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P R O C E E D I N G S

MR. WEST: Why don't we get started.

Good morning. I'd like to welcome you here. I'm Darrell West. I'm Vice President of Governance Studies at the Brookings Institution. I'd like to welcome you to this forum on Health Care Reform, and it's great to see all of the interest in this topic. It demonstrates the broad importance of the subject of health care.

A few months ago our political leaders signaled their intention to pass comprehensive health care reform by this fall, and of course now we are seeing House and Senate Committees marking up various bills. There've been high-profile meetings at the White House. Various industry groups have pledged to cut costs, which have been soaring well above the rate of inflation.

We don't know exactly what the ultimate proposal's going to look like, but legislation has been proposed that establishes a new public insurance plan, requires individuals to own insurance, and mandates that businesses provide insurance for their employees, among other features.

Proponents have argued that these steps are absolutely vital in order to save money, improve quality, and provide health care to those who need it. Opponents argue that we should not expand the role of the government in health care, that we should not have public plans competing with private insurance companies, and that the price tag for those proposed changes is way too expensive.

Public opinion remains quite complicated on health care reform. A recent *New York Times*/CBS national survey found that 61 percent of Americans believe the rising cost of health care represents a very serious threat to our national economy, and 59 percent believe that the government actually would do a better job than private companies in holding down the cost of health care. But at the same time, 77 percent of Americans have indicated that they are satisfied with the quality of the health care that they personally receive.

On top of all this, it's unclear how some of the new advances in health information technology, telemedicine, and mobile health through cell phones relate to the broader effort at health care reform. I have a book, *Digital Medicine: Health Care in the Internet Era*, and I note that there are many exciting developments taking place in the area of new technology in health care. In fact, many argue that new technology actually is the key to long-term cost savings in this area. But we need to figure out how to use technology to reform organizations, change cultures, and alter reimbursement rates, because if we don't get the incentives right, health care reform is not going to be successful no matter what ends up in the final package.

Now, to address the various issues related to health care reform, we have brought together several leading voices. Richard Kirsch is the national campaign manager for Health Care for America Now; Scott Keefer is the vice president of America's Health Insurance Plans; Geoffrey

Garin is president of Peter Hart Research associates, and he'll be providing a public opinion angle on this subject; and John Linkous is the CEO of American Telemedicine Association, and he'll be talking a bit about the role of technology in health care reform.

In terms of our format, I have asked each panelist to make a brief opening statement outlining their views about health care reform, and then following that we will open the floor directly to you so you can ask whatever questions that you would like.

So, we will start with Richard Kirsch.

Richard, what do you think we need to do here?

MR. KIRSCH: Thank you, Darrell.

Good morning.

I know there's folks out there. I can see you. I'll try that again. Good morning.

ALL: Good morning.

MR. KIRSCH: All right. That's not as good as it could be, but I'll take it.

It's a pleasure to be here with you this morning and joining this panel.

So, Health Care for America Now is a campaign that was set up with one simple purpose: To win a government guarantee of quality, affordable health care for all in a system that, in the long run, will deliver better quality and lower cost -- and to do that this year. And we now have

some thousand -- over a thousand organizations in 46 states that represent community, labor, health care providers, doctors, nurses, churches, small businesses, and a host of other organizations around the country.

We actually have organizers on the ground in 43 states, and because we believe, at Health Care for America Now, that the way this debate will get won and the way we actually will have our goal of a guarantee of quality, affordable health care passed is from outside the Beltway. And the demand from the American public for this is so great, despite the fears, that that will carry the day, and in a battle against the health care industry that is spending -- I think we saw, $1.4 million a day on lobbying -- it's only when we get the public seriously engaged in this debate that we have a chance of a change.

We also believe that this is the right time, because we believe when a new era in American politics and it's important as we think is this possible to understand that (phonetic).

If you look at American history, there are these periods that come around every 30, 40 years where enormous changes happen that reshape the social, economic, and political landscape for generations. They usually come as a reaction to errors before them, and we've seen a long period of conservative (inaudible) and huge ever-reaching in the last eight years that really has created the hunger for change and openness for changes that many people would not have thought possible. Even as

the President says -- Presidents back to Teddy Roosevelt have tried to actually have our nation repair what really is the biggest hole in our social fabric, the fact that we don't guarantee health care as a right and failed.

And this is the year we'll get it done, your new historical era, and the contradictions in the system are so great and the failure to do it -- do this in the middle of a conservative era 15, 16 years ago are such that even interest groups then that felt they could walk away from the table realize they can't.

The biggest (inaudible) difference is in the business community, which was willing to throw the dice and believe the health insurance industries when they said they could fix the system through managed care and it could control costs and make things better and has continued to experience over the last decade and a half enormous health care costs that not only are leading to tremendous pressure for families but for businesses and the global economy make it less and less possible for us to compete.

So, those are the conditions that allow us to see if we're going to actually have change. And then on top of that, it is very important that we actually have a President who strongly is personally committed to this. You hear him oftentimes talk about the story of his mother in the hospital dying of cancer and fighting the health insurance company, because her cancer is not going to be paid for because a preexisting condition. A President who really understands what Americans feel and

has a strong commitment to change a system and also understands intellectually that it really is true, as he talks about building a new foundation for the American economy, that we need to fix health care as part of fixing that, and there really is true that the cost of doing nothing here -- that we can't continue, and as Peter Orszag at OMB says, the greatest long-term threat to the economy is not being able to get health care costs under control.

So, since we've just a few minutes, let me tell you what kind of reforms we're looking for and we believe the American people are looking for.

The first thing is people want to know whether they have good health care they can afford. That's a very basic question, and it's one that I think oftentimes gets lost in the debate in Washington. But our people are going to look at this as, you know, at the end of day, the health care I have at work, which I want to hold on to because I don't what else might be there instead, but all the time my employer's asking me to pay more and more out of my paycheck for that -- fewer benefits, higher out-of-pocket costs. Where we see reform that does what, say, the House Bill does, which is require employers to provide good coverage that meet certain benefits and to pay a certain amount of the employer's health care. So, people that work who want to keep their health insurance at work want to be sure there's a guarantee it's going to be good.

And, so those people who don't get health care at work

anymore -- will their health care be good? Will it have benefits that meet their needs? Will it be affordable? Both premiums -- will the premiums be affordable or will it be too high for families? And will the out-of-pocket costs be reasonable? And so that's a very, very basic question, and one of the things that driving that question is how much money do you want to invest in health care?

And one of the things we seem a little concerned about is people picking out these numbers -- we can only invest in a trillion dollars in new coverage. Now, I say "only" purposely, because in a system that's going to spend -- we have health care (inaudible) at 5 percent -- that's going to spend $32 trillion on health care in the next decade to increase spending by 3 percent to be sure that it gets in the system with coverage they can afford or 4 percent as opposed to spending less for health care they can't afford but out-of-pocket costs are too high, the premiums are too high is really pennywise and pound foolish. And it's also politically how the American people will judge this -- is there good health care I can afford? And so if you look at reforms, it's very important that employers are responsible for providing coverage. If employers aren't able to do that, then all the costs are going to switch to individuals and taxpayers and that they're required to pay a meaningful part for good coverage. And that the regulation in the employer sector as well as individual sector means that all the kind of rules on cherry picking and not allowing (inaudible) preexisting conditions but charging people more because of their health

conditions, charging people more because they're women of child-bearing age, because they're old doesn't justify the individual market with insurance industries (phonetic) can see to that but applies to the small business market and the basic rules and regulation for good benefits in the home insurance market. That's a key thing.

