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What's Next? Reporting on Health Reform Between Now and 2014

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ED HOWARD: My name is Ed Howard, I'm with the Alliance for Health Reform. On behalf of Senator Jay Rockefeller, Senator Susan Collins -- who are members of our informal leadership -- and our board of directors, I want to welcome all of you to this briefing for folks in the media on how to cover the health reform story between now and 2014 when big stuff starts exploding.

Our partners in sponsoring this briefing are the Robert Wood Johnson Foundation and the Association of Health Care Journalists. RWJ, as most of you know, the country's largest health and health care philanthropy, one of the most active as well.

I want to recognize, if I can find him, Adam Coyne, who's the Director of Public Affairs and Social Media at the foundation. They have a variety of tools that reporters can use and everybody else who's interested in understanding the health reform issues.

Representing the Association, we have Len Bruzzese who's the Executive Director of the Association. Len, I have a hunch that there are a lot of people both in the room and listening on the conference call who are not familiar with the good work that your organization does and maybe you could tell them about it in very brief form.

LEN BRUZZESE: Why thanks, Ed. As Ed said, I'm with the Association of Health Care Journalists, which is a 12-year-old organization made up of about 1,000 journalists across the country. We're pleased to be partnering with the Alliance and the foundation on this event mostly because of the importance of the topic and the enormity.

It's the very reason that our organization was founded was reporters coming together, reporters and editors, to share resources, to network, to help each other on story ideas and such and to educate each other, which this event exemplifies.

So if you aren't already a member, we hope you'll check out healthjournalism.org and see what we have to offer. Thanks.

ED HOWARD: Great. Thanks very much Len. He'll be available for consultation in the corner there as we go along. By the way, contact information electronically for both of these gentlemen is at the bottom of the agenda in the materials that you have in front of you. You'll also find in your kits a lot of background material as well as a list of even more background material that we didn't kill trees to print but posted online at www.allhealth, all one word, dot org.

I want to draw some particular attention to the sourcebook for journalists. Bill, do you have a copy of that anywhere around? It's online and it's part of our collaboration with the Robert Wood Johnson Foundation. It's a very useful tool setting out sort of what you need to know to get started in a whole variety of topics related to reform.

We've recently updated it with the material needed to make it current following the enactment of the legislation. There's somewhere a flyer that gives you information about that update. There's a Spanish version that we're in the process of updating that is pretty far along as well also available on that allhealth.org website.

I mentioned Bill Erwin. If you need more information about the sourcebook or anything else that will help you chase a story or think through a story, Bill Erwin is the go-to guy. He's standing over there with the handheld mic. He's a seasoned reporter himself. He's our Communications Director at the Alliance for Health Reform.

Bill, you're also kind of the person who makes sure that our cooperation with the foundation in furtherance of journalists' ease of pursuing stories gets done well. I wonder if you could just make sure people know who you are.

BILL ERWIN: Well. thanks. It's a great pleasure to be teaming up with the Robert Wood Johnson and the Health Care Journalists today. This is the first time this particular trio has done a briefing here at the Press Club.

Robert Wood Johnson has a long history of helping us help journalists. The foundation has supported five editions of the *Covering Health Issues* book and what's online right now is really a sixth edition, since we've updated every single chapter.

We’ve been involved with the Health Care Journalists from the very beginning back in Indianapolis all those years ago where Ed and I both had the pleasure of attending your very first conference. So it’s wonderful to be here and thanks everybody for coming and for those on the phone for phoning in.

ED HOWARD: Great. Now some of you are clearly recognizing, and that’s why you’re here, that the new health reform law is a huge step. Many people say it’s a huge step forward, certainly not a complete harmony in the chorus on that question, but you’re probably looking for ways to make your readers and viewers and listeners grasp the magnitude of what’s going on now, what kind of preparations are being made for the huge changes in store in the future and that’s what today’s session is all about.

I have to tell you that as somebody who started out in the newsroom of a small daily in Beaver Falls, Pennsylvania in the 1960s, I am honored to be moderating this discussion.

We’ve got a terrific panel of nationally respected health journalists to give us their best insights into this challenge. I’m going to introduce them very quickly only by name and title not as fully as they deserve, of course, and there’s background information in your packets and ask each to say just a sentence or two to identify themselves, in part, to let our colleagues on the conference call around the country associate a voice with a name. We have four great reporters for you and let’s start with Julie Rovner who’s a correspondent with National Public Radio. Julie?

JULIE ROVNER: Hi.

ED HOWARD: Excellent.

ED HOWARD: Next to Julie is Phil Galewitz who’s with Kaiser Health News and happens to also be a member of the board of the Association of Healthcare Journalists.

PHIL GALEWITZ: Thank you for having me.

ED HOWARD: You guys are great. Going to my left, we have Joanne Kenen who runs the New Health Dialogue Blog at the New America Foundation and has no microphone in front of her.

JOANNE KENEN: Hi, glad you have me here to speak up for the bloggers.

ED HOWARD: Finally, Noam Levey of the L.A. Times.

NOAM LEVEY: Happy to be here, thank you.

ED HOWARD: Okay. We're going to hear from them briefly, not that briefly, but briefly at this point with an initial piece of advice for you to chew on and then we'll open it up to questions both from those of you around the table and those of you who are listening on the conference call. On the latter case, you'll be doing it by email by sending an email to info@allhealth.org.

So let's get started. We'll start in the same order that we heard those eloquent speeches just a moment ago with Julie Rovner.

JULIE ROVNER: Thank you. I can have a little more to say than hi. I am actually a proud charter member of the AHCJ mostly because one of its founding board members, Joanne Silberner sat next to me at NPR and I didn't have a lot of choice but I am actually pleased to maintain my membership in AHCJ.

I thought I'd talk a little bit about how it is I do what I do with the health legislation, which I've been covering for this is now my 25th year and here, for those of you who are interested, I brought my own book to flack. If you want to know more about not so much the bill but about the background of health policy. I've written an encyclopedia available from CQ Press. You can look at it afterwards.

As I mentioned, I've been doing this for quite a while and how I go about it has changed. I was thinking about this yesterday. In 1990, the best way to cover health policy was you went back to your desk and you waited for your phone to ring. By 1995, we had emails and then you went back to your desk and you waited for emails to come in.

By 2005, you could be walking around and you would check your Blackberry for email and now we have 2010 and you get to check your little iPhone and we have Twitter so now things happen a little bit faster but one thing that has not changed is that covering this beat involves an enormous amount of reading. It used to be just websites. Now we have websites, and thanks to people like Joanne, blogs. So I think there's more reading. You have to get up earlier in the morning to stay ahead on this beat.

I don't think any of this comes as a great revelation to anybody who's ever thumbed through the Alliance's wonderful *Covering Health Issues* handbook or perused AHCJ's website but here's some of the places that I spend a lot of time online

when I'm not wandering the halls of Congress although sometimes I do both simultaneously.

This is the problem with having an iPhone. Some of my favorite websites, as I'm sure many of you share, the Kaiser Family Foundation, I think it's sort of the first among equals just the amount and depth of information and the ease of reading that it has is really unparalleled, the Commonwealth Fund and the RWJ websites also have some really wonderful background information, a little bit less common but also some great gems, the Urban Institute Health Policy Center.

