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PARTICIPANTS:

Welcome and Introduction:

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The Brookings Institution

MARK MCCLELLAN, Director
Engelberg Center for Health Care Reform

Opening Remarks:

SENATOR MAX BAUCUS
United States Senate

PANEL ONE: OPPORTUNITIES FOR IMPROVING HEALTH CARE

Moderator:

DONNA SHALALA
University of Miami

Panelists:

MICHAEL PORTER
Harvard Business School

DONALD BERWICK
Institute for Health Care Improvement

CAROLYN CLANCY
Agency for Health Care Research and Quality

PANEL TWO: POLICY REFORMS TO IMPROVE HEALTH CARE DELIVERY

Moderator:

MARK MCCLELLAN, Director
Engelberg Center for Health Care Reform

Panelists:

ALICE RIVLIN, Senior Fellow
Senior Fellow, Metropolitan Policy Program, Economic Studies

ELLIOT FISHER
Dartmouth

DENIS CORTESE
Mayo Clinic

PANEL THREE: TALKING ABOUT REFORM: NEW DIRECTIONS FOR INVOLVING THE PUBLIC

Moderator:

SUSAN DENTZER
Health Affairs

Panelists:

NEIL NEWHOUSE
Public Opinion Strategies

STAN GREENBERG
Greenberg Quinlan Rosner

JIM GUEST
Consumers Union

PANEL FOUR: MOVING FORWARD ON REFORM: DISCUSSION AND POLITICAL PERSPECTIVES

Moderators:

MARK MCCLELLAN, Director
Engelberg Center for Health Care Reform

CHRIS JENNINGS
Jennings Policy Strategies, Inc.

Panelists:

SEN. RICHARD BURR
United States Senate

SEN. SHELDON WHITEHOUSE
United States Senate

Closing Remarks:

MARK MCCLELLAN, Director
Engelberg Center for Health Care Reform

P R O C E E D I N G S

Welcome and Introduction:

MR. TALBOTT: Good morning, everybody. I'm Strobe Talbott and it's my pleasure to say just a couple of words to welcome to all of you, and it's particularly gratifying to see a number of our trustees here this morning because we're putting them through an awful lot of work the next couple of days. But I think the fact that they would join the rest of you for this event this morning underscores the commitment of the Brookings Institution to not just the event today, but to the larger venture of which it is a part which is the Engelberg Center on Health Care Reform. I just wanted to say a couple of words on behalf of the institution as a whole, the Board of Trustees as a whole, and very much myself personally with regard to this enterprise.

The center has been up and running for about 16 months yet it has already established itself as a uniquely respected and influential source of quality analysis and quality recommendations on what I think not only everybody in this room, but everybody in this country recognizes is an issue of absolute cardinal importance to the health literal and otherwise of our nation. I'm sure that today's event is going to convey the breadth and depth of what the center has been doing, is doing, and is going to continue to do in perpetuity which is our expectation and our ability. I'm particularly glad that Senator Baucus has agreed to be with us to get us started this morning. I know that there are a number of other outstanding panelists you are going to be hearing from, and in case I don't get a chance to see her myself because I'm going to be tied up

with business elsewhere in the building, I hope a couple of you will find ways of conveying to Donna Shalala how pleased I that she's going to -- Donna, hello. Welcome. I'm looking forward to seeing you not only later in the day but in the early part of next year.

I finally wanted to say just a word about the context in which the Engelberg Center has been able to go from zero to 60 in establishing itself and the environment in which we're going to be operating as it goes forward, and that is quite simply this. Even in times of really quite extraordinary financial challenge and a very, very difficult economic environment in general, Brookings is absolutely, totally committed to making good on the generosity of our two trustees who are sitting down here in the front row, Al Engelberg himself, of course, and also Leonard Schaeffer who together are making it possible for Mark McClellan as the founding Leonard Schaeffer Director Chair Holder to take the center from strength to strength. So I think that is the appropriate note on which I should turn the proceedings over to Mark who will introduce Senator Baucus. Senator, it's hard to imagine a more appropriate national leader to get our discussion today started. Mark, over to you. And thanks again to all of you for being here.

MARK MCCLELLAN: Thank you very much, Strobe, and I really appreciate your support and leadership for helping make that activities of the center possible.

Let me extend my good morning to all of you as well on behalf of the Engelberg Center for Health Care Reform at Brookings. Welcome to today's event. We're delighted to see so much interest to early in the morning as we discuss health care reform headed into 2009. That includes a discussion of the policy, the public opinion issues, and the politics. As you can see from today's agenda, we're putting a special emphasis on changing the way that health care is delivered and doing a fundamentally better job.

We've got a diverse set of participants here today to help us do this. That includes leaders from Congress, past and present leaders in the Executive Branch, as well as congressional and HHS staff experts, and people from health plans, providers, the business community, academic researchers, consumer perspectives, and many others, and I want to thank all of you for taking time out of your busy schedules to participate today.

I also want to recognize people who have helped make possible this event and all of our work at the Engelberg Center at Brookings, and Strobe alluded to this in his remarks as well. First, Al Engelberg who is the founding donor for the center and a Brookings Institution trustee. It's very nice to have Al here. We had discussions about this going back a couple of years now and it's nice to see what it's turned into. And we're also very glad to have Al's wife Gail joining this morning as well. I also want to

recognize Leonard Schaeffer, another initial donor and sponsor of the Leonard Schaeffer Chair in Health Policy Studies and a Brookings Institution trustee as well. Al and Leonard made it possible to get this center off the ground last year and launched much of the work that is underway today. Since that time, just a little over a year ago, we've added more than two-dozen researchers and staff and scholars and have formed partnerships with academic organizations and the private sector to fulfill our goal of being a do tank, conducting new analysis but also providing the technical support and coordinating role to translate promising new policy ideas into practice. This wouldn't have been possible without Al and Leonard's strong support for our efforts to achieve health care reform from the start of this organization.

Our work also reflects the support of many other people who have been instrumental in Brookings activities. So I want to again thank the Brookings trustees who are here with us today. We very much appreciate their leadership and support.

Finally, I want to recognize the experts who are participating in this event. Many of them are collaborating with the Engelberg Center and its analysts in one capacity or another, and I'm going to highlight some of those activities as we go along. It's great to see all of them together this morning and it's I think a reflection of their commitment to make urgently needed progress on health care reform.

We are here today to take those steps, to address some key questions about the challenge of reforming our nation's health care system. There is more urgency for action on reforming health care than ever. On the one hand, the economic downturn is creating bigger than problems than ever in making health care affordable,

and on the other hand, many new treatments are coming along that hold the promise for more personalized, preventive, and effective health care. There is also a tremendous opportunity as we transition to a new administration and a new Congress, so it's the right time to bring us all together.

One theme of today's even is that it will be hard to achieve reform without improving both coverage and how health care works. Since we can't afford simply to try to buy more people into our existing health care, we need to get more people under coverage while also getting more for the money, and the speakers today are going to address key aspects of this issue.

At the start to kick all this off we're going to hear about the outlook on health care reform from Senator Max Baucus who has a critical leadership role to play in this process, and at the end we'll also hear some bipartisan reflections from Senator Burr and Senator Whitehouse who are both committed to achieving broad-based effective reform. In between we're going to have some lively discussion on three panels. The first will be about improving the way that health care works. We'll get some perspectives on how it can be done, how it is being done, real health care reform, not what happens just in Washington, but what happens when people actually get health care around the country. Improvements are taking place but often they're isolated and it's a challenging process. Why is this so hard and what's standing in the way of these approaches to deliver better care at a lower cost? What's standing in the way of their becoming more widespread?

Our second panel is going to deal with what can happen here in

Washington and in state capitals and in other policy efforts around the country to improve the quality of care and reduce its cost. What health care policy reforms can achieve both improvements and in access as part of reforming health care financing and coverage? I wouldn't be surprised given the perspectives that we have on both of these panels if the two topics blended together a bit.

The third panel is going to deal with the most-important perspective on action for health care reform and that's what Americans think and support. How is the public viewing health care reform? And with that in mind, how will they review efforts like you're going to here about today to try to make health care work better as part of reform? Are there better ways to engage the public to improve the outlook for health care reform?

What you will get today is a lot of back and forth, some frank discussion and interaction, among the moderators and the panelists and hopefully involving many of you as well. What you won't get today is a bunch of formal presentations and papers. There are plenty of those around. We have added a couple. First of all, there's a background white paper on health care reform being released by the center today setting the stage for real health care reform in 2009. It provides an overview of some of the reasons that reform is on the front burner in the policy and political agendas now that reviews some of the evidence on effective ways to reform health care as delivered and some of the policy ideas that have been forward to support better care and lower costs as part of an overall health care reform strategy. This draws on the work of many of today's participants and some of you in the audience as well. We're also releasing a

shorter document in priorities for reform that's included in your packets as well. This paper highlights some of the key reform issues and strategies from an action-oriented perspective with an emphasis on some of the activities taking place right now at the Engelberg Center. Please use these and other papers for background. Today we're taking all that background for granted and challenging our participants on how to move forward.

Before we get started, just a couple of final housekeeping points. We do have some press in attendance despite the early hour, and also this event is being videotaped and will be available on the Brookings website soon, so everything here is on the record. And we've got a lot of ground to cover so I'd like to remind the presenters and the members of the audience to keep their remarks and questions brief so we can keep as much time as possible for discussion.

That brings me to a very special privilege, and that's the opportunity to introduce our lead-off speaker today. Senator Max Baucus has dedicated his life to serving the people of Montana and the United States. He just got reelected by a wide margin. Congratulations. Something I expect that all of you know is that Senator Baucus is chairman of the influential U.S. Senate Finance Committee. In this job he plays a critical role on issues related to taxation and tax cuts, to the future of Social Security, to trade issues facing the nation, and of course to health care reform. His committee and his leadership will be critical to health care reform efforts in 2009 and he has made clear that health care reform is his number-one priority including tax and financing reform and steps to promote reforms in the health care delivery system. He

views it as part and parcel of dealing with the severe economic challenges facing the nation. To back this up, he just released a unique comprehensive paper on health care reform, "A Call to Action in 2009," laying out some key elements that could form a foundation for building broad support for achieving health care reform next year, and he's following that up with a Senate Finance Committee hearing on Wednesday. Having worked with him on Medicare and many other issues, I know he has a real passion to make this happen and he's putting the groundwork in place to move it all forward.

Something I expect that most of you don't know about Senator Baucus is that he has that truly special kind of stamina that it takes to see through such a major reform effort. As I understand it, after you get health care reform launched this week, Senator, you're planning on doing a 50-mile run this coming weekend. Is that correct? So there you go. That's the kind of stamina that we need to lead these efforts. Senator Baucus, please join us up on the podium. Thank you.

Opening Remarks:

SENATOR MAX BAUCUS: Thank you, Mark, very, very much. It's either stamina or foolishness. I'm not sure which, but thank you for that very kind introduction. Many of you know I've known Mark for a long time, and a lot of you have known Mark for a long time and know what a great person that he is and is very talented and so dedicated to public service. And thank you, Strobe, too, for all your service to our country. I've known of you, watched you, read articles by you often and I've always been very impressed with what you've had to contribute. Thank you very much. I want to also thank and recognize Chris Jennings. I don't know if Chris is here in the audience. Chris is another person who's been very involved in health care reform as many of you know in various capacities. I don't see Chris here, but I do want to compliment Chris for all of his work.

The 19th century British philosopher Herbert Spencer wrote, "The preservation of health is a duty." The duty in this instance is that of Congress. It is the duty of the next Congress to write meaningful health care legislation that provides coverage for all Americans. We have a duty to address the underlying problems in our health system. We have a duty to enact it in law this year. The time is ripe. The moral imperative has never been stronger. At this moment, 46 million Americans have no health insurance, 25 million Americans have some insurance, but it's lousy insurance. A big illness can sink them financially. Health care spending of medical bills play a role in half of the household bankruptcy cases in America. Half of the household bankruptcies in our country are medical bill related. Health care costs are out of control.

Between 2000 and 2007, health care premiums in my state of Montana increased by almost 89 percent, and that's five-and-a-half faster than wages. And that's just premium costs, it's not out-of-pocket costs which makes that proportion even worse.

It's not just cost to families that matter. Our businesses are struggling, and federal health care programs are consuming a larger share of the budget each year. The health care system is broken for individual Americans and it's straining our economy as well. Moreover, whether you have insurance or not, regardless of how much you spend, there is no guarantee you will get good quality care. Americans get the best recommended care only half the time. We rank nineteenth out of nineteen countries in preventable deaths. Without reform, none of these problems will get solved.

For all these reasons, last week I released a call to action which aims to do three things. Get everyone in America covered with decent health insurance. That's everyone in America. Second, reduce health care costs so that everyone can afford the care they need even if their insurance is pretty basic. And third, make America healthier with better quality care and more preventive care.

The plan will covered the uninsured by strengthening the employer-based system, by targeted expansions in public programs, and by creating a new arrangement to -- insurance exchange for individuals and small businesses can go to get affordable coverage. The plan calls for everyone to have health coverage. Everyone. An individual responsibility, and responsibility for employers to provide coverage or contribute toward covering the uninsured. We all are in this together and so everyone is

expected to be part of the system.

This notion of shared responsibility is also why the plan calls for significant progress in reforming our health care delivery system. Providers need to carry their weight also, and by that I mean they have responsibility to improve the quality of the care they provide. My plan would improve quality by strengthening the primary care system. Primary care providers including community health centers watch over a patient's whole medical history and keep them healthier all of their lives. Yet our current system undervalues this critically important work, leading to a shortage of primary care physicians. The call to action rewards primary care by increasing reimbursement for primary care services, providing additional payments for primary care doctors who improve care coordination, and encouraging more medical students to choose a career in primary care through pacing more value on primary care work.

The plan also proposes to pay providers for the quality of the care they give patients. Today's system pays doctors, hospitals, and other providers based on the amount of care they deliver, not for the quality of care that patients receive. The call to action takes important steps toward putting in the financial best interests of providers to do everything possible to improve quality. How? By establishing a pay-for-performance program in Medicare that will reward hospitals and provide the highest-quality care. Next, creating new policies that penalize hospitals with high readmission rates. And next, testing models to bundle or combine hospital and physician payments in an effort to encourage them to work together to provide quality care and reduce costs.

Finally, the call to action invests in new tools for providers. In order for providers to reorient themselves toward improving quality, they need tools to make evidence-based decisions. To this end, the call to action invests in, first, comparative effectiveness research that will give providers unbiased and actual information about what treatments, what technologies, and what procedures work best for patients. In addition, health IT that will reduce medical errors immediately and over time allow providers to share patient information and connect with colleagues to more effectively manage care.

These elements of the proposal are essential. In my view, delivery system reform is not only integral to health care reform, but it is essential. Each of the key challenges facing our health care system, lack of access to care, the cost of care, need for better quality care, must be addressed in concert. Covering millions of the uninsured through a broken health system will be financially unsustainable. Attempting to address the inefficiencies plaguing our system and the perverse incentives in the delivery system without covering the uninsured will fail to alleviate the burden of uncompensated care and cost-shifting. The time for incremental improvements has passed. Health care reform must be comprehensive in scope.

You're wondering how will move forward to get this done. Obviously, moving this legislation will require collaboration, working with the new administration and with the Health Committee, with many colleagues, Democrats and Republicans, Senate and House members, all together we must work together. I often believe that nothing of consequence ever gets accomplished without teamwork and without

collaboration, and that is certainly true here. In fact, I'm meeting with the Health Committee leaders and Senator Grassley tomorrow.

The Finance Committee has spent a good deal of time in preparation for this debate. We've held lots of hearings, and we have another one scheduled Wednesday about health care and the economy. Let me be clear. There is no way to really solve America's economic troubles without fixing the health care system as well.

If you fix Wall Street, you fix the housing crisis, you change taxes, you fix everything else and you don't fix health care, then government spending will keep going up. Health care costs suck up more than 16 percent of our economy, and they're growing. Deficits will continue to rise and America will just have more economic troubles down the road if we don't fix our health care system. And our businesses will keep struggling to compete here at home and around the world. If we're going to have a 21st century economy on a 21st century playing field for American innovators, entrepreneurs, and workers, then we'd better get a 21st century health care system now. That's the focus of our committee's hearing tomorrow.

I'm going to need your help. I'm going to need your support to make the changes needed to make the system work better. The research you're already doing is very helpful. Your work is directly related to some of the reforms I envision in the call to action. But I also need all of you here to help me create a can-do environment for health care reform. I'm asking you to evaluate every proposal based on whether it will make the system work better and not worse. It will take a lot of us working together with open minds but I believe we can do it. Taking incremental steps in the face of so many

challenges no longer makes sense and I believe that the policy ideas in the call to action are the right way to start. In fact, here it is right here, the little booklet. Frankly, I'm very, very proud of this. With all respect to the great academic expertise at Brookings, I must say that I think this is probably going to be close to the bible that everyone is going to look at in trying to figure out what our health care reform changes should be. I see Secretary Shalala here sitting in the front row. I want to thank her very much for all that she's done. We've had 12 hearings this year on health care reform, and she was in our lead-off hearing and I just want to thank you, Donna, so much for your wonderful contribution.

Anyway, we're off and running and I'm making this as Mark said my top priority for the year. It's got to be done. It's going to be extremely complicated. But I've never felt such a sense of teamwork already, providers, insurance companies, the pharmaceutical industry, medical equipment manufacturers, everybody knows we've got to do something and I do believe the time is ripe. In fact, I just got a call from President-elect Obama just a couple of days ago when I was home in Montana. The plane landed and my cell phone rang. It said private number so I pushed it. I said, hello. And the person in there said, "Max? This is Barack." And we talked about health care reform and what we needed to do to get health reform passed and now is the time we're going to get it done. So thank you everybody very, very much.

MR. MCCLELLAN: Thank you, Senator. Senator Baucus has time to stay for just a couple of questions, so if any of you in the audience have anything you want to ask about this bold agenda he's laid out, now is the time to do it.

QUESTIONER: Senator, are you going to start by drafting a bill? What's the process?

SENATOR BAUCUS: We put together basic concepts in the white paper. Now I have to start getting some cost estimates to figure out what different components and that takes legislation so that the CBO can score it. There will be some back and forth with CBO I think before I introduce the bill. Also as I indicated, I'll meet with Senator Kennedy this week and Senator Grassley and others to work together. I don't know whether it will be one bill or not, but I do know that we need to get scores and to get scores we have to have legislation. Again, we'll be working with the CBO to get those scores to be able to dot some I's and cross some T's.

Having said that though, I very much meant it when I said I want to work with all the committees. I mean that. When I talked to Senator Clinton about health care reform a short while ago she said one of the mistakes they made was that it was a little more top down in administration and committees have to work better together and also allow this to originate in the Congress. We're going to get this done. It's going to take work, but I just feel that the time is ripe and we're excited about it.

I've been going around talking to a lot of Senators, Republicans and Democrats, asking them what they want and what makes sense to them and encouraging everybody to suspend judgment if for only a nanosecond to suspend judgment. Let's just keep an open mind about all these different components. There will be some things that Republicans traditionally don't like and some things Democrats traditionally don't like, but let's keep an open mind about this and see how we can get

some of this together. My goal is as implied is that this is bipartisan. We may have to get partisan and I very much hope not. My first goal is to make sure we work together.

MR. GUEST: Jim Guest from "Consumer Reports." It's got to be bottom up as well as top down. I'm wondering if you have thoughts about how to mobilize public support and how to mobilize consumers around your proposals because that's going to be an element that I think was missing last time that is going to be crucial now. And by the way, Mark, I might just say back in the 1960s we were both staff members here in Washington and he was a hell of a touch football player.

SENATOR BAUCUS: Thank you. That was fun back then. Thank you. We're working with the various groups to mobilize support, the SEIU and Divided We Fail and all the other organizations that are very much interested in health care reform. You're absolutely right. It's the approach we took frankly, I don't mean to step on some toes in this room, I don't think very many, in stopping the president's effort to privatize Social Security. My chief of staff and I worked with lots of outside groups and spent a lot of time making sure that not just Congress but the outside groups were working in concert with what we were doing. I've lost him now. He's going to President Obama, but we're still working together.

MR. MCCLELLAN: I think we have time for one more. Larry?

QUESTIONER: (inaudible)

SENATOR BAUCUS: Yes, it does. Absolutely. Absolutely. Our incentives for chronic care to address the problems of chronic care costs, I've forgotten the exact figure, but about 30 to 40 percent of health care costs are chronic care related

and that gets to the reimbursement system for primary care physicians, for bundling, for the concept of medical home, to address excessive chronic care costs, and prevention, so that doctors are seeing patients earlier. And also we have written into this something that was called the Right Card or something like that, Right Choice, provision so that people who are uninsured for whatever reason can go to a community health center or provider, it's a 2-year demonstration project, to get screened and to potentially head off some of the chronic care problems they may have, and also to address chronic care remissions, if it's diabetes or heart failure or whatever it is that they may have. Chronic care is a huge big problem that we're trying to address here.