But I also want to say -- I want to really cover everyone, and in this debate that means everyone who's here legally should be covered. We did that in the SCHIP. Legislation that passed will remove the silly thing that you had to be here five years legally before you get coverage. It's very important that we do that as part of this debate, so we really want to cover as many people as possible, make it affordable. And we want to do it in a system that provides some structure, and so we're seeing this consensus emerging right around these exchanges. One-stop shopping.

It's important that individuals and small employers be in those exchanges. Within those exchanges, they have a choice of not only regulated private insurance, which has to behave in responsible ways based on the public good, not on what insurance companies' legal -- you know, insurance companies are for-profit companies for the large part.

Their legal fiduciary responsibility is to maximize their profits, and that's why we need a regulatory system that says you actually have to be concerned with health care first and make profits in a reform system that requires you to behave differently, and a choice of the public health insurance option, which will both be over the fact that there's almost no

competition.

According to FTC standards, 94 percent of local markets in this country are highly concentrated. But it's not just the -- and there's huge barriers to entry in the system, but not only the question of (inaudible) competition but the right kind of competition because, as I said, a public -- for-profit entities' mandate legally is to maximize profits. A public entity's mission will be to maximize people's health, and that will drive a different set of constraints in the system but also make it, frankly, a whole (inaudible) for the public health insurance option, because all the tricks -- even with regulations the private insurance industry does to avoid risk -- the public option won't want to do that. In fact, there will be lots of disadvantages to the public option competitively, which the insurance industry doesn't want (inaudible) why we can't compete doesn't really want to acknowledge.

Let me finally say that we need to have a system that really does have the kind of delivery systems that control costs and put value first. This is a huge struggle for us. We continue to provide a level, tend to think too often of health care as a commodity, and the kind of incentives that lead to physicians or hospitals building a surgical center next to one that's already across the street or MRI -- that we don't need three across the street from each other -- or to provide more services because they make more money that doesn't focus on having good information on what works and doesn't work.

How we understand fundamentally how -- you know, we talk about how the best systems in the country have financial assistance centers, like salaried physicians, and appropriate ways of focusing on care and use information well. And how we drive those changes is important, and we believe that a public health insurance option is one way to drive those.

If you look at a lot of the papers that have been put out, you'll see that Medicare is often the model for how to do this. We've also seen ways that the private insurance industry is innovative in some of that way, too. We think we need both.

Let me conclude by saying, you know, there really is a common sense approach here, which the American public understands, about a choice of public and private insurance in a reform system that guarantees them quality, affordable health care. There's going to be a lot of scare, fear mongering, and nay saying, trying to get people not to do this. But at the end of the day, because of historical error and because of the political leadership, because of the enormous pressure we will do this.

There's an enormous commitment from the leadership in the White House to get this done remarkably in a time frame which would even have it done by early this fall. I actually think that's going to happen, as crazy as that may seem.

And we will celebrate something that we have not seen in American history before, which is actually having our country make health

care right. It won't be perfect, but it'll be an enormous step forward. And I hope you'll all join us in helping making that possible.

MR. WEST: Scott Keefer, what would you like to see in health care reform.

MR. KEEFER: Yeah, thank you, Darrell, and thank you, Brookings, and thank you for the terrific setup.

I think, as was alluded to, we'd probably find that there's quite a lot of consensus around many of the issues, and as Richard spoke to I think, from our standpoint in the insurance sector, we've suggested that we recognize that there's a need in the context of reform to change the way that we do business, and within that need to change the way we do business there's a recognition that a reform system will be very different if we get everyone in. And Massachusetts has demonstrated that. And I think that's what's really different about this time for reform versus, say, 15 years ago.

And when we look sort of at the experience of Massachusetts, as well as the other states, the pursuit of aggressive market reforms and the advance of coverage requirement, we recognize that the system grew up in a way that wasn't perhaps most beneficial to the system and definitely to the country, and that is that in the individual market in particular people could wait that system out in many states where they had guarantee issue rules and compression of rating, and that caused many problems.

So, that's where we sort of start, sort of at a basic level from the standpoint of insurance and providing insurance. And I think within that, there are a couple of recognitions that we recognize that are really important from the standpoint of the political leadership that we have right now, and I would sort of start with the President and what the President has said in that the only thing that's not negotiable is the goal and the outcome. And, again, I think there's quite a bit of commonality with respect to many of the points that Richard made that we would certainly agree upon.

I think the real challenge, of course, is the cost issue, and Richard alluded to many of the challenges with respect to managed care and, as he said, the inability to control costs. And we know that cost containment and cost growth was very slow in the middle to the late '90s, and the lid sort of came off that, and that's a reflection of the health system and the fact that health insurance is expensive, because health care is expensive, and we shouldn't run from that. And I actually agree with Richard on the point that we probably are making a mistake in having sort of these artificial thresholds when we talk about a trillion dollar bill or this sort of limit.

One thing that I would like to point out as someone who did serve as a member of the Budget Committee in the past -- when we talk about a one-trillion dollar cap, where Richard I think got it a little bit wrong, we're only talking about the federal budget implications, and we know that

in national health expenditures, only about 40 percent of that is what we consider on budget. So, when we talk about the impact downstream on employers and individuals and insurance companies, there are a lot of costs in the system that are not on budget. So, when we're talking about a trillion-dollar bill, we're probably talking more like $3 trillion worth of change over the 10-year period.

Now, again, that doesn't mean that we should be sort of guided by any artificial barriers. But I think when we get right down to the substance of this and the issue of private versus public, we've recognized that the private system and the public system have a very, very critical role, and as Richard alluded to, AHIP and its board has long been on record supporting things like expending Medicaid to 100 percent of the federal poverty level.

We strongly supported the expansion and the reauthorization of the SCHIP program, as also was alluded to, and some of those on the other side were very upset with the industry, going back to the Bush administration, with respect to this.

But when we get right down to the issue -- but unfortunately in my view is sucking a lot of the oxygen out of the room -- and that's whether to create a new government-run plan -- and I say "unfortunately" because there are so many bigger issues with respect to expending coverage to everyone with respect to reforming the delivery system so that we get better value and better outcomes, again a vision that Richard's

organization and my organization largely share, which may be a surprise to some. And, again, that sort of highlights the fact that this issue of a new government-run plan has sucked a lot of the oxygen out of the room.

But when we talk about this issue, I think fundamentally there are two threshold questions. I'm glad that my friend, Geoff Garin, is here to join us because I think is one is inherently political, and I'm really not the expert on that issue, but it seems to me we need to decide what role of government people are comfortable with. So, we hear a lot about the political support for this notion -- broad notion conceptually -- of a new government-run plan to keep and to compete with us and to keep us honest. But when we get below that, I think it's important to understand how many Americans would enthusiastically run to that system.

And, as Richard noted, many Americans like their existing coverage. How many Americans would be willing to give up what they have now and gladly join the ranks of a new government-run system? That's a political question. At the policy level, I think there's a serious and inherent question. All the issues that relate to payment, whether it's going to be Medicare, whether it's going to be negotiated, whether it's going to be mandatory participation for providers as is sort of the case in Medicare, which we know there's an access issue there, or whether providers are going to be voluntary -- all those issues come down to governance. So, it's sort of appropriate that we're here to discuss them in the context of the Brookings Institution in the governance forum.