Some of that can be a little bit harder to get through. It's a little bit wonkier but really good stuff, Center on Budget and Policy Priority has some wonderful background papers.

For those on the other side of the political spectrum, the American Enterprise Institute, the Heritage Foundation, and CATO have some really good stuff. Then there are the blogs and this obviously, you could spend days and days doing nothing but reading blogs. One of my favorites though is called THCB, The Health Care Blog.

Again it's a little bit wonky but it's a source of not just really interesting stuff but stuff that I tend to get ahead of the curve. It's really some of the big thinkers in health policy and a lot of different big thinkers in health policy. Then sort of a one-man blog that I'm fond of is Bob Laszewski, who's a former insurance consultant. I guess he's still an insurance consultant but I think you hear him, you see him quoted a lot.

You hear him quoted a lot and there's a reason, he's a really smart guy—the New America Foundation and not just because Joanne is a friend of mine but because there's good stuff there. The blog that Health Affairs runs, again they bring together a lot of good, smart people who do good, smart stuff; Think Progress, that's the Center on American Progress just because it's fun to read. They also have a lot of good stuff and Ezra Kline, friend of mine, smart guy, and I like to read his stuff.

Here's a little advice about what I'm doing these days. This is how I'm going about taking this 2,700-page behemoth and trying to break it down a little bit. I think that this can apply to not just national reporters but local reporters. I'm actually trying to take the bill apart piece by piece and do individual stories. There's still an enormous amount of misinformation, some of it intentional, some of it

unintentional about what's in this new law.

I've recently done stories on the CLASS Act, that's the long-term care piece, a story you have in your packet about young people being able to stay on their parents' plans. I mean these are things that I think a lot of reporters have already done. There's lots more pieces you can do. You can get a summary of the bill. The Kaiser website has a particular good one.

Frankly you can throw a dart at it and pick any portion and go after it but here's a couple of examples that you can really localize. One of them is how would the new law affect small businesses? There actually is no employer mandate particularly obviously not for small businesses. There's a tax credit already in effect this year for small businesses that many don't even know about. What would be the real impact on this law on Medicare and on seniors?

Seniors are very confused. We obviously have seen this argument now going on in Washington. Republicans say that the Democrats are issuing propaganda. Seniors don't know what to believe. Yes, some seniors may lose extra benefits from cutbacks in Medicare Advantage plans but many will see new benefits for preventive care. Obviously this is a story that could be done again and again and again and can perform a real public service.

There's lots of smaller less covered stories in the bill that you could do locally. There's a tanning tax. There's tanning salons in every town. There are requirements that will come into effect next year to post calorie counts on menus at chain restaurants. I mean you could find out if other restaurants will be doing that that aren't required to just to keep up for competitive services. So there's an awful lot to keep everybody busy and my advice is go for it.

ED HOWARD: Alright, very good. I guess I would be remiss if I didn't point out that today was the day when the first donut hole prescription drug checks were supposed to be mailed out. So if you haven't followed that story, at the local level, you probably can get two days from now a great story of somebody ripping open that check and going to Wal-Mart. Let's turn now to Phil Galewitz. Phil?

PHIL GALEWITZ: Hi there. Well I've been on the beat well not as long as Julie, only 20 years instead of 25 years. So I was asked today to talk about well how can we keep the health reform stories fresh, keep our editors interested. I guess I think about well I've been on the beat for 20 years and

it's mainly all the same issues. We were writing about Medicare, Medicaid, the uninsured, businesses can't afford health care. There's nothing new here. We've been writing this for decades.

So the challenge that we face in keeping this fresh is the same challenge we've always had. Before I go on, I guess I wanted to ask the audience who here has been on the beat for less than two years? Would you raise your hand? Hi. Who here has been on the beat for less than five years?

So this is a pretty seasoned, experienced crew we have here. We have our work ahead of us. So basically the things I'm trying to do in looking for stories kind of like Julie was saying was sort of looking for the nuggets. There's so many pieces of the bill that you could write whole stories and get really into depth.

So what I think we, as reporters, need to do, I think we've done a good job already but as a continue to, following the money is a big thing. There's so many new dollars in here and new programs that haven't got a lot of attention.

I mean some of the main debates of the bill I think have been covered but now we need people to see sort of where the money's at, programs like National Health Service Corps getting millions and millions of dollars, money for nursing home pilot programs are a couple of examples but there's dozens and dozens of examples as you look through the bill of programs that are going to be getting a lot of money over the next five, six, seven years.

My view is even if we realize the effect of that money, we won't know for a long time, it gives us a good entry view to look and see well how are those programs running now. the other thing I think we really need to do is sort of related to the money is how are groups, both non-profit and for-profit, hospitals, health insurers, doctors, clinical laboratories, how are they all sort of strategizing now to take most advantage? Everybody's looking to make money off of health care reform. Like health care, people want to make money off of it. I don't see health care reform any different.

So I think a key thing that journalists need to do is really see how many different aspects every kind of health business, every health-related business, what are they doing, sort of change how they're operating? How are teaching hospitals changing to react to new money, new programs in the bill to try to shift the workforce toward more primary care is one example.

How are clinical laboratories trying to change what they're doing because people are going to be able to get health care coverage without any co-payments? So for example, people expect there'll be a much higher demand for a lot more tests, a lot more in the laboratory, a lot more blood tests because they won't have to pay their own Medicare or in private they won't be paying that co-payment.

The other thing I think we sort of need to do is keep a really good eye on the states. I mean as we look at the national government, what's going on there, I think a lot of things we'll see at the state level, we'll see some states move ahead. Obviously we've all written a lot about Massachusetts but I think it's worth looking at some of the reforms going on in other states.

Obviously Utah is another state where they've tried exchanges but they've got a lot less publicity than Massachusetts. They've tried to do things a little differently. Other states have passed health reform laws to expand coverage ahead of the federal government, Colorado, Oregon are a couple of examples. So what I try to do is sort of look at the states. There's a lot of states where I think there's a lot of interesting things going on. So I would keep doing that.

The other thing, just on following the money is sort of following the calendar. There's a lot of things being implemented right now or the next few months as we know, the dependent coverage, the small business tax credits, the highrisk pools.

I think we've done a pretty good job as everybody following the regulation writing but it's also going to be a lot of things happening in 2011 with the CLASS Act and that's going to start. I guess the money will start to be collected in 2011.

The medical loss ratios for the health plans, well have to deal with that, again, the cost sharing being eliminated on some things with Medicare, new incentives for Medicare, recipients to live healthier, and I think it's important for us, there's a lot of things going on now about how the government and how industries are preparing for these changes that are going to be occurring beginning in next year.

As always, I think we have a lot of stories that we've always followed that we've got to follow even more intensely. Come this fall, come September/October, we're going to hear

about all the changes with Medicare Advantage and a lot of these changes really aren't necessarily about what was in the law but was in the funding cuts for next year.