QUESTIONER: (inaudible)

SENATOR BAUCUS: Long-term care is not included in this. It's all care in America except for long term and also not military. We don't have VA included in this or TRICARE military care. Maybe down the road we'll include some of that, but right now we don't have that (inaudible) health service though. That's a big problem in America, a huge problem. I'm excited about this. We're going to make this happen. It's going to work.

MR. MCCLELLAN: Senator, thank you very much.

SENATOR BAUCUS: I see Senator Whitehouse who is a really strong advocate of health care reform too and he's part of the team. I want to have Liz Fowler stand up. Liz Fowler is the head of my health care team and she and her team wrote this paper and they are really good.

MR. MCCLELLAN: Thank you. Senator and Liz, I really appreciate your

taking time with the Senate in session and with the hearings coming up and with your launching this effort in a major way, we really appreciate your taking time to come up and help move things along.

This is a comprehensive overview and I'm going to just make a couple remarks while our first panel is coming up if you all could take your seats. This is a comprehensive overview that answers the question of why now. It answers the question in terms of improving health insurance, markets, and the availability of health care options. It includes everyone having a role and responsibility for coverage. It includes as the Senator emphasized a major emphasis on improving quality of care through better measures, through payment reform, through better evidence on what works. Delivery system reform as the Senator said is not only integral to health care reform, it's essential.

The report also includes how, some discussion of the political process and the fact that that's starting right now. And Larry there is even some discussion in there on long-term care and what we've learned about how much can be gained by giving people more of an opportunity to choose and control how they get their services. So it is a very comprehensive effort.

PANEL ONE: OPPORTUNITIES FOR IMPROVING HEALTH CARE

Now we're going to turn to some of the details about what needs to get done and how. The topic for the panel is Opportunities for Improving Health Care. As you've heard, again, this is a critical part of effective health care reform both in the short-term and the longer-term. I'm very pleased to have our moderator Donna Shalala here with us. Donna was the longest-serving HHS secretary in history and she is not tired at all. She continues to serve in a range of critically important public leadership roles including co-chairing the recent commission on care for America's returning wounded warriors. So it was no surprise that she was recently named one of the 25 finest public servants of the last 25 years. And you're going to hear shortly from another recipient of that award, Alice Rivlin, on the next panel. Donna is now serving as President of the University of Miami and she remains actively involved in Brookings activities, and hopefully, Donna, that's going to include more work with us here at the Engelberg Center.

Joining her is Dr. Michael Porter, Professor at Harvard Business School. He is a leading expert if not the leading expert on business strategy not just in health care but in the application of competitive principles to social problems such as the environment, corporate responsibility, and of course health care. He has written one of the most widely cited books on real health care reform called "Redefining Health Care: Creating Value-Based Competition on Results."

We'll also have on the panel Dr. Don Berwick who is the president and CEO of the Institute for Health Care Improvement, one of the most visible and effective

organizations in the country to actually get out on the ground and get to more reliable, effective care in health care organizations. Don is also one of the nation's leading authorities on health care quality and improvement issues. He is typically busy today. Right after this event he's going to the Press Club to announce the initial report of the National Priorities Partners, an effort to bring together momentum around a core set of critical goals for improving our health system and our health.

Then finally not least at all is Dr. Carolyn Clancy who is the Director of the Agency or Health Care Research and Quality. She is a specialist and expert and nationally recognized leader not only of the AHRQ but also in this entire field of improving health care quality and patient care. I've had the privilege of working with Carolyn and working with some of our staff here at Brookings in providing infrastructure support for the Quality Alliance Steering Committee, a public-private effort to make available better, more consistent, and comprehensive information on the quality and cost of care. So thank you all very much for joining us, and Donna, let me turn this over to you.

MS. SHALALA: Thank you very much, Mark. We have a very tight assignment. At this moment somewhere probably in this city and in Chicago some young staff person is assembling a book which most people in this town called "Promises, Promises," and it's every darn thing that the president-elect said during the course of the campaign about a variety of but particularly about health care. Then someone early in January that book will be broken up and the new secretary-designate will be handed the section on health care and look at it and say, he didn't say that did

he?

The president will bring more focus to all the darn things he said by saying to the secretary, and every president does this, I'm going to run for office again in about 3-1/2 years so you figure out what in this book you can deliver that I can run on, simultaneously take a very careful look on what we can do about fundamental health care reform. For most Americans and for most politicians with Senator Baucus being an exception, when they're talking about health care reform they're talking about coverage, how can we figure out a way to get most Americans covered. You heard from Senator Baucus and you will hear this morning particularly in this panel and the next one that the rest of us are not simply talking about coverage, we're talking about quality and cost. What do we know that the president-elect could implement now? What requires legislation? And what requires more long-term study? This is a very pragmatic season for those of us who have worked in the vineyards for so long on health care reform and this panel in particular with three distinguished panelists will talk about improving how health care works and what we know and what we don't know and what we would specifically say to the new president-elect and his team.

So let me start by asking Michael Porter to speak, then Don Berwick, and then Carolyn Clancy.

MR. PORTER: Thanks so much, Donna. It's very exciting to hear the Senator and to hear this hopefully momentum building for fundamental changes in our health care system. I think the point that the Senator made is really the starting point for what I'd like cover in my very brief introduction.

We know that universal insurance is a fundamental and important goal for a lot of reasons, but we also know that it's not enough. We know that even if we have universal coverage, unless we get the system to deliver more value, better health outcomes per dollar spent, that fundamentally we will not have reformed the system and we will not succeed.

How do we know that insurance is not enough? We know because as we look at Sweden, Germany, Finland, and other systems around the world that have achieved universal coverage, they have persistent and difficult problems of value. Everybody is worried about value whether you've got universal insurance or not. How do we dramatically improve the value that we deliver in the health care system? We're starting to learn more and more about that question and what we've learned is that it's not going to be because we make incremental changes. We're going to have to restructure the way we actually deliver health care. That's going to be complicated, but that's the only way. We can't just kind of tinker on the margin. We actually have to restructure the way we deliver care, the way we measure care, the way we pay for care, in order to achieve this goal of dramatically improving value.

What does that restructuring look like? What are we starting to learn by seeing the most excellent organizations, by seeing the leaders and the pioneers in this field? First of all, we're learning that value must be the goal and not reducing cost. There's a trap. If you start the exercise to try to reduce cost, you'll actually raise costs. You have to start the exercise actually by trying to drive improved outcomes because only improved outcomes actually lower costs. That's one key message.

The second key message is that we know that the actual delivery of care must be reorganized. The way doctors and nurses and others practice medicine needs to be reorganized. We have to move from a silo, intervention-based, specialty-based system around the integrated care for the patient's medical condition which stretches not over any one intervention but over the cycle of care. I call this new model the integrated practice unit where we put in one organization the responsibility for the total cycle of care for the patient's problem with one administrative infrastructure to schedule the appointments with all the skills necessary to deal with the problem as well as the complications and the co-occurrences. Many of the most leading organizations in America and around the world are moving to this model, it's not easy, but we know we actually have to reorganize care delivery.

Third, we have to change reimbursement. We've already heard this morning we can't reimburse the way we do now. We have to reimburse in a very different way. I think what we're starting to understand is we have to reimburse by paying for the bundle of care and not the discrete services. We need to pay for the care for a diabetic over a period of time and not for all the discrete interventions required to deal with that diabetic's illnesses which would involve nephrology and endocrinology and education and testing and a variety of other interventions. We have to move from discrete service intervention to bundled reimbursement for substantial parts of the care cycle. That's the only way to get everybody on the same page, to encourage efficiency, to drive improved outcomes, to avoid paying for mistakes. We have to change the reimbursement model.

Fourth, we need to measure the value that's being delivered. There's a growing understanding that we can't improve value unless we measure value, and we've had some good experience moving down that path. We'll hear I'm sure from Carolyn about the important steps that have already been taken to start to measure processes of care, adherence to guidelines, but the real kahuna here is to measure the outcomes of care, how well the patient does in terms of their health and the sustainability of that health over time. That's a challenging goal, but we've done it in some areas like transplantation and -- fertilization and cardiac surgery. Where we do it, it really works. So we have over time to achieve a system where we have mandatory and universal measurement of outcomes.

We have to open up competition for patients in order to drive a reduction in the hyperfragmentation of service delivery. Right now we have every hospital providing every service at small scale without the experience and expertise required to do it really well. We need to open up competition for patients and reduce artificial restraints to competition across geography, across states, within regions. We have to shift the nature of competition in health plans, and this is one of the critical links between insurance and delivery. We have to get health plans competing to improve value for the patients, not competing to exclude sick people or just push down the prices for the interventions the way they're conducted today. Again one of our big mistakes is we're been trying to push down the cost of each of the steps and the drugs required the way we deliver care today. That effort has failed for 20 years and we have to move beyond that.

Finally, to improve value we're going to have to have universal adoption of electronic medical records. I think the shape of what those records need to look like and what they need to accomplish is becoming more and more clear. The urgent need today is to set standards. We have to define standards for what information means, standards for treatment, standards for interoperability, so that we can lock in on a set of standards which will allow us to drive electronic medical records going forward.

These are some fundamental steps required to redefine the way we deliver care to ultimately improve its value, but the context and the policy environment today is not supportive of many of these steps. In fact, it's working orthogonally to that. So the challenge we have is how to put in place a series of policies that not only achieve universal coverage but also at the same time create the context, the incentives, and the environment which will allow this restructuring of the delivery system. That's fundamentally the challenge that I believe is before us.

MS. SHALALA: Thank you very much. Don?

MR. BERWICK: Thanks, Donna, thanks, Mike, and all of you for the chance to join you. Mark, I really appreciate the chance to be here.

I'm going to make brief comments on some very complex terrain and perhaps will return to it in questions and answers. Everyone agrees that we can't where we need to go with coverage without restructuring care. Let me add a little more texture to that idea. I think it's helpful to think about restructuring as not one problem but two, and they're not the same and they're equally difficult. The first is removing defects from the care that people get when they're sick. Some of the statistics that Senator Baucus

cited and that Mark mentioned recite the overwhelming evidence we have that when you're in the hospital or in care in our country today, things go wrong. The Institute of Medicine in 2001 gave the aims more granularity by defining six goals for improvement, safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. That's a canonical list of defects or aims for improvement, safety, stop harm; effectiveness, align care with science; patient-centeredness, give patients more power when they are sick and need to be in control; timeliness, reduce delays; efficiency, reduce waste in the care process; and equity, largely close the racial gap in health status.

The gaps are enormous. They're very persistent, but there's a lot of good news which is that through the work of many organizations we now can see health care improve with respect to care of the sick dramatically but in pockets. It's not universal. The problem here is not feasibility, it's comprehensiveness.

Let me give you a couple examples. I got an email last week from a small hospital in Upstate New York that we've been working with in our 5 Million Lives campaign, Claxton-Hepburn Hospital it's called. They've gone 4 years without a single ventilator pneumonia. When I was in training in internal medicine I thought ventilator pneumonia was inevitable in maybe one out of 10 ICU patients, and 4 years and not a single case. The Mayo Clinic, the leader in American medicine in my opinion in quality in so many ways, has reduced its error rates by 50 percent in 2-1/2 years and that's documented measured results in all three of their flagship sites. The Medical College of Georgia is an heroic place in August, Georgia, which is changing the whole landscape of patient-centered care is breaking all the rules and putting patients and families in

power like they never were before. Owensboro Medical Center is a turnaround, it's in Kentucky, a small critical-access hospital, that I heard a report from a couple of weeks ago. They're working with us also on our campaign with a 30 percent reduction in all cause mortality and a list of complications almost eliminated that would take your breath away. So it is possible to improve care.

There are savings from that especially organizations that get involved in lean production in the Toyota production process and they're showing that you can save substantially in care while improving the well-being of patients. The barriers are enormous. There is toxic payment mechanisms that Mike mentioned and that Senator Baucus referred to that have just got to be removed. We have to stop the possibility that you can make money on defects. It's not true in other industries and it needs not to be true in health care.

There are very serious leadership challenges. We haven't trained medical or lay leaders especially in the acute care community to lead quality. It's not in the curriculum. So there's a lot of retaining going on as people begin to understand that's important and it goes right to the board room because hospital boards have never before felt responsible for what happens to patients in hospitals, quality of care, they're responsible for the economic well-being of the hospital, but not necessarily for care and that needs to change.

I'm very optimistic about that. I think we can align things right and I think we can move from pockets of excellence to generalized excellence with some smart policies, but won't solve the problem, not the second problem, not the big problem, the

big problem of value that Mike refers to. I disagree slightly with Michael although it's only because I'm wrong and haven't understood him thoroughly yet, but I also think the problem is cost. It's total cost. It is manifestly possible for a Western democracy to give all the care its population needs for about 10 percent of GDP. It is possible. You can't say it's not possible because it's being done. We're at 16 percent or 17 percent. We're wasting probably 40 percent or 30 percent of the dollars we're putting into health care. That's true and I don't understand, Michael I know will come at me on this, why we just don't target that as an aim, reduce the total cost. Thirty percent waste easily in our system. I think he wants to get there by working on quality and value and that's probably right, but don't take your eye off the ball.

At the Institute for Health Care Improvement, my organization, we put on the screen something called the Triple Aim. The Triple Aim refers to improving care like reducing defects, improving the health of the population, reducing obesity and violence and depression and social generators of ill health, and reducing per capita costs, all three at once, better health, better health care, and lower per capita costs. Michael terms of integrators is exactly the same one we use. We need responsible organizations in the country to emerge who have the Triple Aim as their duty. You can't fragment these three or you'll end up with suboptimization and you don't square the circle. The gaps with the Triple Aim are absolutely enormous. The reasons are complicated and won't fit into the couple minutes I have left, but first the biggest probably structural supply driven care. It's what Elliott Fisher will be telling us about in the next panel.

We simply have a toxic dynamic in health care, that if you make

something it will be used. No other market works that way. And maybe if we got good advice from Michael and others we could get rid of it. We have to target supply driven care as a matter of public policy. It's very, very, difficult.

The second is integrated care for chronic illness and the gaps there in. The Commonwealth Fund is now our lead, I guess, scrutinizer of that problem. Seventy percent of costs go into chronic illness care. Probably half of it is pure waste. And a lot of it happens because we don't have the integrated flows that we need for a restructured care system.

The third really might be American exceptionalism. It's our inability to learn from successful models outside of this country. Countries that function with better care than we have; we are 19th out of 19. That's OECD data, that's what Senator Baucus said and he's right, compared to countries that are functioning at 60 or 70 cents on our health care dollar.

We've got to learn from these other models and not throw them away because we assume that stuff like that doesn't work here. It will. It's our decision, what we choose we can choose to change.

The problems and barriers are enormous to get at this waste and the Triple Aim. There is an oversupply of services we don't need. There are handoff failures and duplication of the effort everywhere because we do not have integrators of care. There is poor use of capital, misallocation of rules, poor end-of-life care, weak coordinated functions, and massive under-investments in prevention.

In a Triple Aim world, hospitals would try to be empty, not full. Elliott

Fisher will be happy we wouldn't be driving care with supply and patients would feel remembered.

I've got some political advice but I think I will hold that for later on.

SECRETARY SHALALA: Thank you. To reassure you I just bought a hospital. Carolyn.

MS. CLANCY: Good morning. And I too am very pleased to have this opportunity particularly looking at the substantial intellectual capital in the audience here.

Mark I couldn't let the moment pass without saluting your leadership on all of this, so I think the Center for Health Care Reform is only going to do fabulous things.

Senator Baucus started off by reminding us about that famous study from the RAND Corporation that said Americans receive recommended care a little over half of the time. That was in 2003 and over the past five years we have seen steady incremental improvements. That would be the good news.

A lot of this I would argue and I think others would as well, that this is in response to a strong focus on transparency, focusing on quality, measurement, putting it out there and frankly a lot of providers taking this to heart very seriously. It is not yet consumer friendly.

The slightly less good news is that our pace is modest, if not glacial and it is not going up, improving at anything like the rate of our constant increases in costs. So last year, we report to the Congress every year on quality and disparities. Last year we found across all settings and populations as a nation quality improved 2.3 percent.

Now if you're starting point is 55, I will celebrate any momentum going forward. But at that rate it's going to take us, my statistician told me, 18.994 years, he's a precise guy, to close the gap between best possible care in the care that's routinely provided and we can't possibly afford it.

That same year the expenditures went up 6.7 percent and then disconnect anyone can get. You don't need to know the technical specifics of how to measure quality and so forth. We're simply not getting the returns, so I'm agreeing with my colleagues with a great deal of enthusiasm.

There is a lot of talk in terms of improving the cost equation by looking at the concentration of health expenditures. Where do we spend the most money? And it turns out, if you think about that in quality terms there is a pretty high degree of overlap and congruence and where that is it's for people with chronic illnesses.

In the Medicare population we see that the 20 percent of patients with the multiple chronic illnesses are the same 20 percent that incur about 72 percent of the expenditures. So if we could focus our efforts there like a laser beam we've got a lot of improvement to do. That has to be coupled with two additional themes.

One is eliminating disparities in care associated with patient race, ethnicity, education, and income. We've known about these for years, I think we've taken it as background noise and we're seeing now that we can do much better. And the third piece of this, no matter what happens with chronic illness care, when people are in the medical care system they're there, that's a tiny, tiny proportion of the time that they live with that illness. They manage it at home. So we've got to be seriously

focused on engaging consumers in their own care.

So, again, if we focus where we spend the most money and provide the worst care I think we can achieve what my colleagues have described in terms of improving quality and value in health care for much less cost.

So to make this tangible let me give you a very explicit example. This past year we have been working with the Administration on Aging, part of HHS, in eight communities to reduce disparities and improve care for Hispanic elders.

So this includes Chicago, Houston, L.A., the lower Rio Grande area, Miami, New York, San Antonio, and San Diego. Within each of these communities we are working with the clinical care providers and with the area agencies on aging. So in other words you are connecting the care delivery system with community resources or boots on the ground to actually help people with the additional steps they need to take to make sure they can manage their own health and health care effectively.

So in New York they focused on helping Hispanic elders in East Harlem and the South Bronx manage their diabetes after reviewing the data from our report which had been drilled down for them in their community. So that was one piece of good news that we could actually develop data driven evidence-based interventions and apply it at the community level.

The second piece focused on the consumer engagement. A number of years ago AHRQ funded Kate Lorig from Stanford to develop a diabetes self-management training program and she learned something that is really, really important. It is not about how much people know, it's about their motivation and their

belief that what they do makes a difference.

She's gone on to work with many, many systems in health care. Right now through this same initiative in these eight sites, that same intervention is being improved and being modified just a bit so that it will qualify for Medicare reimbursements as for diabetic teaching. This is an area where every year CMS allocates resources and yet they don't have enough certified programs to actually be able to invest. So we know that we can do it.

So Donna had challenged us to think about short-term and long-term actions. The first is that under Mark's leadership there were many exciting demonstrations done in CMS. I would say they have two flaws that could be easily fixed administratively.

One is they are not multiple payer. And the same providers see patients whose services are paid for by multiple different insurers, that's one step that would make it easier. They have to move much faster. I'm sure if we had another infusion of Mark's energy we could do that. That is not a game changer. That could happen very quickly.

At the same time I think that we're going to need to couple that with a space for some changes in payments. Right now if doctors in hospitals decide this is it, we can improve dramatic care to get to Olympic class as Don often says, tomorrow. The bottom line is they lose revenue immediately.

Now, no one gets up everyday to think, gee, I need to keep my bills paid so I think I'll provide not so great care. But what that also means is that they don't have

the resources to invest in the nurse case manager or other outreach resources to help people with chronic illness do better. And I think that we have to get very, very serious about consumer engagement. It's not just for those with the sickest patients who were showing up in our reports; it's also very about getting to kids early in school so they understand that they can play a very active role in their health and health care.

No one with chronic illness actually wants to be thinking about their illness all of the time, what they want to do is get on with their lives. And I think if we give them the tools we can do that.

So let me just say that last week my boss asked me what were the game changers in improving quality and so forth? And I told him as far as I could see two things. One is data driven evidence-based improvements, but that means feeding back information to those on the front lines in something close to real time, where we have seen dramatic improvements that has been a consistent theme.

And the other is creating a space and cultivating the consumers' voice.

When powerful, articulate consumers step up and say it doesn't have to be this way, it has an astonishing effect on policymakers, providers, and so forth. They all say you are right, yes we can. So Jim Guest I will salute your efforts with consumer reports and we need more of it.

Thank you.

SECRETARY SHALALA: Thank you very much. Thank you very much. Three very insightful commentaries. Since Carolyn started the process of saying, telling President Obama exactly what he should do at CMS, for example.

Let me ask Michael Porter, if President Obama appointed you as head of CMS, what are the two or three things you would do immediately considering the fact that you have control of the rules that apply to Medicare and Medicaid? What would you do to try to get to what you have been talking about?

DR PORTER: Well, that's a dangerous question to ask a non-Washington insider because I have no idea what's feasible. But I would, I mean if I were going to try to cut into this I would, first of all, I would start pushing very, very hard on the measurement of outcomes.

SECRETARY SHALALA: Okay.