And the governance issue, in my view, I think from a legal standpoint, from a policy standpoint, is what has really driven the conversation relating to alternatives, specifically the co-op, because we know that co-ops are something that generally are governed at the local level, that they're sort of this notion of consumer ownership or interest. And I'm not sitting here to sort of endorse the co-op vision except to say that when we get down to the threshold issues, all of those sort of fall under the rubric of governance.

So, with that I'll close except to say that I really do agree that the time is now. I hope that we can keep the momentum behind health reform. I think it was inevitable that we were going to get into sort of a trough and sort of our peaks and troughs of the debate when it moved to the budget discussion. But these are really hard issues, and I hope all of you will come from this panel with the recognition that we've got to do something to reform the system. We can't miss this opportunity. We've got to reform the delivery system as well as providing access. We've got to drive the system toward value and outcomes and realign the incentives broadly throughout the health care system.

Thank you.

MR. WEST: Thank you.

Okay, Geoff, you're the expert on politics and public opinion.

MR. GARIN: Well, let me see what I can do.

There's a song I like listening to these days. It's called

"Change is Hard." It's about kind of the pressures of young romance, but it is a fitting theme song for health care reform, and let me talk a little bit about why change is hard.

There are a couple of things I would highlight in this regard. First, there is no partisan -- bipartisan consensus in America about health care reform. Democrats -- particularly liberal Democrats -- have a clear priority for health care reform, which is to ensure coverage for everybody. Republicans -- particularly most conservative Republicans -- have a priority for health care reform, which is to keep government out of health care. So, at that level, it's hard to see exactly where the meeting of the minds occurs in terms of trying to achieve something that we would describe as a bipartisan consensus.

The second challenge is that while about two-thirds or more of Americans say that the health care system is not working for most Americans, that we need major reform of the health care system, also, as Darrell pointed out, two-thirds or more of the public say that the health care system is working well for them. So, politically you've got this group in the middle who recognize the need for change, who know that at a significant level we have a broken system, but also who feel that today they've got skin in the game and there are aspects of reform where they might have something to lose.

To break that down a little further, about half of all Americans, when they think about the health care system today, are

dissatisfied with the cost of health care, their own health care. But only 20 percent or less are dissatisfied with the quality of their health care. And in doing lots and lots of research about health care and health care reform, I run across very few people who, at the end of the day, would trade much quality for cost. And people really think about health care reform very much in that context so that navigating that piece is a challenge.

With that group in the middle, the most powerful motivation reform is a very real concern people have that when they think about the trend line in health care today, that somewhere in the not too distant future they can see themselves not being able to get the health care they need when they need it because it's just gotten too expensive either because out-of-pocket costs have gotten too high, they're insurance coverage doesn't cover enough and doesn't -- they're paying more for less coverage, or there's a concern that premiums will get so high that their employer will drop coverage and they, themselves, won't be able to afford a coverage. But this fear of not being able to get the health care they need when they need it is really the thing that animates this drive toward change and what makes it very personal.

I would just add as a footnote that we do a lot of research on lots public policy issues. There is no issue in American politics or public policy that people litigate in as personal a way as they do health care, that it is all about -- everybody experiences the health care system, and the

question really is: What is this going to mean for me and my family? It is not true in the same way of energy reform or any other issue in the country today.

So, it is this very personal way that people think about the meaning of health care reform. They are -- you know, there is -- while at a certain level people say health care ought to be a right and the government ought to provide it to everybody. At the moment, people think of covering everyone as if you've got insurance it's a nice thing to do for somebody else, and in the context of today's economy there are lots of voters, particularly swing voters who are not in the mood necessarily to pay for doing something nice for somebody else, so that it really is about this sort of very personal interest that people have.

There are four kind of, you know, forks in the road. I think that the truth is three of them are very manageable in terms of public opinion. In terms of the employer requirement, the truth is the public supports that and that there is no -- there's not the same kind of unanimity of opposition in the employer community that there was in 1993 and 1994. It is not -- and that the Republicans and Senate seem to be able -- that there are enough of them where employer requirements are not a sticking point.

People don't necessarily love the idea of an individual requirement, but in the context of reforms that make sure that every -- that affordable insurance is available to everyone, people are willing to accept

an individual requirement, especially when they think about the extent to which people who are not voluntarily not getting coverage end up shifting their costs onto the people who do take the responsibility of achieving coverage.

The thing that gets so much attention here in Washington as they kind of -- as a sticking point is this question of the public option -- public health insurance option. And the truth is this is a major issue in Washington. It is not really a major issue in terms of public opinion. That you've heard two different perspectives on this from the public's perspective, they like the idea of having lots of options, and they like the idea of having a public option that helps -- that would help keep the private insurance industry honest and that there is a narrative in the public's mind about how this could help control the cost of health insurance.

This question of being forced into a government plan -- well, you know that you've heard Senator Clinton -- Secretary Clinton now -- when she introduced her plan and President Obama. When they talk about health care reform, they always provide what is a central assurance, which is that if you like what you've got, you can keep it. And so that if that's part of the discussion of whether there ought to be a public option, it's very reassuring to people that at an intuitive level the public does not accept this notion that the existence of a public plan will drive the private plans out of business and will drive all consumers into the arms of the government plan. So, at a public opinion level, that's really not a very

substantial sticking point.

But there is a sticking point, which is paying for health care reform.

You've heard this sort of discussion of a trillion dollars being an artificial number. Well, in a world where we've made a commitment or our leaders have made a commitment to revenue neutrality, a trillion dollars is not an artificial number, because you have to pay -- if you go do it -- a trillion five, as the House Bill does. You have to find a way to pay for it. There's money set aside to get you the -- I think people can see their way pretty easily to $600 million over ten years, but that last piece to a trillion is challenging, and beyond that even more so.

And the main reason why change is hard is the political reality of having to get 60 votes in the United States Senate. You've read in the last couple days about conversations that the Democrats have had about whether -- to what extent they are told that the drive for bipartisanship shape the content of the legislation. Well, here it's really a question of Chuck Grassley, Olympia Snowe, and a few other people versus Joe Lieberman, Blanche Lincoln, Evan Bayh, and a few other people driving this, and the question of how you get to a number that is both acceptable to the public and acceptable to 60 senators on the revenue side really is a big challenge.

The cost is -- the question of taxation is not insignificant to the public here, not because people are chintzy and they don't think that

health care reform is important but is -- remember what is driving all of this is this sense that people are being priced out of the market. And so if out of one -- if they worry about taxes coming out of one pocket as opposed to premiums or other health care expenses coming out of the other pocket, they really see it as, you know, what's the long-term benefit here. So, the paying-for-it part really is a significant challenge -- I don't believe an insurmountable one. I do think at the end of the day we are at a moment where there is a great capacity for reform, that I've always thought of this as like an Indiana Jones movie where the kind of the thing is going to, you know, going around the sharp curve and maybe it's going to fall off the rails and we're all going to hold our breath in suspense. But at the end of the day I think that there is a will to do this that, you know, while people think very much here in Washington about the cost of doing the wrong thing, from a political perspective there is also a cost of doing nothing. And I don't mean an economic cost, but a real political cost, or at a moment that people don't have a lot of confidence in Congress, Congress' failure to be able to sort of figure this out would reflect poorly. There would be a political consequence to that. So, I think there are lots of dynamics that will push people forward to do something. I don't know if it's exactly what Richard will want. I don't know if it's exactly anything that anybody will want. It's going to -- my guess is it's going to -- you know, there will be compromises along the way. But the motivation to do something I think is still quite powerful.