So as a reporter who's covered health care on a regional and national level, Medicare Advantage has always a big story every fall because seniors look forward to see what the changes will be. I think that'll be even doubly important because a lot of people will be following even more closely.

The other thing will be the push. In 2014, with millions of people being added to Medicaid and millions more being given money to help buy insurance more cheaply on exchanges, the question is will these people really sign up for coverage I think is a big question, I think is a big story out there that can be done in every local community, every state, and even at the national level for, do the people that don't have insurance today, will they really go buy it?

Just because there'll be a mandate on many people, not everybody, what will be the real push to how effective will it be to get everybody in there? There's a lot of things going on at both the national level and the state level to make that happen. I think that's definitely one of the stories worth following.

I think it's just important to look for the conflicts, look who's trying to make a lot of money out there in business, follow that. As Len Bruzzese was saying, AHCJ has a lot of good resources. I've been on the board for the AHCJ for the last four years. I'm the membership chair. I was at the first meeting back in Chicago 10 years ago and I joined it largely to network, meet other reporters. I'm a firm believer that yes, we compete every day but I think we're all still in a business where we can share a lot and we can share stories.

I have no problem calling up reporters and ask them how they did a story and hopefully nobody would ever have a problem asking me for advice on finding a source or having a story on how I did something.

I think journalists really have a lot to gain from each other and that's really what the whole why AHCJ was formed in the first place but if you go online, another blog that we have is we have a covering health blog that we started last year that sort of gives an overview of, shows great health care journalism out there.

I think it's something that you should put on your bookmark and we also offer tip sheets covering hospitals,

nursing homes, CDC and reporting guides and just a lot of resources if you go to healthjournalism.org. If you've never been there, I think it's really eye opening. So I look forward to taking your questions and thank you very much.

ED HOWARD: Great, thanks Phil. I believe there are one or two pieces from the association in the packets along with a pretty good selection of some of the timetables that have been put together that will help you follow the calendar as you were saying. Let's move now to Noam Levey from the L.A. Times. Noam?

NOAM LEVEY: Thank you Ed and thanks so much for having me. I am a real baby on this beat compared to my esteemed colleagues at the other end of the table but I spent a lot of time in the hallways of Congress over the last two years watching this sausage get made. I wanted to share with you just a caution and then a couple pieces of advice, I guess, for broader story themes to think about.

The first caution is that I think there is a tendency now with implementation with this being sort of a little bit of this grey area where nobody really knows exactly what's going to happen for an enormous amount of speculation that sort of be filling this void.

I guess what I would warn is that nobody really does know, despite what they may claim, what's going to happen but the critics of the bill are very aggressively sewing stories of doom and gloom and by the same token, the administration and some of the champions in the Democratic side of the aisle are also putting forward probably slightly inflated claims about what the bill will do notwithstanding the $250 checks that a few million seniors will be getting starting now.

But that being said, there obviously are big challenges and there are big opportunities in the bill. I wanted to touch on just a couple of them really focusing on state, what is happening at the state level.

I think, in many ways that is where the most interesting part of the story is right now not only because states will be running the exchanges and expanding Medicaid in 2014 but because they notwithstanding the criticism from Republicans about a federal government takeover, there is an enormous amount that is left to the states to do.

I realize this is somewhat odd for a Washington-based reporter to say this but I think if you can leave here and go and see what's happening out there and if you can't, work with

reporters back at the newspaper where you work to look for what's going on there.

Two storylines that I would point you to particularly, which I think are very interesting and will be decisive in the coming years between now and 2014 and beyond one, insurance regulation. This is obviously what was happening in the insurance market was probably the biggest to date of the healthcare bill. What is happening with premiums now will be probably the biggest debate between now and 2014 and certainly the thing that the administration is most worried about.

One thing that people don't necessarily realize is that while there are a lot of new regulations for insurance companies particularly after 2014, there isn't that much in the bill actually gives regulators the ability to really review and even change what insurance companies can charge. That remains a function that is almost completely at the discretion of states. So what does that mean for the purposes of writing stories? There is an amazing variety in what states are doing out there.

Some states are extremely aggressive in regulating how much their insurance companies are charging on the individual and the small group markets, Oregon, Massachusetts, Maine, some of these states, New York just passed a law actually yesterday to strengthen their ability to review, I would suggest that going and looking what's going on at the state level and the dynamics that are playing out in legislatures and in governors' offices and what is happening with state insurance regulators would be very, very interesting and pretty provocative.

The other thing that I would direct you to a little bit and Phil mentioned this, is the degree to which the states are prepared to actually take advantage of a lot of the opportunities that are coming forward.

As Phil mentioned, there are some states, Massachusetts being the biggest but also Colorado, Minnesota, Utah, that have taken steps already to try to reform their health insurance markets, health care more broadly. Many have not. I was just down to Mississippi doing a story down there where that state doesn't like Medicaid, doesn't like Medicaid and was one of the last states to implement Medicaid when Medicaid was created in 1965.

There are interesting ways in which states have acted over the past few years, over the past decades in terms of taking advantage of public programs signing people up, how aggressive are they? How much have they expanded SCHIP? Then

looking forward, what is the capacity in these states to actually create the infrastructures that will be necessary to get ready in 2014?

We've seen a little bit of the debate about high-risk pools. I think that's a start. I think there's also a question about who's going to actually run their own exchange in 2014? Are there people who work there that do that? So those are a couple of things really quickly, some suggestions just in addition to the wonderful resources that have been mentioned so far.

One would be, I would shamelessly use and abuse trade groups here in Washington, the lobbyists, they have an incredible agenda obviously but they're also in touch with their members back around the country who have stories to tell and anxieties to share. Consultants and analysts are always a good source, people who are going out there, I was talking to a hospital analyst the other day who's traveling around the country meeting with anxious hospitals as they try to figure out what this new world is going to look like.

Then one other source on the web, which I think is good, stateline.org has a really good compilation of newspaper articles out there and as the only representative of that medium up here, I want to plug it and say that they're still doing a good job of reporting what's happening in states. So that's it. Thank you.

ED HOWARD: Let me do a brief commercial for something that Bill Erwin has put a lot of time in, Bill Erwin, and that is the Alliance has put together a list of experts, selfselected, well we select them and then they decide whether or not they will take the time and the trouble to fill out the form that we ask them to so that online 24/7, you could see who would be an expert in an area like Medicare Advantage who lives west of the Mississippi, has B-roll if you're a television reporter and can do an interview in Spanish.

We may not have too many people who fit into that category. The point is though if you can take advantage of that service, the find an expert service, there are a lot of folks who can get you started in a particular issue in a particular way. So Joanne is up to. I'm sorry Joanne Kenen.

JOANNE KENEN: Hi. I covered health care on the Hill with Julie and other people for many years. There are times when I think I spent more hours in the hallway with Julie during the week than I saw my children. Obviously one year when I was on maternity leave, I came back and nothing had

changed.

Anyone who took this year off is going to find that everything changed and yet I think some reporters have a problem of editors wanting one of two things. Either oh, that's so last year and health care's over or they only want to cover it as a political story, who's up, who's down, what's the impact in November and all the Novembers to come?

