



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation¹
(Tip: Click on the binocular icon to search this document)

**Getting to Universal Health Insurance
Coverage Conference - Day 2
Session V: How Can We Overcome the Barriers to Change?
National Academy of Social Insurance
February 1, 2008**

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

DAVID COLBY, PH.D.: The chair of this panel, this is an incredibly distinguished panel of folks who I think each could have given a plenary speech and so it's a great honor to be able to chair this panel today. This panel is about how can we overcome barriers to change, as in how can we move the ball forward on the discussion of covering the uninsured. My name is David Colby and to sort of follow Uwe Rinehart I am a simple country political scientist from rural New Jersey. The deep secret is that I live in the same rural New Jersey town that Uwe lives in, Princeton. Actually there are two towns of Princeton, but I won't get into the geography of that. There may be 50,000 people in those two towns and I have never seen Uwe Rinehart at a grocery store. So when he comes in and talks about being a simple country economist from Princeton you can confront him with that. I've seen him on the train. He used to claim that the train was my office where he met me. But I've never seen him in Princeton in a grocery store.

I want to say a few words of background before we start this panel, first, why this issue is important. We've had a lot of technical discussion and political discussion going on here, but we've not had much discussion about why it's important. Jonathan Cohen last night did have some of that discussion and really talked some poignant stories about the uninsured and the problems the uninsured face. But I want to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

go back to the Institute of Medicine reports that were done between 2001 and 2004, if Willamene Miller is here she can correct me on the exact dates of that, but those were six reports done by the Institute of Medicine on why coverage matter. And those six reports, while they were consensus reports based on the evidence, I think they can be boiled down into some very simple phrases and I think this is why we are all talking about this issue, is the uninsured live sicker, the uninsured die younger, the uninsured are more likely to go broke and people in communities where the uninsured live are more likely to feel the stresses of having large populations of the uninsured.

So I think it's important to sort of step back from the real technical discussion we've been having and really say, why are we interested in this problem. So what are the barriers that we face in this area? I like to go back to the great American philosopher, Yogi Berra and Yogi Berra had this great quote which Casey Stangle then used later on, but he said this seems like déjà vu all over again. And most of us would say that's a redundant statement. We might say it's a redundant statement by, I believe, Yogi Berra had maybe an eighth grade education, but when we get to health reform and when we get to the barriers, I think it is a statement that really rings true and I want to challenge the panel also to say why is it

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

different than last time? Why is it not déjà vu all over again?

So let me just briefly set up this panel with what the barriers are and then they all can give their wisdom about how to overcome those barriers. We have tremendous political barriers and to sort of review the things you've heard here, Drew Altman, yesterday, talked about the incredible chasm between how republicans and democrats frame this issue and he talked about not only how they frame it, but then what are their solutions. We also have to recognize the political fact that most people in America have health insurance so they see this as change and then Uwe Rinehart in the political challenges mentioned Stuart Altman's law that everybody's second choice is the status quo. Everybody has a first choice for change, but everybody doesn't want anybody else's first choice as their second choice. I am reminded also when both in the discussion of Lynn Nichols who I'm ready to give an honorary political science Ph.D. too and Ted Marmer, obviously was ready to give him one too, I think that we have to recognize there are structural barriers, politically structural barriers here and we talked about James Madison being the greatest Princeton graduate ever, well James Madison was one of those people who put those structural barriers in place and justified them in the federalist papers.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

That's why we need that 70 majority, that's why we've got barriers to change any kind of policy change is very difficult and any kind of big change is difficult. I think the second issue that we have to face up to is the cost, Uwe showed his charts, 2 trillion dollars and the healthcare economy is growing faster than the rest of the economy, presumably that will someday raise the issue of affordability, maybe when it gets around 100% of the rest of the economy will raise the issue of affordability, but I think that is a major issue that we have to face and an expansion of healthcare is going to cost us a lot of money and so I think we have to deal with that issue.

A third sort of barrier that I see that's been talked about here are informational barriers. As this is an incredibly difficult discussion, it's a credibly technical discussion, it's difficult for the general public and it's difficult for policy makers. I think you had a lot of discussions, Paul and Gene today talked about how you could do a mandate and what would be the most logical way. Well, that's an informational issue where we need to have people talking about those kinds of issues and those kinds of barriers.

