been a recognition that maybe it's not just expansion of government programs that is the only path forward, and maybe it's not a recognition that you can't do anything to help people with incomes beyond the low income level.

What many of these state reforms have done is find ways to provide some additional help at higher income levels and get out of just a strict

dichotomy between public programs and private programs. That's what happened in Massachusetts, that's what's happened in many other states. That's where a lot of the bipartisan proposals have gone.

And if it's any forecast of what's going to happen next year at the federal level, as Henry Aaron mentioned, many of the bipartisan proposals from members of the House, members of the Senate, include exactly that kind of approach, relying on public programs, in part, relying on expanding access to affordable coverage for people who aren't lucky enough to get it through their jobs, through some new subsidies that are federally support, but maybe not quite as generous at the higher income levels as Medicaid or S Chip might be. And there are some models for combining those kinds of coverage reforms, those kinds of financing reform with reforms in the actual delivery of health care, and that's where the state and local effort have been and can be so important.

You heard earlier today, I think one of the questions came from someone who's involved in efforts here in Cleveland, to try to move people who are paying for health care, with support from health care providers, towards new ways of payment that recognize that there is a lot we can do to improve prevention, to improve coordination of care for chronic diseases, to avoid unnecessary administrative costs in health care. That could get a big boost with further state and federal efforts.

There are efforts underway in places like the Cleveland Clinic

and Alt Care to actually reform care along the same line. And this is also true in Medicaid programs. I want to tell you one brief story about my experience in government, because it's not always what it's stated to be going in.

I remember soon after I had started working in the White House, and you heard a little bit about my bio from Mike, I was doing health care advising for this administration early in 2001, and I got a call from the Chief of Staff at that time, it was Andy Carr, I was up in my office, I didn't see him every day, but I heard from him once in a while, but this call said, Mark, there's some protesters out in the middle of 17th and Pennsylvania, go fix it.

Now, I didn't think that was part of my job description as an Economic Advisor to the President and coordinating health care policy, but when I got down there, it turned out a lot of these people were from an organization called Adapt that some of you may have heard of, which is made up of people with a disability who need mobility assist devices who had blocked the intersection at rush hour, right out in front of the White House, because they wanted control over how they got their Medicaid benefits.

They were saying, look, 40 years ago, when Medicaid began, long term care meant nursing home care, but that's not the kind of care that we necessarily want; we want to choose how we get long term care services, because the technologies exist for us to modify our homes or get kind of assist devices or work with home care attendants, and we can do this less expensively, and we can have a much better quality of life, be much more

involved in the community. Well, sitting out there listening to this at rush hour, it actually made a lot of sense to me. And one thing led to another, and with some good demonstration programs from states around the country, and it always starts with states, and a pilot program that we were able to start in Medicaid over the next couple of years, the result was, legislation passed by Congress in 2006 called Money Follows a Person legislation that gives states a bonus for getting over the hump of reforming and bringing up-to-date their Medicaid benefit program so that people with a disability can choose how to get their long term care services.

And the evidence is overwhelming. We talked about the importance of paying attention to quality and cost earlier and having benefits that support better quality and lower cost. These reforms lead to better satisfaction for patients, by far, beneficiaries, by far, because they get to control how the services are provided on their behalf, leads to better health outcomes, it leads to significantly lower cost per person served, it's kind of a win win win. And now Ohio is moving forward thanks to leadership from the governor and the Medicaid program, on implementing the same kinds of reforms here. So there are ways to do this with a lot of state leadership, and that's what we want to talk about today. We have a very distinguished panel, and I'm going to introduce them in order of their presentation. And we're going to start with Tom Lackovic, who is a principal in the Cleveland Office of McKenzie and Company, where he works on a range of issues with health care payers, including state

governments, including private sector plans, on strategies to improve performance in the health care industry.

And Tom with McKenzie has done a lot of the work over the past year in reviewing the status of the current situation here in Ohio as you face a need at the state level for health care reform. He's been working with the Ohio Business Roundtable to develop and build the framework to help a comprehensive agenda for reform move forward.

And he's also helped develop similar kinds of comprehensive health value strategies for other clients, including both, again, public and private sector, including steps to improve performance of Medicaid programs.

Tom leads the McKenzie Research Program on the transition of the health care industry to what they call a retail orientation, one focusing not on providers, but on consumer or patient preferences, putting the patient at the center of activities is the thing we keep hearing about today. Then I'm going to turn to Representation Jim Raussen. Representative, it's a real honor for us to have you here with us today.

Jim Raussen was elected in 2002 to the Office of the State Representative from Ohio's 28th, which is northeast and north central Hamilton County. As a legislature, his interests have included economic development and many insurance and health care issues which are pretty closely related, as you've heard this morning.

He's the sponsor of the Ohio Health Care Consumers Right to

Know Act, which provided for greater consumer access to important hospital price and quality data. He's Chairman of the House Health Care Access and Affordability Committee, where he is focusing on developing and implementing a comprehensive health care reform agenda through legislation.