So I wrote the first chapter of the sourcebook. It's in your packet. It's online so you know my favorite resources and websites. Try covering health care in the early 90s when there wasn't the Internet and we had to go to these briefings and go home and file everything and then remember where we put it.

So you can see my favorite resources there but I thought what might be useful is to just sort of describe three stories I've done and you're welcome to steal them if they apply to you because there are ways of keeping it fresh and telling it differently.

One is a story I did right before I left Reuters and I talked to colleges about health policy is this huge field. It didn't exist. There was no such thing as an undergraduate health policy major. It's now enormous. You could sort of take that in your community, why are students going into this? What is their career path? What are they perceiving? What are their professors perceiving? Why are universities investing in these programs?

I got a really good national story out of it. it could be revisited locally and it'll be different in each community the way the programs shape up. It was a very fun story. It let me be very narrative and I also squeezed a lot of policy in there.

The second one I want to mention is I don't have it online so we couldn't include it but if you're in the supermarket this weekend, in the June *Washingtonian*, I profiled a family that had three generations of doctors. The grandfather's no longer alive and it took me a year and a half to find them.

So that was the hard part and writing it was really a lot of fun because grandpa was a GP who practiced in the back of his house. People paid him in tomatoes and they mowed his lawn.

ED HOWARD: Chickens?

JOANNE KENEN: There were some chickens there too right? There actually were a couple chickens but the son is the head of vascular surgery at Washington Hospital Center here in D.C. and of the three grandchildren, two are doctors and one is the woman who wants to combine career and children is, of course, an anesthesiologist, really interesting.

The person, she's doing only regional nerve blocks for orthopedic surgery for people whose hearts can't withstand general anesthetic. Basically that's how specialized she is. The grandson is an endovascular surgeon doing minimally invasive aortic repairs at the Mayo Clinic doing things I can't even pronounce.

That let me really tell the story of specialization to subspecialization, fragmentation, the problems of coordinating care, let me really tell, and also bringing it back to Mayo and integrated care. There's a great-grandson who follows his dad around with the black bag.

So it was a tremendously fun story to do and it really told people a lot about what does our medical system look like, what does our health care system look like, and what are the changes these people may face in the future.

The third story I want to talk in a little bit more detail until Ed picks up his little sign is a story I did for a fairly small magazine actually and it got an enormous amount of feedback. I got a lot of feedback. It got a lot of attention even though the platform was sort of small. It also was useful for those of you who are writing in different medium, it was a story where I was able to go back and forth between my blog and the magazine piece.

They fed off each other over a period of months in sort of an interesting way. It's a story I did, it's in the packet, on disclose and apologize: an alternative to medical malpractice. Like everybody else on the Hill, I had covered the annual malpractice fight between the Democrats and it's one of those things that can make you very cynical because there's all sorts of deals to be had.

Nobody really wanted a deal. Everybody just wanted to get up and give their set pieces about it about two very rigid approaches that weren't going to go anywhere. You could write your story before it started. I mean none of us actually did that but we could have [laughter].

Some of us might and yet a year or two later in 2008, I

guess it was originally, I was with Tom Daschle and I heard him start talking, he wasn't in his office anymore and he said something different about malpractice and my ears perked up.

I began paying attention, listening to people as I heard Democrats beginning to speak not office holders but people, I mean Daschle, Zeke Emanuel, other people I began paying attention to what they were saying and writing. I was hearing something different and I began blogging on that because it opened a door to some new ways of looking at this. Then I wrote a piece for one magazine about alternative dispute resolution and why it wasn't just a fight over malpractice caps, why there were issues.

There were the issues of why the people who were involved in the quality movement really care about this, people who see it or who want to do new forms of delivery systems, see the doctors' perceptions and doctors' perceptions and economists' perceptions are not the same, why this is an obstacle to change and how do you pair away the various incentives, how much is it defensive medicine, how much is it you could just make more money doing all that stuff whether you're even conscious of those incentives.

So I began looking at this both on the blog and in the first magazine piece from a bunch of new voices and new perspectives. So I got interested in it partly because it was also the nexus of so many things that are wrong with healthcare.

I mean I like writing about hospital readmissions for the same reasons. If you can fix that problem, you could fix an awful lot of things. The model I kept hearing about was the disclose and apologize model. We've all read stories about the University of Michigan.

Now there's a lot written there and Obama likes the disclose and apologize model. There's federal grant money coming out very, very soon, which is another keep an eye on the ARC website because those grants are going to be made pretty quickly and in 25 communities, you'll have a local story about it, up to 25 communities. I don't know how they do the grants.

Then I went to talk to the people at Michigan and Illinois, which is the other model. The story we'd been hearing all the time is if you say you're sorry, the family won't sue. Well I thought well that's easy. Why aren't all hospitals doing this? It turned out to be really complicated. It's hard to replicate.

I came away with sort of two lessons. One is there are all sorts of technical reasons where it's hard to replicate having to do with whether you're self-insured and how many malpractice insurers are in the room. A university system is different than a community hospital.

The other reason was it really isn't about apologizing. It's about fixing things. If you say I'm sorry that doesn't make the family go away happy. If you say I'm sorry and I'm accountable and this is what I'm going to do and then there's actually an arbitration process. It's more complicated.

So I did that piece and then of course, I was able to go back and blog and I got comments on the piece and I blogged about that. So it all interconnected and it really took me away from a very stale political debate about malpractice to a much more complex debate about health care quality and new delivery systems and financial incentives and accountability. So I actually had fun with that story to write.

ED HOWARD: Great, thank you Joanne Kenen. You've all been very patient and I've noticed a lot of scribbling of story ideas and approaches. So maybe you haven't been bored while you listened to these presentations. I certainly have been taking a lot of notes.

By the way, if you have questions about any of the sources that have been cited and you can't track them down, let us know because we can get you the websites without any trouble and maybe some people to talk to.

The floor is now open. If you will be kind of enough to raise you hand and let somebody come to you with a microphone so that everybody can hear the question, not just everyone in the room but those of you on the conference call, I would appreciate it.

If you'd identify yourself, I would appreciate it even more. Let me just say once again to the folks who are on the conference call that if you want to ask a question, email it to info@allhealth.org and we'll work it in. Yes, go right ahead.

MARY AGNES CAREY: Hi, I'm Mary Agnes Carey with Kaiser Health News. Talking about the regulatory process, some groups make their comments known, comments they're giving to the Department of Health and Human Services to writing the regulations.

How do you find the comments from the groups that don't necessarily make them public, aren't giving them to you? How

much time are you spending reading these comments and how do you track those and follow those through the regulatory process to see how they shape the regulations? We've only had a couple regs so far but sort of how are you managing that with your workflow?

ED HOWARD: That's a good question. Let me just clarify. You're talking about the agency having issued draft regulations or interim final regulations?

MARY AGNES CAREY: For example, [inaudible] and so on as you go forward how are you [inaudible]?

ED HOWARD: Anybody want to take a crack at that? Go ahead.