MR. WEST: Okay, thank you.

John Linkous, you're the CEO of the American Telemedicine Association. Talk to me about technology in health care reform.

DR. LINKOUS: Yes. Thank you.

I'll take a little bit of a different tack now from the previous discussion, but it is interesting that this -- I'm marking my 35th year now in Washington, D.C., and it's always amazing to me how those of us in this town do tend to think inside the Beltway and kind of where we are in a lot of the issues that do seem to be very big for us are necessarily quite as big outside, but I think health care is one of those issues that's pretty much got everybody across the country unified in terms of we need to do something; it's just a question of what. Fortunately for our sake, in terms of information technology there does seem to be a little bit of a consensus that gee, now maybe time has come to do something in that area. For those less involved in technology -- and ATA was founded in '93 -- we always thought well, it's right around the corner, finally someone will notice it. And they are noticing it now. Which is the good side, but of the bad side I'm sure we're going in the right direction and so I wanted to put a couple of notes on, which I think is important to put out there some of the issues.

Scott mentioned that, you know, the issues we're talking about are not just public policy, not just the public funded issues, that there's a lot of health care that's not government; it's private sector, and I

think nowhere do we see that more than some of the things that we're seeing in technology today. The real emphasis is on the development of electronic medical records. That's been really the area -- when people talk about health technology, that's where they talk about electronic medical records. And although we would endorse -- it does involve telemedicine -- certainly endorse the development of electronic medical records, there's a little bit of a problem in terms of looking at that as a "solution to health care." It's not a solution. We all know it's not the solution to health care.

And just focusing on a piece of technology, just focusing on it -- and this maybe sound a little funny from the Telemedicine Association -- but looking at buying technology is not going to be solving your problem. It's like buying a computer and expecting you to write the great American novel.

It's really a question of what you do with it and how it's integrated within the system. And that's what we're finding more and more -- is with the debate right now, and what's the role of government in terms of setting standards in terms of looking forward, and how does it really take into perspective so much that's going on in technology, so much that's being transformed in health care that frankly is not part of government, is not part of the debate in terms of health reform but really we feel that in the long run is going to have a very major impact on what's happening in terms of the way we get health care -- not health care policy but how everybody in their own lives somehow get health care in this

country.

So, there's a couple of things I wanted to point out. First of all, with the idea of electronic medical records being a great savings of money, there will be a tremendous improvement in health care if everyone has electronic medical records. We won't necessarily save money, and I point out an example. *Health Data Management*, a magazine in the industry, talks about the return on investment for electronic medical records.

A lot of CEOs of hospitals don't particularly like to invest in technology. They see it as a black hole. But they're very attracted to electronic medical records. Why? Because it allows them to capture costs. It allows them to look at the way you get revenue. As a matter of fact, one study showed that a hospital was very happy to put in electronic medical records, because it increased billing per physician by $58,000 a year. Well, that's wonderful for a hospital. I'm not sure what that does in terms of public health care.

But I'm not speaking out against doing electronic medical records. I guess what I'm talking about is you can't just put in the technology. You talked about the process. Telemedicine, for example -- and that's just one of the areas -- you can't just buy technology and not pay for the services that go out to consumers. It doesn't help to just say we need to get all the hospitals wired, and we're not talking about wiring for the consumers themselves. And I think that's really one of the keys

that we see is the pitfalls and really one of the things we need to look at, and that's the changing role of traditional medicine in health care. We're really on the cusp of it. Maybe too early to poll. Maybe too early to really measure effectively. But very surely we are going to go into a major change.

You know, health care the way it is today is not the way it was a hundred years ago. Maybe there's good things to that, but there's also some bad things to that. We're very traditionally focused. If you need health care, you go to the physician's office. If you need health care you go to the hospital. Well, that's still true today, but it's not necessarily going to be true ten years from now. It's a very different type of application.

For example, if you look at the iPod or the iPhone, the iPhone now has consumer applications, of course. There's about 150 to 200 applications dealing with health care on the iPhone. Very minor thing maybe right now, but in the long run I think it's just a precursor of what's going to happen with consumers taking a hold of their own health care and using technology and using other types of things that's really transforming what we're doing with health care today.

I don't see that recognized in terms of the health plans. Maybe it's too early for some of that, but I think we need to start looking at some of the role of consumer-directed health care and where that's going to fit in the long run in some of the systems, because with the internet and the help/information internet, you talk to any physician now -- one of the

great challenges is when they have patients come in with a certain diagnosis, and in fact they've already done so much research in many cases they're smarter than the physician when they come into the system.

On the other hand, they also may be misled by information that they really shouldn't be looking at because it's giving them the wrong direction, and so physicians which were gods -- I mean, it's the way we've looked at the health care -- is that the hospital and the physician is the almighty altar in terms of where we should go and you tell us what to do and we'll do it.

I think that's changing right away. And that's going change the way that we do health care. It's going to change the way that health care is -- that the traditional health care providers are going to be playing a role in this country. There's a real need to change the system and the way we provide health care so that the health care professionals are more guides, they're more the people who really help the consumer figure out what's the right direction. It's not going to give you an open heart surgery. You're still going to go in the hospital for that. But for so much of health care, particularly some of the high costs, which we're talking about end of life and chronic care, a lot of that can be changed dramatically by the way that the consumers are now working with technology and getting access to their own information and making their own decisions. I have not seen that in the health care debate. And I would like to see some kind of a discussion on how that opens up.

So, we talk about the technology, we talk about how health care is going to be changed in terms of the government role or the public plan to the private plan, and certainly one of the nice things about being in information technology right now is both the private insurers and the government are saying yeah, we need to have more technology.

But, again, their technology is -- right now the technology implementation and the priorities that they are -- are primarily wiring hospitals and getting electronic medical records into the hospital systems, which are important, but really, in the long run, our role is to really push technology out of the hospitals and into the hands of the consumers in their own homes. Wireless applications on their bodies, in their own systems -- it may sound like space age, but it is here. It is here, and if you don't believe it, then you go right into your own community and you look at the people who are runners that are using pedometers that are hooked up to their shoes that are now uploading to the internet that you compare what you're doing with everybody else that's running out there. You look at people who have diabetes that are now checking their blood levels -- blood sugar levels -- and they're checking onto a monitoring system that's doing it on a daily basis. You look at people with pacemakers that are now having it checked remotely over the telephone. Millions of people are doing that.

And, yeah, I'd just like to say that with all the debate, with all the discussions on health reform, one of the things we need to keep in

mind is the patient or what we would like to call the consumer, because I think that's what we're transforming into a consumer-based health care system and how they play a role into what this big debate is about where we're going with health care.

MR. WEST: Okay, I thank you very much.

We'd like to open the floor to questions from you. If you could give us your name. If you represent an organization, let us know, and we would ask you keep your questions concise so we can get as many people as possible.

