



The Next 100 Days: Some Final Hurdles to Health Reform
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name's Ed Howard with the Alliance for Health Reform. On behalf of Senator Rockefeller and Senator Collins and our board of directors, I want to welcome you to this program, a look at what might be in store, over the next 100 days of debate over health reform or insurance reform, these days I'm not sure. The partner in today's program, we're pleased to say, is Robert Wood Johnson Foundation, America's largest philanthropy that's working to improve health and health care. You'll hear, in a few minutes, from the CEO, Dr. Risa Lavizzo-Mourey.

We're right at the cusp of a period of a few months when we're either going to get to yes on a substantial initiative to reshape the American health care system or we won't. What's at stake is not just the \$2.5 trillion we're going to spend this year on health care in the U.S. and more in the years ahead of course but the quality of lives, maybe even the fact of life for millions of people who lack access to affordable quality health care.

Everybody knows that President Obama will probably launch this next phase of debate with his speech to the joint session of Congress next week. The reason these weeks are so crucial is and you may have heard this before, there is still a

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level of disagreement about what to do on some of the major issues in health reform.

In fact, there's some controversy about almost every major element of the packages that are being debated. Congress and the President are going to have to come to some agreement on these major issues or agree not to decide some of them if there's going to be a significant reform plan enacted. That's what occasioned today's meeting.

We brought together some of the best health policy analysts in the country to address as many of these issues in response to your questions as we can cram into the next 75 minutes or so. So without further filibustering, let me present my co-moderator and the President of the Robert Wood Johnson Foundation, Dr. Risa Lavizzo-Mourey. Let me just say she is a geriatrician by training. She still sees patients.

She also, sort of on the side, runs the largest philanthropy in the country devoted to improving the health and health care of all Americans. She's not only going to serve as a co-moderator but I hope be taking an active part in the discussion as well. Risa, thank you for being with us.

RISA LAVIZZO-MOUREY: Ed, thank you for hosting this and inviting me to be co-moderator. This is obviously a critical time to have this conversation. The Robert Wood Johnson Foundation has been working on this for a long time.

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Back in January, if we can all remember back that far when we began talking about this debate in earnest, we laid out six big areas that we thought needed to be addressed in order to achieve what we all want, which is a healthier population and health care for everyone. So first we need to have coverage.

We all, I think, agree that having the equivalent of 24 states without having health coverage is unacceptable. It's unacceptable because if we don't cover everyone, it's hard to see how we're going to get to the second thing that most people agree we need, which is higher quality, higher value health care, and more equity in health care.

You can't get to that without having everyone included. We have to address issues of health care spending. We're spending, as you've already mentioned, \$2 trillion more than any other country and yet we don't have the highest quality care.

The next area we identified as being critical is prevention. We all have had a lot of debates over these last hundred days about clinical prevention but I think most people agree with the data that primary prevention and community-based prevention does lead to healthier people. That ultimately is going to be needed if we are going to reduce the burden of illness in this country.

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Then there are a couple of other things that are absolutely critical in proving the public health system and addressing what makes us healthy in the first place, that is those things that happen outside of the medical care system, the social determinants of health.

Now these last two -- it's hard, in today's environment with all the heat that we've had over the last month, to see how we're going to get to all of those things in the next hundred days. But I hope that, as we have this discussion today, we stay focused on the fact that what most Americans want is affordable, high-quality care that is accessible to them when they need it.

That is something that I think most everyone can agree on. Hopefully we can bring out during this debate, that doing nothing is not an option.

The Urban Institute's study, recently, showed that if we don't take action, we're going to have more uninsured, higher costs and probably higher costs of the government as we need more people to be enrolled in Medicaid and the like. So doing nothing doesn't lead to universal coverage. It'll just lead to universal pain. With that, Ed, I turn it back to you.

ED HOWARD: Thank you. Thanks very much, Risa, and I think the paper, the Urban Institute paper about the cost of inaction, is in your packets. Quick logistical note: you have

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in those packets not just that paper but extensive biographical information about our speakers and a lot of background information.

If you happen to be watching this on C-SPAN and have access to a computer, you can see all of those materials on our website, which is allhealth.org, and follow along. In about a week, there'll be actually a transcript of this session that you can read on that same website.

Speaking of websites, I would commend to you healthreform.org, which is organized by the Robert Wood Johnson Foundation. Darn, you stole the URL I wanted, but it's got lots of useful background information and I commend it to you.

We're going to just kick things off by asking each of our panelists a single question, letting them respond, and then we'll give you a chance to weigh in with your questions. Any problems or questions that you have, Bill Erwin, our communications dDirector who did all the heavy lifting putting this session together, will be delighted to help you. And Adam Coyne from the Foundation is also here who can answer some of your questions.

So let me give the briefest and least deserved introductions that I can for, that I can get away with for our panelists. We're going to start with Gail Wilensky. She's an

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economist and a Senior Fellow at Project HOPE. She has run the Medicare and Medicaid programs.

She has served as President George H.W. Bush's Health Policy Advisor. Her current areas of concentration also include military health issues, which she has described as one of the greatest fascinations she's run across, and comparative effectiveness.

Dallas Salisbury, at the far end on my left, is the CEO of the Employee Benefit Research Institute, headed its staff since its inception in 1978. If you haven't discovered EBRI's resources yet, you've been missing out. What Dallas doesn't know about employment-based coverage, probably you don't need to know.

At the other end of the table is Ken Thorpe. He's also an economist. He heads the health policy department at Emory University. He's also the driving force behind the Partnership to Fight Chronic Disease, which is a group of more than 100 national organizations of every stripe that's trying to shape a health care system that prevents and treats chronic conditions better.

Now let's get to the questions to start this off and Gail, why don't we start with you. I mentioned your connection to Medicare, and Medicare plays a big role in the plans that are being developed from generating savings that are going to

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be used to offset expansion of coverage, costs, testing new models for payment to improving the drug benefit and a whole range of other things.

Are most of these provisions likely to survive? And how should Medicare beneficiaries like me or, for that matter, the rest of us, feel about those provisions?

GAIL WILENSKY: I've regarded the proposals affecting Medicare that we have heard thus far, in many ways, as a metaphor for some of the challenges that are facing health care reform in general. The Medicare program has a clear sustainability issue. It has made promises (that) it is not in a position to fund as of yet. There are clinical appropriateness and quality issues, as is true for the rest of health care.