NOAM LEVEY: I can tell you I'm not doing as much as I should. I mean I have reached out to organizations to try to keep track of it but I don't know that I have a good suggestion for getting them other than going to the organizations directly, sorry.

ED HOWARD: Anyone else want to take a crack, Phil Galewitz?

PHIL GALEWITZ: I don't have the website on me but there is a federal website like we've been doing some stuff with the web portal contract that's going to come out and there's a federal contracting website.

Sort of every federal contract that goes out is on this website and we'll make sure we get this to the Alliance so they can print it but on this website it usually lists sort of, has an interested parties section to it. They won't all have to bid but interested parties who want to get information about these federal contracts, some of these contracts might be related to things in the reform. I think that's one area. That's new to me that I just discovered.

JULIE ROVNER: Yes. I have to say this is, the whole regulatory process is not a very radio friendly story. I've been agitating to do more with it because it's obviously really important to how this comes out. There's an enormous amount in this law that is to be decided later and later means in the regulatory process and obviously as you point out finding out what the agency decides isn't necessarily dependent on the comments but it would be interesting to track.

It's more interesting to track back later what the agency decides and see who urged them to decide that. That's

not necessarily going to be a quid pro quo. They're going to decide what they decide probably regardless of the comments. As you know, for a lot of these big regs, there's going to be 30, 40,000 comments.

I don't think there's anybody that's going to be able to read all the comments but certainly the major players are pretty eager to, I'm doing a story right now, I won't say what it is, but I already just in making calls, it's like oh did you see our comments up on our website and I said no I didn't and so oh I'll send them to you. So it tends to be not that hard. If they're making comments to a federal agency, they're usually pretty happy to give them to you.

PHIL GALEWITZ: The only thing I would add, I mean the regs, I think in this case, can be pretty exciting because there's a lot of sway how much of an impact a lot of the law will have will depend on the regulations.

I mean I wrote a story with Mary Agnes Carey a couple weeks ago on the grandfathering clause and we're still waiting on the regulations to come out on well what is a grandfather, how they defined what's going to be grandfathered and what's not is going to have huge implications.

ED HOWARD: Thank you, Phil. Other questions? Yes sir, on my right.

CHRIS SILVA: Thank you. Chris Silva, American Medical News. Are you having problems sometimes digesting what is actually in the bill? I've had sources tell me that they will pull in a team of lawyers sometimes before they can actually understand what the heck some of it means. So I mean do you have to read over it, re-read it again sometimes? Do you have, perhaps, a staff or other folks helping you out just to kind of get what exactly it's saying?

ED HOWARD: Let me just say that I've been in sessions where the committee staff who presumably wrote it said, in response to a question like that, gee I don't know or yes and no respectively. So that's a very good question. Julie?

JULIE ROVNER: Just after the bill passed, I was doing a Q&A where we had listeners send in questions about what it would do and I can't remember what the question was but I wasn't quite sure of the answer. So I sent the question to one of the staffers, actually sent it to the Senate and to the House staffer about what would happen to this person. I got four different answers.

JOANNE KENEN: From two people.

JULIE ROVNER: No, four different answers from four different people.

JOANNE KENAN: I would think that there's two issues here. I don't think any of us have a staff figuring out for us but some of the law firms do have some webcasts that are open to media and you. I mean their time doesn't mean they sit through a webcast but some of them do help.

I think one reason it's more ambiguous than some laws we've dealt with, part of it's scope. It's enormous but the other thing is remember it's the Senate bill was written to get 60 votes in the Senate in December of 2009. Nobody thought that was actually going to be the legislation. It was like a really good draft and it ended up being a law with some modifications. People thought it was going to go through more iterations.

So when you try to go out and do reporting, I've actually just written a piece about states, I mean an awful lot of it is to be determined. So we really don't know. I have found one pretty good detailed summary and it doesn't answer all your questions but it's the most detailed accessible one I can think of as the CRS, Congressional Research Service that's online. It's about 50 pages or so.

JULIE ROVNER: The other thing I know from years and years of doing this is that reading anything that's written particularly into Title 18, which is Medicare, you almost have to pick up the code, the federal code, and lay it side by side. That's pretty much the only way to read it, reading it, I mean that made me incredibly insane last summer when people said I've read the bill. It's like you cannot read anything that's written into the Medicare statute on its own and have it make any sense.

You have to read it as it flows back into the Medicare statute. It's like saying that you've read it. It's like reading ancient Greek. It's like you cannot possibly pick it up and read it and have any idea what it means unless you actually are sitting with a copy of the code next to it.

ED HOWARD: Just to clarify, that's because what the law that gets signed says is we hereby amend section 18, 16 of the code or the Social Security Act and you've got to see what that is to see what it is they're amending and how.

JULIE ROVNER: And if you don't know what it is that

they're amending, it means something totally different.

ED HOWARD: Yes, Noam Levey?

NOAM LEVEY: One of the things that, just one other suggestion I guess I would make is, I mean is ort of tried to basically cross reference what my understanding is with various people who are interested in that particular section. So for instance, if you're talking about grandfather plans and so forth, there is a lot of people who are getting paid a lot of money in this town to try to figure out what grandfather plans actually means at this point.

Now going to them doesn't mean you have to take their word for it but if you're getting, I've been sort of bouncing it off of lobbyists that I know and others as well as staff with the caveat that Julie mentioned that there is often not agreement.

ED HOWARD: Let me just take a question, thank you very much, take a question that has come in from one of the listeners on the conference call who wants, it's Diego Abrezzio, from the Kaiser Family Foundation in el Diario la Prenza, did I say that right? The question is what is the timeline of health reform news from today to August 2010 to pay attention to? How about that for a short-term goal?

You've already ticked off half a dozen things that could be on that list. What do you think's the most interesting, the most important? I think we have people who are writing stories. How about the high-risk pool? Talk about that for a little bit.

JULIE ROVNER: The high-risk pool is to start July 1st. we've got 28 states, I believe, who have expressed a desire to run their own. The rest will be done by the federal government. So that's the next big thing that comes out. Remember we've got this small business tax credit that's already up and running, the young adult coverage, which doesn't start until September.

I think again not having a timeline in front of me, there's not that much else that happened between now and then. Do you have it?

NOAM LEVEY: Yes, a couple of other things, obviously the new web portal, which is sort of going to be a precursor for the exchanges actually is supposed to start July 1st. it's going to be a listing of every individual and small group health insurance plan that's sold in the United States, which

it sounds pretty interesting.

It's going to be pretty useful in the first several months because it's basically just going to be a Yellow Pages and it won't list any benefits or any costs. It's just going to be a list. The real use of it will be several months down the road when it will list costs and benefits you can actually use to shop for plans.

ED HOWARD: It is supposed to be organized by state, isn't that right?

NOAM LEVEY: Yes. I can't remember the deadline for the return but the grant solicitations have begun for states to step up their insurance regulations. They'll be coming back with their proposals for how they plan to do that. That may be something to watch this summer.

ED HOWARD: How about that medical malpractice grant program, when is that—

NOAM LEVEY: 2011, next year.