In the very back. There's a microphone coming right there. Yep.

MR. JONES: Hi, my name is Mike Jones. I'm an actuary, and I've spent 35 years in the consulting business with the largest consulting firm in the United States. I've been through health care from the bottom to the top throughout my career.

I think the gentleman on the left there made the point that the health care organizations are profit-making institutions. Let's recognize that every organization is. The lobbying organizations are; health care are profit-making organizations. They survive on grants and contributions. The doctors are health care organizations and profit-making organizations, and so are the hospitals. So, in going to national health care, we have the potential for goring everybody's ox on this. One thing I haven't heard about, which is on a little bit different subject, is getting rid of

the requirements of each individual state. Cost care can be reduced quite a bit if that can be done, and if you look at it from any organization that's across the country, you'll see how that could affect people.

The gentleman (inaudible) technology is very accurate. Increased technology if we can get around, the confidentiality of data is tremendously important. The rhetoric I hear -- I'm trying to keep these brief.

UNIDENTIFIED: (Inaudible)

MR. WEST: Yeah, can we get the question please.

MR. JONES: Question is what's being done to bring all of these conflicting forces together? I don't see an organization that has all of the organizations and skills necessary to do that.

MR. KIRSCH: Well, I'd just say that I think that's what's going on in Washington now, and it's -- you know, it's messy, it's how our government works. But if you look at things like the agreement announced by the Vice President yesterday that the hospitals have said we're going to lower our costs $155 billion over the next decade, similar agreement from the drug industry. It was part -- as part of some questions about reducing costs for seniors for their prescriptions. You have different contributions, even though Scott's organization -- ours different views in many things and also both active in a debate and no points of agreement. So, this is actually a fairly remarkable process. It's not pretty, but it's a lot of voices -- both of people, as you say, who's oxes are going to be gored

because they're making a lot of money in a $2.3 trillion industry, and everybody, as Jeff said, is personally invested. It's actually -- if you step back, it's actually a marvelous thing to watch, and hopefully Jeff and I hope it will be an outcome that will make us all proud.

MR. WEST: Okay, in the very back.

MR. HIRSCH: Aton Hirsch (phonetic) from Harvard University. My question is -- listening to this debate here and all debates on health care, it seems like there's still so much we don't know about what's going to happen next and how we're going to do this, particularly the last speaker on technology. We don't know what's going on moving forward, and so my question is are we really ready to do this, or do we need to have more experimentation in the states encouraging that from the federal government do different experiments like the Massachusetts case throughout the country first?

MR. KEEFER: I'll try. I don't think it's sort of an either/or preposition. I think that, you know, we know that in the context of reform and with respect to the exchanges, for example, there's going to be flexibility for the states, and I think this is important in recognizing that states are very different. So, where Massachusetts was to adopt their reforms, they sort of had a baseline where they've moved up toward being in a position to move to universal coverage fairly rapidly. It's going to take more time in other states, and that's specific to the previous discussion where there was mention of the unevenness of the regulation. And that's

one thing that should be done through reform -- is that the regulation should be made more consistent to give the states a platform in the context of sort of strong federal rules so we have expectations of how the states can operate and execute. So, I really don't think it's an either/or, and if you just look at the help committee construct, for example, which, you know, may actually provide too much flexibility for the states -- and I don't want to get too far into the weeds -- but the construct is that you have states that would establish a gateway, which is what they call an exchange. You would have states that ask the federal government to establish a gateway for them. And then you would have states that there's a fallback. Then within that you have the potential for regional or interstate gateways or exchanges. So, I think we're invariably going to see again at the hired level sort of federal rules, and then down below that in terms of executing and meeting the objectives that we all share for reform, there's going to be a lot of flexibility for the states.

MR. GARIN: Can I just make one quick -- there's a very important public opinion implication to the question you're raising. There are a lot of political imperatives why this needs to get done this year and things that relate to the biorhythms or the way Congress works but why it needs to get done this year. But from a public opinion perspective, the public cares much more about getting it right than getting it quickly. And when they hear people talk about we need to get this done now or we need to get it done by some date, it makes them very nervous so that this

is more of a communications point than an operational point, because I think that the process is pretty far along. But if I were the President or anybody else communicating about health care reform, rather than talking about the fact that we need to get it done by a certain time, I would talk to people about how long we've working the problem and that, you know, while we are arguing about some details of it, people have been thinking and working on this framework for a long time, and that's true. I mean, Senator Baucus' white paper was essentially prepared before the election. So that the question you raise is are we rushing into this. People get that health care is really complicated. They don't want sort of a feeling of that this is a hasty process. They want to make sure that it really is deliberative, and the truth is, it has been just extraordinarily deliberative.

MR. LINKOUS: I just want to comment on that. For many years, through many administrations, Republican and Democrat alike, the standard response of the Center for Medicare and Medicaid Services whenever a new idea has been floated is let's do a demonstration, let's do some research on it, which is another way of delaying. I think demonstrations are the snooze alarm for health care reform. It's way past time -- we're going to have demonstrations, we're going to have a lot of innovations. It's going to go on whether you like it or not, and it's important to have that go on. But that is no reason to stop health reform.

MR. WEST: Okay, (inaudible) question.

AUSTIN: Hi, my name's Austin. I'm just a citizen. I'm not

really representing any organization.

I have a question about the public opinion about this, because my sense just as a person is that one of the reasons that I care about this is when we look at our job losses and we look at, you know, other developed countries that don't charge employers for health care, isn't that -- I mean, you said that, like, people who have health care through their employer. I mean, couldn't there be a communication that well, that's great, but you're not going to have a job, because, you know, if health care costs keep going up and people in France and Britain and Japan who all have longer expectancies than we do with half the health medical costs, don't charge their employers for medical care then they're going to be able to hire people and we're not. I'm just curious that something that resonates with any segment of the public, or do you feel that it's something that doesn't?

MR. GARIN: It does. There is resonance to that. It is much more of an intellectual argument than an emotional argument, and health care fundamentally. I don't mean that it's emotional in the sense that it's irrational, but people have a pretty powerful emotional connection to their own health, and at the end of the day, you know, while they question our competitiveness and our ability to be successful economically and the job's impact of all of this does matter to people. The ultimate decision point is someone's own health and their family's health, and they all think about it in terms of their day-to-day health care. That is, what they think

about is, okay, if I get leukemia and brain cancer and break my leg all in the same day, am I going to get the health care I need. And there's nothing that trumps that in terms of how people think this through. But intellectual level -- it is sort of -- you know, it is an important secondary argument.

MR. WEST: Back there on the aisle, there's a woman -- about two-thirds of the way back, yeah.

MS. BURKE: Hello, my name is Amy Burke, and I'm from IBM. I have a question about incentivizing physicians for electronic medical records, because how is it that we can facilitate adoption of physicians in using electronic medical records? And I almost disagree with your comment about the ROI, because we've done a lot of studies around that. But more importantly than return on investment and cost is the return on investment and quality, and if we can look at clinical outcomes that drive predictive modeling, then that leads to comparativeness effectiveness. I just wanted your comments on that.