DR PORTER: And start to make the process not a bubble's up, it's going to take a hundred years, we're going to fight over everything kind of process but a process in which there was a group established, charged with that responsibility with a time frame that we could get that done.

A second thing would to be to start very dramatic, accelerating the reimbursement reform around bundled pricing. We've been fighting for years whether doctor should get paid separately from hospitals. The answer is no. It's stupid. It's idiotic. We've got to get on with that. We've got to put the inpatient and the outpatient reimbursement together and that requires some heavy lifting in terms of divining what service bundles are and how long those servers bundle should cover. But I think that bundle reimbursement will drive so many other things.

If the reimbursement is bundled the care will then almost naturally be forced to be coordinated and integrated. The resources expended will be thought of

carefully across the various specialties and interventions. The need to reduce complications that you have to bear out of your own pay will all of a sudden be acute.

So I think those two areas are kind of frontline areas and then there is some very artificial stuff that is getting in the way of integrating care in coordinating care like Stark laws, which are well meaning but intrusive like corporate PACs to medicine laws, like state licensing laws, like cumbersome licensing process. So there are some smaller things are big, but they are still smaller. But the big kahunas I think are the measurement in the reimbursement reform.

SECRETARY SHALALA: Great. Don.

MR. BERWICK: I agree with what Mike said. If you take my two-part analysis defects in care and then population-based care. On the defects side I agree with Mike, we need more transparent outcome measurement.

A lot of the measurements that are floating around in CMS and elsewhere are way down in the process, in the particulate level. We just need to know that people live or die, what are complication rates, and move transparency up to outcomes.

Hospitals also need help. I think one of the mistakes in public policy where we are right now is the weakening of the good part of what the quality improvement organizations intended to be. We need like the Agriculture Extension Service in agriculture, we really need that in health care so hospitals can get probably under Federal sponsorship the kind of technical support that actually they can start to get from AHRQ if we beefed AHRQ up and supported a robust new QUIO structure.

We need goals also. The President needs to articulate some goals. The

IOM laid out safety effectiveness. Why don't we have a White House that's says, now let's get here country on safety effectiveness, timeliness.

On the population-based side it's much more difficult politically. The amount of money on the table is enormous. I mean we're talking here about gain sharing opportunities and recoveries that would be, well Paul O'Neill is saying a trillion dollars. I don't think he's that far off actually.

It's hundreds of billions accessible if we could move back to population-based care management. We've lost in the country. We tarred the concept of managed care with all sorts of garbage, but the core of the idea is correct. The old managed care idea that Paul Elwood articulated that started Kaiser Permanente, that started group health, is still correct. You take care of the population and pay a caregiver for care of the population with a limit.

That's going to require emergence of integrated care. Medicare should do that. Medicare Advantage is not working right now. It's been grabbed a hold of by forces that don't understand true care integration, but somehow we've got to get back to that.

My wife is Under Secretary for Energy in Massachusetts and she has taught me about decoupling in the energy world where utilities now in at least 20 states or so, aren't paid for volume. They can make as much money by saving a kilowatt as by making one. We need to do that with care. You ought to be able to somehow treat an empty bed as an asset. Right now we don't do that at all.

SECRETARY SHALALA: Carolyn, I'm switching you from AHRQ to CMS.

MS. CLANCY: Sure.

SECRETARY SHALALA: In the new administration, what are you going to do first?

MS. CLANCY: Well, I would like to just build on this idea of rapid demos with multiple payers.

The reason I think we need that is any effort to improve quality and value that's national by definition limits our ambitions, because it has to be available and easy for all or at least possible for all providers to participate. And what it doesn't create is any space for Olympic class performance. And the kinds of potential savings that Don is talking about, I think that we could accomplish at a state or regional level.

What this would require is that we stay away or that we move beyond our thinking where we don't want to contaminate one demo site with another demo site. You know, so Health IT has got to be in a separate place than another one focused on improving hospital care, physician group practice, and so forth. We need all of it.

And I don't think that this is beyond our collective experience. I see Senator Whitehouse nodding here. He's been doing this in Rhode Island before he came to the Senate. I mean we know how to do this if we create the space for it to happen.

SECRETARY SHALALA: Great. Let me pull the audience in and see what questions you have for our panelists.

Questions? Yes, back there.

MR. WEIL: MR. Porter, if I understand (off mike)

SECRETARY SHALALA: Why don't you identify yourself.

MR. WEIL: I'm Alan Weil, Director of the National Academy for State Health Policy.

MR. Porter if I remember some of what you have written, part of the implication of your thinking about the financing is to eliminate the ability of basically discounting as a technique for competitive advantage from the payer side. I hope I understood that correctly.

And so, help me and with MS. CLANCY's comment about multi-payer, this whole notion to moving to value and aligning different payers. If we did move away from discounted negotiations as a fundamental basis for competitive advantage that would have big regulatory implications, big fiscal implications as we think about the changing payments of Medicare and Medicaid.

So could you expand on that component of the agenda for transparency and competition for value?

MR. PORTER: Well, that's a very complicated question and could be punted in terms of if I were trying to implement a series of reforms.

The basic idea is that right now we sort of assume the interventions as given, that the patient is going to go have all of these visits and they are going to have all of these treatments and they're going to have all of these tests. And we try to beat down the cost of each one by limiting doctor payment and reducing the fees for this, and this, and this.

And so the first key point is that just beating down the cost of each of the

interventions, assuming that they all stay the same and they are as complicated and convoluted as they are today, you know, that may help but it's not going to get us to the goal line. We've got to rethink the whole structure of what sort of interventions over what period of time.

The other thing that that comment picks up is that when health plans get a lower rate because they have a bigger population of members, that actually doesn't really increase the fundamental value being delivered. That just means that it is a bargaining power game.

And it's that bargaining power game that's gotten us, you know, in many ways moving in the wrong direction in terms of the nature of competition. So the problem we've had is health plans have competed on excluding sick people and using their clout to bargain lower prices for the same old services that we deliver and I argue that that actually isn't driving value. So what we need to do is eliminate the ability of health plans to compete on selecting out sick people. We have to end that so that they have to take their fair share of everybody and then we have to get them focused on competing on value and improving health outcomes per dollar, not just beating down the price for the same old care.

That's the idea and there's various ways to approach that. I believe the best way would be some kind of fundamental reimbursement reform, again, with a bundled pricing model.

I'm a little bit hesitant to go to global capitation to pay a provider group to deal with any possible problem a patient might have. I have – very comfortable of the

idea of creating a very different reimbursement structure for primary care which has certain limits drawn around it that will incent primary care providers to do a great job and maintain the health of the patient, but I think once the patient then gets into having, being a diabetic or having congestive heart failure, then I think we need another capitated model for the care of that condition over the cycle of care.

And I think it is a mistake to make care providers into insurance companies. And so that's an area where Don and I perhaps have a difference of opinion.

SECRETARY SHALALA: Don, do you want to follow up on that point? You're really talking about two different pricing because of the complicated business of trying to price the acute care I take it to price the package, whatever you would pay the capitation?

MR. PORTER: Well, I think that if-- let's take suppose you have breast cancer.

SECRETARY SHALALA: Right.

MR. PORTER: I would argue there should be a bundled price for the care of a breast cancer patient with a risk adjustment for the stage of the disease and severity of the disease. And that should cover the really, the whole process of care which is going to include some surgeries and chemotherapy and some other interventions. It's going to involve some inpatient stays, some outpatient stay.

Again, we do that in organ transplantation believe it or not. There's a bundled price for a kidney transplantation that includes pretty much everything. That

was driven by Kaiser Permanente saying we want a price. We just don't want an open ended thing where you just do whatever you want and charge us for each service.

That model I think has been a great model in really driving a greater sense of value improvement in that area. So it's that –

SECRETARY SHALALA: Well, it's also made that area a cash cow because people have figured out that that's a very nice payment for what they do. Every transplant center I know makes a lot of money.

MR. PORTER: Well, so then we ought to have competition which starts then to say okay, let's let that bundle price go down and measure very carefully the outcomes. A nice thing about transplantation is we have universal outcomes for everyone of those centers.

SECRETARY SHALALA: Right.

MR. PORTER: So we can now start the value based competition at work. But without the reimbursement model that gets all of the services bundled together and gets the provider organization to think about how can we produce the best value across all these services. Then I think ultimately we're going to be flailing away here.

SECRETARY SHALALA: Don, do you want to give into that a little bit?

MR. BERWICK: Sure. First let me say I have enormous respect for Michael's work and gratitude for his entry into health care. It's going to help us more than almost any other intellectual contribution that we've seen in the decade. It's a tremendous gift. But I don't totally agree, on two things in particular.

I do not have Michael's skepticism about the lack of wisdom in uniting

payment and deliver. I wouldn't use an insurance model. The concept of insurability is over. We now can predict people's fate and actuarial calculations don't apply anymore. I would like to give providers of care a pot of money and say here's a group of people, please take care of them, and do it under scrutiny and maybe have some competition around that.

But I am not suspicious of that and some of the best care we have is of that type and in Europe where the care is better than ours, in many respects that's how care is often funded. But I don't know. Maybe we need two kinds of experiments and see how that starts out.

With respect to sectoring off specialty care, Michael's model involves designating a patient as having a certain kind of need; breast cancer or maybe heart failure or heart care. I don't think that's how patients come packaged. I think the needs of the average chronically ill people are very protean. They are tentacular and I think it's better to put it under the same roof.

Now of course an integrator and we badly need integrators, this intermediary which I would have be the old version managed care will have to contract with specialty services and there, there might be competition. There might be a breast cancer service of the type Michael imagines that's trying to win business through value. But I wouldn't divide the patient into parts. I don't think that's very wise.

SECRETARY SHALALA: Good. Carolyn, why don't you take you microphone off and come down here so I can integrate this discussion a little better.

Do you want to comment on that? And then I'll take the next question.

MS. CLANCY: So I wanted to make two quick comments. One was building on your point Don about how bundleable are patient's needs.

If you look at chronic illness, just under ten percent of people with diabetes have only diabetes. That is to say there are -- the vast majority have several conditions and trying to figure out how we would create multiple pathways, I think would be a little bit challenging and I'm not sure we would find one.

I love your idea of expanding the role of primary care, but in full disclosure I am a primary care internist by training. But I would also say that you can't have a medical home unless it's in a friendly medical neighborhood. And I think our big challenge is going to be to find out can we replicate some of the clear advantageous in performance that we've seen from some of the best integrated care delivery systems with delivery systems that are virtual.

I think we can do this. I think this is frankly how the concierge practices do it. And the question is what is going to be the integrating function to do that?

But if you look at some of the Medicare patients who see 37 different doctors in a particular year, it is beyond my imagination to imagine that they have a common game plan or a shared idea or a shared script for what ought to be happening with this patient. Then it's not surprising that we have so many opportunities to reduce waste.

SECRETARY SHALALA: I should point out that I am from Florida and the providers have a common game plan there.

Let's take the question, there.

MR. LEWIN: Yeah. Jack Lewin, American College of Cardiology. MR. Shalala, great to see you. Four heroes up there on the stage. I appreciated your comments very much.

I'd like to ask a process question if you will for the CMS administrator out there. In that I think that we want to get to this, this outcome measurement idea is where we need to go and it's very exciting and there are some good signs about how we can get there.

But it appears that we lack a business case, a strong enough carrot to actually get people to move in that direction, even though we're looking at integrators and trying to change the delivery system around having, you know, multi-specialty approaches and hospital-physician approaches.

What you think about the idea of putting something as a step in the direction, of a significant increase in reimbursement for say, electronic reporting through an accredited registry that actually collects all of the guidelines, performance measures, science that we have today as a step towards getting that information and moving toward outcomes?

My fear is that we will be kind of putting little steps together around the edges and slowing our progress.

In cardiology, I mean if you just look at it's probably $180 billion in Medicare of cardiology services and a lot of that service relates to those, you know, 20 to 30 percent of heart failure admissions who comeback in, in 30 days. If we just reduced by ten percent, you know, those heart failure readmissions we'd have enough

money to put a seven or ten percent increase for every service for those who took that step.

So I think we need a business case and a step for the administrator to move us from where we are to where we have that data and can begin to measure it. Any comments there, please?

SECRETARY SHALALA: Yes, let me have one of them answer so I can get around to the questions and then we'll have a final discussion. So Carolyn do you want to --?

MS. CLANCY: Sure. Jack, I think given where we are on health care delivery today that would be a giant step forward. I would also say it is necessary, but not sufficient.

I mean today we have patients getting technically excellent cardiac care who either don't get the point or have other challenges taking their medications, which may be cost, it may be side effects, and so forth. So I think we have got to have a commitment to outcomes and what I would prefer is that we had a coherent approach rather than simply trying to ding hospitals for potentially avoidable readmissions. Which I think is a good tactic, but it's not a strategy to figure out how do we actually get to what we want to achieve.

SECRETARY SHALALA: Right here.

MR. HASELTINE: William Haseltine. I've just finished through my foundation, a study from the Rockefeller Foundation supported by them and administered through Brookings on efficiencies and health care delivery in India, a

number of experiments in India.

One thing I hadn't heard discussed very much is dramatic improvements in process. Their heart surgeons do ten times as many surgeries per day and per year as ours do. They use their heavy equipment five to ten times more heavily. They rely on a completely different structure of manpower, deskilling, and changing the way manpower is used to drive costs down.

If we implemented those systems we could probably save 50 to 80 percent of our costs. I think it is well worth looking at those kinds of innovations, which I have not heard you guys discuss. Really radically changing process using high technology and getting the kinds of the outcomes we expect.

They do this with getting high quality outcomes. And if we did that I think we could make a major change, I haven't heard that kind of radical restructuring of process discussed in any coherent way.

SECRETARY SHALALA: Right, Michael. Thanks, Bill.

MR. PORTER: Well, there is a very large book that has a little bit on that and it. But the basic idea is that right now we deliver too many services in a very fragmented way with not very much volume, with not very much scale for a given set of services. And as a result we don't do very well and we're not utilizing equipment and facilities. We do not think about how to deskill, because we don't really have -- it's a hyper-fragmented system we have in this country.

So I think one of the things that you are absolutely right, that one of the fundamental things that has to happen is we can't have thousands and thousands of

hospitals all offering exactly the same services, even if ten of them were in the same city. That model of doing things in a very, very small scale really drives us to the inefficiencies that we see in many of the processes.

MS. CLANCY: Just to make a quick point, Denver Health, a public system has done this. They have brought in experts from other industries and they have managed to continue to improve quality, which was already very good and make even more rapid improvements and to save the system money. And they take care of some of the sickest patients in that community, so we know it is possible.

But I think our reimbursement system has to actually give some rewards for doing that, because right now it's kind of an act of altruism.

SECRETARY SHALALA: Yeah, Don you have written on this too.

MR. BERWICK: Yeah, I mean Bill is right. It is all about process; it is all about design at whatever aggregate level we are talking about as long as we have an industry that can make its primary business plan revenue increase, people are going to be interested in process.

SECRETARY SHALALA: No.

MS. SIEGEL: Ellen Siegel, Forensic Cancer Research.

So in this really important discussion we're having there seems to be an absence of research and the impact of research. So as an example, even in the model that you are talking about with breast cancer we certainly don't know how to prevent it and often treat it.

How, and we're talking about personalized medicine, how does that fit into

this discussion? Because that is really the future of getting better and more effective treatments that are personalized and that seems to be absent from the discussions.

MS. CLANCY: Sure. Recently there was an article in *Newsweek* called "The Valley of Death" and it talked about the drop off from biomedical breakthroughs to actually developing patient interventions. And I actually think there is a second valley of death that we need to pay attention to as well, which is all of the research that we have funded that takes way too long to actually get translated as patient benefit on a routine basis.

So as we make advances in Health IT, I actually think the delivery system can be a platform for discovery as well as for providing superb care and that think we should hold out for nothing less.

SECRETARY SHALALA: Last question.

MR. MINNIX: Larry Minnix with the American Association of Homes and Service for the Aging.

MS. CLANCY you mentioned having, you can't have a medical home without having healthy neighborhoods. Any of the panelists thoughts about how we move from the silos of care and service delivery that are in every rural and urban setting in America to creating networks of care and service that make the delivery much more seamless?

How do we incentivize communities with providers, business, consumer groups to create that sort of a more seamless approach to ongoing care delivery of home can be more of the center of care?

SECRETARY SHALALA: Don why don't you.

MR. BERWICK: I can't think of a way to do it without population-based care designs where someone at whatever community level you are talking about is responsible for the care of a community. It could be all of the employees of a company, it could be the citizens of Massachusetts, it could be the people of a certain demographic but until someone says I've got your back to a population and I have a budget to take care of you I don't think I can get that care integrated the way you are talking about.

SECRETARY SHALALA: Let's thank these three remarkable health leaders.

(Applause)

PANEL TWO: POLICY REFORMS TO IMPROVE HEALTH CARE DELIVERY

MR. McCLELLAN: All right. I'd like to ask our next panel to come up. If you noticed from the agenda we did not schedule any breaks in this very tightly packed morning, but you should feel free to get up and stretch your legs or do what you need to do when you need to do it. We're going to keep moving right along though.

I can tell from the questions at the end of the last panel that there is a lot more we need to address related to policy steps to actually improve the delivery of care. And that is something that this panel is going to pick right up on. So we are going to continue the discussion that we just started on. We've heard a lot about examples of ways in which the care that's being delivered could be done much better and is being done much better.

Better quality, lower cost, but it is not yet routine and it is not yet systematic in the delivery of health care. This panel is going to focus much more directly on the policy reform questions that we are starting to discuss at the end of the last panel, including the budget realities, including the need to get to affordable, sustainable coverage for all Americans.

And to do this we've got another very distinguished panel it includes Elliott Fisher, seating at my left who is a Professor of Medicine including Community and Family Medicine at Dartmouth Medical School and the Director of the Center for Health Policy Research in the newly established Dartmouth Institute for Health Care Policy and Clinical Practice.

He also now leads the Dartmouth Atlas of Health Care which reflects

some of the most widely cited analysis ever in health policy documenting variations in medical practices that seem to have much more to do with medical system capacity and the policies that influence it, than it has to do with having an impact on patient health.

Elliott's also a member of the National Institute of Medicine and is currently the Co-Chair of the National Quality Forum Committee developing recommendations for a national framework for measuring and improving the efficiency of health care in the United States.

And I'm also very pleased that Elliott is working very closely with the Engelberg Center at Brookings as part of our joint program on health care payment reform.

Next to Elliott is Alice Rivlin. A Senior Fellow in Economic Studies at Brookings and also Visiting Professor at the Public Policy Institute of Georgetown University. She also directs the Brookings Greater Washington Research program.

In addition to all of that I have had the privilege of working with her as Co-Chair of the Robert Wood Johnson Foundation Commission to Build a Healthier America. Previously MR. Rivlin served as Vice-Chair of the Federal Reserve Board and as Director of the White House Office of Management and Budget in the first Clinton Administration. Before that she was a Founding Director of the Congressional Budget Office.

She is a frequent contributor to newspapers, television, radio, and I think with the current economic crisis you are probably on the PBS *Newshour* more than Susan Dentzer used to be.

Finally, I'm also very pleased to have Denny Cortese here. MR. Cortese is President and Chief Executive Officer of the Mayo Clinic, Chair of the Mayo Clinic Board of Governors, and a member of their Board of Trustees.

MR. Cortese did his residency training in Internal Medicine and Pulmonary Diseases at Mayo and he has been a leader in lung disease and a leader in actually rolling up sleeves and implementing reforms in health care at Mayo every since.

MR. Cortese is also a member of the Institute of Medicine and chairs the IOM's Roundtable on Evidenced-Based Medicine where he is jointly chairing an event today. So literally being in two places at once.

Over the past couple of years he has been the moving force behind a Mayo lead effort with many outside experts and stakeholders to identify a path forward in health care reform. An effort that fits well with the activities underway here.

So we have heard some about ways to reform health care and obstacles that can stand in the way of getting to better integration of care, more efficiency, higher quality clearly can be done better, but that's not happening systematically in our country. We've also heard initially about some reforms to address this.

Hopefully we're going to have a lot of further discussion of those kinds of issues and provider payments and coverage, how health care is financed. All of this needs to take place in the context of the budget realities our nation is facing and also with the high level, very high level of public concern about getting to more affordable health care and health insurance now, the real urgency on the part of the public to not just address quality issues, but to meet the challenge of affordable health care and

health insurance.

So how are we going to do it? How does the fiscal outlook effect how we can do it? What's the best way forward? Let me start by turning to Elliott.

MR. FISHER: Those will be some easy things to answer.

Thank you very much. It's really a treat to be here especially after, I think, the first panel raised a number of the key challenges that we have to face. I'll focus my brief remarks on the delivery system changes that I think we need to see in some of the policy steps we might make as we move in that direction.

There is clearly increasing agreement on the attributes of high performing health systems. You know Mike and Don may disagree at the margins, but you know, we need virtual or real integrated delivery systems with strong primary care foundation, shared or interoperable electronic health records, organization support for clinicians. Decision support, feedback to those clinicians, comprehensive performance measures on cost and quality, and somehow to pay for value.