In some ways, it is even lagging further behind the rest of health care in terms of moving toward integrated delivery systems and more management of chronic disease.

We see the challenge that Medicare and health care reform, in general, face very clearly in the proposals that have been laid out to raise money. What the administration is looking for in order to finance health care expansion is quick money because it's clear we can spend money very quickly in order to expand coverage. Massachusetts has made that very clear.

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The problem is that many of the changes, while ultimately likely to benefit the system, Medicare, and produce savings over the long term, might not do so in the short-term.

I want to use two examples to try to clarify the tension and challenges that the administration and the Congress face in trying to come up with sure money quickly versus doing things that, in the long-term, are likely to provide sustainable, important (savings) but probably not much money that would be scored by CBO in the short-term.

One is reducing inappropriate admissions. This is a major piece of funding that the administration has listed as a potential funder for health care expansion. One out of five admissions to Medicare is for readmissions, some of them appropriate, many of them inappropriate reflecting quality problems in the admission itself.

So you might say, well what's the problem here? The problem is (that) the way you reduce inappropriate admissions best is by getting nurses to follow patients when they're discharged to make sure that their medications have been fulfilled and are being taken, and that the doctors' appointments or nurse practitioner appointments that are necessary are scheduled and met.

All of these take money in the short-term. It's particularly problematic when you look at where there are large

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numbers of hospitals with high readmission rates. They happen to be rural and disproportionate share hospitals. For those of you who don't know what that means, they have a lot of Medicare and Medicaid patients. Now, since Medicare reimburses hospitals at a minus six-percent rate, that means not covering the cost.

Medicaid, frequently, does worse. It means that the hospitals that are most likely to have these inappropriate admissions are the least able to be able to finance the kind of strategies in the short-term to fix the problem -- rurals and those that have a lot of Medicare and Medicaid (patients).

Can it be done? Absolutely. Will it produce savings? It will. The problem is the tension. You want money now for expansions. Most of what we need to do will take some time.

A second one is nursing home rates. It has been known for a long time that Medicare is a relatively generous payer for nursing homes but it makes up for some of what Medicaid does not pay for nursing homes.

If you pull out money for Medicare, which as a former Medicare person I have some sympathy to, without making sure that the other big payer, Medicaid, changes its reimbursement strategies, you are going to put what has been a pretty fragile area of health care into real financial distress. Nowhere do I see additional monies for that.

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So these are the tensions. You need to slow spending. You can do it but the ways that you get money quickly are not the ways that produce the kind of changes you need to improve quality. It's a dilemma.

ED HOWARD: Okay. Thanks Gail. Let me turn to Dallas if I can. Dallas, all of the bills that we've seen emerging, at least on the Democratic side, seem to affect employers substantially and directly, either imposing some requirements or some alternative taxes that would have to be paid to provide or pay for coverage for their workers. How do you characterize the position of big employers or, for that matter, small employers on the reform proposals that we've been seeing so far?

DALLAS SALISBURY: Well some things, Ed, are a sense of déjà vu, as we started doing our surveys and data on this in '81. Consistently, if you think about employer opinion, the number one issue that they've always cited is similar to what Gail just noted, which is cost.

A genuine view across all entities -- that is similar to where the President is and the Republicans verbalize things -- is the unsustainability of the existing system, be it public or private, on a cost basis. They include employment-based coverage in that.

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The second reality that employers deal with across that spectrum, and have for decades, is the key role that they recognize health insurance plays in (employee) attraction and retention and even in the exit decision. Our value-of-benefit surveys that go back to the early 80s repeatedly underlined about 80 percent of workers say that health insurance is deemed number one - (the) most important supplement to pay. If you then say, "if you could have a second benefit, what would you want?" Thirty-six-percent say more health insurance.

When asked, are you willing to take a reduction in current wages in order to have better health insurance, over 50 percent consistently say "yes." Then you take another factor, about a third say that they are in their current job because of the health insurance.

So if you want to keep people, that's a good thing. If you want labor force mobility -- some employers do -- that's a bad thing. But the other is that 35 percent say that health insurance was the key factor - the most important factor - in taking the last job that they took. So it's very important to job selection.

So employers are in a catch-22 of knowing cost is an issue, knowing that their employees want health insurance but against a third factor, the employer wanting choice and flexibility.

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That comes down to what big business has supported since the early 1970s when it was enacted in the Employee Retirement Income Security Act of 1974, called the ERISA preemption, which allows employers and quote, "self-insurers" to avoid 100 percent of state laws, state mandates, state differentiation.

Maintenance of ERISA has been a number one priority of all businesses since that point in time. In fact, in the current debate, if one tries to find a differentiation point on that, one can't because one of the strongest points made on the website and in speeches and in testimony by the small business end-- the chamber and the National Federation of Independent Business-- is what they want out of health reform is the ability for every small business to have the equivalent of ERISA preemption without even having to self-insure.

They want the federal government to say here is a high deductible, catastrophic protection program that is the barest of bare bones coverage and avoids personal financial disaster, which any small business should be able to provide on a nationally consistent basis through state, cross-border purchase, et cetera, et cetera with a structure, be it, called a co-op, be it called an association health plan so that they can avoid 100 percent of the current state mandates, state

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regulation, et cetera, et cetera. So there's consistency there.

The other piece of that flexibility that comes through from all of the groups is most readily identified as a total repudiation of tax change of employment-based health benefits, which the largest businesses (say) may be a little. But as the months have gone by, that seems to have dropped off and any willingness to discuss that.

In the Clinton years and during the 1980s, this was very heavily debated on Capitol Hill. The Tax Reform Act of 1986 included many, many debates and discussions, and so-called Treasury One in 1983 and 84 would have fundamentally changed the tax treatment of employment-based health benefits. So this is not a new issue, but the positions have not changed.

Then, on perhaps the most important issue in the context of House and Senate bills beyond the ERISA changes that are in the House bill that are uniformly opposed by businesses, are issues related to mandates, be they individual or employer mandates, across the business spectrum, when one looks and listens.

Any form of employment pay-or-play mandate at this point is generally uniformly opposed. Even though they've been willing to live with some of that in Massachusetts, that was a price of inevitability if you read some of the surveys.

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On the issue of an individual mandate -- some flexibility but not much. The general statement that businesses make across the board in their trade associations is that any cost savings need to come out of the system in order to pay for the universal coverage. It shouldn't be done in a way that leads to cost shifting. Thus, there also you will find in the positions and the surveys, fairly uniform opposition to the public plan or any government takeover but then I'll close with the final irony.