And last we'll have implementation issues that we need to talk about. Last night Jonathan Cohen talked about the implementation of Medicare, that is classic Medicare, the time when my grandmother was a charter Medicare beneficiary in 1965.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And the implementation then contrasts the implementation of part B. How are we going to implement these issues and what kinds of answers can we give about implementation. Let me just mention briefly how the Robert Wood Johnson Foundation is approaching and where we are going to approach these issues and then I will move to the panel.

We have really sort of three thrusts of our work, one is to maximize enrollment and maximize enrollment in current programs, Medicaid, and SCHIP and the reason to maximize enrollment is to build support for these kinds of programs and it's also to show that they can be implemented. We spent a great deal of money on a program called Covering Kids and Families in which we tried to work on simplifying enrollment practices in SCHIP and Medicaid, coordinating eligibility policies, and outreach to families. So we've learned those lessons and we need to apply those lessons.

The second area we are doing a lot of work and trying to lower barriers is in supporting state-based reform. Why support state based reform, one is, I think it's because there's a political momentum around it and it pushes the national agenda and the national debate and it's also a way of trying ideas out. The old state's as a laboratory idea. We have the state coverage initiatives which is technical assistance and grants the states who are going to reform and expand coverage, we have a new program State Health Access

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Reform evaluation project which is about evaluating the reform the states are doing, try to get the information needed to help other states work on this and then we are supporting consumer voices for coverage, efforts by consumers in states to move the needle on this issue.

And last we are working on national reform issues. I think we and other foundations, Commonwealth and Kaiser, really our role in the national debate is largely one to provide information to support the discussion, but the Robert Wood Johnson Foundation over the last couple of years has played another role. We have played a role around what I will call the strange bedfellows. For we have tried to pull together people who in 1992 to 1994 took different sides of the issue, pulled them together and see if they can overcome Stuart Altman's law as can they get a second choice that they all agree upon. I don't know that the strange bedfellows will be the form that this takes in the future, but I think you can think that we will be trying to create a petri dish where people are talking about the issue and trying to compromise around the issue.

Not let me turn to this panel and briefly introduce everybody. There are bios in your program, much more extensive bios and as I said earlier, this is a very distinguished panel. And before I lose my voice like Drew Altman did, I should say I'm a danger with water. I once was testifying before the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Senate Aging Committee, knocked over the water, didn't miss a beat, but it was rolling down on Ken Thorpe and I. So if people in the audience didn't know I did this, but the senators sure knew I did this. And I'm glad it was a long sort of testimony, I tried out before I had to get up and walk away.

So let me introduce this distinguished panel, Christine Cassel is the President and CEO of the American Board of Internal Medicine. Next to Christine is Cybele Bjorklund who is the Staff Director for the House Ways and Means Committee. Leonard Schaeffer is next; he's the Chairman of Surgical Care Affiliates and Senior Advisor to TPG Capital. William Hoagland is the Vice-President for Public Policy at Cigna. And Juan Figueroa is the President of Universal Health Care Foundation of Connecticut. I've asked them to each say five minutes about how they think we can overcome the barriers and then I will ask them some questions and I hope you will be stimulated and start moving to the mics to ask your own questions. Christine.

CHRISTINE CASSEL, M.D.: Thanks David. First, I think I want to say that having a political scientist talk about petri dishes is a really good way to sort of lead off. What I want to do is just expand the disciplinary perspective of this discussion today. Let me just ask, how many physicians are in the audience? Any nurses? One over there, okay. I did notice all day yesterday and today that until the very end of Jim and Len's session this afternoon there was almost no mention of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

doctors and patients. There were occasional references to providers and as my friend Kathy Deangela, the editor of JAMA points out, what mother is proud of her son the provider. It's a very different way of thinking about what is actually a very human interaction, the doctor/patient or health care professional/patient interaction.

Now that observation is often used at the beginning of a testimony or an advertisement or something try to kill healthcare reform, so I am very aware of that. As a way of saying the status quo is too precious and we can't threaten it. But what I want to do is urge us and this group and I've been a member of this group for a long time to think about ways that the professions and particularly my profession, the profession of medicine, can actually be allies and advocates in healthcare reform rather than how they are usually thought of as being political barriers. And there's good reason for that, but I also have reason to believe that you are talking about changes and why it's not déjà vu all over again, I reason to believe from the window that I have on the physician world that this might be a window of opportunity for a different kind of medical voice to be advanced.