There are some barriers to getting there and I want to highlight three that I think Congress would be wise to think about and that we should pay particular attention to.

The first is the fragmentation in our current delivery system, small physician practices, primary care physicians. It is remarkable listening to the discussions with European Health Ministers last week. All of them are struggling with exactly this problem of fragmentation and the barriers between primary care and specialty care.

The second barrier I would highlight is out current payment system, which is truly toxic, supply driven, and will be hard to change. Figuring out how to do bundled payments will take us many years. How to do that? What's a fair payment for a particular bundle of services?

And many of the current initiatives, whether it's pay for value, episode-based payments as they are currently being considered or even the medical home model. Risks reinforcing the fragmentation in our current system and certainly won't slow the growth of health care costs. As long as we can have specialists continue to purchase new services, see their patients at their current rates the medical home will be powerless to deflect the growth of spending in the acute sector on the specialist side. Without creating that medical neighborhood that they can work effectively in.

The third barrier I'd highlight is that I think many of our policy initiatives currently conflict with each other or compete with the provider's attention and are an increasing burden to the practice of clinical medicine. Whether it's performance measure, pay-for-performance initiatives, they're all going and not thought through carefully. So let me make three suggestions as to strategies that we might consider.

To deal with the fragmentation I really believe that we should encourage the development of real or virtual integrated delivery systems. Mark and I are calling these Accountable Care Organizations. Steve Shortell and Larry Casalino would call them Accountable Care Systems. It doesn't really matter but they should be accountable for the overall care of a defined population in some way and their care overtime for the costs and for the quality.

What's interesting is from the empirical work that we've shown before is that most physicians within these. That is most physicians already refer their patients to one or two hospitals. Most physicians make their referrals to local, other specialists within their community. So it would not require much disruption in practice to create those virtual networks. So we want to foster the development of accountable care systems.

The second obvious issue is this payment reform problem. What hasn't really come to the table yet is a notion, the decoupling was already mentioned, which is critically important. If you want to deflect the current payment system we have to decouple volume from rewards, very quickly. Otherwise supply driven care will continue to see the kinds of growth and spending that we see.

But with decoupling, one can develop shared – global shared savings models that reward providers in accountable care organizations or in accountable systems or in their communities for reducing the overall costs of care while improving care. The Physician Group practice demonstration is a perfect example of this. I mean its current iteration, but it was targeted at large medical groups. We should rapidly expand that to figure out how to move global shared savings models that really would allow Don's model of the Triple Aim to be achieved.

If you think of places that are trying to do this, Vermont is taking a population-based perspective on how to improve the health of the population it serves within a budget. They are talking about accountable acre organizations as an approach to think about reorganizing the finance.

The third problem of the competing initiatives I think deserves particular attention. We need a roadmap for reform that leads us strategically toward real or virtually integrated delivery systems with comprehensive cost and quality measures in interoperable health records and what we know those attributes are.

If we could define that goal clearly, then we should be able to think clearly how to align interim policy steps with those long-term goals. So the medical home becomes a very important pilot if it's part of a broader network that ensures cooperation with others within a local or regional accountable care system.

Electronic health records. We should support those, but we are supporting lots of electronic health records now regardless of whether they are interoperable with the other systems in their community.

Performance measurement. Excellent. But let's do it in a way that encourages physicians to come together in groups and rewards them for better outcomes.

And then payment reform pilots need to be integrated together to move us toward integrated population-based payment.

Those would be the three things I would suggest and I'm sure we'll get more chance to talk.

MR. McCLELLAN: Thank you Elliott. Alice.

MR. RIVLIN: Let me pick up on that. The title of this session is rather polite. It's getting to higher quality, better value, and sustainable coverage. That's a polite way of saying the current system is wasteful, excessively costly, often provides

poor quality, even harmful care and the number of the uninsured is growing and we have to do something about that. And we heard a good deal about that in the first panel.

The number one imperative in health care reform is moving toward the system that gives us more health for the large number of dollars we already spend and slows the arte of growth of health care spending for the future. If we can't do that, we won't have a sustainable health insurance system and we won't have a sustainable Federal budget.

Don Berwick on the first panel talked about cutting costs and getting rid of a third of what we now spend. I think that's a bit unrealistic, although people say that. What we can hope to do is cut that third or whatever it is gradually overtime as we fight against the other forces of technological change and advance in medicine which are leading us to spend more and end up with a system that while still growing as health care spending is still growing as a percent of GDP grows much slower. I think that's an attainable goal.

The rapid increase in health care spending is the primary reasons why the current projections of the Federal budget's tax and spending programs show deficits that cannot be financed. We can't borrow that much money, we can't close down the rest of the government, we can't raise taxes to keep up with health spending without endangering economic growth so we've got to do something about it. But the private sector projections look exactly the same.

Per capita spending increases have historically and for very good reasons

been about the same for private sector and the public sector, so it doesn't really matter whether we show projections of enormous increases in Medicare and Medicaid leading to impossible to finance budget deficits. Or we look at health care spending driving out other priorities in private budgets. They are two aspects of the same problem and the answer is the same, finding ways to get more bang for the health care buck.

Now it's often said that we cannot effectively reduce the rate of growth of health care spending until we move to universal coverage. And we're all for universal coverage, but the opposite is more nearly true. We cannot get to universal coverage, we cannot expand coverage unless we find a way to control costs and improve quality. Adding more claimants to the existing system will only exacerbate the current problems of rapid increase in spending and poorer quality.

So where to start? Well, we actually already have universal coverage and a single payer in a huge piece of the system called Medicare. And I think we must, initially, use Medicare to lead the way to a system that rewards effective treatment and discourages waste and inefficiency.

Elliott and his colleagues have shown that there are huge differences in resources that are not related to outcomes. And we're all quoting Elliott in every speech we make. See, it can be done. But now we have to figure out how to do it. And I think the first step is to build on the Dartmouth knowledge and begin changing the reimbursement system in Medicare.

Now the political obstacles are real. Med PAC has tried to suggest ways of doing this, maybe not even very drastic ones but they've run into roadblocks in

Congress. And the all time ridiculous no brainer it seems to me is competitive bidding over durable medical equipment. Who could be against that? But it has failed in Congress. Who, except the manufacturers of durable medical equipment? And it has not gotten there yet.

It will take strong political leadership in the Administration and the Congress and I think it ought to have high priority changing the reimbursement procedures in Medicare for the Obama Administration right away. It's the test of the ability in this moment of change to explain to the country that we have an opportunity and an imperative to run the health system more effectively.

Now there are those who say, oh, we can't do that in Medicare. The opposition is too great. We have to wait until we have universal coverage. I'm not sure why these people think it will be easier to get this after we have universal coverage when the stakes are even higher is the political power of the vested interests like the manufacturers of durable medical equipment, just going to magically disappear? I don't think so. I think we have to take it on now.

Now the budget choices facing the new Obama Administration and the leadership of Congress are daunting. They must move quickly with stimulus and investments to encourage future growth. They must move quickly with investments in infrastructure, but infrastructure doesn't mean just roads and bridges. It can mean a major investment in health information technology that will enable collection of the information that can make the delivery of care more efficient. No point in just collecting that information, though, unless we use it.

Now stimulus and investment in future growth will make the deficit bigger, and the tendency will be just to say “oh, that’s all right because we’re in a recession and we need a bigger deficit, and we don’t have to worry about the future.” Wrong, we do have to worry about the future and the looming deficits out there if we primarily change the efficiency or reduce the rate of growth of healthcare spending. And I would propose that the new administration and Congress actually work on both ends at once, on the stimulating of the economy and growing it on the one hand, but at the same time, simultaneously, not just wave their hands and say “ah, yes, we’ve got these future problems.” But say “right now, we’re going to start fixing.” And there are two things to start fixing. One is fix social security, which is not the subject of this panel, and the other is the one that is. It is to put Medicare into the lead on controlling healthcare costs and reforming reimbursement.

So doesn’t the private sector have a role here? Of course it does. And I think one can bring them together in a joint effort to collect and disseminate information on effective care. We need a new institution, isolated as well as possible from the political system, to do that. Some people have called this a “health fed.” That may have been back when the stock of the Federal Reserve was a little higher than it is now. The idea, I think, is right. It should be an institution with prestige, a distinguished board, political independence in the form of long terms, and people removable only for something like moral turpitude, and a secure funding stream which could come from the insurers, both public and private. That sounds a bit like the Federal Reserve, but I think this analogy shouldn’t be carried too far. Some of the proponents of a “health fed” --

and there've been several papers on this -- have said "well, the Federal Reserve has 12 regions. We should have 12 regions." No you shouldn't; that's too many. And -- but, what this organization should do is collect and analyze and disseminate widely the research on what is effective care and what is not, and what is effective delivery and what is not. So I think however we go about broadening coverage, and we should, we need to start with efficiency, value, cost, and it can be from day one.

MR. McCLELLAN: Thank you, Alice. Denny?

MR. CORTESE: I'll build off many of the comments I think that Alice made and also Elliott. When you heard Don Berwick speak earlier, he described -- I came in from The Institute of Medicine, and today at The Institute of Medicine is their eighth workshop, and this one is dealing with the topic of value and how to pay for value. That is an important component that arose as the Roundtable on Evidence-based Medicine found that we can't get anywhere without paying for the value. So that is an additional workshop that we've added into that topic even though it isn't in the scope of the original work of the Roundtable. Now the three aims are better health, better healthcare, and at lower cost. That's the value equation. Value equation is the outcomes, safety, and service compared to the cost over time. Alice put it another way; said are we getting what we paid for? Every Congressman you talk to when you say what's the number one problem in healthcare in the United States? They say "we're not getting what we pay for." The unfortunate answer to that statement is "oh, yes you are." That's the saddest component. We are -- this country has gone so far to make sure we are paying for non-value that somebody's got to stand up and say it is time to pay for

value. I know it's hard, but so is a lot of things. And there are many ways to identify outcomes, safety -- safety's easy to measure; it should be all zeros -- service should be real high; that's easy to measure; and cost, how much easier it is to measure cost than we already have. So this is a solvable problem if people will put their mind to it.

Mayo Clinic Health Policy Center for the last two and a half years has come up with four cornerstones out of a consensus of a large number of people. One is the issue of getting value out of the provider network. The other is getting integrated and coordinated care. Those both make sense. They've already been touched upon. The other is the payment reform to pay for value. And the fourth one is insurance for all. I'm going to take the last two because now I'll go through my recommendations to think about.

Number one is the general set of recommendations related to the federal government. What can the federal government do? Well, it can pay for value. It can make sure that Medicare, as the model that the government may want to address to start with, Medicare goes to a pay-for-value model, and it helps people get insurance. The government can take maybe a role in both of those. So let's talk about the two.

If you begin to pay for value, best outcome is better safety, better service, lower costs over time. When you begin to do that, that will require a delivery system to respond in a way that it generates value. That means it will become more evidence based. They'll start to get integrated function even if it's virtual. They'll start to work together collaboratively; otherwise they're not going to get paid. They'll have to have transparency around pricing and outcomes. When you begin to look at that, you'll also

find that the delivery system to get to that value will have to find ways to become integrated and coordinated. So just focusing on the concept of value will get you there, and it will bring clearly forward the need for evidence-based medicine, evidence-based decision making, and -- someone asked earlier today -- what's the role of process in lean management, engineering, and healthcare? It brings forward the role we have begun to describe, the science of healthcare delivery, the engineering science that's required to help deliver the better value. When physicians are working together in focus factories, providing better care related to just open-heart surgery, you'd better believe they're using lean management, and they find it's in their own self interest to do so. So it exists. We just don't pay for it. So we need to begin to think about those simple things, and let's pay for what we say we want. You want value? Why don't we pay for it. It's sort of a simple question coming from a physician who kind of looks at what's the root cause of the disease. And I think that is one of the root causes.

The second item is the helping government, helping people to get insurance, because I agree. Everybody should have insurance. Perhaps creating pooling and a purchasing mechanism like a federal employee's health plan model type of a thing where you can choose from. Maybe you have a public's plan in parallel with those so people can choose. And then of course the biggest role for government is to provide financial assistance for those who might need it to purchase their health insurance. And we think people, by the way, -- in our health policy discussions -- people ought to own their own. And at our Mayo Health Policy Center, our recommendation is that it's mandated. That's how far we've gone in our discussions.

Okay. Then the next set, category two, is Medicare. When we look at Medicare -- Alice raised it -- I think that's a perfect model to focus on. A couple of points that Medicare will have to change the way it does business, and we have seven recommendations on it, what needs to be changed within Medicare to make it function better? One, they need to pay for value. Of all the organizations that can identify where value is, they know where it is. They just need to begin to find -- maybe with pilots -- some ways to do it. They have to get rid of price controls and reduce price controls. Price controls have done nothing to control the rate of spending, absolutely nothing to control the rate of spending throughout the last 30 years or so. And to have in place of that, put transparency of pricing and value, and the transparency that reports where everybody's performing. There ought to be a mechanism to let people, individuals, pay more if they choose to do so. Maybe that's the only way you will get pay for value. Let individuals decide what is of value to them, and let them choose some. Allow comparative effectiveness studies to be done. Comparative effectiveness studies are absolutely crucial in helping to decide what to design for coverage and what to actually cover. That currently today is explicitly not allowed for reasons that are vague to me. It's totally, in my viewpoint, totally mindless. It's another example of a mindless attempt to try to regulate something through Congress, and the unintended consequences are we don't use evidence to decide anything basically. So you get what you pay for. Coverage with evidence development, one of the outstanding programs; we should have used that in this country for CTN geography. That's a terrible mistake that was made in this country in the last four months, six months, because of politics. Another

lost opportunity. This is a crucial thing that Medicare has to be unleashed to do to turn this country into a vibrant, translational, organization for learning about healthcare in this country. Move to a premium support model. This is what Medicare will be forced to do in time. Some sort of a defined contribution model. It will be forced to do that at some point. Ultimately you absolutely -- maybe, not ultimately, maybe the other way around, you've got to get Congress out of it. Congress as the Board of Directors of Medicare has demonstrated a total inability to be able to run an insurance company. I don't remember when I've read the Constitution any words that say we're electing the Board of Directors for insurance companies. So what is Congress doing in the middle of daily operations of Medicare? We've got to get Congress out of that, and Alice alluded to that. The idea comes out of that kind of concept, the ideas of a federal board or whatever has begun to be raised. The Blue Ridge group actually submitted their report a week ago, two Saturdays ago, their reports come out. However, here are some things to think about that should be removed from politics. I'm not going to call it a federal board; this could be a public/private group or some of the things I will list can be assigned to already existing agencies or functions, public or private. One: Facilitate and simplify payment administration. That could be a federal board of some kind to be able to do that. Second: Facilitate a functioning insurance market. What I mean by that is no exclusions and with risk adjustments. Somebody needs to be able to do that. Serve as an insurance exchange. Maybe that could be the Office of Personnel Management, maybe it could be a new group that we form. There are ways to maybe look at that. Fourth: Define value. Maybe that's a role for the IOM or AHRQ. There

are possibilities to do that. Develop models and pilots to pay for value. That'd be number five. Certify the accuracy of outcomes in the metrics that we're using to define value and pay for value. It could be another body that could do that. Maybe AHRQ. Certify, maintain -- I'm sorry -- create and maintain and disseminate medical information. That's a crucial role that somebody needs to play in this country. Another possible role is to plan for the future workforce. What's that workforce going to look like? With new models of care, you need many fewer physicians than you think you do in this country. We think we need a whole bunch of physicians. You don't if you'd redesign the medical care delivery system. And the Dartmouth Group has shown that. We're probably overstaffed in positions if you change the delivery system. My favorite is where do we report medical errors and near-misses? It is a disgrace in this country that we do not have a place that is populated by engineers that can look at the mistakes that are made in the delivery of care in the United States. We do it in the airline industry. We should do it in healthcare. Many more people die in healthcare than they do in the airline industry. We need this model and it needs to be in place. And then finally, perhaps further reporting. Maybe you move into an arbitration environment for medical/legal settlements rather than staying in the tort reform system. So those are the key elements. I think these are policy implications, and I'd like to see the President of the United States when he wakes up every day to ask the same four questions on healthcare and then go on with the rest of his day. One: Are we getting value? Two: Are we paying for it? The answer for the first two years is going to be no and no, but you keep asking it and some day it's going to be no and yes, and pretty soon it's going

to be yes and yes. But if you don't ask the question, you're never going to get there. The third question they should ask is everybody insured? And that should be a yes this year coming up. And then the last one is who died last night in the United States in hospitals that shouldn't have died? And the President ought to be able to get his finger or her finger on the names of those people just like you can in the airline industry. If we can get those things done, we'll go a long way to improve healthcare in the United States. So thank you very much.

MR. McCLELLAN: Thank you all for some very wide-ranging comments on this broad topic of improving care at the same time as we can improve coverage. There are a lot of recommendations here, many of which face some real political obstacles. We heard from Senator Baucus earlier. There's at least some willingness to take some of this on. I want to push a little bit on another aspect of the challenge here, which is that if you talk to many Americans -- we'll come back to this more on our next panel -- you talk to many Americans about their biggest concern, it really is the cost, and what they're paying out of their own pockets and concerns and anger about how unaffordable it seems to be getting. One of the challenges in implementing some of the policy reforms that you're talking about is that many of them seem to be investments of one kind or another. If we're investing in these steps -- if we're also taking steps, as Denny suggested, try to get all Americans into coverage, what can we do to try to make sure that from a budget standpoint we're not looking at higher costs in the short term and maybe the long term? Alice, you emphasize the need to take on these budget issues in a very front-and-center way as part of dealing with broader healthcare

coverage reform. Yet if you talk to some of your former colleagues at the CVO, many of them and other actuarial experts are concerned that a lot of these steps might end up costing money in the short term if not the long term, adding coverage expansions on top of that makes the budget outlook even more challenging. So how can we really put this together from a budgetary standpoint? And that wasn't just directed to you in my comments.

MS. RIVLIN: Well, let me start. I think you have to recognize that some investments are necessary, take health IT, that's going to cost something upfront. But we need to do it, and it's got to be combined, I think, with the reimbursement rate restructuring. My own doctor whom I tease mercilessly as she shuffles through papers says we're going to -- you're absolutely right and we'll do it when Medicare says we have to. And I think that there's some wisdom there. But it is just a question of what are the absolutely necessary investments we have to make, but how do we change the reimbursement system so that we pay for value and not for waste, and gradually over time that will give us a more efficient system in which the rate of growth of costs of spending is less? It's not going to be zero.

MR. FISHER: I want to -- I think it is the question and it -- we've recently started to look at how different regions are in their growth, in their annual growth rates. And I think it offers us hope except for Donna in Miami. If you, you know, look across U.S. regions, growth rates vary dramatically in per capita Medicare spending, so inflation-adjusted growth in Salem, Oregon, was 2 percent per year, exactly at GDP growth over the last 15 years. San Francisco was at 2.5 percent, you know, half a

percentage point above GDP growth. And Miami was at 4.7. And then there's McAllen, Texas, as anyone here from the Inspector General's office, they were at 7 percent a year. But these regional variations in spending growth give us both hope and should also discourage us because they're all operating under exactly the same payment system. So the fee-for-service payment wasn't exactly it. There's something else going on there. But I think if I were, you know, given the opportunity to try to steer this, it would be to think about how to reward the systems that are growing slowly for continuing to do so and doing a good job, and then start to have some threats laid out there for the rapidly growing systems. And say if you don't join a shared savings model or don't join in some way of slowing the growth of healthcare spending, your actual future costs, you know, you're going to be penalized in the future. So there's an outlier penalty that gets -- is held out to threaten folks to join integrated delivery systems, to come together to have an opportunity to provide population-based payment. I really think we can, you know, the fact that so many places have been growing reasonably says these are conscious decisions made by hospitals trying to expand their, you know, you have a construction boom ongoing or by physicians trying to expand their incomes or recruit more physicians, and we need to change the growth incentives in the current system. And something like that is, I think, should be in the near term, a path to getting us some fiscal responsibility.

MR. CORTESE: I would agree with both sets of comments, and the Dartmouth data also does indicate some things that give us some hope that we can actually get in this direction. When you begin to look at that variation in the growth and

spending, spending is a function of the price per service times the number of times you get the service done, and that's called the utilization rates. And the fact is that the predominant cause of the rate of growth is not the pricing, it's the utilization. It's how much is being done. And that practice variation, meaning how much we do to people, is quite dramatic and in many cases it's inappropriate. In many cases, it's just plain waste. We shouldn't have to do it. And part of it is waste that's not necessarily due to greed by the individual providers, it's that they're not connected, not integrated, not communicating, and there's a lot there that can be gained. So these comments give us hope that if we can actually improve the way practice is done and you get more standard approach to solving problems, there's a chance that you'll drive down the major driver of healthcare spending, which is utilization. I think your data shows about 70 percent of the driving of the growth is due to utilization through the Winberg data. The other thing that is of interest is that when you look at Medicare data, that there are groups of people who have maybe the top five diseases in the United States, that account for roughly 70 percent of the spending that Medicare sees. When those patients have a contact with an integrated group practice model, something happens when they get that tune up with that integrated group model. And then they leave that practice, they go back into their home environment. Their spending actually drops from Medicare's perspective for six months up to two years I think is what the data have shown. In other words there's a halo effect of that one-time tune up. It almost gets you to a point to say maybe the really sickest patients and the most expensive ones need to have some kind of a special tune up that's paid by Medicare. You go get this done. We

may see some spending reductions over time with that periodic touch with one of the top-value, integrated, delivery system models. So there's some ways to maybe get to that part.