MR. LINKOUS: Well, you know, in terms of getting physicians to use electronic medical records, my dentist, a very good personal friend of mine who I've known for many, many years, does not own a computer. It's a personal embarrassment to me. I've talked to him about this. I've had him to our conferences. It's awful. However, my last trip to the dentist he said to me there's a new system that's out and it's a lot more cost effective, and all of a sudden the numbers have changed for

him and he's starting to put in electronic medical records. It has nothing to do with (inaudible). I'm not saying that there shouldn't be. But I'm saying the change in technology and the costs are changing now and the software has changed now, because it's been primarily focused on the large systems, and the real issue for electronic medical records is not so much the hospitals; it's in your individual doctor's office. When you can get them to pick up on it, when you can get the cost paradigm changed and have them adopt it, that's when you're really going to get that type of implementation. Yeah, I'm all in favor of electronic medical records, don't get me wrong, but I think we need to be very real about what the cost savings are out of it.

MR. KEEFER: Yeah, I think it's -- if I could comment on this point. It's really important. Sixty percent of physician practices are still four or less, and that's sort of the key issue.

And the other key issue, as John mentioned, is sort of having uniform standardized operating rules, and this is one of the real important focal points of sort of the off-budget versus on-budget discussion that I mentioned, and through the prism of administrative simplification and what we can do to break through the silos and have the federal government finally sort of effectuate and realize the dreams of HIPAA that we have adoption of electronics information and health information technology that's comparable to other sectors of the economy instead of lagging, we need to have the uniformity in operating rules, and

this is something that we need to do in the reform context regardless -- and the delivery system reform -- regardless of whether it's going to save a lot of money, and that's the important distinction that I wanted to highlight, not to suggest that the budget issues weren't important. But regardless of the savings to the federal government, we need to do this but it needs to be consistent. Everybody needs to be talking or we're sort of going to have the old classic data vs. VHS problem. And if we -- you know, if we sort of give this to physician offices and we have that problem, we're only sort of kicking the can down the road.

MR. LINKOUS: Let me make a quick point on HIPAA that was brought up. Someone else mentioned privacy earlier. It's a real bugaboo that people talk about well, privacy's a real problem with going electronic or electronic medical records. I could put on a white coat and go in any hospital in town and come out with a handful of medical records. I mean, it's the truth, come on. But if you're -- it's electronic and we're using encryption, which every electronic system they use in health care does use encryption, you're talking about a lot more privacy than you are in just regular health care systems. So, I don't think the privacy factor has anything to do with it. If anything, it's probably pushing us more toward electronic systems.

MR. GARIN: That lady right there has your health care records.

MR. LINKOUS: Welcome to it.

MR. WEST: (Inaudible) right there.

SPEAKER: My name is Antonio (inaudible), and I'm a physician.

With regard to your question, sir, it is interesting that we do have quality care, even though, as Mr. Keefer says, it is expensive. The cancer rate in the United States is 16 percent lower than in Canada, and there is a reason for that. We treat them. The patient that was dying of cancer that the president quoted as his brother was denied care -- well, I have seen those patients and we fight tooth and nail to get them treated. But if we have comparative, effective studies, the specialists are going to be (inaudible), because the cost of this care is very high and the value is relatively low unless you (inaudible) as your brother or your mother, because the life expectancy of these patients is going to be lower no matter what we do. But --

MR. WEST: Can we get your question please.

SPEAKER: My question is -- you know, I hear all of this talk about comprehensive care that everybody wants but nobody wants to pay for it. There is a big fight now in Congress. Labor unions are against taxing. The sweetheart (phonetic) insures us because it is labor that's getting it, not the rich. Nobody wants to tax people who make over $250,000 because labor union said well, those are our employers, those are small business, we're going to lose jobs.

MR. WEST: Okay --

SPEAKER: My question is --

MR. WEST: Yes, please.

SPEAKER: -- doesn't it make more sense, even though you disagree with me, to try out and find out how much money we're going to save with information on technology, how much money we're going to save with reforming the administrative plans, costs of insurance companies, how much money are we actually going to save by reducing costs in hospitals before we plunge into a system that we don't have the money to pay for?

MR. LINKOUS: Allowed to save money, you guys.

MR. KIRSCH: I want to go back to this -- I mean, I -- it's interesting the people asking about this question of delay. Fourteen thousand people a day are losing their health insurance right now in the economy. Fourteen thousand people a day are losing their health insurance in the economy. Two-thirds of the personal bankruptcies in this country are (inaudible) because of medical costs, and most of those people have insurance that basically craps out on them because there's too high out-of-pocket costs or it doesn't pay for a serious condition. So, you know, there is a moral dimension to this, which I think most people understand and I think it's always important to remember.

And in terms of controlling health care costs, we have those people (inaudible), We have the most expensive health care in the world by far. And as we've pointed to all those over and over again, there are

places in this country which provide health care, much lower costs, where if we spend a lot more money and get much worse outcomes.

We have to believe that we have the ability to move forward and try to do better, because in terms of a lot of these issues, we can't do any worse in terms of actually using the resources we have to get good quality care. We get good quality care in places, we get not quality care in places, we spend a lot of money, it's not connected to quality. We can do better, and we have to set up system changes that drive in the direction and have a basic moral foundation for our system. And I just -- you know, at some level that remains true.

MR. KEEFER: Yeah, I'd really like to add, because this is really important and sort of it goes again to the issue that I've made about the on versus off budget distinction and sort of preventive care. It's probably the most important component here. There's a lot of consensus around preventive care and including sort of core preventive benefits that the United States Preventive Services Task Force tells us there's evidence behind that we know -- things like cervical cancer screening, a great example, a simple task. If we find it early in stage 1 or stage 2, we're going to save lives -- 10, 15,000 lives, maybe more, a year. If it goes to stage 3 or 4, beyond, it's pretty much a death sentence. And those that have been impacted personally by that understand it all too well. But the point is that when we talk about savings in the system, the Congressional Budget Office sort of tells us that more people are going to seek things like

cervical cancer screening. Then the money that we're going to save from the number of lives that are going to be saved in the reduced treatment cost of that. But something that we know that there's a clear benefit morally as a society -- I mean, we shouldn't think that we should wait in health reform to encourage more women to get screening that's going to save their life.

MR. WEST: Lady in the second row?

MS. MONTGOMERY: Jean Montgomery. I guess you could say I'm sort of a professional student. In a previous life I worked with a large -- not a gigantic but a large database in terms of trying to answer a variety of questions, so for me the idea of health information systems is a capacity out there out to mine it for information about drug interactions, for example. A good example here would be the Medco Plavix PPI knowledge that we have gained from matching up prescription data with claims data. But in the long term in terms of cutting costs for health care, it seems to me we need to be prepared to use the health information database to answer questions about comparative effectiveness, about better ways of treating people, more effective ways of treating people. I understand it's not a clinical trial with matched people, but you do have a large number of people in your database, so you can detect possibly some minor effects of new drugs that weren't caught in clinical trials for example. I'm interested here, since we have the presence of a person who's doing public opinion research, whether this is something that's hit the public

radar, but I'm also interested from the health information system's point of view whether this is something that people are really planning on doing, because if you are, you need to include more of the results of tests, you need to have more of the definition of the nature of the outcomes, some of which could be fuzzy I recognize.