We did hear yesterday from Jonathon Gruber and actually from almost everyone who spoke that one of the things that really is seeming more and more urgent is this issue of affordability and how that stands in the way of any serious

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

look at expanding coverage. Katherine Schwartz said that the payers and I assume mostly this means the insurers, will have to be more aggressive at managing care and I just again would remind you that where the care interaction goes on is in the clinical interaction. What the payers mean by that is managing the providers and that's their angle on managing care. But it also has been, if you look at all these grafts, notably ineffective in many ways. And so here's my hypothesis that I just want to put out for you to consider. Physicians are big drivers of cost, not actually mostly or even in a major way in terms of their own income, but in terms of the power of the pen and the way in which they really determine what gets ordered. And we have, at least for the last decade, endorsed and embraced the idea of a healthcare marketplace as solving the quality and cost problems of the nation.

We haven't seen too many good results coming out of that, but we still very much believe in this marketplace. But that model, when you talked to a professional, is in fact an unfamiliar model. We talk about productivity, we talk about efficiency, we talk about business acumen, entrepreneurship, those things might get you some things in medical care, but it's not going to get you better and more affordable overall care of patients particularly the 20-percent, 10-percent, or 5-percent of whatever we think that number is that account for

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the major portion of the costs that are the most complex, most difficult patients.

For that there has to be some kind of model that rewards fundamental expertise and professionalism. Using that word, I want to wave this little thing around which was in your folder. You are probably wondering what in the world is this and why is it in a meeting on health insurance and a meeting of NASI. This is a charter on medical professionalism that was published five years ago now by a collaboration of the United States and European physicians feeling like the Hippocratic tradition was an important one, but was inadequate for the modern market based economy.

This simple little piece of paper has gotten wide attention and endorsement in medical schools, medical societies all over the world, translated into 17 languages, much more actually in Europe and in some of the countries that have national insurance systems. But if you take a look at the ten basic commitments that are in here they include proving quality of care, improving access to care and managing medical resources and managing conflicts of interest. Those are core professional commitments which actually could be leveraged if we thought about it that way to help get us to affordability and accountability on quality. So the key then is if the payers, whoever they may be, think about the incentives that are being provided in a way that supports that kind of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

professionalism rather than undermining it. Here I would just point out to you there was actually a press conference in this very room just before the holidays from the Commonwealth Fund and the Annals of Internal Medicine and our foundation, the ABIM Foundation about a survey that David Blumenthal did of physicians in the United States, some of you may have seen the press on it, showing that by and large physicians agreed with these core values and wanted to be able to practice in this way but found many of the incentives that were being put in front of them to be actually inimical or at least in conflict with what they were taught in medical school and why frankly most of them went into medicine.

If we go too far down this route of making doctors entrepreneurs and rewarding them for the market model we may, in fact, erode and lose that fundamental professionalism which I would offer to you would be very hard to get back. So, let's think of how the insurance world can actually help support the profession and in conclusion just to this little introductory part, the window that I have from the American Board of Internal Medicine which certifies 200,000 internists in the United States including all the subspecialties of internal medicine, is that most of those doctors are not political activists, they aren't the ones who are the barriers that the politicians see, they are struggling to see patients and get their job done and do it in a way that is personally rewarding

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to them as well as financially. And many of them would welcome different ways of thinking about how they interact with the payment system.

DAVID COLBY, PH.D.: Thank you Chris. Cybele.

CYBELE BJORKLUND: Thank you. I wanted to thank David and Paul Van de Water and folks for inviting me to be on this panel. I feel a little bit like the nursery rhyme about one of these things doesn't belong here. First and foremost of the health staff, we are never supposed to be out there on our own, so if there are press here I think I have to be treated just as a democratic aid because it wouldn't serve me well to have my name in print anywhere, not that I'm going to have anything particularly notable or quotable to say.

I would say also, to clarify that David gave me a promotion. I'm the staff director of the subcommittee not the full committee. In any event, I think what I'm really thrilled about is that we are in fact I think I'm a cusp of another try, so to speak, and another opportunity and it's very exciting and I wish I could have been here over the past two days to participate in the panel discussions and here what's been said because it sounds like there have been a lot of really interesting discussions. I think in terms of the déjà vu all over again I, as a young buck coming out of graduate school 15 years ago was just certain that the opportunity was going to pass me by and I wouldn't have any work to do and I regret to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

say that for the time being picked a profession for full employment and I'm begging everybody to put me out of work, I think, or at least give me new challenges.