He's also got a lot of professional experience in the industry, in the insurance industry, with a background in risk management and property and casualty issues. And you'll hear from him about some of the key components of his recently proposed legislation, the care plan, which has gotten that name from its four pronged approach of coverage, access, reform, and efficiency, and also talk a little about the general prospect for health care reform coming up and how it fits into the federal agenda, then he's going to dash off to work on the Capital Budgeting Bill, and we appreciate your taking the time to fit this in.

Then we're going to hear from Doug Anderson. Doug is the Chief Policy Officer at the Ohio Department of Insurance, where he's provided legal and strategic advice on a broad range of insurance and health care issues since 2001.

Doug is currently leading efforts to develop reforms to Ohio's health insurance and health care system, and in particular, it's coordinating the activities of the Governor's State Coverage Initiative Team and Health Care Coverage Initiative Advisory Committee.

Before being at the Department of Insurance, he was a partner at

Porter, Wright, Morris, and Arthur in Columbus, and he's going to talk about some of the insights into what the Governor's State Coverage Initiative is working on now and preview some of its recommendations or go over some of its recommendations to expand coverage to many of the Ohioans who don't have it now, and to increase the number of small employers who are able to offer health insurance to their employees. And finally, we're going to hear from Cristal Thomas, who is the Executive Director of the Ohio Executive Medicaid Management Administration, and is a member of Governor Strickland's cabinet and a close advisor on health care issues.

In her role in this directorship, she's responsible for helping to achieve the budget, operational and strategic goals of the Ohio Medicaid Program, and improve the coordination of policies and business practices across six different state agencies, all related to improving access to high quality health care.

Previous to this position, she served as the Ohio Medicaid Director under Governor Strickland, and oversaw a $12 billion budget and more than 400 staff responsible for providing health care coverage to the two million Ohioans who get their coverage through Medicaid and related state programs.

Ms. Thomas has also been involved in the state coverage initiative efforts, and she's going to talk about the Ohio Medicaid program, provide a bit of an overview of several key approaches for reforming health care delivery for lower income and vulnerable populations, including ways to

improve quality and affordability in long term care. So a lot of distinguished panelists. And with that, Tom, I'd like to turn it to you to kick us off.

MR. LACKOVIC: Thank you. Well, first I just want to thank our host for the opportunity to be here. Just a quick word on McKenzie, the firm I'm a partner at, we're a management consulting firm globally, we serve top management to both private and public institutions, and really, particularly that last five years, we've done a lot of work, not only in the private sector across each of the major sectors of health care, but also with government, both in this country, as well as internationally.

And we're completely non-partisan, we consult on managerial and operational issues, not on policies specifically. So my comments are going to come from a base of experience, both here in Ohio, as well as in other states and other countries.

There's a couple of points I'd like to make; first, a little theory, if you'll forgive me, on how at least we think about health care reform and health systems reform, and then a couple specific observations about state level health reform. So first, the theory; I think it's important to recognize there is such a thing as a health system. And when we talk about reform, we should talk about it in terms of a system, how do we get a system to perform better. Systems can exist, health systems at multiple levels, a lot of energy gets put at the federal level, but there is absolutely both a state health system and then local health systems. And those systems include lots of different entities,

different providers, different payers, different -- other stakeholders, employers, and other facilitators.

I think in our -- what we find to be very helpful is to actually view things as a system. What historically happen, I would observe, is folks tend to come at health reform from a particular lens given the stakeholder that they are either part of or represent, which I don't think actually serves us very well.

So our government will look at it in terms of a budget, an employer will look at it in terms of their employees specifically, a payer or a provider will look at it relative to what they get or pay from the other party. So I think it's awfully important to look at a health system.

In that context, our observation would be there is a huge opportunity to actually do better within the context of a state and within the context of local areas. So there's a lot we can do outside of federal reform. The second point I'd make, a little bit more the theory of the case is, when measuring the performance of a health system, or asking the question, how do we know if we're doing a good job or not, we would argue that it's right to look at it in terms of value. And others have mentioned it today, but just to draw that out a little bit more, value to us is basically what we give for our investment.

As an example, in Ohio, the Ohio health system, broadly defined, spends somewhere in the neighborhood of $90 to $100 billion a year. That's going up at a pretty healthy clip, but that's a -- investment. We also invest a lot of our best talent in health care in Ohio. So that's what we're putting into the

system. We can ask the question, what do we get out.

At the most basic level, we get out a certain life expectancy, a certain standard of living, so there's an output we can look at, we can measure, we can ask the question, how well are we doing. The other aspect of value is, frankly, how satisfied all of us are with the system and how it functions. So we can have a system that's either more or less convenient, more or less understandable, more or less accessible. And so we actually believe that you can look at a health system, measure those things, measure them over time, and actually track how well you're doing, and you can really tell, hey, are we doing a better job, if we implement reform X, we can look at it over time and say does this work or not.

That's particularly important within the context of state reform, because states historically have been the beds of innovation, and so it's awfully important when we try things to know whether or not they work.

The last thing I would just mention is, a couple -- brief observations around state reform across the country, the primary one being, most state reform efforts have at least historically, and I would argue, to date, have been focused on not -- primarily on access, certainly a very noble goal, important, but there are a number of other large opportunities to improve our health system other than access.