About the only business group, at this point, that has been willing to be aggressively what one might describe as negative, is the National Retail Federation. Almost all of the business entities and business groups have taken instead the position of: Plan A is the necessity of comprehensive reform because the current system is unsustainable. There is no plan B they all say. There must be reform.

Then if you look at the letters and the statements that they send to Capitol Hill, for example, one dated June eighth. Well, we've got problems with any change in taxation of health benefits. We don't want creation of a public plan. We favor no employer mandates. We favor no employee opt-outs and we want national uniformity in ERISA preemption, oppose all the provisions of the House bill related to ERISA. But we do still strongly support comprehensive health reform [laughter].

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If you go to the NFIB website, you get similar. If you go to the Business Roundtable there's, on their website, a full verbatim text of a conversation in early August and it's the same type of thing -- support for most of the provisions that Risa mentioned except when one gets to the specifics.

I was born and raised in the state of Washington at the feet of the great Senators Warren Magnuson and Henry Jackson. Warren Magnuson's staff produced the book, *The Dance of Legislation*, which is good reading for this topic and every other.

Henry Jackson, always at home, said look at, pay no attention during the process, because legislation is like making sausage. At the end of the day, you just hope for a compromise that has it tasting good. I think that seems to be where we're at here -- tremendous disagreement over the details but a recognition that employees want health care, that employers must make sure they have it but employers don't like being told to do anything. So they want a free reign tied to the current ERISA preemption. That seems to be universal.

ED HOWARD: Okay. See how easy this is going to be? Let me just finish off this initial round by turning to Ken Thorpe. Well, everybody who has spoken so far has talked about health care costs and certainly the bills moving forward have attempted to put some cost controls into their provisions.

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They've also been criticized pretty severely for not doing enough to hold down health care costs.

I wonder if you think that's a fair criticism and if it is, what changes would you advise Congress to make and the President to make in this final plan keeping in mind what the NFIB and the chamber were saying as Dallas was articulating.

KEN THORPE: Well, it's a tough starting point but thanks, Ed. If you take a step back and think about it, we started this discussion about health care reform really trying to address two major issues. One is to move towards universal coverage. I think there's, as Dallas mentioned, I think there's broad agreement about that as an objective. Obviously there's a disagreement tactically about how to do it but I think we have broad agreements about moving to universal coverage.

I think about 95 percent of the attention and discussion and reporting on the issue has really focused on that particular topic of the approach for moving to universal coverage. The other hand, if you think about it, the other thing that we're trying to do -- and if you go back and look during the campaign and how the candidates talked about this -- was to control the growth in health care spending. That was a major objective of health care reform.

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I think while the reform packages, as they stand, are a good start, none of these things are going to be perfect. I think the question is directionally. Is it moving in the right direction? I think so. But I think if we do this in steps, which I think we'll have to, this isn't going to be one bill and then we go home and forget about it.

This is going to pass something, I hope, and then we're going to come back and continue to improve on the legislation. But I think what we have to do is focus some more over the coming months and, I think, years on finding ways to control the growth in health care spending in addition to moving to universal coverage.

I think if we're going to be serious about it, we've got to go back to the basics about what's driving the growth in spending.

Gail kind of touched on one of the issues. We know that one (is) the share of adults that are clinically obese in this country has doubled since 1990.

That doubling, by itself, accounts for a third of the growth of health care spending; it's led to an explosion of diabetes, hypertension, back problems, asthma, pulmonary disease. You can go down the list, but the rate of treated chronic illness in this country is rising at a very rapid rate

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across the board: kids, adolescents, young adults, and seniors as well.

So we have to really pay attention, in terms of cost containment, to a broader tool kit than we traditionally used to really attack this issue of lifestyle but do it in a way that is not punitive. Do it in a way that's thoughtful. Do it in a way that gives people options about programs that work. If they want to make a change, they can. So targeting smoking and weight is one objective of health reform.

Two is that if you look at where we spend the money, 75 percent of the spending is on chronic illness. Indeed, in Medicare, 95 percent of what we spend in the Medicare program is linked to chronically ill patients, people that have four and five and six different conditions.

The irony is that Medicare is probably the only program where we do absolutely no care coordination. If any program needed to have care coordination built into it, working with patients at home, making sure they're not admitted to the hospital in the first place, as Gail talked about reducing the rates of readmission. Those, to me, are improvements in the program. We've improved the quality of health care provided Medicare beneficiaries and at the end of the day we've saved money.

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One of the things that we could do in health care reform is provide care coordination, over time nationally, in the program by building on this medical home model but really building community-based primary prevention using nurses, nurse practitioners, other primary care providers to work with physician practices and patients, to keep them healthy, to keep them out of the hospital, and keep them from being readmitted.

We're going to have to invest in this. This is an important change in the delivery system infrastructure. It's one well worth making. It'll provide dividends, over time, no question.

I'll give you just a quick financial example. If we are going to build care coordination into the Medicare program nationally, based on some models that are already up and running in North Carolina and Vermont and some other states that do this for their populations, it would cost about \$25-30 billion over the next 10 years.

Now that sounds like a lot of money and it is. But in the context of the numbers that we're talking about in terms of the overall package of reform, that's almost in the second and third decimal points of what we're looking at. I mean, this is almost an estimation error in terms of the cost of moving toward universal coverage but yes, it's going to cost money to do this.

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If we took readmission rates in the Medicare program from 20 percent and cut them in half -- which we know we can do, we have programs in place that Pennsylvania and Colorado, and other states that have been shown through randomized trials can cut readmission rates in half. Medicare has very high rates of readmission.

If we build that transitional care program into this care coordination model in Medicare, we could save \$100 billion over the next 10 years on just that one aspect of care coordination. Now, we know how to do this. We just have to make the investment.

So if you think about it on the cost containment side, if we really are going to deal with the long-term deficit, we've got to address per-capita growth in Medicare spending. There's no question about it.

If we're going to really improve the quality of care in the program, I think we need to make these investments in primary prevention but we really need to change the delivery model to improve the quality of care provided, improve the health of seniors.

We can do a lot to reduce readmissions and admission rates in this program but we can't do it within the current payment structure and delivery model that we have.

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So I think, as part of the promise of reform, that we should not only just be doing health insurance reform. That's a major piece of what we should be doing but we should also be doing health reform, which is really trying to find ways to improve the health of the population, redesigning, reengineering the delivery model to improve the quality of care. At the end of the day, I think in both the public and private sector, we have the chance of producing a better health care system that generates better outcomes.