MR. McCLELLAN: Let me open this up to the people who are here today. Any comments or questions from the audience? Yes?

MS. RIEFBERG: I'm Vivian Riefberg with McKinsey and Company. One of the things I'm struck by is that the largest health insurance program in the United States we have not mentioned at all, and that's Medicaid. It's federally overseen and state run. The Governors can't keep printing money, unlike the federal government. What is your perspective about immediate things that could happen to address that challenging part of our system?

MR. McCLELLAN: Medicaid is part of this reform effort?

MR. CORTESE: Are you talking to me? I'm glad you raised that. It is. It's clearly one of them -- and Mark asked me to keep my comments to a very small number -- Medicaid's a key one. Of course, that's at each state level, so each tactic has to be different. But the overarching strategy is, again, to get value out of Medicaid and to do that by joining forces, and we practice in five different states and we are talking to each of the states. Florida is the toughest to get anything original accomplished. Minnesota's probably the easiest. But the fact is that when you talk with them and you begin to look at models, we have found so far the best way to approach that is focusing on their big expenditure diseases, so maybe creating a model or two for just a couple. I'll give you one example. People who have had their first myocardial infarction, now

enroll them in some kind of secondary prevention program. Just do this on an ongoing basis totally driven by non-physicians. There's a physician conducting the orchestra, but the orchestra providing the care is all kinds of other non-physician providers and the cost begins to come down. So developing -- being allowed to produce models of care that produce value and get paid for it. Those are the key interactions for discussions. No more of this stuff about discounts off of your fixed prices. Forget all that. It should be new models of care and are you allowed to actually take care of people and get paid for it? That's the key component that has to be discussed. And it may be easier to do at the state level actually than the federal level.

MR. McCLELLAN: Thanks. And in fact some Medicaid programs are serving as a hub for some multi-stakeholder efforts, including in Vermont as Elliott mentioned. Other questions? Yes, Leonard. Microphone.

QUESTIONER: To raise a point that Thad made earlier, if you look at old fashioned managed care, which now only exists in Medicaid, what you find is that the most cost effective parts of Medicaid programs are managed care programs, okay? And the quality in terms of both the care and the health status has improved significantly. It's the only place where you can make those kinds of things work in our culture. You know, the people running insurance companies, the people running HCFA -- excuse me, CMS -- are not dumb. They're trying very hard to make progress. One of the things that I observed is that the suits can't tell the white-coat guys what to do. The white-coat guys have to decide what they want to do and how they're going to do it. And there's a huge absence of physician leadership. Mayo is an example of what

physician leadership can do. It's an incredibly effective, cost effective, healthcare effective, institution, but it is an unnatural act. It doesn't exist, or it doesn't exist very often in the rest of our healthcare system. What can or should be done to create more physician leaders who are willing to take responsibility both for cost and quality?

MR. CORTESE: Let me tackle that. I think physicians are -- they're wrung out by the time they're done with medical school. We do -- when they leave medical school, physicians need to learn how to work in integrated practices; they have to learn how to work in teams. Even if they don't want to, they're forced to work in teams as they work with other hospitals. This idea of an accountable delivery system will require special training in medical school so we select people differently. We ask them really to take care of people in a way that requires them to work with nurses, other physicians, families, et cetera, et cetera. I asked our own medical school when's the last time one of our graduating classes took a clinical test collectively so they got it 100 percent right for their patients? And the answer still today is that it's cheating. That's still cheating. And frankly when they come out of medical school, the first night on call they have to do that. So if you begin to pay for value, if we begin to pay for the outcome of whatever that group is that's producing the music of care, then the training will have to be different. People will have to learn what does it take to take care of somebody who's got five complicated diseases? What does it take to take care of somebody who's 28 and they now have a gene test that says that they're at a 50 percent risk to develop high blood pressure, stroke, and Alzheimer's disease by the time they're in their eighties? How do you actually design the care for that person? You don't need a

doctor to do it. So it's going to go all the way back, but if you're not paying for that to begin with, none of the rest falls into place. So I say you've got to start over there. And I don't know how -- you got to do it, and the rest of the group will begin to change or they'll chase the dollars.

MR. McCLELLAN: Elliott?

MR. FISHER: I don't think it's just the payment system. I agree we have to change the payment system; that will help pull new people through. But I think the professional model we have as physicians is actually the problem. We are trained to treat people one on one. The only way we affect or provide our services is through an individual contact with an individual patient. I think it's going to require fundamental new professional models and developing educational systems that support those models. The University of Minnesota is actually embarking on a very exciting effort to completely redesign their curriculum collaboratively with all of the other health professionals so that medical students might actually think about learning in an environment that requires working with others. But I think we've got a barrier between care delivery in almost every setting where professionals see their job as seeing a patient by themselves and walking out and writing a recommendation, and not learning to practice the way Don would have taught us, if only Don would have been in our second-year and first-year classes.

MS. RIVLIN: We shouldn't kid ourselves that it's a win-win for everybody. Some of those doctors in Miami will be worse off.

MR. FISHER: They may, although there's so much money in the system,

we could afford to retrain them. You know, if you look at what we're spending on GME and what a well-structured system would have in terms of how many physicians it requires, let's devote 30 percent of GME training to retraining physicians in new work so that they have a future job. Just the way in the economy, I understand, you take unemployed workers and you retrain them for something else. We should do the same in healthcare.

MR. McCLELLAN: Next question.

MS. DENTZER: Susan Dentzer from *Health Affairs*. How do all of you see us addressing state scope-of-practice laws, barriers against practice of telemedicine, all the things that militate against the deskilling that was mentioned earlier and the kinds of reconfiguration of who actually provides health care?

MR. McCLELLAN: Alice's health fed.

MR. FISHER: I mean, seriously, I think it's a tremendous barrier. I mean the reinvention and redesign of care. Even all of the hospital regulations that require us to have very, you know, high capital-intensive hospital beds. You know, so much of our accreditation and certification is designed to drive the costs up and support the current trade groups that are in various positions. I think it's a serious challenge and I'd love to hear what Alice says on the issue.

MR. McCLELLAN: And there are exceptions, in ERISA, in many aspects of the Medicare law to state regulation that would otherwise apply. Is that what you all have in mind? Does it need to be coupled with some new structures?

MS. RIVLIN: Yes, but I think it starts with definitive demonstrations that

there's a better way to do it and that has to be established and disseminated.

MR. CORTESE: I think it's a huge battle. It's easier to do some of the things we're talking about overseas. We are able to do this easier in Bangladesh and in India and the Middle East than we are in the United States. We can do telemedicine. We can do virtual consultations, advice to people, deliver healthcare with advice to the telephone ladies who go visit people in the rural communities with Muhammad Units and things like this. This can all be done in the United States. You have to change the licensing law and you say single medical license, and you have to change the scope of work -- maybe under supervision -- by team, become members of a team that's delivering this care and have nontraditional providers giving advice, health, and healthcare in nontraditional settings.

QUESTIONER: Do you see us addressing this state by state by state by state by every provider group along the way?

MR. CORTESE: No, it's got to be done at a national level. I think -- again maybe a health board, I'm not sure who, but somebody needs to tackle it. It's a good point. I've got to add it to my list.

MR. McCLELLAN: Last question. Nancy Johnson.

MS. JOHNSON: We have at many levels, certainly at the intellectual leadership level of healthcare, gained a pretty good grasp of the vision that should drive change. But we are really having a hard time because we haven't identified clearly enough what current laws are absolutely prohibiting that change. For example, there are very sophisticated homecare systems that now during the episode of care focus on

behavioral change. Then behavioral change needs support, but if you support that patient too long after the episode, you are now illegal and corrupt, and can be prosecuted by the federal government. Areas that have very much slower rate of growth and cost are penalized by the budget neutrality provisions where the money goes to the high-growth areas, and they get cut even though they have kept growth to 2 or 3 percent. So, transparency. I was shocked to find out that doctors can't talk to each other about what plans pay them. Hospitals can't talk to each other about what they pay for certain devices. You know, we'll just never get anywhere if we don't -- these are rather simple changes actually, but when I look at the demonstrations, the demonstrations haven't been able to demonstrate what we want them to demonstrate because the laws don't -- and literally don't -- allow them. You can't get a group of physicians to work with a local community hospital around bundled payments because the law doesn't -- literally doesn't allow it.

One last point along that line in terms of electronic health records: You know, there are groups in the nation who where the private sector payers will populate electronic health records with their claims data. And the state will let Medicaid do that, but Medicare can't. Well, you can't ask a physician to try to reframe his whole office workflow and everything if he can't get all that information into the record as a starting point. So really I think Congress would be very willing because they're getting it, too, to change some of these laws. But we've got to buckle down and -- I mean, one advantage of it still being out there working with real care/real world providers as members could -- and used to more than they have time to now -- is that you do see

these barriers in law that prevent us from getting the information we need. And so maybe a demonstration that would waive all these laws like we have done under Medicaid.

MR. McCLELLAN: So kind of getting back to the same theme of a number of underlying rules is on for different healthcare system getting in the way of moving to a fundamentally better one. Quick comments on this issue?

MR. CORTESE: I would say that you should be a member of this health board that ends up because I think you're talking about the very tactical issues -- and there are other barriers than the ones that you've listed, too, and they need to all be addressed to be part of the tactics to get to the strategy we're talking about.

MS. RIVLIN: I agree.

MR. McCLELLAN: Okay. Thank you all very much. I'd like -- if you'd join me in thanking our panelists for a great discussion.

PANEL THREE: TALKING ABOUT REFORM: NEW DIRECTIONS FOR INVOLVING THE PUBLIC

MR. McCLELLAN: All right. We're going to continue our strategy of moving right along in this discussion with now our third panel, which will be talking about what the public thinks about some of the problems and thus about the solutions in our healthcare issues related to quality of care and access to affordable coverage, and how these issues might evolve in the coming efforts for healthcare reform next year.

And let me start by introducing our panelists for the third panel. Our moderator is Susan Dentzer, who is now Editor in Chief of *Health Affairs*, the nation's leading journal of health policy. She's also an on-air analyst -- or continues to be an on-air analyst -- on health issues with the "NewsHour with Jim Lehrer" on PBS. Susan assumed the job of Editor in Chief on May 1, 2008, after working for a decade as the on-air health correspondent at the "NewsHour." Susan has some unique qualifications to moderate this panel. On the one hand, healthaffairs.org is the go-to website for practical and relevant health policy analysis, and on the other hand, Susan has a tremendous amount of experience and unique ability to translate this sort of analysis into practical, clear, implications for the American public.

Joining Susan on the panel are three people who truly are experts in what the public is thinking. Neil Newhouse is a partner and co-founder of Public Opinion Strategies, which has been described by the *New York Times* as the leading republican polling company in the country, and his firm was named "pollster of the year" by the trade publication, *Campaigns and Elections*, in the 2002 election cycle. Neil's gotten praise from both sides of the aisle for his broad range of campaign work, and continues

to have a big impact on political campaigning.

Stan Greenberg, who's the founder of his polling firm, Greenberg Quinlan Rosner, after a decade of teaching at Yale, provides strategic advice and research for leaders, companies, campaigns, nongovernment organizations who are working to advance their various public policy issues and other issues in these changing times. He's also served as a pollster for many international leaders, not just here in the United States -- people like President Clinton and Vice President Gore -- but also British Prime Minister, Tony Blair, and presidents of nations from around the world. So, we're looking forward to hearing their perspectives given the recent election and given the prominence of healthcare and its relation to other economic issues right now.

Finally, again not least, is Jim Guest, the President and Chief Executive Officer of Consumers Union, who has a long career in public service and working for the consumer interest. Thanks in good part to Jim's leadership, his organization has become very focused on healthcare. In addition to publishing consumer reports, Consumers Union has launched several newer initiatives, including consumerreportshealth.org and a consumer reports health rating center which served to educate and provide information in a way that consumers can use to make more informed healthcare decisions and get to some of these goals of better care.

Susan, let me turn this over to you.

MS. DENTZER: Great. Thanks very much, Mark, and good morning to all of you. When we think about the public's involvement in healthcare and healthcare reform, many of us who lived through 1993 and 1994 -- I guess all of us lived through

1993 and 1994, but perhaps with varying degrees of attention being paid to us -- but most of us will remember the famous comment made by an elderly woman who ran into Senator -- then Senator -- John Breaux in an airport in Louisiana and applauded him for his efforts on health reform, and then said to him “but Senator, whatever you do, don’t let the government take over my Medicare.” This being thought of as the emblematic piece of public opinion on healthcare reform and underscoring Congressman Barney Frank’s famous statement that “people complain about the politicians, but the voters aren’t so hot either.” As we move into an era where the voters are going to be asked -- if we take Senator Baucus at his word -- and we are going to see some major moves on health reform very soon, we are going to actually be depending on these voters to support those efforts. And I think that gets us to our conversation today.

Our panel was charged with asking two questions: What does the public understand about healthcare system problems and solutions? And what might be done to educate the public better? What are the messages that could generate support for broad-based reform? What would cause people to lay their concerns aside? Now we know that those concerns are already legion. We know from the polls, Stan, that you and Neil have done, that people who voted for Barack Obama placed third on their list of reasons that they voted for him that he would produce a system of affordable healthcare for all. We know that there’s enormous frustration with the U.S. healthcare system. The Commonwealth Fund surveys show three-quarters of the public or more wanting a completely rebuilt healthcare system or one that is improved in major ways. So the expectations of politicians now are quite high.

On the other hand we also have as the iconic voting figure of this year, Joe the plumber, whose basic concerns appear to be that he's distrustful with taxes, distrustful of government, and as we've been hearing for the last couple of hours, much of what we're talking about are major, major actions instituted by governments to reform the private system possibly with some additional taxes down the road. So with that by way of introduction, Neil, let's start with you. Your party was on the losing side, so we'll let you go first.

MR. NEWHOUSE: I thought it was the other way around.

MS. DENTZER: Okay. What do you see as the best -- what's the current understanding of the public of what are the best potential means for improving that understanding and getting buy-in on any reforms that go forward?

MR. NEWHOUSE: All right. I brought a few slides in PowerPoint, if we can bring those up, if that's at all possible. Oh, we're experiencing technical difficulties? Let's start with, I think, a look at the big picture here. You pinpointed exactly the priority of the healthcare issue in the exit polls. The problem is the healthcare issue is being completely overwhelmed by the major concern about the economy. President-elect Barack Obama's to-do list is an extraordinary to-do list. It starts obviously with the economy, auto industry, unemployment, bailouts, Wall Street regulations, economic stimulus, mortgage foreclosures. It is -- there is no other issue than the economy. Now, of course, healthcare reform falls into that, but it is number one -- it's a public that is dominated by concerns about the economy. And secondly, if he had -- his number two priority is going to be getting troops out of Iraq. That's number one and number two.

And beyond that, everything else is going to pale. So, I mean, this is not like the 1994 or 1992 kind of ground swell support for reform that we thought was there. This is now overwhelming a concern about Iraq and the economy, and then underneath that the two major issues of healthcare reform and energy independence. And I think, I mean, that's enough for eight years of Barack Obama's presidency potential rather than just four. So that's -- those are the top two issues.

When you get to the -- when you cite the data on healthcare reform, what's really interesting when you go through the data is there is no question that Americans overwhelmingly believe that it ought to be reformed. They think it's, you know, it's a time for -- the status quo in healthcare is about 15 percent. Nobody wants to keep it as it is. But then when you ask Americans how about your healthcare? How do you feel about the delivery of healthcare to your family, you and your family? Seventy percent of Americans express confidence that they're getting -- the quality of their care is pretty good. Then when you juxtapose a question -- just flip it and say how about the rest of the country? And the rest of the country, the number is just inverted. About 20 percent say that the healthcare in the country is going well, and about 70 percent say it's off on the wrong track. So it's almost like "I'm okay, but the healthcare system nationally is broken."

MS. DENTZER: And that's a typical response that people have about Congress versus their individual --

MR. NEWHOUSE: No, no, no, no, don't go there. No, Congress -- they hate Congress and they're lukewarm to their Congressmen. This is "I'm okay, my

healthcare system is fine, but the rest of the country is really hurting." In fact, if we can go down a couple of charts here -- you were right, it did come up. One-third of Americans believe the healthcare system in the country needs to be radically changed, 51 percent reformed, just 12 percent status quo. Remarkable numbers and from that we would obviously take that there is a significant sentiment for change. Next one. And yet 71 percent say they're happy with their own healthcare compared to 24 percent say they believe that the healthcare in the country is going well. So this is -- these numbers are just the inverse of each other.

MS. DENTZER: So what's the disconnect?

MR. NEWHOUSE: Well, here's one more. The tradeoffs -- in order -- when -- I think one of the major pushes on the healthcare issue over the next few years is not going to be the cost. Cost is really the major issue, but over the next few years because of layoffs, I think it's going to be the number of Americans without health insurance. I think it's being driven by the real concern about the economy. And when you ask about the uninsured? What are the tradeoffs? Reduce access to healthcare service among those who are currently insured: 80 percent say that's not acceptable, 61 percent say it's not acceptable to raise taxes, 57 percent say it's not acceptable for more government involvement in managing the healthcare system. And then finally, 34 percent say it's not acceptable on employer mandates and individual mandates. So what's -- there's a disconnect here in terms of the need for reform, the perceived need for reform, the perceived nature of the problem -- it's not me, it's you -- and what Americans are willing to stomach in terms of what's acceptable to them to help solve the

problem. But I think this is where we're headed in terms of covering the uninsured, even though the cost is a major issue and people are concerned about it right now, the news stories over the next couple of years are going to be about those who are laid off and unemployed and don't have healthcare coverage.

MS. DENTZER: And if you had asked a Don Berwick-style question or a Denny Cortese-style question that didn't say reduce access to healthcare services, but said I'll give you much better value for healthcare services --

MR. NEWHOUSE: Nobody's going to believe that. You know, I'm not sure that's a believable proposition.

MS. DENTZER: Okay, then, Houston we have a problem. Stan?

MR. GREENBERG: Well, I'm guided in this by the Pakistani taxi drivers who I always ask about what's happening. And they always had a rule on the election -- actually they volunteer it because they began to know who I was -- the rule was that Obama has to be ahead by six points or else he's not going to be elected President of the United States. So it was the Pakistani six-point rule for the election. Now the point and raised before I came to give this speech from my Pakistani taxi driver was "ah, but is he going to be able to keep any of his promises?" Which is where I think we will now focus.

I was there in the, painfully -- that's part of the process because others here are dealing with the Clinton healthcare plan after the '92 elections and the '94 debacle, so we know how it can go badly wrong. I think we're in a very different moment. I'm not -- as I listen to you, I think I'm in a different place on how I think this

plays out and what role the public plays in it. Actually I won't go through my slides except maybe one slide, but what's clear from the post-election polls and the exit polls and everything, is that there are four issues that people think are going to come out of this. That Obama and the democrats are going to focus on the economy and creating jobs above, you know, above all else, you know, energy independence and getting off foreign oil, affordable healthcare for all, and getting out of Iraq. Since President Bush just signed the, you know, the withdrawal on a fixed deadline from Iraq now, we, you know, we only have to worry about the implementation of George Bush's policies for Iraq. But whatever battery of questions we go through, you end up with those kinds -- the four clusters of issues as what people expect to come out of this election. I think there's more space being given to him, given the scale of the crisis that we're in the middle of, but the mandate matters, and the learning and the election process matters, and how people became engaged in the process matters. Healthcare affordability, this is not just a choice of word in surveys, this was not about uninsured. This was totally about cost, it was totally about affordability, and affordability encompasses rising premiums, rising deductibles and co-pays and total costs that are borne increasing by employees and there is an acute sensitivity to rising costs particularly now, just as there was over gas prices when those were rising. Particularly now, and, so, it's a cost-centered and not an uninsured piece, and the other part of it is that people get it is totally integrated with their understanding of the economy.

This isn't about the insurance companies. You come out of 1992, look, we did run on universal coverage, the showing during the president's speech of the card,

your insurance card; you cannot lose was the underlying principle, the fundamental change was that everybody was going to have insurance.

Okay, this is not about that. This is about affordability and that an almost two-year campaign led to an election in which affordability is talked about as the mandate, and what the president has to address totally changes the scope of what has to be addressed in this.

Also, there was an extraordinary engagement of the public in the primaries. There was a high level of engagement, as we know, in the election process itself.

I remember the failing of the Clinton healthcare plan. I remember the battle over trying to get the unions to support us in order to advance the plan. It was a struggle to get union support until it was decided whether Cadillac healthcare plans were going to be taxed –- I think it was $5,000 at the time, but the issue of taxing Cadillac plans kept unions back.