I'd just draw out a couple that hopefully we can talk a little bit more on this panel, the first of which is really just broadly define population

health. On the previous panel, we talked about obesity briefly, but a number of behavioral issues, population health issues, obesity, smoking, inactivity, alcohol consumption, a number of these things have a large and growing influence on particularly the cost side of health care, but also the productivity of our citizens. Just a few quick facts here many of you might be aware of; obesity is rapidly accelerating. What's particularly problematic is the rate of morbid obesity is increasing quite quickly.

Right now, close to 20 percent of all of these persons are morbidly obese. That rate is going up to the point where over a 15 year period, without major intervention, we'll have about twice as many of those folks as we do now.

The challenges are, of course, is that an obese person is likely to die three years -- have life expectancy three years less than a non obese person, they're likely to consume anywhere between 20 and 70 percent more health care resources, largely because they suffer from a greater incidence of disease and medical conditions.

And the last thing is, there is a difference in productivity. So even small changes in the rate of obesity has a huge impact on the cost and productivity of the health system. There are many other issues like that as it relates to population health. And the last thing I would just mention, broadly, fanatically is, I think there's an opportunity to do a lot more at the state level in a much more coordinated way to improve the health delivery system itself. A lot

of energy gets put on the system of intermediation, so the payers, be it the Medicaid program or the Medicare program, private payers, and there's an awful lot of opportunity to improve that.

What I observed, though, is that all the care is delivered by a set of other people, providers, hospitals, physicians, nurses, et cetera, and by almost any objective measure, we can do a lot better in the delivery system, both on the demand side, so how do we incent and help create more value conscience consumption, both on consumers and in the case of providers, as well as on the supply side, how do we use the assets and the capital that we deploy more efficiently than we do right now.

And I think there's a big opportunity at the state level to do more and think more broadly about how, both from a public policy standpoint, and frankly, as a private sector, we do more to improve the system.

MR. RAUSSEN: Thank you, Tom. Representative Raussen, working on legislation, and that picks up on many of those themes. And thank you, and good morning, everyone. A couple of thoughts about -- that I had at breakfast. Discussion number one was -- to be here today, and someone said, well, is that because you're speaking at the Cleveland Clinic, I said, well, kind of -- so I thought that was an honor. But then it was quickly followed by looking at the list and finding out that I was the only elected official, which means, again, that my colleagues are much smarter than me in avoiding the --

Let me just say a few words, if I could, about what I think is so

important about the state level and what -- You've got to know the rules before you know how to advocate and know what you're fighting for. Here's what Ohio's dynamics are based on. One, you have a term limit in government, both in the -- and the legislative -- that is difficult. You have people who can only --

All right. Is that better? There we go. Usually they always anticipate elected officials having enough volume and voice to carry the day, so it's another assumption.

But, again, a term limited government, people talk about education reform in Ohio, you had legislators in office for 30 years who weren't able to come up with a unified education reform budget, and now you're asking members who average tenure are between five and eight years to fix health care in the state. So you've got to empower individuals, which is what -- and I'll explain further what we've done by going across the state and having a designated committee on aggregate health care reform in general, but you have a term limited government both in the legislative branch and the executive branch, that's a unique dynamic.

Item number two, which goes back to my earlier comments, Ohio is a state of city states, you know, the Peoples Republic of Cleveland, the Peoples Republic of Cincinnati. If Columbus burned down, either one of our cities could really care less.

I know it hurts the Columbus peoples feelings when I tell them that, but it's how we are. We are regional city states. That's how we deliver our

health care, that's how we deliver our education system, and that's why it's difficult to come up with unified comprehensive reform efforts, because that's how we operate, and that's a unique dynamic that other states don't have.

We also, unfortunately, are older, sicker, and poorer than those other states that have done more comprehensive reform. Massachusetts has a higher median income, and had less adult uninsured, and they had more indigent care money coming in than what Ohio currently has. Folks, we are the TWA of states. We are paying for our legacy. So when I talk to folks on the presidential campaigns or when I talk to folks that are in Washington, you know what I say to them, thank you, I know everyone is talking about a national solution, I also have some beach front property in Arizona I can sell them.

What we need is flexibility from the federal government in how we apply Medicaid, help our legacy as we develop these great states in the west, help us in those needs areas that matter the most, and get the heck out of our way, because Ohio's needs are drastically different than some of the other states that have done health care reform.

Where are some of the success stories? If you're healthy in the state of Ohio, and you have a pretty decent job, health care insurance is pretty affordable, because it's risk based, which means we don't have community rating. My friend, one of my colleagues from Cincinnati says his son just graduated from college, is on his own, healthy as an ox, $80 a month and a pretty good plan on his own, not bad. Where do we get in trouble?

Chronic conditions and pre-existing conditions, and the individual market and the small group market. People always talk about coverage in Ohio and insurance reforms, but let's break down the types of insurance coverages there are in the state. Medicare, Medicaid, the uninsured, self-insured, ARISA, a lot of people say, oh, well, Procter and Gamble has Humana, no, Procter and Gamble hires Humana to administer their self-insured plan. And then the smallest group, the small business, medium sized group in the individual market.