ED HOWARD: Thank you. Let me just say that there are green cards in your packets to write questions on but given the array of eager people in front of me, I would urge you to actually ask a question orally because you probably won't get a chance to have your question read if that's the way you choose it.

We have microphones, if you want to ask a question raise your hand and please wait for the microphone to reach you so that those of us in the room and those of us around the country can hear you. Identify yourself and try to keep your question as brief as you can. Right in front of me is our first questioner.

AL MILLIKEN: Al Milliken, AM Media. I was curious how each of you think the threat of death panels has been addressed in recent weeks. Have any of you had the opportunity to read

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this booklet that the veterans are supposed to have the opportunity to receive, injured veterans, that may actually give them, seems like, the option of choosing death over life? It was addressed on Fox News and the former Bush administration, I think it was Jim Toohey, it was addressed on Fox News on Sunday morning a week ago.

GAIL WILENSKY: I have not read the VA booklet so I will not comment on that. I would like to comment on the death panels charge, which I've done now a number of times. I think it is really unfortunate that this has been raised and received so much attention because there are serious issues to debate in health care reform -- how we finance the money, the whole notion of a public plan, and whether it is or is not compatible with private insurance as we know it, whether we're not talking enough about reforming health and health care costs and talking only about health insurance reform, many issues.

I regard the death panel as a red herring issue to the extent we are talking about proposing payment for physicians that are asked by their beneficiaries, by their patients, to have counseling on either hospice benefit or end-of-life advance directives once in every five years.

The reason I think it's unfortunate is really two-fold. In the first place, this is already, hospice is already a Medicare-covered benefit now. In addition, nursing home

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administrators and hospital admissions individuals are supposed to ask people who are on Medicare, when they are admitted to hospitals and nursing homes, if they have advance directives and if so, to mark it in their chart so that those advance directives can be followed.

Given that that's already the case, I regard this as a way to pay physicians to provide that counseling if they're asked to by their patients and fundamentally to empower patients to have their wishes known about advance directives if they choose to do that. I don't know how many of you in the room have advance directives. I do, did when I was at Medicare. I had one made.

This is when this first arose in Medicare and allowing people, particularly not when they're going into a nursing home or a hospital, to have this discussion with their physician or their nurse practitioner or their family members to try to help them think through what is an issue that individuals may face - - being put in a position when they're not able to register their own will in terms of how they would like to be treated is an important part of life. It doesn't, in any way, require people to have these discussions, just as Medicare doesn't require people to have hospice as a benefit. It allows it.

I think it is a major empowerment for seniors. But any senior that doesn't want to have this discussion, either about

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a hospice benefit or an advance directive, need not do so. That's why I find it so upsetting that there's this notion of death panels.

ED HOWARD: Risa?

RISA LAVIZZO-MOUREY: I think that you said it beautifully Gail but I, as a geriatrician, I have to comment. Because what people don't often appreciate is that the vast majority of people don't really understand what kind of care is available to them at the end of life, what kind of palliative care they could access that would actually make their quality of life better.

Our foundation has funded a lot of this research. It is critical that people get this information. So you said it so well, but I think that for those of us who've actually had to counsel people at the end of life, this is an important part of being able to do what we want to do, which is deliver high quality care.

DALLAS SALISBURY: Ed, if I might just quickly personalize it: I recently lost my father just short of his 94th birthday. My parents both, for many, many years, had advance directives. I've had one for 25 years.

I can just note that at 93 and a half and 92, my mother and father were both awfully glad that Medicare provided for the hospice care they got at the end of life. So I think that

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it's extremely unfortunate that this has been turned into political record. That's a personal view but it's something that I fully agree with what has been said.

JILL WEXLER: Thanks. Jill Wexler, *Managed Health Care Executive* magazine. I'm wondering if the panel thinks that the public plan option, at this point, is dead or, if it's not dead, whether it would be advisable in order to have health reform legislation for it to fade away quietly and disappear.

GAIL WILENSKY: It clearly is not dead. It is one of the most contentious issues. And unfortunately, it seems to have dug itself into a position that is going to make it hard to negotiate around. Because you have people like the speaker of the House and Howard Dean, in a program that I did with him, indicating that without a public plan, health care reform isn't worth doing. Other people have said having a health care, a public plan is going to impact the rest of health care and have a lot of negative consequences.

As I indicated, I think that a public plan is not desirable as an addition because I do not believe a public plan will long avoid using the power of government to set below market reimbursement. That is, to not pay for the costs of health care being provided.

We see this in Medicare. Medicare pays physicians about 20 percent less than private plans. Medicare, as I

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mentioned, pays hospitals about six percent less than their costs. If you have a public plan also doing this, you're going to do what Medicare does, which is push costs into the private sector, which will over time, unravel private insurance.

There are a lot of ways to accomplish, in my view, what a public plan has been postulated as doing in terms of driving change, making sure that there are choices available, and making sure that insurance companies don't discriminate according to health status and pre-existing conditions, which is a part of any insurance reform that is likely to be a package. But it is very unfortunate.

And it's particularly, in some ways, frustrating because, as several of us have mentioned, Medicare in many ways is the least desirable model to think about driving to an integrated delivery system that focuses on chronic disease management and moves away from disease focus in acute care and to one of wellness and managing chronic disease.

Medicare is even a step behind the private health care system, which does pitifully too little of that as it is. So I just think we need to be clear what objectives do people look to for a public plan and find other strategies to achieve them, which I think are quite achievable. But when you have people making statements, people in leadership positions making statements that without this very contentious strategy, health

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care reform is not worth doing. You just put yourself in a box, I would think, as a politician, you never want to be in.

ED HOWARD: Okay. Now Ken?

KEN THORPE: I just was going to sort of comment from my experience working on this, I guess 15 years ago or so with President Clinton. At that time, we really had a strategy that it was universal coverage or bust. We had bust. My concern with this discussion is that I want to take a step back.

We're trying to accomplish slowing the growth in health care spending both in the public sector and in the private sector to make it more affordable for families, to make it more affordable for business to keep their health insurance and also improve the quality of care that we get.

Two, if we want to move to universal coverage. Those are the two objectives. We're having a tactical discussion about how to do it. I think, as Gail mentioned, as I talked about one of the things we should be doing is adding to and building on some of the good pieces that are already in the legislation on cost control and over time, try to expand them so that we can do these programs nationally.