MR. KEEFER: Well, it's not -- it depends which part of the public you're talking about -- this is not central, but that there is a sort of a general recognition that, you know, health care ought to be evidence based and that, you know, that there was a substantial amount of money in the Economic Recovery Bill for comparative effectiveness research, and so that that -- and health reform is moving in that direction. Something that can be -- something that invites public support or that raises questions in the public's mind depending how it gets used. The end of -- people want the information to be available. They want doctors to know it, they want consumers to know it. They do want to make sure physicians have flexibility in how they practice medicine and so that they don't want it sort of, you know, imposed in a kind of rigid way. But people, I think, you know, given what terrible cost of problems in the health care system. If we learn that one thing works a lot better than something else and costs the same, and they weren't -- the think, you know, the system ought to create incentives for using the thing that works better.

The -- really, the sort of analog that sort of, you know, becomes the basis for all of this is the way we treat generic medicines,

and that to the extent that comparativeness creates new things like that where you compare two treatments and their costs, they think it makes sense to integrate that. But there is another caution in the public -- is they do not want -- they want doctors to have the ability to practice medicine, given the, you know, specifics of an individual case.

SPEAKER: (Inaudible)

MR. LINKOUS: Clearly, you know was just mentioned, there's been a lot of money going to be put into comparative effectiveness research. And the Institute of Medicine just came out with a series of recommendations as to how this should be done or some areas that are priority. I think there's going to be a lot of public debate in that area for the next few years.

Even on the private sector, if you look at some of the databases that potentially will be accumulated through the Microsoft Health Vault and Google's activities, I think there's a great potential there of looking at that database and looking at what the outcomes could be, assuming there are just appropriate privacy and other protections to it. So, I think that's where we're going, and I certainly wouldn't challenge public polling onto this issue, but it does seem to me that there is increasingly a consumer focus address on this, and what consumers want is the doctors to be able to use this, but I think they want to know the information themselves.

MR. KEEFER: I agree. If cough medicine doesn't work for

my child, I sure would like to know that when I'm a parent and like to know what does work, because that's really -- so, it's really public light on this, public information, having that available to everyone in some form that they can actually use. That's sort of -- that's going to make some --

MR. WEST: Right there is a question.

RON: Thank you. My name is Ron. I'm currently a medical school student, and my question is regarding the sequence and granularity of health care reform. So, basically health care reform right now is -- like part of the current debate is basically focused on the adoption of a public plan, but as we saw today the issue is much more granular. There are many more issues involved. So, my question is if we just go ahead and adopt the public plan before we actually take measures to lower cost, lower cost for physicians, lower barriers of entry into the health care field, then we run the risk of having this appear at a time where physicians face a huge influx of patients while having lower payments and still face huge amounts of debt. And we often compare with Europe where we say health care costs are lower, quality of care is higher or the same. You have one issue that's often overlooked -- that med school there is either free or really cheap. So, there's a much lower financial incentive for people to go into specialty care, which is a huge factor in lowering costs. So, I just wanted to hear your thoughts about what the sequence of health care reform should be and what we should do first and next instead of just going right in and adopting a health plan.

MR. KIRSCH: First of all, your question reflects a confusion, which I want to clarify, because it's a confusion in the public and it's part of what I think Jeff and Scott referred to as sort of the public plan taking up so much of the debate that people don't understand what the debate's about.

The debate is fundamentally about whether we're going to give people a guarantee of coverage. Offering a public option as part of that is just one part of the reform but is not the central part of the reform. We think it's central for good reform, but it's not what we're talking about. So, we are talking about saying everybody in this country is going to have access to affordable coverage. And public options is part of that, so I just want to -- but you're really asking as I hear it is if we bring tens of millions of people into the system, who's going to care for them? Whether they're private insurance or public insurance through Medicaid, whatever it is. And that's a good question. I mean, if you look at the reform package, again in the House Bill there's serious investments in primary care, in new primary care practitioners, in training, in things like nurse practitioners and physicians' assistants. We're going to have to do it, and one of the things that we've long advocated and we're starting to see is, you know, increased reimbursement for primary care practices. We've long thought that, you know, we should have a tradeoff where medical costs are reduced for primary care practitioners -- medical education costs. We need to invest in that in a serious way.

But two things. One is the political will to do that will be tied to the political will to bring everybody into the system. These things will not happen in isolation. And while it may mean that there's access problems -- there's tons of access problems now, there's lots of people in emergency rooms who don't have access, and there'll be shifts in the system -- and, again, I go back to the fundamental question of whether it's fair to ask people not to have covered (phonetic).

Scott talked about cervical cancer. Twenty-two thousand people a year die, and that was a few years ago, because they don't have coverage. So, if there's a moral imperative to care for people here, let's do it all. That's what the political system's demanding.

MR. KEEFER: I think, you know, to build on that, I certainly agree with a lot of what Richard said, especially with respect to primary care, and I think we have three issues here. One is sort of the transition that I sort of alluded to earlier and making sure that we allow the states sort of a glide path to get this done and to get it right, as Jeff said, and not to sort of have, you know, an unrealistic time frame.

The second is sort of one of capacity but in two parts. There's capacity for the government, and part of what I think you were asking is the capacity for the government to implement a new government-run plan, and I think, as one of my colleagues said, there's not a building big enough in Baltimore to do this honestly, and I think when we talk about capacity we also have to talk about issues like state

premium taxes, solvency, all the rules that are important for a level playing field that I sort of alluded to earlier with respect to governance.

The final piece that Richard discussed is sort of a capacity of the system to care for people, and one of the things that we've learned from Massachusetts, particularly with respect to primary care, is that there's a lack of capacity to care for people as they're brought into the system, and all the states are -- with respect to rules relating to nurse practitioners and physician assistants, all the states have different rules, and this goes to the question earlier. So, we need to figure out a way that we can leverage those nurse practitioners, the physician assistants, making sure that they're supervised, of course, by a physician, but to leverage them so the base-level primary care we can get people in, it's less costly, it's more efficient, and then we can have a system that everybody would be proud of.

MR. WEST: Here's a gentleman on the aisle.

MR. WANG: Good morning. My name is Yun Wang. I'm from Wesleyan University, and I have two questions.

The first --

MR. WEST: Could you speak up just a little bit.

MR. WANG: Sure.

How real are the cultural challenges, the cultural barriers to providing affordable universal health care to every American, given our American exceptionalism to emphasize individualism and the private

market?

And, second, how should health care reform address the shift -- the Democratic -- the demographic shift as more Americans are retiring and as the public Medicare fund will expire in 2017?

MR. KIRSCH: Well, let me try those quickly.

Did everybody hear those, or shall I repeat them? Did you hear them? No, I didn't think so.

The first question was, in terms of American exceptionalism, is this something the country can do; and the second, as this aging population, how do we deal with that?

So, (inaudible), who writes for the *New Yorker*, is a physician, has written two really interesting articles about health care reform, one focusing on the delivery system challenges. The first one is if you look at health care reform around the world, each system emerges from the current system, and one of the reasons -- and we think that's what's happening here. There's lots of good policy arguments we can make for different kinds of systems than we're talking about. We're talking about a very complicated set of Rube Goldberg solution, because we've got a whole system in place that has private insurance and has public insurance and Medicare, and so we're coming with our own American system. It is a uniquely American solution. It's funny, because that's one of the things that we've wanted to say from our polling, and that's Scott's organization, Colbert Organization, Campaign for American Solution.