So when people come and say, oh, we need insurance reform, that's the smallest group of insured lives in Ohio, ladies and gentlemen, that's the smallest group. So if we're looking at aggregate coverage options, know who the payers are before we decide, oh, if we take care of this, this will fix it all, well, states don't take care of Medicare, states have very limited ability to inform Medicaid, and we can't take care of an uninsured who doesn't have a policy, and certainly we can't take care of Arisa, a self-insured plan, because every federal appellate court tells us we never win in those cases.

So what did we do across the state? Last summer I convinced, conjoled, and bribed my fellow colleagues to go to five cities across Ohio. We did our own field hearings. Now, let me tell you, folks, when I bring some of my colleagues who have never served in other branches of government before, they get very nervous coming out in the firing line. As someone who came from local government remembers awful zoning hearings, where people

threatened to burn your house down, let me tell you, it's not so bad. But we went to five cities across the state of Ohio, and we came up to Cleveland, and let me tell you, those that are not involved in health care, you all are -- the American public is starting to get a little bit more wise and a little bit more crafty. We're not at the tipping point yet.

The old days of debate used to be, we hate the payers, we hate Medicare, we hate Medicaid, we hate the insurance companies, and we hate our out of pocket costs. Those were the traditional debates of argument. We still had those, but we also had, I'm worried about my safety, I don't know if I'm going to the best place, I want to know if I'm getting value for what I'm purchasing, I want to know why I don't have access to good oral health care, which, by the way, Ohio ranks 47th in the country on access to oral health care.

We want to know why I don't have other options. Why do we have only 33 federally qualified health care centers in the state, yet 162 emergency rooms? We're getting a little bit more wise. And so lots of times in the health care debate, and I always joke with health care professionals when I go out there, that is kind of like Mandarin Chinese for a while when you first get into this business. CPT codes, diagnostic, DX, RX, TX, I almost need subtext or something to handle all these types of words that are out there. It's a different language.

And I think the American public says, at least Ohioans are saying, we don't want to become doctors, we don't want to become heads of

major plans, but we want a little bit more skin in the game, we want more skin in the game.

And so I think what you're going to see on the Ohio front as we diagnose our committee and through working with the governor's office and being a part of the State Coverage Initiative Team, which I' proud to be a part of, as well, is diagnosing and then proper treatment. And here's some of the things I want to touch on before we go on to the next speaker.

Information technology is important, not just the medical records, but health information exchange. Let our regions talk amongst themselves so that Medicaid providers can know when they go to the ER, when a patient goes to the ER room, the federally qualified health care center, and the clinic, all in the same week, and not after we receive the bill. Allow us more ability to interoperate with one another, we have to do that regionally first, then we'll worry about the whole state. Health and nutrition standards in the classroom. Ohio has a very generic statute.

Again, the shared relationship between state government and local government, it just says you shall provide health and nutrition in the classroom. Probably because we're an old industrial state, as I said earlier at breakfast, and most of our kids, or most of our grandparents, I should say, were working in the mills, were working in factories, where they were very labor intensive, and so, therefore, it wasn't needed as much.

But we're the 14th in obesity, depending on what report you read,

we're fifth in smoking prevalence in the country, and we're 15th in low infant birth weight. We're behind the times on health education standards and curriculum in our schools. And that will not be an easy battle to conquer, because the local school boards want their way of doing it.

A couple other components that I think, raising the dependent age I think is a good thing to do on family coverage policies, that is one coverage reform. Why? You traditionally bring healthy lives into the mix. Remember, as Doctor McClellan mentioned, I come from the property casualty risk world, you don't have property and casualty coverage for drivers who only have DUI's and multiple accidents, those aren't the only people that buy. We need more healthy lives in the risk pool of health care, more healthy lives, better risk to offer better policies.

We need to have an alignment on charity care definition. We have 170 hospitals in the state, all doing a variety of different care, and mostly very good care. But like our cities, townships, and counties in the state, there's one or two that maybe could do a little bit better of a job. So aligning common definitions in charity care.

High risk coverage for chronic conditions, that's a challenge. There's multiple ways of doing it. One, reinsurance, reinsuring, which is something, again, we've done in the property and casualty world for years, reinsure those risks for state subsidies so they can buy affordable coverage, get their buy-in and get them either in a high risk pool or through a reinsurance

program. That is important, and that will help the state dramatically.

Two other things, the nursing shortage in the state is a real problem. We have a two year waiting list, that's access to care, that's delivery of care. But please note, here's where it all becomes difficult, ladies and gentlemen, for us that have the choice between -- they only give us two buttons, the green button and the red button. And why bipartisan support is so important on health care, because there are so many associations and partners in the health care debate.

It's not like education. If you don't have bipartisan support in health care reform, you won't get it, because as Brother Tocqueville, one of my favorite books, Democracy in American said, Americans are good at voluntary associations, and boy, are we good at them in health care.

There's 40 health care provider associations alone in Ohio, provider. I didn't say payer. You add the two together, you're looking at close to 70 associations in health care delivery. That's a lot of players to balance. If you don't have cooperation and bipartisan support, it won't get done.

So thank you for your attention, and all I ask is, help us in the debate, help us provide solutions, because the folks in Ohio are giving us a window of two years, as mentioned earlier by Aaron's comments, we have two years of a pass by most folks in Ohio and across the country, to come up with aggregate reform. The rest of the turf battles will continue, the rest of the firing fights of risk, to gain risk, will continue in health care, but the American public is

giving us a two year window to come up with something that can make the system achievable, and more importantly, financially sustainable in the years ahead. Thank you.