JOANNE KENEN: The ARC was going to put out the grants in September but I got an email the other day telling me I should look at their website it's going to be sooner. So I don't know when. I mean I guess sooner can mean sooner than September, could be August 30th but I've been looking at the website.

Then there's the other set of programs. It's two malpractice, one was done before the bill passed. It was just through Obama issue regulation and set up that grant program. There's another $50 million in the bill for pilot projects run by the state. I think that's 2011 but I may be wrong about the date. There is a date in there.

ED HOWARD: We actually have a question from Lindy Washburn from *The Record.* I guess that's the *Bergen Record,* which falls into the very timely category. Could you talk about the doc fix and its roots and permanent solution? I'm looking for ways to balance the message that doctors are putting out to their patients about refusing to take Medicare patients any longer because of poor reimbursements.

One doctor even, something, called the owner of the newspaper and asked for coverage at this issue. Another part of that bill is FMAP, that is the Federal Medicaid, something percentage, Assistance Percentage, which is the—

JULIE ROVNER: Federal Matching Assistance Percentage.

ED HOWARD: Thank you. The federal share of Medicaid, it has big state budget implications but it's hard to interpret or explain what's going on in Washington regarding this. Do you have any suggestions for background information?

JULIE ROVNER: Well that bill was, that's what I've been doing for the last two weeks. The bill is on the Senate floor right now. It's a tax bill. It's actually called the Tax Extenders' Bill. This has sort of been the bane of my existence for the last oh, yes, pretty much 10 years. I just keep this, now it used to be Congress would set this aside for years, sometimes two at a time. Now we're down to doing it every month. Just for those of you who aren't following it as painstakingly as some of us, is a 21-percent cut.

Thank you very much pretty much Republicans in Congress who, before they left in 2006 when they were still in charge, decided to put off the cut to get rid of it and rather than pay for it, just make the cut bigger in the ensuing years. So it just kept getting bigger by not having it.

Now it's up to 21-percent, which pretty much everybody agrees is a non-starter. The Democrats in the House put off the, tried to get rid of the cut and put it in the health bill but when they realized it would cost $250 billion that made the cost of the health bill too big. So they took it out.

Then the Senate tried to put it through unpaid for by itself last November and they couldn't get enough votes because all the Republicans voted no and some of the Democrats voted no too. So they can't seem to find a way to pay for it.

They can't seem to find a way to not pay for it. They can't seem, in other words, to find another way to fix it at all. In the mean time, everybody, Democrats, Republicans, doctors, the AARP agrees that doctors on Medicare should not be asked to take a 21-percent pay cut. This is not what we usually talk about in Medicare reduction in the increase. This is a cut. This is a 21-percent cut.

So I think quite reasonably one would expect doctors to probably at least stop taking new Medicare patients if not stop treating the Medicare patients they have. I mean this is the real deal. They've been trying to get this through, as I say, a month at a time.

Every time we're in this huge game of chicken, the last delay expired on June 1st, what Medicare can do is what they're

doing now, which is hold payments for about 10 days and not pay them in hopes that Congress will fix this before oh the 10th of the month, which would be today although I can think it's business days so you may have another day or two.

Meanwhile the Senate is rather slowly pushing its way through this bill, which as the caller points out also has some money for to help states with their Medicaid costs and it did, in its last couple of iterations, extend money for subsidies for COBRA, for people who have been laid off to continue to pay for their health insurance although that hasn't made it into this current iteration again because they're having trouble figuring out ways to pay for it. This is getting to be sort of like the bad penny that keeps coming back.

On the one hand, they don't want to find ways to pay for it. On the other hand, they want to keep doing it and it keeps going around and around and around. As I say now the Senate seems to be in no hurry to get this done although as I mentioned, this 21-percent cut is in the process of taking effect.

Now I've had recently a couple of reporters suggesting that this is doctors crying about not getting their raises but I think this is a fairly serious thing if you're a doctor or if you're a Medicare patient.

PHIL GALEWITZ: I think the story at the local level on this is what are doctors doing in reaction to this? I mean doctors in the AMA have said for years well it's going to be more and more people leaving Medicare but the data has shown MedPac year after year, that the percentage of doctors in Medicare has remained pretty steady right?

JULIE ROVNER: They've never taken a 21-percent cut.

PHIL GALEWITZ: Right, right but it hasn't gone into effect either. They've been threatened with it. So there's supposed to be a balance that as reporters we face is that on the one hand they're faced with this threat and they threaten to leave Medicare yet the data so far shows that they're not but I think there's a lot of stories to be done in the community about what are doctors doing to raise revenue or what are they doing on the side if they're so threatened with this, then are they running to join integrated groups?

Do they want to be owned by their local hospital and typically not. I think there's a lot of good stories to be written about how are doctors, because they're business men and women, and how are they reacting? What are they doing facing

this?

ED HOWARD: Joanne Kenen?

JOANNE KENEN: Phil just made a few of the points I would have but I think you can look at a few things. I mean we’ve heard doctors saying we’re not going to take Medicare patients anymore for 10 years now but we have never seen a 21-percent supposed, I mean I don’t think any of us think that there will actually be a 21-percent decrease but I agree with Julie, this is a different magnitude but I think there are a couple things you can do story-wise.

I think look at some of the data in your community and the Dartmouth data are also where some doctors, not all, some doctors, they get paid less per visit, they just do more visits. There are places that see their hypertension patients every couple of weeks. There are other places that’ll see them once a year.

So what is your community doing and is it changing? If you can find that out, I mean there’s not up-to-date data lists for every practice in town.

Anecdotally, you’ll find stories like that though. The other thing though is there’s this really big disconnect because here we are having this huge fight about payment and fee-for-service medicine for Medicare, at the same time that we’ve just had this legislation that’s supposed to pave the way toward new payment systems and new incentives.

So it’s one of the many cognitive disconnects I think in the health care system but I think that to talk about what Phil was doing about looking at doctors as business men, there’s also a lot of stories in the way younger doctors expect to practice versus the 50-year-old practices of two and three doctors, the Wednesdays and Tuesdays they call them. There’s some evidence that’s sort of come out.

You can talk to local doctors, what’s your nearest medical school because I think talking to young doctors, what they don’t know about the health care system is sometimes, I mean I’m not supposed to know more than they do but what they think that they can give their patients or how they think the world works is actually sort of an astonishing story sometimes.

ED HOWARD: Before we leave this question, can I go back to the other half, which was the federal matching percentage of Medicaid money. How critical is that say relative to the doc fix?

JOANNE KENEN: If you're a state and you've already put that money in your budget and your legislature has gone home, which is something like 38 out of 50, it's a lot of money. I mean it's huge. So I personally think that something will happen in Congress because red states and blue have already put that in their budget.

JULIE ROVNER: Yes. What actually happened is that the House passed the bill without the Medicaid money in it but the bill that's on the Senate floor has put the money back.

ED HOWARD: Noam?

NOAM LEVEY: One thing just to broadly to think about in the context of this FMAP debate is sort of I don't know that it has sunk in yet necessarily that the big shiny new health care system that sort of is envisioned as this super highway, which begins in 2014 but we're going on this rutted dirt road that is basically collapsing between now and 2014. States are struggling. They need the FMAP money just to maintain their current Medicaid coverage.