I'm hoping that the moon and the stars are aligning to be different this year and I think some of the things that Chris talked about in terms of the dissatisfaction and the lies within the healthcare professions and some of the other issues that are before us may make a formula for success. I would say in terms of the barriers, we need to start obviously with everybody's commitment and buy in or at least their openness and by everyone not just democrats and our traditional allies, but and I will come at this from a democratic perspective, clearly, it's going to take republicans, it's going to take business, it's certainly going to take the healthcare profession and folks are going to have to be willing, obviously, to all get in the room and talk about it. I think that's difficult. The last 12 years I think have been very difficult to overcome, but I do think the excitement and enthusiasm that we are seeing out there this year on the campaign trail and elsewhere hopefully really is without wanting to sound trite, breeding an appetite for change.

I think timing is everything and when you look back at the timeline during the last health reform effort where admittedly hindsight is 20/20 it becomes very clear that not only did we have sort of process and procedural problems and

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

issues around the substance and attacks from the outside, but timing. And going back and reviewing the post mortem on the coverage and analysis of it having lived through it but trying to get a different view of it right now. You really do see where critical opportunities were missed and I think just going forward with our eyes open will have to be more aware of what's right at the right time and how to move into a window of opportunity.

I think the next administration irrespective of who it is, if they are pursuing health reform will obviously need to work hand in glove with congress and I think that that's just a critical aspect because you need only look at the efforts around us last year where we got into the realm of the ridiculous to see that we can't do it without a willing administration, the administration can't tackle something like this without the congress. I know that's obvious to all of you, but I think just bears repeating that we've all got to be sort of in it together as opposed to something hoisted on each other.

And I think having flexibility around meeting goals, I think we just have to, of course this can be thrown back at me next year when I'm advising our members to stay where we are, but I think it's really important that if we share similar goals there are going to be different roads to get there and notwithstanding Stuart's analogy in what's going on, people

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

might have to take a second best route and people are going to have to make decisions about whether something is good enough if it's not exactly perfect and whether we can get a running start. My members have preferred approaches, whether that can carry the day, I don't know, but hopefully there's a commitment to the goal we can get there even if it has to be a route that wasn't planned by the folks at the outset.

I think we are also going to have to really, in terms of overcoming the barriers for change and looking at the lessons from the most recent go round, probe the breadth and depth of support for change and whether there is a mandate, and I'm not talking individual or employer, but a mandate for change and how real it is. A lot of that will bear out over this year what's going on and to really manage public perceptions and expectations as well as the politics sets of issues. And I would say too that obviously healthcare is never simple. And so I hate to try to say that it is or should be, but I do think the concepts need to be readily understood that what we talk about as we are moving forward and things have to be translatable in a really fundamental fashion to the people you would see in the grocery store if not in Princeton, then Peoria. And I think this time that they are, I optimistically like to think we could make it happen.

And finally I guess I would say that I think this gets back on the flexibility point, I haven't seen necessarily a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

leading democrat yet, while they each may have their ideal notion of what they'd like to do, that the plans they are talking about right now and the things, and I mean on the Hill or on the trail or anywhere else, are a public only one size fits all big government approach. Everybody and I mean right down to my bosses, Chairman Stark and Chairman Wrangle, are talking about what essentially can be described as public/private approaches. And I don't think for a minute that we should be giving an opportunity for the foes of change and the fans of the status quo to scare people into thinking it is Canada coming down on the U.S., but nor is it going to be and I think it is clear that a private sector only approach is not going to work either. For the record we never thought that would work. But there's a role for the public programs and a very important role.

What our goals are is to build on what works and to shore up current coverage, create opportunities for folks that either don't have any under the current system or who are treated poorly under the current system and that, I think, is a growing class and a big reason why I'm even more hopeful this time around because you have a lot of people who realize they are but for the grace of god in terms of the uninsured and I remain sort of hopeful that notwithstanding the many barriers that are out there we have lessons learned if we can get a strong level of commitment and some of this I think we'll

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

discuss in the Q&A that David wants to lead us through. We can get there from here, I'd like to think. My glass is more than half full right now.

DAVID COLBY, PH.D.: Thank you. Leonard.