MR. McCLELLAN: Thank you very much. Doug.

MR. ANDERSON: Well, I wanted to start out by just thanking the Cleveland Clinic for the opportunity to come here today and to talk about what's happening in the state in terms of health care reform.

I'm involved in a project that was started by Governor Strickland, to develop reforms, to cover Ohio's uninsured residents. And I wanted to start with some of the goals that Governor Strickland has set forth in terms of covering Ohioans with coverage.

Currently we have about 1.3 million Ohioans who are uninsured. And a good number of those, about 250,000 to 300,000, are eligible for current programs. So we have about a million Ohioans who are uninsured, who don't have access to public programs, employer sponsored coverage, and they haven't purchased health care on their own. And Governor Strickland, when he took office, set forth a goal of covering half of those by 2011, so 500,000 more Ohioans with coverage by 2011. The other goal that Governor Strickland has put forward is to provide every Ohio child with access to affordable coverage. And in the last budget, there were great strides made in that area raising the income levels for children. I know there's been struggles getting those expansions approved. But there was a bipartisan agreement that children

needed to be a priority, and so efforts in that regard have already moved forward.

And the last thing is helping small businesses afford coverage. Small businesses are particularly effected by rising health insurance rates, and small businesses, in greater numbers, are not offering coverage. Over the last six or seven years, the numbers have dropped dramatically.

And so Governor Strickland wanted to develop strategies to achieve those goals. And what he did was, he put together an advisory group, a group of people that consists of members of his administration, members of the General Assembly, and some key stakeholders to get together, to work together, and to come up with bipartisan strategies for achieving the goals of covering Ohioans.

And Representative Raussen is on that team, as well as Cristal Thomas is on that team, and the Ohio Business Roundtable is on that team, and Tom has been working with the Ohio Business Roundtable. So it's a bipartisan group of leaders in our state that are trying to come together to develop strategies that will accomplish the goal of covering Ohioans.

Our smaller group is composed of about 12 people. And as Representative Raussen says, there's a lot of associations in Ohio, and there's a lot of interest involved in our health care system.

So we developed a larger advisory group of about 40 stakeholders, including the hospital association, the medical association, to

advise us, so that as we develop reforms, we can go to them and get their input.

And the whole idea behind this whole process is, we want to develop reforms in an open atmosphere, in a transparent atmosphere, in an atmosphere that is driven by the data and by a common understanding of what the problems are, what the data is, and that will lead to solutions.

And so the whole idea here is to get bipartisan support and to get support from everyone involved in health care as the strategy that will accomplish the goal that everybody shares who's come to this process of getting Ohioans covered. One of the first things that we did in our group was, we looked very closely at who in Ohio is uninsured. And I think we came to really two groups of people that we identified are the reasons why people are uninsured. One is income level. Over 80 percent of the adults that are uninsured are below 300 percent of the federal poverty level, and 300 percent is about $30,000 a year.

And I think it's pretty commonly agreed that, you know, that these folks need help. They can't go out and buy an insurance policy, they simply don't have the money to do so. And so in order to get these people covered with insurance, there needs to be some help in that regard, to give them subsidies.

The second group of people who are uninsured are people who have health conditions. And they may be lower income people and they may

be very high income people. But the way our insurance markets work today is that if you have a health condition, a serious health condition, you can either be denied coverage, or you can be issued coverage that might exclude your ailment, you might get a policy if you have diabetes. It won't cover anything related to diabetes. Or you could be issued a policy that is very -- it has very high premiums that are unaffordable for most people. I think the underlying thought about coverage is, really insurance coverage is financing for health care services, it's a way to pay for health care. And I think that a real focus of our group has been, is that we want to pay for the right care, at the right place, at the right time.

And so we want to not just provide people with a policy, but we want to focus on those things that help them become healthy and productive individuals, and to -- that gives them some financial stability against high health insurance costs.

One thing I want to say about the high risk people, I just want to explain to people how our individual health insurance market works, because I'm not sure everybody realizes this. If you don't have employer sponsored coverage and you want to get an individual policy, you need to go to like an insurance agent, a local insurance agent, and you'll fill out an application for health insurance, and they'll ask you to fill out your age, and where you live, and what your occupation is, and if you have any existing health conditions, or if you have any prior health conditions that may have gone away, and they'll

use that application, and they'll take it to the insurance company, and the insurance company will underwrite you, which underwriting is basically a term for, are they going to accept you or reject you. And in Ohio, if you have any -- if you have even a moderate health condition, you can be denied, and often are denied coverage.

And some insurance companies, not all, will offer people with health conditions a problem, but they will permanently exclude conditions. So if you have diabetes, you get a policy, but it'll never cover anything resulting from diabetes.

If you are offered a policy either with or without a rider, you can be charged very high rates. There are some limits to rates, but rates commonly exceed $3,000 -- $4,000 a month. We do have a program that's called open enrollment, which is Ohio's program to make coverage available to everyone.