I mean there's every indication that employers are going to continue to sort of slice away at the benefits that they provide. Premiums are going to rise. So there's something to think about is to get back to what Phil was talking about earlier that in some sense, the stories are the same as they've always been. Those sorts of problems that everybody's had with the health care system aren't probably going to get addressed by an extra $5 billion for a high-risk pool between now and 2014.

ED HOWARD: Okay. Yes, right over here if we could get a microphone.

KYUNG SONG: I'm Kyung Song with the Seattle Times. What do you think are the major regulatory decisions particularly at the federal level that would really ultimately determine what this health reform bill accomplishes?

ED HOWARD: Do we have enough time to get an answer to that question? Joanne Kenen, are you going to take a crack at that?

JOANNE KENEN: Well I think there are probably a thousand but we don't know what the exchange is going to look like. I mean we know that there's going to be some kind of federal parameters. We know that states are going to have leeway on how they meet those parameters but we really don't

know what the federal, we know more or less what Medicaid looks like. I mean they're going to get a lot of money for the expansion. They're not going to get more money for the current, there's two populations of Medicaid.

There are the people who are currently eligible, only was it roughly 60-percent, real round numbers, I may not have this exactly right but roughly 60-percent of the eligible people in the current system are in Medicaid.

Don't quote me on that exact number without looking it up but I'm in the ballpark but there's this whole new world of newly eligible Medicaid people up to 133-percent of poverty including childless adults. That's a huge change.

The federal government is going to pay the bulk of this FMAP thing we've been talking about. It's different for this new population. The federal government is going to pay about 95-percent of that from 2014 to 2019. So that part, we know what's broken in Medicaid.

Lots of things are broken in Medicaid. We know what it looks like. We really don't know what, I mean think of how a state like Oregon is going to build an exchange versus a state like Utah. I mean they're going to look very different. So I don't even think HHS really knows what. So if I were to ask what's my big regulation question, it's what's the ceiling? What do the states have to do for the exchange?

ED HOWARD: Phil Galewitz?

PHIL GALEWITZ: I'd add to that on the exchanges. What are outside of the exchanges? What's going to be the market outside? If the market outside remains relatively big, you could basically just get all the sickest people inside the exchange and healthy people be outside the exchange.

JOANNE KENEN: Except the subsidies are on the exchange.

PHIL GALEWITZ: The other fact that you have to look at is that I'm waiting on is this, how to define a grandfather plan and are they going to define that if you make a simple change to a health plan, if you change co-payments or a change of deductibles, a change to the premium, does that end your grandfather status or does it have to be something?

Health insurers basically say you should be able to do almost anything and keep your grandfather status and if you can keep your grandfather status, it means you don't have to follow

many of the new rules that will go into effect such as eliminating cost sharing because eliminating cost sharing you may not have to do that.

So health insurers are really pushing. It's a big debate going on right now and I think that's why the White House and the administration hasn't met with regs because they don't know what to do because it's a question of the President said, in the outset of the debate, was if you like your plan, you can keep it. Well that's great but he also said well we want to fix the broken system and how do you balance those two things? That's what they're struggling with.

JULIE ROVNER: I'm really interested in what they're going to come up with on some of these new payments systems and how they're going to define some of these things. Obviously the big medical loss ratio fight was what's a medical, what's administrative versus what's medical. That's going to bleed over into some of these new payment systems in Medicare about the medical homes and the accountable health organizations.

I mean some of those are not technically regulatory but in setting those up, this new center for innovation, so I think that's going to be, in the end, what's going to determine whether or not this law really does work to kind of bend the cost curve and change the paradigm about how health care is delivered.

I think those are, in the end, a whole lot more important than some of these things about which everybody's fighting and everybody's concerned for how well this works in terms of making people, of the current marketplace, but I'm thinking much longer term whether this works in terms of creating a new paradigm about how health care's delivered and paid for.

ED HOWARD: Hang on just a second Craig. Let somebody get to you with a microphone. By the way, we have only about 10 minutes left. So I would ask folks who are asking questions and our panel to be as brief as they can in the exchanges. Yes, Craig Palmer?

CRAIG PALMER: I just wanted to say look beyond the usual suspects where you go to find the answers to that. The HHS and the ancillary, look at the IRS for instance, we're going to do a lot of defining of how this is going to go, tax on devices, the SFAs, there's fertile ground beyond the HHS, which we presume is going to be the major arbiter and it'll have a great impact.

JULIE ROVNER: The Department of Labor is going to play a very major role in a lot of this.

ED HOWARD: Thank you. Yes, we have someone, do you still have a question? Yes?

MAUREEN GROPPE: Hi, Maureen Groppe with the Gannett Washington Bureau. I write for Indiana papers and the Governor of Indiana has spoken out a lot against this. He was here this week. He's going to be here next week. He's been in the Wall Street Journal. I wondered if there are others, other governors who are speaking out as forcefully as he is against this or if he kind of stands out there as a notable on it.

ED HOWARD: Phil?

PHIL GALEWITZ: Well Haley Barbour's been very vocal as well. A number of the red state governors have been pretty critical of this. I mean funny thing, I was listening to the Indiana Governor talking, I think he said part of the reason for his projection that the state couldn't afford to do this was because 100-percent of all eligible people would sign up for Medicaid. So it's just a caution to again sort of take what is said with a grain of salt.

ED HOWARD: Before we go over here, let me just take a couple of questions that together I think should be on other sides of the same coin. One from Felice Freyer at the *Providence Journal* says she'd like some suggestions on how to make these stories interesting to average readers. How do we get over the wonk echo chamber effect?

On the other hand, Elizabeth Slowick from the *Grand Rapids Business Journal* says as a health reporter for a very small and business-focused publication, part of the problem in covering reform is finding anybody local who knows anything about it. Everyone seems to shrug their shoulders. What types of folks are the best local state sources and how about a go blue shout to Julie Rovner for that purpose? Either one of those stimulate an answer?

JULIE ROVNER: Well, hi to Liz who's a college classmate of mine -- the nice thing about health care is that everybody uses it. So it's easy to find local people. That's not to say that you can't find local people who use health care and then find national experts to comment. That's obviously an easy way to do your story, find local small business people, what are they doing and then you can get your experts from out of town.

You don't necessarily need to find your experts in town. You're probably not going to. As we point out that even the experts here, even the people who wrote the bill don't necessarily agree on how it's working but you can certainly find your local people who are impacted by it because everybody's impacted by it and then go outside to find the people who can comment on it.

ED HOWARD: How do you find the people who don't reinforce that wonk echo chamber that the other reporter's asking about? Where do you find people who talk English?

PHIL GALEWITZ: Sometimes that's a reporter's job. I think we got to know how to speak these other health reform languages but then turn it into languages that we just can do. So I guess sometimes it's hard to look for a good quote. I've been in this business 20 years, if anybody can help me to get good quotes, I'm happy to have the advice but I think it's understanding the language and reaching out and talking to, bringing the story down to its localest level.