So I think this discussion about the public option is really speaking volumes to the fact that we need to build in more things that are going to control the growth in health care spending.

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For me, I think the best way to do this is attack the core problems. The core problems are this explosion of chronic disease. It's also the fact that we have poorly managed chronic illness in this country, particularly in the Medicare program. We can do better on both of those fronts.

As Gail and I were just talking about, these aren't partisan issues. This is just good common sense clinical preventive medicine and clinical management of patients.

We should be able to get this done. This is something that we could build a bipartisan approach to do because if you think about it, in our group, the Partnership to Fight Chronic Disease, I've got 120 groups in it and yes, it's got the National Retail Federation too, AARP, and PhRMA, and the labor unions.

We've come together to agree on this issue around cost containment built on these two principles of primary prevention and really modernizing and improving how we deliver health care. That's the direction that we should be going on this. So if we're really serious about doing cost containment, those are the areas we need to focus on and not let it derail us from the broader objectives of slowing the growth in spending and moving to universal coverage.

DALLAS SALISBURY: Ed, I just want to quickly add one point, which came to mind when Ken did his opening comment,

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(which) is universal coverage, to many, means everybody has health insurance. If one uses the ERISA pension example and you apply it to health benefit programs, coverage doesn't mean you have health benefits. It means you have access. Participation means you have it.

This goes back to the debate in '91, towards the end of the Bush administration and multiple times since then is the public plan. When you read everything surrounding it, the public plan is using the term universal coverage as the objective of everybody actually having health insurance, everyone as a participant in a program.

If one looks, the groups that Ken just mentioned, the NFIB explicitly says in all of its documentation, testimony, and speeches, their definition of coverage is the old Bush Administration definition. It is access to the opportunity to purchase coverage. It is not participation. If one looks at a number of the other business group positions, it is coverage equals access, not coverage equals participation.

If you, on the other hand, turn to Governor Dean's statements and all agree with them or disagree with them, they're equating it to participation. They're arguing the public plan is the way to get actual participation. And all the other means, including Massachusetts where you do not have universal participation, or even frankly the Netherlands where

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you do not have universal participation, you have three percent choosing not to purchase, another three percent in between jobs.

So setting aside EBRI (which) doesn't have a position on any of these things, I think the public plan issue is, really ends up almost being this absence of a clear debate over participation versus access, which really underlies a bunch of it.

GAIL WILENSKY: But that's really a completely different issue. I mean you can have a mandate for individuals to have coverage and not have a public plan. It's a question of how you want to enforce it and what the default position is for people who may not choose it.

Again it's why if people, rather than talking about the public plan as the Holy Grail, ought to indicate what it is they're trying to accomplish and, because it's become so contentious, see whether or not there aren't other strategies.

Individual mandates are an issue that has been discussed from time to time. Massachusetts has a soft mandate where they allow people who don't have access to what might be regarded as affordable coverage to not be fined, and the fine itself is quite gentle.

But the question of whether or not you want to push required coverage is a good issue to have out in the open for

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people to be debating and not hiding behind this debate about a public plan. So again we need to be sure we understand if you want them, what it is you think it's going to do for you.

ED HOWARD: I believe that we had you here first and then we go there and there.

SABRINA EATON: Hi. I'm Sabrina Eaton from the Cleveland Plain Dealer. What are the issues that you guys think Congress and President Obama will actually be able to achieve consensus on? What do you think are the issues that are going to be too controversial that they'll end up kind of getting tossed by the roadside and left for later?

KEN THORPE: Well again, I'm eternally optimistic on the issue of cost that we can really do something meaningful in modernizing the Medicare program and do something effective in helping to slow the growth in spending on Medicare, not by rationing care but by improving the quality of care we provide in the program.

Those are approaches that are well understood in the private sector. I think they're approaches that we've seen other states actually do this statewide. Vermont, West Virginia have both just passed statewide legislation that would basically modernize the delivery system infrastructure statewide in those states. It had wide bipartisan support. So

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I think that those are areas that we can build some bipartisan support on.

As I mentioned before, I think that they're common sense things to do, the things that we've been talking about for the last year or so were really central to doing health reform.

I think the road to universal coverage always has been a bumpy one. I think we can make steps to get there. I guess the question's going to be how big of a package, how much should we chew off this time? None of these, whatever we pass, is going to be perfect.

I think that the notion that if we can pass something that's fairly major with the notion that directionally we've moved in the right direction, that we can come back and take another whack at it, perhaps next year and the year after, is a way to go. It is very hard to get everything that you want, your entire wish list passed in one fell swoop.

I think we learned that 15 years ago when we had a very big comprehensive package. Perhaps if we had broken it up and had a trajectory of two, three years but agreement on where we're going to end up with this, which I think is universal coverage and better quality care and cost control, then maybe we can get it done.

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GAIL WILENSKY: I don't know the answer to your question. It's a very good one. It will depend first on how much can be financed.

What has been clear is, as a result of the TARP package that was passed last November and the stimulus bill passed in February, there is no additional appetite in the Congress to have any additional unfunded major expenditures, which has made all of this more difficult.

So the question is going to be where will there be agreement on funding, not just among the Congress but scored or acknowledged by the Congressional Budget Office as being real money in the relevant time range.

I don't know how much agreement will be possible in terms of what that funding package looks like. I think it may well be smaller than what we're talking about right now, the \$900 billion to a trillion dollars over 10 years.

My assumption is that the subsidies, at the higher end of the income scale, are what will be cut back and/or possibly eliminated, so that more of the concentration will be on the expanding Medicaid coverage to the 133 percent (of poverty) and the subsidies for people beyond that to purchase health care in a health insurance exchange. But how big, how much subsidy, I don't know.

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I don't know whether or not this will be a go-it-alone strategy as people have been increasingly talking about where it is only Democrats and done through the reconciliation process, which would be unfortunate but is clearly been raised as a possibility.

If that occurs, it not only lowers the bar in the Senate in terms of only needing 50 votes. It may restrict the kind of legislation that can be passed in terms of doing the kinds of things that Ken and I and Dallas have talked about of reforming the delivery system. Because, as most of you know, the rules about what can be included in a bill if it goes through the budget or reconciliation process are narrower and therefore, some of the health care delivery might be out of that.