And so insurance companies have to hold open enrollment at particular times of the year. And they put in the newspaper little ads that says, you know, this insurance company is holding its open enrollment this year from this time, within this window of time, and if you come to us, we'll sell you a policy. But the problem with open enrollment is, it's very, very expensive. People cannot afford to pay open enrollment. And kind of an anecdotal story is, last Saturday in the Columbus Dispatch, there was an open enrollment notice, and it listed the rates the insurance company was charging. For a

person between 30 and 35 years of age, the yearly premium for that policy was about $54,000.

So, you know, I think that that company is putting an ad in the paper to comply with their legal requirements about open enrollment, but they're not complying with the spirit, because absolutely no one is going to pay $54,000 a year for an insurance policy. So, you know, open enrollment doesn't work, and the Department of Insurance has done some studies of open enrollment, and very few people are enrolled.

So our Health Care Advisory Committee is trying to find solutions to providing people with coverage. And some of the principals we've developed to guide us in our work is that, first, all Ohioans need to have access to affordable coverage.

Second, we need to leverage existing funding, including available federal funding and available employer funding, funding that's out there, because if you look at health insurance as a funding mechanism, I think it's important not to leave money on the table in terms of getting people the right care, at the right time, at the right place. We also are focusing on primary care and care management and preventative care, to make sure that the coverages we provide focus on those things.

Our current system for the lower income people who are uninsured, they certainly can get acute care at hospitals, but we need to get them into a system where they get primary care and preventative care to keep

them out of those situations.

Another principal is, it needs to be sustainable. And so our group has thought long and hard about fiscal impacts, because we have so many lower income people, we need to help fund that coverage. But our state is in a very difficult position fiscally, and so we've thought long and hard about the fiscal implications of what we're doing.

In terms of our actual recommendations, we've put them into I think three categories; one is to focus on employers, to help employers cover their workers and to help workers take up coverage. And Representative Raussen mentioned reinsurance, and that is one of our recommendations, that the state sponsors a reinsurance program to help small businesses insure their workers. Another one is, have a program to -- for lower income Ohioans to help them take up available employer provided coverage. And in that way, the state is leveraging the employer's contribution toward the coverage. Another recommendation relates to the Section 125 plan. A Section 125 plan is essentially an employee benefit plan.

If someone goes out and buys coverage in the individual market, there's no tax deduction for that. But if they get coverage through their employer, there is. And so if we can set up a mechanism where employers can put in place a structure so the employee buys individual coverage through an employer plan, the worker will get a deduction. And it -- for even moderately -- people with moderate income levels, that can result in a 20 to 30 percent

savings off the cost of coverage.

Another set of recommendations that we're focusing on is on the individual market and the issue about people with health conditions being denied coverage or forced to go to open enrollment.

We're looking to go to a guaranteed issue market, where every insurer would be required to offer a basic and standard benefit plan. We're looking to reduce the rating variation within the market, down to more tighter rating bands, so it can't be, you know, the young and healthy get a policy for $80 a month and, you know, the family that's 30 and 35 in open enrollment gets it for $54,000. So we want to squeeze those down so that there's more fairness in rating.

We also have talked a lot about an individual mandate. And I think that in order for us to move to a market that's guaranteed issue and has tighter rating bands, that an individual mandate is needed to make that kind of market work.

And there's a lot of discussion within our group, and there's a lot of hesitancy about in individual mandate, but all the experts that we've talked about in terms of a guaranteed issue in this market with individual -- with rating restrictions have talked about a mandate being needed.

The final area that we've looked at is Medicaid type reforms, leveraging the Medicaid program, because with Medicaid, its coverage is provided through Medicaid 62 percent in Ohio; 62 percent of the cost of

coverage in Ohio is paid for by Medicaid. And so I think that that would be a good segue into Cristal's remarks. And, Cristal, let's hear about those Medicaid reforms.

MS. THOMAS: Sure, happy to. I wanted to also thank the Cleveland Clinic and Brookings for inviting me to be here today. I'm happy to be a part of this distinguished panel. And I wanted to start off just giving a brief introduction to the Medicaid program. Medicaid, I think it was alluded to in my bio, in Ohio, covers 2.2 million people throughout the year and has a monthly enrollment of about 1.7 million people. So it's a very large, probably the largest insurer in Ohio, and has a very significant budget. About $13 billion is a significant part of the Ohio's budget.

And as the previous panel talked about, the rise in the cost of health care and the cost of Medicaid is a significant concern across the country, but also for Ohio, and the implications for future Ohio budget, so we are very much paying attention to the question of health care reform, both coverage reform and cost, and I'm planning for the future for the Medicaid program.

As far as -- for the health care reform, we have several different strategies that we are pursuing in Medicaid, and the first is the strategy for coverage. As Doug mentioned a few minutes ago, the governor came into office with a goal of reducing the number of uninsured in Ohio by half, and the first step for doing that were the Medicaid expansions that were proposed and passed in the budget for state fiscal year 2008/2009, which we are currently in

that biennium. In the past year we have implemented several Medicaid expansions. We have expanded coverage to more pregnant women, to young adults who are aging out of foster care, to workers with disabilities, or people who want to work with disabilities.