That would be my two cents to the local reporters because I've been there and talking to the hospital CEOs, talking to doctors. You're not asking them what's in the bill and I wouldn't ask them how would you be affected?

I would ask them today what are you doing to control costs. If I was meeting with a hospital CEO, you're going to get less money from Medicare and they know that. That's pretty simple. What are they doing to control their costs and talking to health insurers, what are they going to do? They're going to have less money to do and how are they reacting to that?

ED HOWARD: Yes, Noam?

NOAM LEVEY: One thing to add. I mean I think Phil's absolutely right. The people are actually practicing, the people who are running hospitals, running medical clinics, running insurance companies. They don't tend to talk as much in jargon at least in my experience because they're actually down there figuring what nuts and bolts are, it's sort of people in Washington, the quote/unquote usual suspect experts. We tend to sort of get lost in that big policy sort of wonky talk.

ED HOWARD: Can I just throw in that one of the answers to that question that Phil Galewitz' comments evoked from me based on a conference that I've been going to the last couple of days, you might want to talk to the big employers in the area because they're the ones who are telling the insurance

companies what they're going to be allowed to do to hold down costs.

PHIL GALEWITZ: Right and the big employer is often your local school district. In most towns, it's the schools and it's your city and City Hall and it's government in the large majority of towns in America.

JULIE ROVNER: And the hospitals.

PHIL GALEWITZ: And the hospital itself ironically.
ED HOWARD: Yes, over here.

JEFF YOUNG: Hi, I'm Jeff Young from Bloomberg Government. We all try to do our best to exhaustively cover the contents of this legislation as it went through Congress but speaking for myself, after the President signed it, I kept running into things and going wait, what's in there? Some specific fairly interesting things and I won't go through and list them now partly because it's sort of embarrassing but that said, I'm wondering if you guys have examples of stuff that you had a wait, what moment sometime in March, April, May, or maybe earlier today.

ED HOWARD: Or June or July?

JOANNE KENEN: I think we're going to be having them through 2014. I mean every time you look at the bill, you do find, I mean Kaiser Health did a story a few months ago about like mid-wives that I didn't know about. I guess the nursing mothers, I actually knew about so I don't know what that says about how much time I spend reading this stuff but the menu label thing, which Julie mentioned, it's been really covered. And talk to anybody, they don't know what's in there. I mean I think we're all still being surprised when we read.

JULIE ROVNER: I still have a few but they're on my story list that I don't really want to share with a lot of other reporters right now.

ED HOWARD: I'm going down one of the many timetables that have come across my desk and one of the ones I start has a date of July of this year and it is described as the interim final rule, the deadline for it, for designating medically underserved areas and health professional shortage areas through negotiated rule making.

Now this is a big deal for distributing the money that pays the salaries of the National Health Service Corps people and the debt forgiveness allocations for med students to serve

in these areas. So there's one to pay attention to.

JULIE ROVNER: And the debt forgiveness just got increased in this bill by, I believe, to $50,000 a year too.

NOAM LEVEY: I mean one piece of advice I do and I'm a little ashamed for Kaiser again but they have this great summary and it's like a 14-page summary, it's pretty small typing. It's got a lot of stuff in there but even when you go into some of these things when it lists some different benefits and new programs, and then what you do is you go into the bill and you hit control-F and then you find the details in the bill even getting into extraordinary more details.

I think there's a whole avenue, so many stories through there. So that's what I would do, read the summary, a lot of details there and then do that and try to find them in the bill.

ED HOWARD: We have time for just one or two more questions right behind you Jill.

JILL WEXLER: A really quick stupid question. I'm Jill Wexler. I write for a trade press for a pharmaceutical and insurance Industry. Is there consensus on the name of this bill [laughter]?

PHIL GALEWITZ: It's not a bill.

JULIE ROVNER: It's a law.

JILL WEXLER: I have noticed that all the HHS press releases are now just calling it the Affordable Care Act and everything else before that, in fact I'm looking at *Health Affairs* state patient protection affordable care act, I saw some reg recently that explained that it's combining two bills or something into the Affordable Care Act. Maybe somebody can say is there a consensus among journalists who try and get things accurate?

JULIE ROVNER: No, I had an argument online. I can't remember whether it was on the AHCJ List or, there was a big fight about whether it's PPAC, I mean just about the acronym whether it's ACA or PPACA. Of course it did. I mean the reason that it did combine, the reason there was no printed copy of the final law for so long is because it did combine, remember it combined the Senate version of the bill with the reconciliation bill and it took a while.

Someone quietly told me that there were actually

mistakes and it was sort of hard to put them together, which happens when you're doing that kind of legislating but no, I have not actually and I've seen official, both White House and HHS stuff that has referred to it both ways. I know, it's a fascinating anthropological thing to me. I have not seen any consensus even from official sources about which it is.

ED HOWARD: Noam?

NOAM LEVEY: Actually this reminds me of just one caution that I would urge too if you are going through the bill and you do find a section that you're interested in, you want to go read it, make sure you check the end too because the managers' amendment that Senator Reed did end of last year is attached right now at the end of the bill.

I made a mistake of going to check legislative language on something I was writing, I saw it in the bill and forgot to go check, oh you know on page 900 it says way back when on page 200, actually we were going to do this so be careful.

JULIE ROVNER: That's right, remember. Yes so it's really three things. It's the Senate bill as amended by the reconciliation bill as amended by the managers' amendment.

ED HOWARD: Got that [laughter]?

PHIL GALEWITZ: So bottom line, let's just call it the health law.

ED HOWARD: Well I think we have, yes, we have one last question we have from Barbara Feder-Ostrov at the California Endowment Health Journalism Fellowships. What issues are you covering relative to electronic health records? There is a ton of money to develop them and hospitals are now wrestling with meaningful use definitions. What are some of the uncovered stories in this area, $19 or $25 billion worth?

JULIE ROVNER: I guarantee it is not a radio for that. That's the ultimate not radio friendly story.

PHIL GALEWITZ: But that's a story that's not really Dis-helpful. That's a story, well that's been a story for years and years but that's the stimulus. That's the money from the stimulus that was passed what 14 months ago and the big money of that comes out next year.

That's a huge story because I think it's what $20 billion that's going to help doctors finally go online because that's if they had to discover it in 2011 but the money from

that actually flows out to doctors. It's supposed to flow out next year.

The money that's been starting to flow out this year is what they call these regional RIOs I think I call, some regional organizations that have slowly gotten some of the money.

So I think it's a huge story. I think it becomes a huge story next year when the billions start flowing into doctors' offices and how they decide which doctors and which hospitals are eligible for that money and then which companies get chosen to put standards together and which companies can put out these new electronic systems.

ED HOWARD: That is going to be the last word Phil Galewitz. Thanks to Phil and Julie and Joanne, Julie Rovner and Joanne Kenen, Noam Levey. Thanks also to the Robert Wood Johnson Foundation and the Association of Health Care Journalists.

Thanks to you both in the room and on the line who kept it lively and made us realize how many more stories there are to tell. Thank you for coming and we'll see you next time [applause].
[END RECORDING]