Everybody's talking to the same people, even with different perspectives. The reality is we're coming in with a uniquely American solution. We think that builds on what works, tries to improve it, and so it's going to fit into this American culture, this American economy, but hopefully do it in a way that makes enough big changes to point us in a new direction.

And in terms of seniors, I mean, yeah, as people age we're going to -- and people live longer -- we're going to need more investments in health care. That's one of the reasons it's so important to do this better, to understand what real quality is, to understand what the right incentive and delivery system are.

To use the kind of things that -- about information technology in a way that's useful to people. We got to do this better if we're going to control health care costs to a loved one, because, you know, if we want to celebrate life expectancy and high quality of life, we don't just have to -- the point is we don't just have to spend more in a blind way just to spend more. We can learn, and we're going to have to learn how to spend it on real quality. And that's our biggest challenge.

MR. WEST: This gentleman here has a question.

MR. RAINES: Hi, Frank Raines from Revolution Health.

Two questions. First question -- there's been no mention of poor people. This has been talked about entirely as a new middle-class entitlement, and indeed in discussions of the public plan, there's been a lot of debate of what the payment level will be, whether it will be Medicare,

whether it will be higher than Medicare, but no discussion about the Medicaid payment level, which creates an enormous access problem for poor people. Where do poor people stand in this debate?

Second question. We have a public plan now. We have private plans. And we have very little innovation within the delivery of health care. New technologies are not finding a role. Why should we think it'll be any different with the health reform with a public plan and private plans the same people are now going to be doing with more money -- why should we think they'll be any different in encouraging innovation?

MR. KEEFER: I think the Medicaid issue is critical, and I have a lot of personal experience. I spent a decade in the Tennessee delegation and watched the Ten Care program grow up, and I think the funny thing is some people in Tennessee say now that well, we already had a public plan, it was called Ten Care. And the budget trajectory that it grew on was unsustainable.

And the Medicaid issues are real. I did mention Medicaid to say that I think there is consensus. Our board back in 2004 endorsed taking Medicaid to 100 percent of FDL. I think that the sort of conflicting Medicaid rules are crazy. We used on the Hill that whether someone's Medicaid eligible depends on whether the sun is shining or it's raining. It seems that arbitrary sometimes.

But back to the point of Ten Care and payment rules, the

promise of Ten Care was similar to some of the promise in health reform, and I think we have to be very careful here, and that is physicians and providers were said, you know, we recognize you're only going to get 50 cents on the dollar for this population, but you're getting zero now. And they said okay, we can take this. And over time, as the program expanded and more people moved into that system, the payment rates became lower and lower.

And I'll never forget, I was on -- I was in my office on the Hill one day and I got a phone call from someone who was a top person at one of the big banks in Memphis, and she said I don't know what to do. You know my son-in-law. He's a primary care physician. He has a small practice. He's re-mortgaged his house. He's about to not only lose his practice but maybe his house. And I said remind me again what his patient mix is. And she said well, you know where he is, you know, it's in the country. Eighty percent is Ten Care. And I was so glad that she wasn't in front of me, because my mouth dropped open, and I thought, you know, how do I come up with a quick but polite, delicate, diplomatic way of saying that, you know, he's already lost the practice. And point being is that there is a cost shift from commercial payers, the public payers and public programs that's no more egregious in the Medicaid population. So, this is a real issue, and we need to think about finding some payment equity, particularly for Medicaid, even more than Medicare.

MR. RAINES: Thank you.

MR. KIRSCH: Yeah, I mean, let's look at what's in the legislation. There's a huge, huge benefit for poor people in this debate. We're talking about a huge expansion of Medicaid nationally. All the Bills in the House and in the Senate would -- making Medicaid up to a hundred on the 3300 -- 50 (phonetic) percent of poverty. We're not sure where it's going. And then people above that getting subsidized, almost fully subsidized care through the exchange. And on the House Bill, there's serious new payment enhancements for Medicaid providers -- well, it can be done, but it's there -- and so -- yeah, one reason you're not hearing about this in the public debate is the public actually thinks this whole debate is about the uninsured. And I think Jeff probably can echo that. But we've seen is that they think the whole debate is covering poor people, the uninsured. And they're not sure what's in it for them, and one of the reasons we always talk about the fact that this is making quality health care for everybody and taking a lot of people who now have benefits that aren't good enough, that have high out-of-pocket costs that don't work for them is to make it clear to people that there's something for everyone, because politically 94 percent of voters have insurance.

MR. WEST: Okay, I think we have time just for one last question.

This -- right there.

SPEAKER: Hello, Zirra Banu from the Brookings Institution Press.

Well, I haven't been in this country too long, but it seems to me like some Americans are afraid or at least overly critical of their government for some reason when it seems to me like this is one of the very few countries that the government actually is accountable to the people. So, my question is what is or will be the cost of a government-run health care for America?

MR. KIRSCH: Well, again, we're not talking about government-run health care for America -- any place. We're talking about a reform system that will bring everybody into the system. And, you know, the cost will be what it -- I mean, no one knows, because it depends on how you do it. But what there is a broad consensus on is that failing to deal with a system which doesn't have any way to have system-wide cost controls will cost more than not doing it, and that's kind of the broad consensus for reform that exists. And we're all going to argue around the country and in this town about how to do that over the next few months, but if we make the kinds of changes we're looking at, it will mean we will -- the cost will be less than it would have been over the next decade and will point the system in a new direction.

MR. LINKOUS: I do think that the fundamental observation is right, though, that people are not particularly trustful of the efficiency or effectiveness of government in doing things. And so that the -- you know, part of the advertising that you see against having a public health insurance option or other aspects of health reform is there's one now that

has a government bureaucrat sort of interposing himself between the doctor and the patient. And people don't want that. They really do not want that. But that ad is a lot less powerful than it was in 1993 and 1994.

In 1993 and 1994 we were still -- we were at the front end of the movement from a fee-for-service medical health service m4dical insurance system for something that is different from that. And so that when people saw that back then, they said ma'am, that's terrible. And when they see it now -- I've actually tested this in focus groups -- they said well, you know, now it's just about picking your poison -- is that we've already got the insurance company bureaucratic between me and my doctor. And so I don't want the -- I don't want the government bureaucrat there. But, really, is it any worse than what we have going on now with other bureaucrats interposing themselves in that relationship? So that in that sense, it's not that people love Government a lot more than they did in 1993/'94? But the context has changed very significantly in terms of how they think about other dynamics in the health care system.

MR. KIRSCH: Just to sort of illustrate that in a fun way, the ad we're running right now -- and this ad tested through the roof. Folks should know the ad you see -- you know, most of them actually tested in different ads. They're not just -- and it plays on that, and it's -- there's a parallel to this (inaudible), which you haven't seen, because it basically says what if you got rid of the -- sorry, Scott -- what if you got rid of the $12 million CEO salaries and $130 billion in profits and the endless

denials and delays and soaring premiums and co-payments? What would you have left? It shows you and your doctor. So, we're both playing in the thing. But the reason that ad's resonant in the way that it wouldn't haven't been 15 years ago is because people's experience is exactly a pick-your-poison experience, and so when they see the government (inaudible) doctor, they always see the insurance industry as -- and they just know they got to do something.

MR. WEST: Okay, on that note we're out of time, but I want to thank Richard Kirsch, Scott Keefer, Geoffrey Garin, and John Linkous, and thank you very much for coming as well.

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