We also passed in the budget an expansion for children, up to 200 percent of poverty in S Chip, and that is something that we are still working with the federal government trying to get approved.

In addition to that budget included, or actually authorized a state only program, a state funded program for children called the Children's Buy-in, which provides coverage to children who are both uninsured and who have been found to be uninsurable in the private market, and that would include being quoted policies that are just unaffordable in the individual market.

And in addition, as Doug segued for me, Medicaid is also a consideration of the SCI team and the health care reform team as a strategy for helping to cover more uninsured, with the idea that, as much as possible, we want to leverage existing and available funding and existing and available infrastructure. And Medicaid offers an opportunity for both in that we are able to cover more people through an additional Medicaid expansion. There's an opportunity to leverage federal funding in our efforts. And also, looking at people who are currently eligible for Medicaid, but are not enrolled, and we have reason to believe that there are a couple hundred thousand of them in Ohio, finding ways to make our enrollment process more seamless, more

streamline, to do more aggressive outreach, to reach those people and make sure that they get and stayed enrolled as another strategy for helping to address the uninsured in Ohio.

And then finally, looking at the existing Medicaid infrastructure as a possible mechanism for reaching out to low income Ohioans who are not eligible for Medicaid, but being able to create some kind of parallel program for those people who could benefit from the existing infrastructure we have and the experience that we and that the Medicaid managed care plans have in caring for those low income populations.

We also have a strategy for chronic conditions in the Medicaid program. And the first step in that was, in 2005, the Ohio General Assembly called for or mandated Medicaid managed care in Ohio for both our CFC, our covered families and children, as well as our age, blind, and disabled populations. And currently we have -- and there are some exceptions and some -- for the ABD population.

Currently we have about 107,000 age, blind, and disabled enrolled in managed care, and 1.1 million of the CFC population enrolled in managed care. And in looking at that opportunity in Ohio, we have worked with the managed care plans on making sure that we are improving on the management and the coordination of care for those populations in Ohio.

There are certain conditions that are mandatory conditions for active care management. For the CFC population, those mainly focus on

children with special health care needs, including pregnant teenagers, including, you know, children who have asthma and children who have special health care needs.

And in the ABD population, there are about ten conditions that mandate active care management, including diabetes, asthma, severe mental illness, congestive heart failure, et cetera. So we are really engaged in kind of an active strategy and continuing to work with our managed care plans and looking for additional opportunities and innovative strategies for addressing and managing chronic conditions in our population in Ohio. We have also, in Ohio, kind of kicked off an effort to create a unified long term care budget, and that was really in recognition of the fact that in our Medicaid program particularly, we have 24 percent of our Medicaid population is in CFC, 76 percent is in the ABD, I'm sorry, 24 percent is the ABD population, and 76 percent is our CFC population. But yet, the 24 percent that are ABD actually account for about 72 percent of our expenditures in that case, seniors, people with disability, the age, blind, and disabled population.

And we expect that population to continue to grow. The Scripps Gerontology Center at Miami University here in Ohio has projected that that -- we will continue to see a growth in our population with disabilities and chronic conditions and the age population in Ohio, and that has significant implications for our future budget.

And so recognizing this, the General Assembly and our House

Bill 119, which was our bi-annual budget bill, called for the creation of a unified long term care budget, and directed our Department on Aging to convene a work group to come together and to make recommendations for creating that budget, and really creating a more balanced and more effective long term care system in Ohio. And we have been engaged over the past about eight months in that process. And the work group has been a very inclusive group of all major stakeholders in this arena throughout Ohio.

The work group created numerous sub committees and has looked at a lot of different -- at different issues including how to bring people in through the front door, what our care management strategies should be, how we can more effectively provide community support and navigation through the system, and has come up with over 100 recommendations, and those recommendations and a final report will be presented to the General Assembly and to the governor on June 1st.

And then we will be focused on working to begin implementing the budget, which will begin in phases, and phase one of the unified budget is expected to occur on July 1, 2008, so a short -- about six weeks away.

And why is this all important? This is all really important because for Ohio, having a unified budget, a coordinated strategy for chronic conditions, for coverage, and for care in Ohio will help us to better plan for the future and better manage the expenditures that we have and that we expect to have in our health care programs. We also have a strategy for health information

technology, and recognizing that access to good and timely information is critical for the effective and efficient delivery of care. Governor Strickland created by executive order a Health Information Advisory Board, and that Board has a mission of coming together and of developing, you know, recommendations and a strategy for HIT in Ohio, and the broad band Ohio initiative.

In Medicaid specifically, we are in the process of implementing a new Medicaid information technology system, which we are calling MITS. And MITS is a replacement for our existing claims processing system. But it will be much more than a claims processing system, it will be an opportunity for us to truly change the way that we do business, and operate more efficiently as a program, and have more timely, actually real time access to information so that we can more effectively manage the people that we serve.

We will be able to know when claims come in, know when people and where people are accessing care, and be able to share information with providers, as well, in order to help them to more effectively manage their patients that are on Medicaid. And we are also exploring the opportunity to leverage and to work with the REOs that have and are emerging across Ohio, and the regional efforts for health information technology, and making sure that we are able to support and to, you know, really effectively enter -- connect with and interact with those regional systems.