Unions, many of the industrial unions sector were not that sure that this plan was one they wanted to support, were in a totally different place. Those, as we've seen in the auto industry, know that their insurance is at risk; the service sector unions are much stronger.

When we tried to get the DNC and others to pay for ads for support of the plan, we had –- it was a couple million dollars for the total effort on behalf of the healthcare plan. We're dealing with a total shift of civil society, which I think puts this in an entirely different context. The Clinton healthcare plan died in committee. Can you

imagine in this environment if you came forward with a healthcare plan and it got in trouble in the Energy and Commerce Committee and Nancy Pelosi or the leadership of the Congress or the president saying okay, that's the end of healthcare, we're not going to go forward? There would be a massive engagement of the public around this process to force this into –- now, the other side of that, and I'll just go one slide.

I'm sorry if I'm going more than five minutes. Go to the next to last slide, which has to do with -– you can read it. The question we ask is whether you want to move on healthcare boldly or whether we should go step-by-step.

What you see is the country split, actually a parallel, I think, for step-by-step. When you get to the economy and a recovery and jobs, people are for moving now, move, and the risk reverse. The current status quo is too big a risk and we need to move. On energy, they don't trust the private sector actors; they have much more confidence in government. When you get to healthcare, people are more nervous and more risk reverse about the kinds of changes you make. So, while we're going to operate in an environment which I think there will be momentum for change and they'll be engagement of public to move the process forward, the public is not -– almost half the public wants to move boldly and half wants to move carefully, and, so, you've now a risk reverse public which obviously creates opportunity for those who don't want to see it happen.

And I'll just end with part of the discussion here has been over a bipartisan process. Elections matter. John McCain authored a market-oriented solution on healthcare. I'm sure it was caricatured in the attack ads

that said he's going to tax healthcare benefits, but, regardless, no one is going to become forward to the market with that type of incentives away from employer-based healthcare to a market process. The elections matter, and, so, we're going to be operating within a conduct in which I think sectors of industry, major sectors of industry will be at the –- bipartisan will mean not so much parties; it's going to mean different sectors of the economy who know this change need to happen, and President Obama trying to bring them together to move toward a solution.

MS. DENTZER: Okay, well, Jim Guest, you have your fingers on the pulse of this risk reverse, cost-reverse public. How do things appear to you?

MR. GUEST: Well, most of all, it is a cost-reverse public. I mean, our Consumer Reports National Research Center surveys pretty much say the same things that you're saying, and what we find out from the surveys, from the focus groups, we can talk about quality of care, we can talk about access, we can talk about all of that. What's on people's minds, if it's real estate, it's location, location, location. For consumers, it's cost, cost, cost. That's really when you ask all the things, that's what they're very much focused on.

And, so, I think, again, we did a recent survey in mid-October of what's happening to people in the economic crisis and got some very sobering returns. I mean, 1 out 5 consumers say they're unable to afford their medical bills or drugs, 15 percent say they've lost coverage already, 1 in 4 say they put off doctor's visits or getting medication because of the economic fears, and all the way through.

When we talk –- we did an article last March where

we talked about healthcare, people have fear of being bankrupted. Seven out of 10 fear they'll be bankrupted if they have a major illness or accident, 8 out of 10 are concerned they'll be unable to afford coverage when they retire, 2 out of 3 fear of losing a health insurance coverage if they lose their job and so forth.

So, I would say in terms of now, where does one go? I think the prescriptions that we heard in the two earlier panels are fairly consistent. The findings about public attitudes on healthcare are fairly consistent, as well. How do we link those together in a way to try to mobilize public support in a way that it hasn't really been there, hasn't been galvanized for major reform?

I've got a few ideas we may talk about in the Q and A, but one of the things that's crucial, we've heard all of the national statistics and the survey results on things like that, but I certainly think that to get the public mobilized for healthcare reform, it's all got to come down to the personal level. We actually set out this summer -- we've got ourselves sort of a healthcare reform campaign that we're engaged in. We sent an RV around the country with two grassroots organizers and a videographer collecting individual stories from their experience with the healthcare system, and I actually think if we've got the technical skill here, we can show some -– give you a sense of that. Maybe without the sound. Can we get it with the sound?

MS. DENTZER: Yes. It's probably even better.

(Video plays)

MR. GUEST: So, just in a nutshell, I think the challenges that take what you're talking about here and it does two things, translate it to the terms that the

average person can understand in a personal way, educate the public, educate individuals through various means about both the problems in the system and how the changes we're talking about will, in fact, be good for them, will be good not only for their healthcare, but for their pocketbook and then to activate people, and we can talk more about how to do that. But I think the audience is different this year than it was this time around -- than it was 15 years ago and the tools through the Internet, through the kinds of mobilization that can happen are there, and now the challenge is, I think, to sort of come together on the major elements of reform that most folks are talking about and then bring the public along and get the public bringing the pressure on Congress and policymakers. So, that's the next step in making something happen.

MS. DENTZER: Well, it also sounds as if some of the goal has to be bridging the gap between the people who Neil mentioned, who think their own care is just fine, it's just everybody else's is so bad. Bridging the gap between those folks and the people you just filmed there who can testify to just how screwed up things really are.

Neil, do you have ideas about how that happens?

MR. NEWHOUSE: Well, that's an extraordinary job. In one of the memos I reread this morning that was handed out to us ahead of time, the question was raised: Who can lead this fight? Who's the spokesperson? Who can we turn to? And I go back to what Stan said, the democrats won this election. It's Barack Obama. I mean, it's got to be –- he's got to make this fight and he's got to lead on this issue to make Americans pay attention. He has the attention of Americans like no president in, I think,

recent history, and he has a ton of political capital, and I think he's going to have to –- if this is a priority, he's going to have to make it himself because I don't think there's any other spokesperson out there who can lead this fight.

MS. DENTZER: Let's open it up to some questions from the audience, and we'll continue some discussion around how we do this because the how of this, Jim, as you identified, is critical.

MR. GUEST: Yes.

MS. DENTZER: Let's start over here with Gail Wilensky with Project Hope.

DR. WILENSKY: The numbers that you show, the disconnects, what existed in some ways with the public in 1993, 1994, although, there clearly are some differences, so, it's the what do we do now because I'm concerned when I see a polling that suggests when people talk about healthcare costs, they only mean their own costs, and they mean the affordability, the deductibility, the deductions, the premiums, the co-pays, they're not really worrying about what we talk about here, the general affordability, the systemic costs.

And when you look at the litany of issues that the president elect is going to face, is it your sense that because this is not likely to be number one, it's going to be the economy and the whole panoply of activities associated with it, that it would be reasonable for the Congress to try to pick a few areas where the Congress may be able to provide some leadership and then assume it will either be years three or four or years one of a second term of Obama? It sounds reasonable having his own

credibility in trying to drive change, may be able to get around the box that we've been in in the past. It's just hard to see that realistically happening in years one or two, given the issues that you've identified, both the economy and clearly getting out of Iraq, and maybe the energy independence before that. So, it's what do we do to get something done if there's some question that we actually can get a major involvement of a president when there are so many ways to screw up this ability to go forward?

MS. DENTZER: Stan?

MR. GREENBERG: I think it would be a mistake not to address this as part of the first wave of things that he does. The economic recovery plan may be on its own. But the point I was making about insurance companies and the critique that was part of the attack 15 years ago, people understand that the healthcare affordability is totally linked to changes in the economy. They understand what's happening to the globalization, they know what's happening to large-scale industry, they know what's happening to non-competitive employers because of the burden of healthcare costs. They know this stuff is structured into the economy, so, I think it's very hard to address the economy and how people are experiencing this economy and leave healthcare out of that equation. People already have, I think, a quite integrative view of it.

You also have, unlike 1992 –- in 1992, democrats lost seats. There's been a change, we've had two wave elections 2006 and 2008, and you've had in total 15, basically 10 senators, 15 who are House members who came in in the same wave.

In 1992, Ross Perot got 20 percent of the vote and was talking about deficits and most members of Congress who were swing members on healthcare and a majority of people who had voted for George Bush and Ross Perot. This is a part of a wave that includes the new members, as well as the president, and, so, I think it would be a mistake not -– I don't think you have to convince people that healthcare is important and it's a big problem. I think they get that. We don't have to convince them that this is central, and I think that's there.

What they're worried is they're going to screw it up while you do it, and, to me, what was most impressive about –- and I watched it happen with Blair in his first election in Britain where they reassured, reassured about not raising taxes, about freezing the budget at the level that the conservatives had, and what happened was the more they reassured, at the very end, there was a surge in support for spending on healthcare and dealing with the national health service. The more they get -- when they became reassured that they weren't going to be taxed, that the budget wasn't going to be blown, they wanted to spend it on healthcare.

What happened with Obama was -– and I'm impressed with it –- he stuck with it. He never let up with I'm not raising taxes for 95 percent. He did it through the end. I think you'll see as part of that a rise in support for addressing healthcare. Because I think people –- so, I think the issue here is reassurance, and that has to do with reassuring that you're not losing your doctors, that you're building on current system, which is very different than what happened in 1993, 1994, and, so, assuming

they're in fact, moving in a step-by-step way, I think once people are reassured that this is incremental, that is building on these things, your choice of doctor is not at risk, I think they know how to reassure, and I think we know on what to reassure that makes it possible to say all right, I'll take the risk of the change.

MR. NEWHOUSE: But don't you think if they do this in an initial wave that it's got to be step-by-step, piecemeal, kind of incremental approach rather than major healthcare reform? And how do they sell it? Do they sell it as major healthcare reform or do they sell it as steps to improve healthcare?

MR. GREENBERG: No, I think it's got to be big change, but it may be that it's step-by-step over 10 years to get there, but I think they got to know where it's going.

MS. DENTZER: We may hear from the next panel and Chris Jennings that it turns out incremental is just as hard to do as the big thing because people fight just as hard even when you're making small moves.

I want to just shift the conversation a bit because I want to tie this back to something Carolyn Clancy said in the first panel, which is about the need for engaging consumers more in their own healthcare and getting to the issue of personal responsibility, which all the candidates spoke about in the campaign. Essentially having people motivated to make a difference in their own health.

Is the public ready for that yet? Is there anything that senses that people understand the degree to which their own commitment to their own healthcare and maintaining their health may have to change?

Jim?

MR. GUEST: Well, you've probably done more polling on this than we. I'm not sure that there is that kind of public understanding now, but just picking up on the last point and then something more on this. I mean, we would support a really strong push for major reform. I think if you don't do it in the first go-around, the notion that you can do it later in the first term or maybe in the second term, I'd be quite skeptical about, and I do think that there is a climate of a possibility of doing this.

I'll come back again to tying it to people's real fears and the economic crisis that they're in, and we actually did a survey in the third week in October asking people how are you responding to and reacting to the economic pressures and what do you think needs to be done? And among the top, I guess it was seven or eight things that people said they thought it was most important to do for them, for their concerns, the biggest one was a concern about their pensions. But among those 7 or 8 top ones, 8 out of 10, approximately 8 out of 10 said they thought it's important to ensure affordable healthcare for all Americans. So, I was quite surprised to see that. Eighty percent said that something should be done, Congress should act or the government should act to ensure that no American would be without healthcare coverage if they're laid off or lose their job. That's 8 out of 10. Another nearly 8 out of 10 said that they should be ensured that you don't suffer financial ruin due to a major illness or an accident.

So, those things are very much on people's minds, so, I wouldn't see them as two entirely different things: What do we do about the economic crisis for people and what do we do about healthcare? I would try to link them and try to capture that

opportunity. So, that's what I would say there.

And then a variety of ways to engage consumers. I think, yes, that the leadership has to come from the president and we're certainly seeing that there is strong leadership coming from Congress, but there are a number of organizations who are doing various things. We see Divided We Fail, we see AARP, we see some other campaigns about to put out advertising and so forth.

One of my concerns right now from Divided We Fail is saying Congress needs to do something or the government needs to do something. Now, I think, there really needs to be a push around trying to educate people more about what's wrong in the system that's going to harm them and what changes can actually be to their benefit. So, it needs to get more specific about it.

But the third group that I would look to is the variety of organizations to try to coordinate better and really raising public pressure from the ground up.

MR. NEWHOUSE: I think it's going to be difficult trying to educate the public in terms of everything that's wrong with the system and in terms of when you talk about the paperwork and the value for the dollar, and it's just I think Americans will get confused very quickly on this. I think you've got to keep it relatively simple and address a few key issues, put it under the rubric maybe a major reform, but once you get down to the details in this, you would lose American voters.

And, keep in mind, their attention spans are pretty damn short right now. They are worried about losing their jobs, they're worried about losing their savings, and with all that, then comes the concern about healthcare, but when you have hundreds of

thousands of people being laid off of jobs, the first thing is income they're worried about then comes healthcare. So, it's the more you dive into the details of the issue, the more you're going to lose them.

MS. DENTZER: So, what's the message?

MR. NEWHOUSE: We lost this election.

(Laughter)

MS. DENTZER: Right. Think about that message for 10 seconds while we see if there are other questions in the audience.

Yes? Here, please.

MS. POWELL: Hi, I'm Eva Powell with the National Partnership for Women & Families. And my question is kind of a question, kind of a comment, and it springs off of what Neil just said.

In listening to the whole conversation about value, the way we talk about value is very, very system and provider centric. I have never been in a conversation where I've heard value discussed from a patient or a consumer perspective, and I think might be –- if we can begin to have those kind of conversations, we may address some of the very things that are sticky wickets, as this panel has talked about, and I certainly don't have the answers, but I'm wondering how we might begin to do that because I think it does have implications for patient engagement, has implications for patients and consumers taking more responsibility for their healthcare, it has implications for what kind of policy decisions do we make to encourage some of these changes in the provider system in terms of medical homes.

Are we going to just assume that if we are able to facilitate a medical home model that then would be more friendly to involving patients in their care? Is it just going to happen? And I'm not sure that I -- while I think all those things are good, I'm not sure that I'm ready to make that mental leap of thinking if we reward providers for taking more time with their patients and involving them in conversations about their care, we'll get to that next step that there's really that patient-consumer interaction.

So, I guess my question then is what kinds of policy work can we do to really change the nature of the conversation to be truly patient-centered in the context of also having these conversations that impact providers and all the other players who are in the system?

MS. DENTZER: Okay, so, back to that question: What's the message? Stan?

MR. GREENBERG: Well, I'm going to use this question just because you made a statement, to broaden the statement, and to build also from the prior statement.

One of the problems on part of the republican argument or conservative argument has been overuse. That is, trying to bring healthcare reform that incentivizes certain kind of use and puts more responsibility on individuals on whether to use healthcare services. People do not believe the problem is overuse by individuals. In fact, right now, they're in an environment in which they can't afford to use it, and, so, they're looking for a change that allows them to use it more, and, so, how you make a systemic change that deals with different kinds of incentives for different kinds of

behavior or when people think right now their problem is being able to use the system, to be able to afford to use the system, I don't know how to make that change.

I do think that the –- and I don't know if this is a message. I think there's a process here. I remember when President Clinton was elected and we tested his various promises, and we thought, well, can he go back on his middle class tax cut or this or that, and people basically said you know what, if we trust him that he's really acting in the long-term interest of the country, do what you think is right, and that is you have space to do this.

What I'm worried about is that when we move to healthcare reform, you're going to see all kinds of interests who are going to pour into Washington, who are going to make their arguments and various kinds of arguments about what kinds of provider, care at home or various things. They'll be a range of arguments on why each of these things makes sense, but it'll look like a special interest circus that's come in.

Part of the reason why people don't trust government to do this is, one, they've seen an incompetent, corrupt government over the last eight years, but why wouldn't they expect that if this government enacts healthcare reform, it won't be driven by all the special interest that dominate the process?

So, for me, the message is: How do you create a process in which I think President Obama has to be the driver of this, in which people believe that the public interest will somehow –- that the public is playing a role in this process, that the president is somehow allowing all the interests in civil society to get to the table without it being a special interest process? If that turns.

I mean, if it's seen as somehow –- because I think the country wants to do this, but if they think that the public interest is the end product of that, there is something driving it toward that, but the moment it crosses, and it very easily crosses the line to being just a bunch of special interests trying to shape this change in ways that favor their particular group, then you lose people. And, so, the process may be the message.

MR. NEWHOUSE: You know what's interesting is just as we showed poll data here showing how difficult it is, the political environment actually makes this a little bit easier for Barack Obama. The mood in the country –- Stan and I have polled all over the world. We had, what, 10 percent right direction in this country? There are a few countries around the world that had lower than 10 percent of people saying the country is heading in the right direction.

The sense for change here is extraordinary, and Barack Obama has the opportunity to really use that mandate and begin to form this mandate for change. It's not going to come out of the Senate. It's not going to come out of the House. You don't look for leadership in the healthcare issue out of those bides, you look for it at the top of the ticket. It's going to be Barack Obama who is pushing this and pushing this mandate, and I think he can convince Americans to potentially take a leap of faith and use the bully pulpit of the presidency to knock down special interests and to push for this so that Americans almost kind of close their eyes and buy it and they don't want to know the details, details are too difficult for them to understand, but they trust this guy to make the kind of changes they want.

MR. GUEST: And I would say taking Neil's point on that, that's all the

more reason why you've got this opportunity to really go for something substantial because this opportunity isn't going to be there over and over again.

MS. DENTZER: How does that square though with what people say about Barack Obama, which is that he is fundamentally a community organizer, he looks for opportunities to get people around the table, to have Biden? He's not going to, we are told, come up with the plan that will come out of the White House. He's rather going to turn to the Congress to have the kinds of efforts that Senator Baucus talked about this morning, develop out of the system? So, what is his role if he's really going to be the community organizer and chief here?

MR. NEWHOUSE: Well, having seen an administration design its healthcare plan, I'm all for having the Congress take the lead. But I do think the process is the message. I mean, he's got to oversee this process so that this looks like all the people who were trying to change the healthcare system, get around the table interacting, and collectively they're acting in the public interest, and he plays the role of making sure the public interest is what dominates the process and puts pressure on it when he needs to, but I think the process is the message.

MS. DENTZER: I think we have time for one more question here.

MR. LEWIN: Hi, Larry Lewin.

Much of the support for health reform has come from consumer groups, and, yet, what often seems to block it are the powerful interests and particularly the one group that patients listen to in the final analysis, which is physicians.

The first time the AMA seems to be talking about approaches to reform,

do you see any hope of trying to build coalitions of support among providers and insurers for change or are they just going to dig their heels in and we're going to hear from Harry and Louise in the past?

MS. DENTZER: Well, and I guess that's another question to ask. Who's the Harry and Louise of this cycle if there is one?

Neil?

MR. GUEST: Well, of course, Harry and Louise have been out in favor of reform –-

MS. DENTZER: Now, right.

MR. GUEST: Literally, Harry and Louise are the ones who did it.

MR. NEWHOUSE: I can't answer specifically, but I have to believe that those -- I think this is a process in which people are encouraged from what were traditionally competing polarized parts of society coming together because there needs to be –- there's such a sense, not just change. There's such a sense of crash of having let this problem totally out of control, people in trouble. I think that creates an environment where people who have been on competing sides of this issue are somehow at this moment in time either forced to or want to come together to find a basis for going forward, and, so, I think that's going to happen early in this process.

I think I'm less worried about Harry and Louise than I was. I mean, I'm assuming insurance industry has a lot to lose in this.

MR. NEWHOUSE: And I think what they're going to find is if they're convinced that change is coming, that then I think they're going to be around the table

and help mold that change into something they can live with. Or the --

MS. DENTZER: But what about the fact every provider group now has a plan for reforming the system that involves paying them more or creating more of them?

MR. NEWHOUSE: Right, in the public interest.

MS. DENTZER: The primary care groups want the medical home to pay primary care providers more, the specialists are warning that we have a huge shortage of specialists coming as --

MR. NEWHOUSE: You mean you're surprised they're not suggesting --

MS. DENTZER: Primary care.

MR. NEWHOUSE: That they say cut funds to me?

MS. DENTZER: Well, to the point, to Larry's point that people listen to their doctors. Their doctors are going to tell them that unless the plan comes out advantaging their particular part of the provider sphere –-

MR. GUEST: They can't afford to go to the doctors.

MS. DENTZER: It's not going to happen, so aren't they in as powerful a position as ever to influence patients' opinion on this? And couldn't that potentially derail reform?

MR. GREENBERG: Well, that's probably true to some extent, but you talk to physicians today, there's a greater and greater frustration among the profession, and, so, I got to believe that there are elements of those in the physician community or the provider community, and I would look at nurses and I would look at other providers, as well, that are frustrated with what the status quo is anyway.

And, so, I guess I'll look at the glass as sort of the half full rather than half empty in that I think that you can sort of pick off elements of the medical community to mobilize around significant change along the lines that's been talked about here. I mean, I'm not going to be Pollyannaish about it, but I don't think it's going to be sort of monolithic opposition. I think one of the problems back in the 90s was they basically froze out the medical position, and that turns out, I think, to have been a mistake.