I don't know where that's going to end up. It clearly is a big challenge not just whether or not they're going to be able to find a bill that attracts several Republicans but where the more conservative Democrats are going to be on these issues. The Blue Dogs in the House and the six or eight more conservative Senators, Democratic Senators, in the Senate but directionally, that's what I expect.

I am hopeful, as others here, that we will see health care reform package of some sort come out. These issues of expanding coverage and slowing spending and improving quality

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of care are not going to be helped by just kicking the can down the road for five or 10 years. We have seen, over the last 15 years, that these are issues that will only be addressed by direct policy changes. We need to start making these changes in the course of several bills over the next few years.

ED HOWARD: Yes? Right here.

RITA GERONA-ADKINS: Yes, thank you. My name is Rita Gerona-Adkins. I write for Asian/Pacific American audiences -- Asian Fortune, Philippine News, and also I correspond for some publications in Asia. There has been an assertion, which has become sort of a belief, that illegal, undocumented people in the United States right now contribute, in large measure, to the health costs.

Now, other than it being perpetrated in talk radio but also among even in the Asian/Pacific American community including doctors, it has also been asserted by advocacy groups with data. Would you be able to address the serious side of this question or this anxiety -- how precisely the health cost is being gobbled up or caused by illegal people who, in the first place, are not supposed to be here?

GAIL WILENSKY: That's a very hard question. About 30 years ago, my activity in Washington was focused on helping to put together the first of the large expenditure surveys called the National Medical Expenditure Survey. It's now an ongoing

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survey that the Department of Health and Human Services collects.

I actually have been curious about some of the numbers I had been seeing reported as to how many of the people currently reported as being uninsured are people who are illegal immigrants and how many people who would remain uninsured are likely to be illegal immigrants.

So I had some emails with some of the people that I worked with who continue doing survey research, because my question had been how would we ever actually know that. The answer is it is almost impossible to know that. Though when we make estimates (we) use the annual Current Population Survey, which is done by the census, and then every 10 years you have the full decennial census, which we're getting ready to do.

The populations are blown up to the known numbers of the country. The estimates based on these 50,000 household population surveys are used to try to get estimates of who does not have insurance or who has income of various amounts. It is extremely difficult to get estimates about the numbers of people who are here in an illegal status, reliable estimates.

When you think about it, it is so much more difficult to imagine getting information about the insurance status of people who generally do not want to have any discussions with

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people who are from the census or anywhere else that is part of the official.

So I think the answer is that there clearly are parts of the country along the borders who face stress because when people are in acute illness, hospitals may not turn them away. It's one of the very serious charges -- a law called EMTALA requires hospitals that provide Medicare services to not turn anyone away if they're in an emergent situation. And they will come get you, as a hospital, if you are charged with pushing people away for whatever reason including that they didn't have coverage or anything else.

So it's not that there isn't care particularly provided in communities along the borders or where there may be unusual congregations. But there is very little that is known accurately about the impact of illegal immigrants.

There has been some work -- I think actually Robert Wood Johnson may have funded it -- there's been some work that has been done looking at the impact of immigrants who are an illegal status. And as I vaguely recall, I had thought that the use of services was, more or less, offset by the tax contributions in the employment that these individuals were providing, but I don't recall the studies very well.

I just want to caution people -- just have, take any of these estimates about the impact that illegal immigrants are

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having either on costs or on insurance estimates or uninsured estimates with a large grain of salt because we do not have good information about this.

DALLAS SALISBURY: I'd just stress Gail's point on the census and the CPS. The Census Bureau will put out the new numbers actually next week, so you're likely to see some attention to this variation next week because of the new numbers. The Census does not ask people, in the process of the census, whether or not you are a U.S. citizen.

Studies that we've done, over the years -- there are numerous of them at EBRI.org -- have looked at the border states specifically on this issue. What the Census and the CPS clearly show us in the border states (is that) the percentage of the uninsured of Hispanic origin is exceedingly high.

What it doesn't tell you is legal or illegal status, But that is one of the primary drivers for the state of Texas having the highest percentage uninsured of any state in the nation, et cetera. But to Gail's point, there is no way to make categorically the division, because my understanding, from the hospitals, is when they do provide the service you're describing, they do not ask either. So it's an awful lot of assumptions and hypotheticals.

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KEN THORPE: Let me just raise the broader point on this because it goes back to the discussion we're having on health care reform.

I agree with both Dallas and Gail, we don't know, nobody knows the answer to that question. I think if they say that they do -- I don't know if they're making it up but I don't know where they're getting it from. Because we just don't have the data.

But we do have data on the following: We know that there's roughly 45-46 million people that don't have health insurance coverage. That's a mix of (illegal) residents and legal residents. We also know that if you look at total spending in that population that they incur spending of about \$50 to \$60 billion a year.

A lot of that spending is not explicitly paid for, which means two things. One is that we're spending a lot of money today on the uninsured.

We're not spending it well. We're not spending it wisely. We're not doing preventive care and so on. We could do a much better job, which is what this discussion about covering the uninsured is about. But if you look at how we pay for this, we're spending about \$20 billion a year in federal spending today to provide financial assistance to hospitals and

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other institutions to provide health care services for the uninsured.

So we already have \$20 billion a year we're spending. What's not fully paid for gets bumped into the cost of private health insurance. There's a whole bunch of different estimates about how big of a bump that is, but we're paying for it one way or another.

We pay for it out of our health insurance premiums for the uninsured. We're paying for it in terms of federal funding. In Atlanta, Grady Hospital, our big public hospital down there, the local taxpayers pay for it, a piece of it. So Fulton County and DeKalb County chip in about \$110 million a year to help offset these costs.

So I think I like the point because it brings us back full circle to what we're trying to do in this discussion. There's a lot of money being spent on the uninsured poorly in high cost places, too late in terms of when they get their health care. I think it highlights attention in the fact that we can do a better job of providing health care services to people who don't have it and redirecting some of the resources we currently use to fund a piece of it.

GAIL WILENSKY: But just to be sure people understand -
- the uninsured use about half the health care of the insured population, even when you adjust for health status. So while

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it is true that the uninsured receive some health care now, usually fragmented and in expensive places when they receive coverage, they will use a lot more care (after health reform) and hopefully care that will allow them to lead healthier and more productive lives and maybe, over the long-term, to receive that care in better environments.

ED HOWARD: Let's go here, and I've been ignoring this side of the room but I promise not to do that again.