LEONARD SCHAEFFER: I'd like to thank Kaiser for the invitation and particularly I'm happy to be sitting next to you and hearing all this optimism. I, it turns out, I'm not a member of this organization in 1986, so I'm even older than that. I was an intern in the field in 1965. And they made great progress then in Medicare and Medicaid in the past and we ain't done much since. So the question arises why with all the conversation about the uninsured hadn't we gotten to a place. There are lots of reasons historically. But right now I believe the real reason is money. We are at a point in our history as a country where healthcare is becoming unaffordable and it isn't the old traditional issue.

I remember when Teddy Kennedy and I were both young, he's older than I am, but we were both young at the time. Healthcare was right, and there was no limit that you could put on how much of our budget, our money, that we should spend on healthcare. The problem is it's not our money. We are spending the Chinese's money, we are spending the Saudis money and as healthcare continues to cost more and more it becomes a threat to our economy and over time a threat to our national security. Please, don't underestimate this. It is very real

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

and we are seeing it now, the beginning, and in 10 or 20 years it's going to be a huge problem. So it seems to me if we want universal coverage we need both universal coverage and a mechanism to slow the growth of healthcare costs and a mechanism to insure we are getting quality. Later on, I really respect Chris, we'll talk about, I think professionalism and quality and the way that term has been used to say I'm trained to do it, but whenever I use the right thing and it's add value, so we are paying for a lot of stuff that may not be needed, it's professionalism and I think we have to be clear on where the money is going.

So it seems to me we've got to do both. We've got to try to expand coverage, we've got to try to control costs and improve quality. The difficulty is that to achieve that we have to change things that are very, very difficult to change. We have to change the underlying structure and processes for how the American health care system works, we have to change the system which is backwards and we have to change social values and those are all extremely, extremely difficult places to be. I have my list of barriers and I'll go through them very quickly just to set up what I think we can do about it.

But I think the first barrier to successful healthcare reform that I've been observing for a long time is that it's very difficult. It is a very complicated product. If there was an easy answer or a right answer we would have done it. I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think you all know that Franklin Roosevelt had a health plan, Harry Truman had a health plan, Richard Nixon had a very good health plan. None of them ever sold a thing; this is a tough sell.

The second issue and it's been referred to, but I think is very important is that the key players of health care normally perceives that they will win in a reform environment. In fact they all perceive self interest of both elected officials, people involved in the financing of health care as they probably will end up less well off. So there really is the constituency in the healthcare community for submitting the change. But the worst problem from my perspective, because I'm an operations directed person, is even if we knew what to do and could agree on it it wouldn't get done and it wouldn't get done because the American health care system is leaderless, it's poorly managed and it's not accounted. We've got no mechanism to make it better.

Physician behavior is very difficult to change; physicians are well, well trained over a long period of time. You could say they are behavior modified into a way of doing business and is not necessary efficient or, well, not necessarily efficient. The other side of those issues is that efficiency can and has recently been demonstrated to reduce profitability. So if we want a more efficient system, that may mean that players in that system are going to end up taking

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

less, in fact, what we have in the American health care system is exactly the reverse. In other words, individuals and institutions act in a matter to optimize their own situation and in so doing, suboptimize the whole thing.

What this country needs is more of what I do, because I'm sincere and I do it well. So, give me more money if you want to improve healthcare and I'll take that money and I'll make my situation even better and more effective than it used to be and in so doing I probably won't help the system as a whole at all. Now it's not just the financiers and the health care professionals, what we've done in our country with advertising and communication on the internet is we've created a voracious appetite of perspective patients. The internet positive patient is real, they walk into the doctor's office, self diagnosed with a 30 page print out, they know what they want and they get it a lot, an awful lot, it's hard to say no.

I mentioned social values, maybe we'll talk about it later, but I think those are the most important issues that we fail to talk about. And if you look at healthcare systems around the world, it used to be they varied based on technology or economics. That isn't the case anymore. Technology diffuses dramatically across the board. There are poor countries and rich countries, but there are a lot of rich countries and their healthcare systems vary dramatically and the reason is social value. What is your healthcare system all

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

about? Post World War II in Britain they were going to get rid of this business of aristocrats having a good life and everyone else having a bad life, but then they have an actual health service, free at the point of service everybody is going to get the same treatment, everybody is going to wait as long as they have to wait, that's the problem or they are going to get it immediately. Each of those healthcare systems that go around the world reflects a set of social values. Our social values are very confused because we don't articulate social values or social policy, but we pass laws. We have all kinds of expectations that are inconsistent with the way that healthcare system works.