And we're hoping that the new flexible technology that we are in the process of

implementing through the Medicaid program will help us in that effort, as well.

In the interest, again, of having a more integrated and coordinated care delivery system, we first decided that we needed to look in-house within the state government in how we are managing our health care programs and our Medicaid programs.

And in recognition that our system has historically been fragmented and siloed and is not coordinated very well. My office was created, which was the Executive Medicaid Management Administration, with the expressed purpose and mission of improving coordination of Medicaid programs across the six different state agencies that all have some piece or portion of Medicaid, making sure that our policies are consistent and uniform, making sure that we are operating in the most efficient and effective way, that we are not duplicating functions, that we are not asking our members or our providers to duplicate functions in their interactions with us, and also to make sure that we are able to have a comprehensive and cohesive strategy for caring for our overlapping population, so that we can support providers in trying to deliver coordinated and effective care. So with that, I will close, and I'll be happy to take questions.

MR. McCLELLAN: Thank you. Thank you very much for your comments. Now, this makes up a very comprehensive overview of things that are going on in Ohio, and it clearly is covering the spectrum of issues from improving the way that care is delivered to improving coverage. We have time

for maybe one or two questions, so please go up to the mike. And while that's taking place, Representative Raussen, I was wondering if you could give me a little bit of an outlook on where things go from here, what's the legislative outlook, can it include both, some of the steps to improve access to coverage that's been talked about, including addressing some issues at the individual insurance market, maybe even going so far as mandates and major insurance issuing reforms, and what about all supporting all these steps to get the right care to the right patient, as many of you all said, with emphasis on prevention, primary care, and care coordination.

MR. RAUSSEN: I think we have to look at a couple of things, one, we're about to hit silly season for the presidential election cycle, so we have to be cogent and brief on step one and two, the continuing debate. I think there are some parts -- I mean coverage is driving the bus on health care reform, but it shouldn't be the only member or passenger of the bus, as I mentioned earlier.

So look at some sustaining steps, some elements, whether it be dependent coverage expansion, dependent age coverage expansion, maybe it involves charity care guidelines, a couple components to get through this cycle, and then build on those through both the SCI team initiative and some of the things that we had hearing on across the state and in Columbus to be part of the general revenue operating budget that will come out in January of next year.

So that's the time frame that I see how we can work, get a couple wins so that we can prove to people that we're actually doing something for their hard earned tax dollars, and then build on it for the beginning of '09.

SPEAKER: This question is for Tom. What we're looking for, of course, is accessibility, affordability, good care for everybody. Now, you've studied health care systems; as a physician, I know that we can deliver good health care. But the system is like a malignant tumor that's about to kill us. And I would like to know if you have some ideal thoughts about a system. We've talked about lots of things this morning; in my estimation, these are like Band-Aids when we need major surgery. What would you do, if you had an ideal system that would give us these things, how do you see it as you've studied all the other systems?

MR. LACKOVIC: Thanks for the question. Well, I wouldn't speak to any particular, specific policy today. I think when you look, as mentioned before, if you look at other health systems, frankly, in other countries, but also if you compare regions of this state to other regions or other states, you find that we actually do have pockets of greatness certainly within our cities, within our states, and so part of the equation is, frankly, just to figure out what we already do well and figure out how to do it more consistently across the board.

The Winberg work was referred to previously. I mean there's lots of evidence that we actually do know how to do things better in the system. When you really peel back the onion, there is unbelievable variability

underneath what happens in our health system, in the country, and here in Ohio, and that really is true both in terms of quality at the physician level, at the organization level, as well as inefficiency. And so if you look even at the procedural level, and you say a common in-patient or out-patient procedure, and you just compare how efficient -- how much it costs to do that, by institution or by physician, you see ten, 20, 30, 50 percent variation in the cost to do that with either similar outcomes, or in many cases, worse outcomes for the places that are higher cost.

So I think a big part of the equation is just finding out what we do better already and doing it more consistently. The other thing I would point out is that when you look at the health system, most of our energy is usually focused on a particular lens or a position on a specific issue, which has a certain benefit to it.

I think if you really want to reform a system, you need to have the full set of stakeholders looking at it together. And so, just as an example, a lot of people have mentioned reimbursement in payment form, right, a great topic, a lot of opportunity to do that better. What I would observe is, there are, you know, there's discussion at the federal level, there's discussion within individual health plans, individual providers, lots of discussion amongst all of us personally that are interested in the topic, but what I see very little of is systematic comprehensive discussions at a state or a system level amongst the stakeholders about how to do that better, so I think we need more of that.

SPEAKER: I'd like to thank the panel for their comments and thank all of you for coming. We heard a lot today about both the need for and the real opportunities for reform at the federal and state level. And these last comments from Tom about how there are some real opportunities to identify effective ways of delivering care, emphasizing prevention, emphasizing care coordination, better care for chronic disease, doing it through paying for what we really want, better quality and a lower cost, that can happen at the federal and state level.

And our hope is that through efforts like this one, to bring together those different perspectives, to help build up that collaborative approach to truly reforming care, we are going to make it possible to get to affordable, high quality care for everyone. Thank you all for all that you're doing to help make that happen. It's been a pleasure to be with you here today.

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