MERRILL GOOZNER: Hi. I'm Merrill Goozner and I'm a freelance writer and I write for Gooz News. On the question - Ken, I think you said that there was \$100 billion in savings over 10 for better care coordination. Gail, you said that there was money to be had by reduced hospital admissions.

I presume that's all CBO scorable. But in the current political environment, these are perceived as Medicare cuts and, of course, we don't want the government putting their hands all over our Medicare. My question to you is sort of politically what do you think will be in the final bill in terms of Medicare administrative changes that will improve the efficiency and quality of the system? How can that be pitched so that people don't describe them in ways that people perceive these as Medicare cuts.

And then a question for Dr. Lavizzo-Mourey. We had one more study come out this week that said prevention doesn't pay,

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or at least if it's very long-term, you have to take 25-year time horizons. Just out of curiosity, why do we have the entire economics profession rave against the idea that prevention will pay?

KEN THORPE: Let me start with that. I want to take on the second one first and I'll come to the Medicare question.

[Laughter]

This prevention one is a curious discussion because if you think about it, there's a whole bunch of things that we can do on the prevention side.

About 99 percent of the attention to the discussion about prevention has been on detecting disease, doing screenings and immunizations. The primary goal of doing disease detection is not to save money. The primary goal of disease detection is to intervene earlier clinically to make sure people have healthier lives, better quality lives, and hopefully live longer.

There are other forms of prevention: averting disease in the first place, preventing it is a way I talked about in terms of making sure people who are pre-diabetic don't become diabetic, people who are overweight become normal weight.

We have interventions there that not only work and we have randomized trials -- the diabetes prevention program is a good example -- to show that they work. We now do them in

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community-based settings to show that they save money. So those type of preventive interventions save money in work.

Then there's another type, which is for people who have multiple chronic health care conditions, to make sure that we can manage their conditions so that we don't have complications resulting from them. They'll lead them going into the hospital or emergency room or clinic.

Yes, we have programs that are well designed. Not all of them work, but the ones that are well designed save money and improve outcomes.

So there's really sort of three dimensions to it. Those two that I talked about, which are designed to save money, if you design them right do (save money), (and third) detecting disease, which is not designed to save money. It can work if you target people appropriately to intervene earlier to improve outcomes.

On the Medicare side, just quickly, we have some good reforms built in. They're moving in the right direction changing how we pay, moving away from unit fee-for-service payments. Doing something on the delivery system side, I think the challenge is we need to build those out so that they're available nationally so that we can really make a dent in the growth and spending.

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Those aren't cuts. In fact, if you think about care coordination, that adds to the benefits the Medicare beneficiaries get. That improves their benefit package. You don't have people working with you at home helping to manage your disease. You have a nurse working with you in the hospital to do discharge planning and medication reconciliation when you leave. So those are benefit enhancements that are just not only good quality care but if you do it right, save money.

So I think the combination of payment changes, care coordination are not only good things to do. I think they enhance the value of the Medicare benefit package and those are the types of things that we should be building on in this reform discussion.

GAIL WILENSKY: The comments or the studies you see by economists with regard to prevention typically are focused on, as Ken said, screening and very narrowly focused activities.

Now it's important to understand that whatever the purpose of using additional screening is -- even if it's a good thing because it provides a strategy for intervening earlier -- doesn't mean it will necessarily save money. You ought to, again, make your arguments correctly.

If you're doing it because you think it is a way to be able to avoid a human cost and a medical cost down the road, it

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may or may not actually save the system money depending on how well you can target who's actually at risk and how expensive the screening test is.

You may choose to do it anyway and regard that as money well spent. But you shouldn't make the argument that it saves money if it doesn't save the system money or it doesn't save a particular payer money.

Many of the specific prevention activities that are cited in these studies fall in that category, whereas if you could change behavior with regard to obesity or smoking or others, that would have, in the long-term, potentially a lot of effect or being able to intervene more effectively with diabetes.

With regard to Medicare, you have to be careful about how we phrase this and what it is that CBO is likely to be willing to score, because a lot of what we've been talking about is directionally the right change. We don't know exactly how to make some of these payment changes. Ken mentioned there are a lot of demonstrations and pilots that are either ongoing or that are included in the legislation.

We need to make sure that there's an ability to scale up and impose them as they show themselves to be effective. CBO is not going to give you a lot of credit, and they shouldn't. Because we don't actually know which of these will

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work in practice, in terms of changing away from a system that rewards more and more complex and more treatment of acute care to one that attempts to provide incentives for more integrated care and more chronic care.

We know what we would like to have it look like. We're not quite sure how to actually get there.

What we do know is that the kind of spending that we're talking about for expanding coverage is quick and it's certain. If you don't plan to spend unfunded money, you need to have, on the other side of the ledger, quick and certain funding. That's really the dilemma that is being faced.

Most of the quick and certain money is either whacking at reimbursements, which is likely to be antithetical to all the changes that Ken and I have talked about doing that will be good down the road. Or it's increasing revenue through additional taxes or it's changing the tax treatment of employer-provided insurance, which have their own issues but that is the dilemma.

Now can you tell a beneficiary on Medicare "don't worry." They're going to slow down spending by \$500 or \$600 billion and you won't have any effect? I don't think you can do that.

As I've indicated, I think there are a lot of things that you could do to slow Medicare spending that's going to

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cost money up front, the kinds of changes we talked about with regard to lowering readmissions, which would give you some spending down the road.

But if you're concerned about how much you spend the first five years and if you're using reconciliation, that's the relevant window, and how much money you're going to spend or save the second five years and how much you're going to spend or save the third five years, you need to be very careful that if a good change by lowering readmission, by having people be able to have interventions for their medication fulfillment and for their scheduling with their physician and their nurse practitioner.

You need to watch out about how much is that going to cost you up front and how much might you realistically save in the second and third five-year period.

So this is going to require some very careful crafting because again, if you want sure scoring by CBO, just whack at reimbursement. That gives you the best score.

That's why I'm so worried about public plan, by the way. When government is pressed for money, it usually either goes after the benefit, the population served, or it just whacks reimbursement because that they can count on in the short-term with some certainty.

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Unfortunately, it's antithetical to all the delivery changes we're talking about that would allow us savings in the long-term. That's really the tension that is going to have to get solved by the Congress.

RISA LAVIZZO-MOUREY: Okay. Let me just make three quick points because I think Gail and Ken have really addressed this pretty thoroughly. When someone speaks about prevention, my first question is what kind of prevention are we talking about. Because, as they've said, whether you're talking about screening tests or community-based prevention, gives you a very different answer on what the return on investment is.