MS. DENTZER: Neil?

MR. NEWHOUSE: I am not certain how much individual doctors actually talk to their patients about these issues. We talk about that, but I'm not sure how much that actually happens, and I'm not sure how much the individual doctors want to have a voice in the policy process. American Medical Association certainly, but the individual doctors, I don't get a sense that –- no, I try to engage him when I go to the doctor, and there's a reluctance to really engage in the details in the thing.

MS. DENTZER: Let's close this with a quick set of predictions. A year from now, where is healthcare going to be on the public's list of priorities for moving forward?

Stan?

MR. GREENBERG: Very high, but the legislation moving into the next year. Not passed yet.

MR. NEWHOUSE: Yes, it'll still be number three. Economy, Iraq, then healthcare.

MS. DENTZER: And Jim?

MR. GUEST: I'll say it's moved a little farther along. It may not have passed the kind of legislation we're talking about yet, but I was quite struck. I mean Baucus is saying he's determined to try to do something this year, and if you do get the presidential leadership, which I think will be there and strong pressure on Congress, I certainly think in the first two years I would see major healthcare reforms enacted, and it's got to be –- it can't be too far into the second year.

MS. DENTZER: All right. We'll bring you all back a year from near and two years from now to see if you were right. Join me in thanking this panel for a great discussion.

(Applause)

PANEL FOUR: MOVING FORWARD ON REFORM: DISCUSSION AND POLITICAL PERSPECTIVES

MR. McCLELLAN: All right, we're about to get started for our final panel. And just to remind you all of where we are, it's about to get started. We've had a discussion about the policy on healthcare reform and reforming a delivery system, we've had a discussion about the public opinion aspects of this issue, and now we're turning back to the politics. And I'm very pleased with people who we're going to hear from right now. We have a panel of two and on this political issue I'm getting some reinforcement from Chris Jennings, as well. So, I'd like to start by introducing our two panelists and then I'll turn to Chris for a few opening remarks to get this discussion started.

We have heard a lot today about policy issues for healthcare reform with a particular emphasis on steps that can reform how healthcare actually works like Medicare paying for value, like infrastructure improvements, including health IT investments that are tied to value. Like healthcare coverage reforms that promote these sorts of steps, and we're going to hear now, I hope, about how the politics for these kinds of reforms looks. It seems like there is considerable bipartisan interests. It seems like there is the potential for broad support. I'd like to hear more about that. And we've also just heard a very provocative and challenging discussion around public opinion. Healthcare affordability is the big concern as part of the overall concerns about the economic situation, but it is not really in the public's mind connected to the kinds of issues of quality, value, and delivery reform we've spent a lot of time on this morning.

So, what's the process for making that connection? What's the role of presidential leadership? We heard a little bit about that already, but also importantly for this group, what's the role of congressional leadership? And we've got two outstanding senators to help lead this last panel. Further on my left, Senator Richard Burr has represented North Carolina in the Senate since 2005, after serving in the House of Representatives since 1994. Throughout that time, he's been a thoughtful and effective leader. I've had the privilege of working with him on a range of issues, including healthcare reform, public health issues. He's also been very active on issues related to veterans' affairs and accountability in the federal government.

In healthcare, he has developed some innovative reforms that can help people take more control of their care, an important goal on our process of getting towards more personalized medicine. He's also led the way on some innovative approaches to foster the availability of better treatments against agents of bioterrorism and other public health threats.

Senator Sheldon Whitehouse has been in Washington for less time, only a couple of years, but he's already had a tremendous amount of experience with reforming healthcare throughout his career. He founded the Rhode Island Quality Institute, something that Carolyn Clancy alluded to earlier. It's a collaborative effort between healthcare providers and insurers and the government to pioneer the use of electronic prescribing and electronic healthcare to get to improvements measurable improvements in quality of care.

He also served previously in his career as attorney general and the director of business regulation in Rhode Island. In the Senate, he started out with three bills to reform how healthcare works, including legislation on improving quality and linking payments to quality, and to support a national health IT infrastructure.

They're going to be leading the discussion, and, as I said, I'm going to be assisted in moderating here by Chris Jennings, a longtime colleague and friend and more than two-decade veteran of health policy reform efforts in the Congress, the White House, and the private sector.

Chris is currently the president of Jennings Policy Strategy. It's a consulting firm that focuses on affordable, quality care issues. From 1994 to 2001, Chris served in the White House as senior healthcare advisor to President Clinton through the domestic policy council in national economic council.

And now, he and I are co-directing the Bipartisan Policy Center's healthcare reform project. This is a project led by former majority leaders Baker, Daschle, Dole, and Mitchell, and I'm pleased that the Engelberg Center is providing a lot of the technical support for this bipartisan effort.

Chris, let me turn to you for some initial remarks, then we'll get the discussion going with the senators.

MR. JENNINGS: Great. Well, it's a pleasure to be here, and an honor to be with two senators I really admire from afar. And I have to say I had the privilege of working for 10 years in the Senate before I worked in the White House, and I'll say the one thing about the White House is the White House proposes, but the Congress

disposes. So, we're going to have these two leaders really playing an important role if there is going to be anything to get done here.

And I'm actually quite excited about the prospects. And if I have a couple of minutes, I just wanted to raise a little bit of optimism about the possibility for reform and give some context and then hopefully in a more general sense and laid the predicate for a discussion on where I think we have two experts here, which is the issue of quality and value.

First, let there be no doubt we are in an absolute economic crisis, and with crisis comes opportunity, I would suggest. In this country rarely do we do anything outside of crisis of any substantial proportions. And I think in this context, clearly, there is an openness to greater change, but I think what's very, very different from the time that I was engaged in the last bigger health reform debate in 1992, 1993 was that the economists who are advising the president see this link between both long-term ability to compete out long-term fiscal policy, our whole economy, and our inability to address costs in healthcare are clearly the fundamental or one of the fundamental reasons that will indicate whether we can be successful in these areas. And if you look at Ben Bernanke or if you look at David Walker or if you look at Peter Orszag or if you look at Larry Summers, they are all talking about the integration about the healthcare debate within the discussion about strengthening our economy.

Secondly, the business communities, large, small, are manufacturing retail are all very much invested in and supportive of a long overdue and substantial debate on healthcare. And, interestingly, their big focus has been we spend a lot of money in

this thing, but we're just not getting the value that we think we should. And they have become, through leaders, through leapfrog, and a host of other areas of pushing and promoting significant change. There is never a discussion that Mark and I go to where Peter Orszag doesn't talk about the 33 percent of the healthcare dollar that we spend on goods and services that do not improve quality outcomes. Interestingly, if you apply that 33 percent to the over $2.1 trillion we spend on healthcare, that equals $700 billion a year. Kind of an interesting parallel number, isn't it?

And I have to say that even this issue of the uninsured has started to -– people are starting to understand that people aren't looking at the uninsured as an issue as it relates to the more obliged so much as the cost shifting that is associated with the uninsured, and they're also looking about the uninsured about if the real problems in our healthcare system are our inability to prevent and to manage the chronically ill population substantially well, how do you do that without covering populations in significant ways? How do you do prevention well? How do you do chronic care management well? How do you eliminate cost shifting?

So, even the debate about the quality value discourse I think is increasing understood to be far more also integrated to our success, at least having some basic health coverage within that vision.

And then I think the last thing I'm going to just mention are two or three quick things.

One is the economic crisis does breathe an appetite and greater

openness for fundamental change in this system, and people are ready for change. People want to see a vision, and here's the most interesting thing, I think the interesting component of this is that sometimes -- and we've learned this in Washington -- incremental is no less easy than comprehensive. You have many more levers to pull when you're talking about the issues related to delivery reform; the issues related to financing, the issues related to coverage if you put it all on the table.

Now, we may not get it all done at once, but I have to say the incremental can be very hard because people start talking about how they really don't care that much about this policy except for the fact about how what I'm using to offset or to pay for it, and then you don't get much engagement of the various communities.

And the last point is this, and I think this is probably the most significant irony of the debate that we're seeing. Not withstanding the rhetoric by both Senator Obama and Senator McCain during the campaign about the special interests, the truth is that the special interests or, in Washington, we call them the stakeholders.

(Laughter)

MR. JENNINGS: They're far more invested in and interested in a broad debate, and I heard Larry ask this question about whether the physicians will be involved or whether the insurers will be involved, whether the pharmaceuticals will be involved. Go through each and every one of those stakeholders and you will find that they have a fundamental interest in broader reform. The insurers do because they don't want to be scapegoated, but they also see that if they all want to play a fair game in terms of insurance reform and guarantee issue and in rating reforms, that they

fundamentally need to have everyone covered. The pharmaceutical industry doesn't want to have, again, the scapegoating debates about direct negotiation or re-importation or a whole host of other things. They're open to broader reforms if it also incorporates broader coverage enhancements, and you can get to a significant balance and compromise.

I could go through every single stakeholder in this town, whether they're consumer, business, provider, plan, or a pharmaceutical, or other manufactured and give you the reason why they'll want to engage in a substantial debate, and I think the heart and soul of this though has to start with where we have this discussion beginning, which is that in the end of the day we will not be able to afford our current liabilities let alone those we wish to address, in terms of the uninsured if we don't get better value in the health care that we're providing today and hopefully tomorrow, and with that I think I'm trying to lay the stage for the discussion we're about to have with the senators.

MR. McCLELLAN: Now, I'm not sure which of you -- thank you, Chris -- I'm not sure which of you wants to speak first. I know you you've been working together --

SENATOR WHITEHOUSE: The senior senator should speak first.

MR. McCLELLAN: I know you've been working together and working with some other Republicans and Democrats on just how we can get the health care reform done, even putting a big emphasis on reforming the delivery system as part of that. So, how's it going to happen?

SENATOR BURR: Well, I think we have -- as it relates to specifically what

Sheldon and I have to tried to facilitate, we're trying to do the easy thing. So, if you can move the pipes and get a different result, we've been trying to focus on that for the balance of this past year, and I dare say we've made some incremental progress in identifying some things that are easy to change if they don't accomplish what Chris just talked about. And let me play devil's advocate for just a second. I think he laid the typical scenario that everybody who's a stakeholder probably has for some time wanted a robust debate and reform of the health care system.

What alarms me right now is the AMA's not out with a physician. Physicians aren't out asking for something. Pharmaceutical companies basically said, you know, here we are, go ahead and do what you're going to do. My fear is that the people who have the most at stake have disengaged from the process, and the question is will they engage in that level of debate. Certainly the platform looks like it's going to be there for a debate.

I'm a little bit concerned that the stakeholders aren't beginning to position themselves in a way that allows us to naturally move through a process. I think the last time there was something big stuck up, that didn't go over too well because it became purely politics and not a debate about policy. To get to the right type of policy, there is a process.

I heard the predictions before we came up for a year from now and where we'd be. Well, I'm going to tell you. With what I'm looking at from a standpoint of the economy, I'm not sure -- yeah, you can debate other things, but I'm not sure how we'd digest much more than the economic crisis that we're in, because at some point you

have to look at the funding mechanism. It's either a change in tax law; it's an injection of federal funds; it's a mandate on companies. I can go through the list. All of you know the list. Tell me, how do we fund the reforms in health care?

I think the goal of where we want to get to is shared amongst all of us, that we know we want to get to a point that the quality is measurable and that it's better, that the cost is reduced by maybe a third. The debate -- the policy debate is how we get there. What tools do we use to measure? Who pays for it? At the end of the day, I'm amazed how we have a tendency to leave beneficiaries out of this process, because at the end of the day it's the American people that are going to weigh in, and if we haven't thoroughly vetted the policy side of it, no matter what we've got, we'll come up on the short end. So, it really does benefit this process that we have a deep policy debate and that at every avenue we try to include the American people.

Now, let me speak from the right for just a second. I'll let Sheldon speak from wherever he's going to go -- go left.

If I had to pick a few common things that I think has to be centerpiece of reform:

One, prevention and wellness. It has to be the nucleus of the health care system of the future.

Two, I think it's safe to say that everybody in this country has to have the resources to either access coverage or to pay out of pocket. We have to significantly change our access points for the delivery of health care. An emergency room has to be there to deliver emergency care for trauma patients and not primary care for people that

don't have the ability to pay or who are without coverage.

Three, every American needs to have a medical home. We can define through the policy debate what a medical home is. That can be a primary care doc; it can be a registered nurse; it can be a community health center; it can be a rural health clinic. But unless a beneficiary has a medical home, then we will never reach the efficiencies that Chris talked about and that we're all striving to get to, because disease management is an absolute key to our ability to drive the cost of health care down. And the only way to do effective disease management is if you do an education program for patients that can only be done through a medical home.

Lastly, I think we can never lose focus of the fact that whatever we do has to continue to drive innovation and breakthroughs. I think there are several designs that you can come up with, but if you stymie the innovation of pharmaceuticals and medical devices and these components that allow us to live longer, allow us to cure disease, allow us to maintain disease, then we will have given up something in this country that others will seize as an opportunity not just to further society in the countries they live in but as a driver for economic growth and for investment in the future. So, it's absolutely essential that we hold on to the commanding lead that I think we have had in the past, though it has slipped some in the recent decade of innovation and breakthrough.

With that, I'll shut up.

SENATOR WHITEHOUSE: First of all, let me thank Mark and Chris and Brookings for doing this. This is an absolutely damned vital discussion to be having, and it needs intellectual leadership, and what you're doing I think is very important. I'm

particularly --

SENATOR BURR: Why'd they invite us?

SENATOR WHITEHOUSE: I know. We snuck in.

I'm particularly honored to be here with my colleague Senator Burr. The group that he's referring to could probably be called the bookends club, because it's me and Sherrod Brown and Richard and Tom Coburn, and I would suspect that 90 percent of the Senate is between us, and -- nevertheless, we have had very, very good discussions, and as you've just heard Richard lay out his top four principles, there's not a whole lot that I would disagree with in those.

I think that we are at a new place. I think that the entrenchment that would well establish politically around the finance and access questions dating back to '93 has been somewhat made a little bit out of date by this whole new discussion that we've had, particularly today, about quality and prevention and delivery system reform. And so there aren't positions that are as hardened there as in the old debate, and I think we're also getting a new sense of urgency that is common on both sides of the aisle.

I spent last week traveling to Afghanistan, and the military guys there talk a lot about situational awareness, and I think we're beginning to get more and more situational awareness of what is happening in health care, and we've talked about Harry and Louise -- Harry and Louise, it's over. This is Thelma and Louise, and we're in the convertible and it's headed for the cliff, and if we don't do something about it, it's going to get very ugly very soon, because we only have two choices. One is to fix the delivery system and bring it under control the way so many speakers have far more articulately

than I could expressed it today. The other is to wait until we get to that what my chairman on the budget committee calls health care tsunami of costs that's coming at us. And we'll only have fiscal tools at that point. We will have -- throw more people off health coverage.

Somebody mentioned that lousy insurance is a problem -- make it lousier; pay doctors and providers less per procedure, do another cut across the board; or raise taxes to pay for the situation. We're way far down every single one of those roads already -- way too far. So, the alternative is to redesign the system, and that has one big problem with it, which is that it takes time to let the stuff percolate through -- maybe a decade, maybe 5 years, maybe 15 years -- but that really I think -- the situational awareness we need to have in Washington and that I think is beginning to take hold -- you certainly saw from Chairman Baucus -- is that now is the time for us to do a delivery system-based reform that will make those really punitive and harsh fiscal remedies that are our only alternative less likely, perhaps not necessary at all. I'm more bullish than Alice Rivlin was on how much can be saved.

I did an inventive-based reform in Rhode Island, which I know -- if you've seen the movie *The Flight of the Phoenix*, you know that they crash in the desert and they have to build the plane from the wreckage and one of the passengers is an aircraft designer and they have a lot of confidence in him until just when they're about to take off the plane they realize wait a minute, he's not really an aircraft designer, he's an aircraft model maker. So, anybody bringing news from Rhode Island has to admit that they're in the business of, you know, being an aircraft model maker.

But we have seen how a system reform that is based on incentives changing that looks into the actual plumbing of how the machine works so it's not creating all these delays and stalls and perverse incentives in places where the costs get trapped and mount up. You can make a huge, huge difference. So, I think that if we do this right, saving a third out of the system is very doable and over time perhaps even more. So, I'm very, very optimistic. But we do have to look at this as a redesign problem. We do have to look at incentives. We do have to look at process flow. And we do have to look at regulation, and that's where we get to the government discussion that my friend, Senator Burr, and I are going to have because government has a very significant role, I think, in all of this.

We start with the role of Congress, which I think is to set up some big picture stuff. If I had to define the role of Congress it would be to put the right question in the right place with the right powers, and if you look out at the landscape of health care regulation right now and try to make that adaptation, I don't think it's a fit. So, I think we need to actually change the government structure that deals with health care whether it's health feds or state and local quality institutes. I mean, we can get into that discussion later. But that's a very important discussion to have. Congress has to know that its role is limited. We can't be making these decisions. Some of them require too much dynamic flexibility for Congress. Some of them should best be local so that you can try 10 or 15 different ways and see which moves ahead. But we do have to get it done. We do have to leave an important state and local role, and ultimately I think this is going to be a fascinating problem that because there isn't such preexisting political

entrenchment, and because it's so urgent, and because it relates -- basically this is a plumbing problem, it's a systems problem, it's an engineering problem. It's like you don't care if your plumber is a Democrat or a Republican, you don't care if the electrician is a Democrat or a Republican, you don't ask the guy who's tuning up your car whether he's a Democrat or Republican. You ask him if he's going to get the job. And I think this is one of those areas where because it's technical, there's a great chance to have this be a political leap forward into a new era.

So, that's my two cents. That's my story, and I'm sticking to it, Richard.

MR. McCLELLAN: Good job.

Chris, any comments or questions?

MR. JENNINGS: Well, just -- I'd like to -- first of all, I think Senator Burr's vision is the right vision in many, many ways, and it's exciting that if you don't get the infrastructure right on the system reforms, we're not going to be able to afford our current liabilities let alone the ones we want to address beyond that, so I think there is an increasing consensus. And one thing I want to give you some hope, you know, because part of the Obama party now is hope.

SENATOR WHITEHOUSE: Rhode Island's motto, by the way.

MR. JENNINGS: Is hope, okay.

SENATOR WHITEHOUSE: Is hope.

MR. JENNINGS: But I think in the past, health reform has been driven as much by fear as by hope, and -- on both sides -- and both sides of the aisle use it in negative and positive ways and all to often in negative ways. And I really don't care the

motivating force, whether it's fear or it's hope, but I have some hope relative to the stakeholders, because I do see now in recent weeks the AMA, the physician community now are talking about coverage for all and the reform delivery system. I saw Jack Lewin back there with the cardiologist really taking a lead in saying we should be focusing on quality and we should be -- we -- our physicians should be held more accountable, and there should be some linkage to reimbursement reforms to incent those things. That's very exciting, I think, developments. So, not only are you looking at the primary care, who, by the way, the family physicians are dying on the vine. If we are going to have medical homes, we're going to have to have more of them. But you're having some leadership in the specialty community that we haven't seen before, and I think that's also quite, quite encouraging. I've talked to the pharma people in recent weeks, and they want to engage.

So -- and then I -- and the last thing I want to throw out on the table is I don't think this is going to be an Obama plan or a White House plan or a Burr plan or a Clinton plan or any plan. It's going to be an American plan. It's going to be a plan that works through the system. And if we don't do it that way, we're not going to have broader investment in this package. It's got to be something that is uniquely American, that reflects many of the priorities that Senator Burr has laid out, and I think it can. And so, for example, the Health Security Act we debated in the 1993, '94 -- no longer is anyone engage in discussions about small business mandates or mandatory alliances or premium caps or all these things that Donna Shalala and I had to defend before. We're now talking about very proactive policy that engages everyone, and a thoughtful

reform of the system that does, yes, provide and ensure coverage for all but in, I think, an affordable, meaningful, more accountable way. So, for all those reasons, I have hope -- and I also believe that those who don't engage have fear that they'll be scapegoated -- and so for all these different reasons I think that people are coming to the table. At least I hope you see them as you come back in January knocking on your door, and I suspect that you will.

SENATOR WHITEHOUSE: When the CEO of Walmart and the president of the Service Employees International Union are traveling America hand in hand to preach the gospel of health care reform, you know something pretty big is on the march.

MR. McCLELLAN: I totally agree.

Senator Burr, any further comments on this? I have one question before we open it to the audience.

SENATOR BURR: No. My only comment would be, Sheldon, I know better than anybody the devil's in the details.

MR. McCLELLAN: That's true.

SENATOR BURR: And it's very applicable in health care, and I think that Chris is right, we could have the window of opportunity open up. The only mistake that we could make on the Hill is not to take advantage of the opportunity. So, I think we go down this road -- and I commend Max Baucus for his White Papers. By the same standpoint, I also recognize after reading it that Max has taken everything that's been talked about on the Hill and thrown it into the White Paper -- 6 pages on the Massachusetts plan and 83 pages on everything else. So, it didn't necessarily narrow

down where we go; it opened up an opportunity for everybody to play. If that's the way we proceed forward, we have a chance. If we go from the 89 pages, 86 of which is inclusive, down to 6, all of a sudden I think even Chris would admit that the optimism would diminish greatly, and that's the process we're going to have to figure out how we move forward.