Most Americans know their rights and privileges as consumers in a market economy so obviously more is better and more expensive is better. I'm a healthcare professional, I've been trained so whatever I do is the right thing. I shouldn't worry about the cost, I have to worry about my patients.

The second to the last point is elected officials, and I mean no disrespect, I worked on the Hill and worked in administration at a state and federal level, about healthcare, they don't want to, it is the new third grade. Social security beats this, healthcare is possible and you never win. I grew up in Chicago and I live in California, but I think that's two great examples. Danny Roznakowski at one time was the most powerful member of congress and if any of you are old enough to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

remember he reformed Medicare, went to an old people's home in Chicago and he was chased out by Nixon in Venezuela.

He came back to D.C. and he unreformed healthcare. Arnold Schwarzenegger, the governor, incredibly popular, powerful, healthcare - I can't get it on my own, I'm going to have to reach a compromise. The democratic speaker of the house they work for one year and he got terminated. He lost, his plan was voted down 7 to 1 in a committee, it never made it to the floor. Most elected officials don't know much about the healthcare system and they are very confused about how their lot. There's for profit, there's not for profit, there's private, there's government, they don't know who the good guys are. They don't know what the solution is. All they know is every time they do something they get in trouble, so they don't want to do very much.

There was a political commentator here who says that before this election cycle the decision was made by most politicians to use the bring your hands option, so whenever healthcare is mentioned you ring your hands, you show how much you feel the people's pain. So, those are some of the barriers. Now, if you look at the healthcare debates about reform there are usually two opposing camps, one are the people's belief of the market forces, the other are the folks who believe the government operations and government solution. I think that the problem with that framework is that it has

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

lead in action for years and the truth is that we don't have a pure market system in this country or a pure rating system. We have a mixed market economy and we've got to use that mixed market economy to find a way to truce. We need a blended strategy that's based on pragmatism not based on ideology. I have, of course, the solution in my personal ten point plan, but I'm not interested in talking about that solution or anybody else. I'm interested in looking at the policy and find a way of seeing that that blending occurs, that if we can link health cost insure problem, we can give up on a perfect ideological solution and end up with something that works, it's going to be a hybrid plan, it's going to be sloppy, it's not going to have the elegance that economists would like to have, who by the way I think they've done more damage to our healthcare system than anybody and you've got a whole policy maker the problem.

The problem, if you look back at history in the debates there's almost to a person the discussions are not based on facts and they speak to the emotionalism in a world that is real. What politicians want is [inaudible] so we have got to do those three things. I think the stakes are very high, I think there is a very short window of opportunity as policy people, maybe the next four to eight years. After that deficit talks come in, we've got to reduce the deficit and the deficit will be driven by Medicare and Medicaid if nothing else is

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

going on. They will fail and then the national security guys will come in and they will say we cannot allow this country to be owned and operated by foreign investors in our day, we've got to cut back in the only place that would be Medicare and Medicaid in our healthcare system.

So I think it's a very serious time, I think there are lots of barriers, but a pragmatic approach, not one that's documented, an approach that says we've got to get something done. We've got to get the right thing, we've got to get something done that extends coverage, reduces costs, and focuses on buying what we call quality care.

DAVID COLBY, PH.D.: Bill.

G. WILLIAM HOAGLAND: Thank you David, I'll go quickly. I realize that we are running out of time here and we are supposed to cover the barriers to change in five minutes after a very enlightening conference I was able to listen to a few of them. I have my three barriers that I've identified from the presentations that I've been able to listen to. The political, the economic, and what I call the healthcare industrial complex all three inextricably linked.

Real quick on the political side one of the takeaways that I take from this particular conference is that if we are going to have universal coverage in this country it's going to have to come at the federal level, not at the state level and notwithstanding the tenth amendment to the constitution. Now

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

this may be obvious to everyone, but I think it needs to be said. If you are going to do something as massive as healthcare reform, universal healthcare reform in this country overcoming barriers to change in the political arena simply means that this cannot be done unless it's done with a compromise, it has to be done on a bipartisan basis, something that has been lacking in this town for some time, maybe some elements showing its head last week, but it also is going to require leadership and I heard Uwe yesterday, one of his statements about how congress didn't care. With all due respect recognizing that I spent the last 30 something years in that institution up there, I think they do care. I think it is difficult. I think it is hard. But I do think just look at, the 108th congress Medicare part D in terms of prescription. They heard the need, they went ahead and congress tried mightily, this congress, on SCHIP and I think they are not over with yet on that.