We know that investments in making the entire community healthier do yield a very positive return on investment in a short period of time. Studies have shown \$5.60 for every dollar invested within five years. So that's the first point.

The second is: what is the outcome you're looking for? If you're looking for savings -- which is a different standard than we hold the rest of our medical care system to -- I would say you're, in some sense, asking the wrong question. Because what we're really trying to do with prevention is prevent disability and allow people to have more productive lives, which then will produce more benefit for the country.

The third point we have to always make when we think about prevention is whether or not the long-term, whether we're

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using the right timeframe for understanding what the impact is going to be.

If you look at how long it takes to get the negative impact of, let's say, obesity, it's 10 or 15 years and yet CBO is scoring things only within a 10-year horizon. So often in order to see the benefit of the investments we make in preventive strategies, you have to look out beyond what we typically do.

So those are the three things that we have to ask ourselves when we're trying to assess whether or not prevention saves money which, as I said, is often the wrong question to ask.

ED HOWARD: We have only a couple more moments. I know there were some people over here trying to get a question in but since that gentleman just left, we're going to go further left.

JIM BYRNE: Hi, thanks. I'm Jim Byrne with Community Development Publications. We have several health newsletters. I've covered this thing for a million years and I hate insurance companies. The thing I'm really interested in is what would the panelists say is their absolute bottom line on a bill being passed could truly be called health care reform?

KEN THORPE: Well for me, I think it has got to deal with these two issues. It's got to do health reform. So the

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bill has to have things in it that improve the health of our population focusing on preventing disease, focusing on people who have chronic illness, improving their health status to keep them out of the hospital, keep them from progressing in ways that are preventable. Those are things we can do. Gail mentioned and I've mentioned too we need to invest in them just like we invested in health information technology.

We invested \$19 billion over a five-year period to put into place information technology, which we know is a good critical infrastructure investment to make. We need to make the same investments in doing prevention and care coordination nationally. So I think that's a piece of it.

I think the bill also has to have a very clear path to move to universal coverage. I think we need to have a track that we're doing both of these, which are the major objectives of the reform initiative in the first place.

I'm less, sort of, dug into a specific trajectory on the second issue of how we do it. I think it's more important to get there and not hold hostage the better goal of universal coverage to exactly the approach to how we get there.

GAIL WILENSKY: I am hopeful that we will revert back to what had started as a discussion on health care reform and has morphed into a discussion on health insurance reform. I am hoping that that was because of polling decisions and not

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because of intent to focus only on health insurance reform.

It's important. We need to expand coverage.

We need to reform the health insurance market, but sustainability and spending and improving quality and clinical appropriateness are even more important because they affect the 85 percent of us with coverage as well as the 15 percent of us who don't have coverage.

A bill that is worthy of the name health care reform needs to have a lot of attention focused on how we are going to begin changing our delivery system and payment system so we will reward the kind of changes that we want to see and we don't move in the opposite direction.

It better have a lot of authority given to the HHS secretary so that successful pilots -- or to another government official -- that successful pilots that show that they can help move a la carte fee-for-service acute care focused health care into more integrated, coordinated chronic disease focus. Delivery systems can be encouraged and scaled up and done so quickly. We need to acknowledge that we don't actually know how to get from here to there.

So we're going to stumble along the way. It's why you probably won't see a lot of credit from the Congressional Budget Office in terms of the savings that could be provided if we do it right and it's because there's so much uncertainty

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about how to do it right and how long it will take to see the savings.

ED HOWARD: Dallas?

DALLAS SALISBURY: If I take your question more narrowly, which is an assessment of will there be a bill, then my response would be yes, I think there will be -- largely because of what I mentioned in the front end, which is most all of the interest groups involved with this business, labor, insurers, PhRMA, et cetera are still sticking to "we have a Plan A, which is we need health reform."

Driven by the factor that has been most readily stressed at this table, which is dealing with cost, dealing with quality, dealing with prevention, chronic disease in the way that you're describing, driven by a recognition of necessity to a, in quotes, highly performing well workforce that they have health coverage, that they have health insurance, they have health treatment.

So employers are absolutely committed to the knowledge that in the absence of reform of any type, they have to continue to provide it and that the cost curve is unsustainable.

So they are in this conundrum and whether it is bipartisan or ends up being a single party bill, I think all of that is going to come together and you're not going to see what

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you saw that killed it last time, which is a whole lot of those interests, relatively early in the process, moving to Plan B, which is kill it from Plan A, which is we need something.

Back then, there was nowhere near the consensus across surveys be they public employers, insurers, you name it. Back then there was not the absolute belief that it was unsustainable. Today, there is a belief that it's just repeated, repeated.

So when I went over from all these positions, there's lots of disagreement on the details. But when push comes to shove, even if it ends up having to be the interest groups just with the Democratic party, I think you will see something that is relatively comprehensive. Because of this absolute recognized necessity that you cannot ask that the provision and sponsorship of health insurance, even if you want to, and have any hope of attracting and retaining the people you need to run your enterprises. That is a fundamental difference of belief behind the necessity of reform compared to prior points in history.

ED HOWARD: Risa?

RISA LAVIZZO-MOUREY: Let me just underscore that by saying the belief is backed up by very credible studies like this from the Urban Institute that underscores the comments that Dallas just made. Whether you look out five years or 10

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years, there's likely to be more people uninsured by 30 to 40 percent. The cost to employers for their premiums is going to go up.

Cost of individual premiums will go up, and that doesn't address any of the issues that we've been talking about in terms of reforming the delivery system so that it is more efficient, higher value, et cetera.

So, at this point, I think there is consensus that we need to have change. It is probably going to require some evolution of the policies in order to get it to where we really want it to be but I think there's no question in anyone's mind that doing nothing is an option.

ED HOWARD: And that is the bottom line of bottom lines. I believe I don't want to hold you beyond the time that we said we were going to. We've already done that a little bit. I know there are a lot of you who have questions to the extent that our panelists can stick around for a little while and try to answer those questions.

I know you'll appreciate that. Let me just take this chance to thank you for some lively interchanges, thank the folks at the foundation both for the support and participation of its staff and its president, the staff at the Alliance for making this thing run smoothly and we'll convene, I guess, on

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December 12th on the hundredth day and see how far we've gotten
[laughter]. Thanks very much [applause].

[END RECORDING]

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