MR. McCLELLAN: Well, that actually leads to my question, which is as we start filling -- as the details start getting filled in, in this process, one of the things that the last panel, focusing on public opinion, emphasized is that, you know, frankly, the public's not quite there yet. They're very concerned about the cost of health care but don't quite see the connection or the necessity of dealing with the kinds of issues that we've been talking about this morning and that could be a part of, as you said, getting the plumbing right and getting much better care from an efficiency standpoint, from a quality standpoint, from a value standpoint, and I wonder if I could push you all on thinking about how that -- your thoughts on how that connection can be better made.

You know, in particular, Senator Burr, the things that -- the four points that you stress seem like things that the public could really relate to in terms of how you connect the issue of affordability of care with the kinds of plumbing reforms as Senator Whitehouse said that are needed. (Inaudible) realize that prevention is not happening to the extent it should in this country. Therefore, chronic diseases are for wellness in the first place. People realize that often care is being delivered in a way that is not efficient, that many people don’t have a medical home or a coordinate place to get their care, and that they are very worried about innovation continuing. They hear a lot about genomics

and all these new sciences, but it's not -- it's not only happening to get them better health; they worried about hoarding it. So, all of those seem like key ways to connect with the public on the kinds of directions for reform as part of this process of getting the details filled in, getting something done that could have bookended support from you, from Senator Whitehouse, from a broad mix of the Congress with support of the President as well. Any thoughts on how to make this connection with the public?

SENATOR BURR: Mark, let me just point to one thing, and this is something that very early on I brought somebody from North Carolina to our meeting to cover with the four of us.

North Carolina had the opportunity to be just like every other state -- except the cost of Medicaid continued to let the population sort of drift as they might from provider to provider, and providers receive less than what it costs to deliver the service -- and just look at it and say 50 states are in the same game. They decided not to do that, and they created a program called Community Care. Basically, what it is -- after you divide regionally the state up -- I think it's 13 different regions -- they brought every provider to the table that would be needed to deliver a service. The public health folks are there, the mental health folks are there, the primary care doc is there. Thirteen different providers, all of who were paid $2.50 a month to participate -- $2.50 a month to be part of this network. And there's also a caseworker for every Medicaid beneficiary. The caseworker is almost the medical home. The network's really the medical home, but the caseworker decides what they need, and they reach out within the network and they pull it in and the service is provided. What's the experience in the first year. The

State of Carolina saved $250 million in Medicaid expense with an expanded enrollment. It was so demonstrative from a standpoint of the savings that we've now gotten a waiver to roll that out to dual eligibles. And my point is this, that you can take the existing structure and on a smaller scale you can reach new efficiencies, better quality of care delivered, working with the tools that are already there. Imagine what could happen if what Sheldon said, which is you change the overall architecture and you allow the flexibility within each local area to design a system that reaches the best efficiencies, the best quality of care -- I think we're crazy if we don't believe that employers will embrace that type of system, that we won't influence 49 other states on Medicaid, and potentially, you know, they're -- I shouldn't say this, but I'll say it right at the beginning, it may influence what Medicare looks like in the future from a standpoint of what seniors demand the delivery be like. So, I understand just how big this mountain is we're talking about climbing.

Part of the reason that it's difficult is we've talked about it for 14 years that I've been here, and we've never approached it from a process standpoint that allowed us an opportunity to bring any finality to it. That's the opportunity that's in front of us, that we've got a lot of people on the sidelines -- employers, beneficiaries, providers -- saying now's the time. But we also have a lot of hurdles that are out there that we haven't had before that are getting thrown in our way.

So, I guess my last piece of advice -- if we're looking to create the perfect, then it's not going to happen. If we're looking to move it down the road in the right direction with some fundamental changes that allow us to assess the effects of what

they are, it's very doable.

SENATOR WHITEHOUSE: I think I would phrase the priorities in a slightly different mode than Richard did, although I think there's just two ways of looking at the same thing. I look at it more as there needs to be a technical fix. A health information technology infrastructure has to be built. It is ridiculous that information technology in American health care is worse than in any other American industry except the mining industry. We have to have a quality prevention and wellness improvement, because those are all areas where by improving them you can actually lower costs, and that grid where it both improves quality and lowers costs should be central to our focus, but presently our payment system doesn't allow it to be, doesn't encourage it to be. And the third, obviously, is you've got to fix the payment system.

Within those, I think that Richard is right. There are going to be some obstacles. For one thing, when Americans -- particularly Americans on Capitol Hill -- talk about infrastructure, they're usually talking about stuff that the Romans could build, and we need to try to figure out what the real definition is of infrastructure and then get that done, because I think if you have a national HIT platform, the same kind of stuff will stand up on it that stood up on the internet once that became available. You'll have Googles and YouTubes and Facebooks and eBays, and it will be transformative and the private sector will burst with entrepreneurial opportunity, but we've got to build it first. We did it for el-ways, we did it for highways, but to get out of our own way and build it for HIT -- but we have to rethink what infrastructure is and we've got to find a way to manage the CBO problem, because there's a huge institutional bias, that has nothing to

do with health care, that casts a dark shadow on a lot of ideas and a bright light on others, and that is whether CBO decides that they can score them. And Peter Orszag is a wonderful guy, but he should not be our health care emperor. We have to figure out a way to work the policy forward in a way that makes policy sense, and for some of us who are pretty deficit hawks, it's going to mean, you know, taking a leap of faith that it will in fact pay back without waiting for CBO to make the move. And I see those that's too big kind of institutional obstacles that we need to work through.

SENATOR BURR: Let me add that we pulled CBO very early into our discussions, and Sheldon and I only had one question of CBO: How do we do this in a way that you will score a cost savings? We're still waiting for the answer.

MR. WHITEHOUSE: They take it into a temple and they take some chicken bones and they burn incense and they put on their robes and they --

MR. JENNINGS: Come out with their decision.

SEN BURR: If what we're doing does not achieve a health savings, then why would we do it? So, the last gauge, the last gauntlet that we have to run in policy is a gauntlet that's going to tell us automatically across the board that's going to cost you; it doesn't save you anything. We know it saves us. I mean, I can point to the inclusion of all the uninsured having the resources to access coverage, and I believe everybody in the room would trust me in saying it will save us $200 billion a year in cost shifting in the system just by doing that one thing, because now you have ended that emergency room cost shift that starts. We don't know where the $200 billion is, but we know it's there, and it doesn't go for the delivery of care. That ought to be an automatic red flag

as to where we run and try to eliminate that right off because we know that there's significant savings, and if you just turned around and pumped that back in to the delivery of care, you have effected potentially the quality or the outcome.

SENATOR WHITEHOUSE: And, you know, fundamentally the thing that brought our bookends club together was the desire to be willing to hold hands and make that leap of faith irrespective of what CBO said when we had convinced ourselves and were willing to try to convince our colleagues that this just makes sense and we don't have the time to wait. There's a real sense, I think, of time -- I have a real sense of time urgency. We can't wait. We have to design this right or better and just start moving, and that may mean jumping ahead of CBO where we need to and trust our judgment. We got elected to bring our judgment to this task.

MR. McCLELLAN: Interesting, and there's more coming from CBO soon, so I think they have been -- they have been listening.

Questions from the audience.

Yes, Zoe. Microphone.

MS. BAIRD: Zoe Baird, Brookings Trustee and Markle Foundation. Been a great admirer of Mark's work. My question goes up a level. How willing are you, as this debate plays out, to leave it to the agencies -- Medicare, CMS, VA -- and to the private sector to design their own changes in delivery system models? And I ask that because, yeah, well, but let me just ask you to think at least for five minutes about it.

SENATOR WHITEHOUSE: Not.

MS. BAIRD: I mean, one thing we know Congress isn't very good at is

designing business models, and if Congress is going to be picking between the medical home and these other business models, why should we think that Congress could get it any more right than they did with the reimbursement system we have, and if 50 percent of spending's private sector, there are ways to structure incentives, and I guess the -- I conclude the question with just asking you to look back at the financial rescue package and our inability to -- I mean, the fact that we had the flexibility in that bill for Treasury to change its mind on exactly where it went into the market is -- was obviously tremendously important, and -- so I just wonder whether part of the mix could be allowing some differentiation by agency, private sector versus government, that kind of thing, and putting that into your package instead of Congress trying to figure out the new business model.

SENATOR WHITEHOUSE: I think it's less important that congress answer all the questions than that Congress understand what the questions are, make sure that some place there is an appropriate locus of decision to address that question, and make sure that that locus of decision has the powers that it needs to go forward. In Rhode Island, you know, years ago when I started the Quality Institute, we brought the Keystone Michigan Intensive Care Unit forum to Rhode Island to go statewide, and the hospitals were, you know, okay with the idea, but they said look, you've got to understand our problem. We can do this. It'll probably cost us $400,000 per intensive care unit per year. We think we might save $8 million per intensive care unit per year, at which point I interrupt, you know, ignorantly, and say well, great, 20-to-1 payback, go. And they say, no, no, no, you don't understand, that $8 million comes off our top line,

and the $400,000 comes out of our very scarce cash flow, and at the bottom line there's really very little benefit to us for doing this. When we understand that problem, which is one of the fundamental problems of the quality failure we're having, then we can set up the right mechanisms to get it addressed so that when a hospital is willing to invest in quality improvement, it sees a reward for that, and there are a lot of different ways to get to it, but I think the most important thing is we've got to have -- as I said earlier, we've got to have situational awareness about what our problem is. Once we do that, some of the stuff actually is pretty simple and straightforward, and I agree with you, I don't think Congress should get right down into the final details. We obviously have to set some parameters. But I think it's some basic kind of institutional plumbing shifts that need to take place, and we need to set it up so that they're empowered to do it and that the system is transparent enough and responsive enough that people have confidence in it and that that confidence is rewarded.

SENATOR BURR: Let me add one thing. In trying to figure out where we go in the future, one has to understand how we've done it in the past, and for the last two decades congress has gotten a little more specific in the language of health care that they've passed primarily because friends at HHS or CMS or wherever might have interpreted a little bit differently than what the legislative intent was and it got tweaked and it got tweaked by them -- and present company excluded from that -- but Congress every two years got a little more specific so there wasn't as much leeway for an entity to understand it differently than what Congress envisioned they were doing, and now we're talking about something exactly on the opposite end. We're talking about creating the

architecture and letting the things fill in.

SENATOR WHITEHOUSE: "Architecture" is a good word.

SENATOR BURR: The private entities and the public entities have to figure out in this new architecture how to do what it is they've been doing. If we prescribe it, I would predict to you today the outcome would be worse.

SENATOR WHITEHOUSE: Let me also one brief argument for a little bit more scope around the whole concept of governance. I think we're coming out of an era of governance that has been fundamentally mid-evil, in which how true is your faith and how close are you to the bishop were the two things that made the difference. We're having kind of a mini-reenlightenment now, and I think we should have a little bit more confidence that if government is directed towards actually problem solving that properly directed and appropriately transparent there's actually a lot more capacity there to make right decisions than we've experienced in the last eight years, and it's going to take a little bit of actually seeing that happen to get our confidence back, and everybody remembers that the best and the brightest weren't the greatest. But still I think that there is room for more confidence around governance than we've been entitled to in the last so many years.

MR. McCLELLAN: Yep.

MR. COLEMAN: I'm Bill Coleman. I'm a lawyer in town. I've tried this once before and people laughed. I'll try it again. I think that part of the problem is that our major universities don't do what they ought to be doing. By now, there should be at least 10 major studies on the whole program and what should be done with the

(inaudible) that submitted, then the insurance companies come and criticize it, and you get something done. And I felt the same way about the tragedy of the banks doing what they did. I just can't imagine why the great universities no longer do that. In my day -- I'm the oldest person in the room -- that's what they did. A lot of the New Deal -- good stuff came out of the fact that first professors worked on it. It was changed greatly, but that really gave you somebody who wasn't -- didn't have a vested interested by either belonging to an insurance company or somebody else.

SENATOR WHITEHOUSE: That's why we have Brookings.

MR. McCLELLAN: Well, we're getting a lot of help.

Larry Lewin (phonetic) and Gail Lewinsky -- and then I think we're going to be out of time.

MR. LEWIN: As I listen carefully -- this has been an excellent panel -- they all have been. This one also provides a little more hope and I hope your bookends get filled in with more like you. But there's kind of a paradox that emerges -- on the one hand, the need to move quickly, and the conventional wisdom that if you're going to move you'd better do it in the first hundred days, because you're half life is short when you're present in terms of (inaudible); on the other hand, Chris and others have talked about the need to build a consensus if you've got the right people around the table. So, what's the right answer here? Do you think there should be an effort to very quickly develop something or, given the financial crisis, should there be a dual-like counsel that spends a year or a year and a half trying to pull the key parties in? What's -- how do -- what's your recommendation -- what would be your recommendation to the White

House on how to play this?

SENATOR BURR: I'm new in town, Richard, you go. You've been through more of these than I have.

SENATOR WHITEHOUSE: Well, let me add to Bill Coleman's question, if I could for just a second. Academia is still very, very important, but academia today is focused as much on the delivery of care and the training of the next generation of health care professionals and I think less concerned with how to study the redesign of the system, and probably one would have to get into higher education funding to understand why their models changed and it's more collaborative with the private sector than it is from the historical academic approach.

Larry, I guess if we had the answer, we'd be out proposing it right now. Sheldon and I have the realities of knowing that, you know, legislation usually happens by immaculate conception in the United States Senate. You wake up one day, nobody knows where it came from but the Chairman and the Ranking Member are for it. So, that's not necessarily the process that you need for a major restructuring of our health care. It's my hope that for key individuals, Chair and Ranking Members will reach out and try to put together some type of working group to do this. I don't want to suggest to you that it's going to be done in a hundred days, and I would hope that we're not here a year from now saying gosh I hope we get this group together. I would hope that if something were established it would begin to filter through. We may get at the end of this process and find out geez, we've got Republicans and Democrats here. Don't think that's what's going to happen. Certainly possible. We should know that sooner rather

than later so that we can still begin to lay this out for the American people. The Congressional piece, the Hill piece, should be easy in comparison to the piece where we go out and take it to the American people and begin to sow what we've come up with. That's going to be the much more difficult thing, and I think we're going to get into a level of complexity on health care policy that it's not like you're going to have 300 people on the Hill wanting to participate. The pool is rather small from a standpoint of those that understand the intricacies over that date.

SENATOR WHITEHOUSE: I think in terms of the timing, President-elect Obama's goodwill will last far more than a hundred days, so I don't think that's as important a day --

SENATOR BURR: Did you say a hundred years?

SENATOR WHITEHOUSE: Hundred days -- maybe a hundred years.

I do think that the next sort of indisputable milestone is going to be the next set of elections two years from now, and as important as this issue is 100 percent of the members of Congress and one-third of the members of the United States Senate are not going to want to have to start campaigning in that year having done nothing on health care. So, I think that's really the window. I think we've got, you know, a year and a half to really wrap this up. I hope sooner, but I think the real pressure is going to come on when we have to go back to the American people and they say hey, come on.

MR. McCLELLAN: Gail.

MS. LEWINSKY: I'm going to -- the question will extend the thought that Larry was just raising and also some of the comments you've been making. When you

look at the challenges of Medicare, it goes to so much of the specificity that's come out of the legislation that the Congress and frequently the administrations have helped create everything we've been talking about today in terms of improving value moves in a different direction without having that kind of specificity. There's so much agreement among people in this room and others who have worried about this issue about the directional changes. What do we need to do to be helpful to you so that the Congress gets away from the microspecification that seems to have been the hallmark since 1983 and the prospective payment -- the first of the prospective payment acts and leads in a way that is necessary for Congress without getting into all the micro areas that get us to a relative value scale where the best physicians practicing in the most conservative way take it on the chin every time because of the inconsistencies in that legislation?

SENATOR WHITEHOUSE: I think that what Richard said about architecture sort of is the answer. My sense is that when Congress has nothing big to do, it'll go out and do little things, and particularly if nobody in particular is looking then delivering this for that group and this for the other group in the Medicare system you can sort of -- you know, nobody really notices, and so over many years that's been the way we've gone about it. If you change out of that mode and say look, we have to fundamentally reshape the architecture of the system so that there is an adequate HIT platform so that the dollars go where the value is and so that we get the quality in prevention improvements that are cost justified and that -- and health justified, then a lot of other stuff I think begins fall more into place. But we have to be put into that problem solving mode, which means I think presidential leadership is very helpful to put the

pressure on us at that level.

I think the other thing is that I get the sense that if we all sat down and had a discussion in this room, we would all agree pretty much on what the goals are that we need to achieve. The next step I think is to take those goals and consider how we get to them. What are the changes in the architecture that need to take place? That's where there isn't much consensus yet among the people who are looking into health care's future. That's the consensus that I think that we need, because I worry that the day comes when the Obama administration, some political person in the White House who's saying, you know, health care's over, now we've got to get on to the next thing, move that train. If we haven't got our house in order on quality reform, on prevention reform, on reimbursement reform, on HIT it's going to be awkward to say no, no, no, stop the train, hold it, we have to work harder. They'll say no, we've got to finance and access stuff to get out. We've been fighting about that for years. We know how to solve it. Let's just go with that. We'll deal with the rest later.

So, I think the more quickly we can come to agreement on exactly what the healthstead looks like, what duties go where, then we can move I think very rapidly and effectively, and that's what I would hope people would focus their attention on. We can talk to each other about the importance of health information technology till we're blue in the face. How are we going about incenting its growth? Where should the power lie? How do you govern that institution?

SENATOR BURR: Let me just add to that -- if we could do -- if the two of us could do it, we could get this done very quickly.

SENATOR WHITEHOUSE: It's the rest of government that's slowing us back.

SENATOR BURR: Murder's still illegal, so that's not an option.

We have to make sure that the ideas that we think merit public exposure are aired and vetted, and hopefully we try to get those to be the winner at the end of the day. To some degree, that means we -- I think we're going to work outside of the typical committee structure on some things, inside sometimes. I don't see this as a product that just comes out of one committee. I think it's a product that's a collective product that comes together from committees on both sides of the Hill, and I wouldn't expect there to be total consensus, and there will be a process after that, I think, that the important part is getting started and sort of stating what our objectives are. And I go back to this architecture and flexibility. We did give it to the Secretary of Treasury. So, I'm suggesting today, geez, we shouldn't have give as much flexibility. I've even written a letter to the Secretary questioning not his actions, the need for him to qualify why, and I was on the phone at 9:40 last night with Secretary Paulson begging me that he had to get off the phone. His wife was -- wanted him off the phone I think, and we were talking about it. We understand that when you create a model like this, it requires a tremendous amount of commitment on our part to go back and make sure that it's still an end in a way that's beneficial to the ultimate goal of what we envision, and that doesn't mean that we're not going to learn new things -- we are. We're going to find out things that work better than maybe what we had visualized.

SENATOR WHITEHOUSE: We've got to institutionalize --

SENATOR BURR: But you can't walk away from this after you create the architecture and say geez, we've done our part.

MR. McCLELLAN: Thank you.

Chris, any final comments?

MR. JENNINGS: No, I just think -- I was going to say that there's two quality bookends here who are going to write a good book in the next year or two, and I want to thank them for being here.

So, thank you very much.

SENATOR WHITEHOUSE: Thank you, Chris.

MR. JENNINGS: Thank you both.

CLOSING REMARKS

MR. McCLELLAN: Now you can -- thank you both. Very quickly, three final comments. We've run a few minutes over and I appreciate our panelists taking a little bit of extra time.

First comment is that there's some material in your packet about the Engelberg Center for Health Care Reform. We are -- you're going to be hearing more from us on many of the issues that we talked about today on measurement where we're providing infrastructure for a national effort to get to better patient-level measures of outcomes and costs; on reimbursement reform where we're collaborating with Dartmouth and engaging in some other multi-stakeholder projects around the country, including with North Carolina where they're now hopefully getting close to getting Medicare involved in that project as well for duals and even more broadly. We're working on some consumer initiatives, including with Jim Guest and others, to help give people the kind of information they can use to get to better decision making. We working on medical innovation with some collaborative steps, including with the FDA and with the private sector on more efficient processes for developing and getting personalized treatment to patients, and in putting this all together on coverage reform events like this are very helpful. We're also working with the Bipartisan Policy Center on a broad effort for health care reform framework. More information about us is available on the website at brookings.edu/healthreform, so that's point number one.

Point number two is I want to thank all of our panelists today -- Senator Burr, Senator Whitehouse -- but everyone from the earlier panels who made such a

difference. Many of them have stuck around, and if you have any further questions for them, hopefully you can catch them afterwards. And also I want to thank all of you. The dialog with participants from the audience here made a big difference to the quality of this event.

Final point, number three, we're not done yet. More to come both from us and hopefully from you all working together to get effective health care reform done.

Thank you all very much for joining us today.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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