But what is necessary for change is not just one-third of your government, but two-thirds, at least two-thirds of the executive in the legislative branch and so leadership with some bipartisanship to grease the sleds is really going to be necessary for any kind of changes to take place. It wouldn't hurt, of course, now I'm not saying which side should have this recognizing that I worked on the republican side for all those years, it wouldn't hurt if the country wasn't so divided and we

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

somebody had at least 60 votes in the United States Senate that would help also, of course.

On the economic front and this is where I'm going to put my budget hat back on. Among other reasons why I think universal coverage needs to occur must originate in this town is something I think Gene and others said in one of the panels, first of all, the universal to begin with, but more importantly from my perspective and witness California as an example, even large states don't have the resources, they don't always have resources and I also believe removing barriers to change, I feel strongly about this in the healthcare arena, starts with changes to the federal income tax code. So putting on my budget hat and not my Signa hat like so many issues that I worked on over the years, major social policy changes, the question ultimately comes down to show me the money, where's the money, how are you going to do this.

Some of the issues that my friend here has raised, some of those out year fiscal problems that I thought were so far out in the future, they are not so far out in the future anymore. Maybe it's the aging process that has set in on me too. We have a real problem coming on the demographics as we know, but also simply the rising cost of healthcare relative to the growth of the economy, but throw on top of that a social security cash. Social security cash surpluses are going negative here in less than a decade and of course the HI trust

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

fund even sooner than that. So finding the resources for funding this change is going to be a huge challenge.

I have a suggestion, my guess is just listening to some of the questions and discussions this is not exactly a pro President Bush crowd and looking at the president's approval ratings I don't know if you could find too many crowds in town that would be pro Bush. So this may sound a little bit like heresy and counter intuitive, but if you are to fund universal coverage in the future then this congress and I'm getting down in the weeds just a little bit, then this congress ought to extend the President's expiring tax provisions in 2010 and keep the taxes low. And why do I say that? I know it sounds strange, but why did I say that? Because under congress's own pay go rules which I support, universal healthcare as we've heard is going to be costly. I give Senator Clinton and Obama credit for even being frank about it, it's going to cost at least 100 billion dollars a year and you are not going to see cuts. Yes, the president is going to put off a lot of cuts on Monday in his budget, you are not going to see that paid for reductions in Medicare and Medicaid.

So let's be honest about it, what there is going to be is there is going to be a democratic conference, I say this having worked for republicans, this will be a democratic conference in the 111th congress coming, Speaker Pelosi will retain her job. But you are going to butt up, then, against

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

your own pay go rules when it comes to enacting universal coverage. If they don't extend the tax cuts now then they will be raising taxes on top of the current law which would automatically reduce the taxes and you'd have to go on top of that. So I believe it's inevitable that you are going to have to go through this route of somehow extending the existing tax cuts before you have money to pay for it.

Finally, just the last point I want to make here is in terms of what I call the healthcare industrial complex. I'm relatively new to this industry, but I have found in my short time, both in the public sector and now out here that one person's benefits are another person's income and this action seems to play itself out almost daily, what I call the healthcare industrial complex. I knew we all existed, I guess over the years, and now that I am one of them I find there are more organizations, more groups in this town across the country large and small to protect this particular reimbursement or this particular rate more so than what we used to say in the old days, more of these organizations than Carter has little liver pills.

My friends at AMA joined with AARP to spend more than 3 million dollars on this Medicare campaign last year to avoid reductions in physician payments under the SGR system with over 8000 some television ads, I get the sense very quickly that making changes at the margin is nearly impossible so yes, you

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

end up with the status quo. And fairness equal time, we had the unplanned, unholy, unhealthy alliance at AHIP and the tobacco lobby working to benefit each individually holding off Medicare advantage reductions and keeping tobacco taxes from increasing. So if you want to remove one of the big barriers to change in this town, somehow all these groups, all stake holders, doctors, providers, hospitals, teaching hospitals, nurses, oxygen providers, AARP, insurance companies, Farmer, and each of us as individuals we all need to step back, lower the noise and all be willing to make sacrifices for the good of universal coverage happening.

DAVID COLBY, PH.D.: Thank you. Juan.

JUAN FIGUEROA: Over here folks. I know we are the ones standing between your plane or your train, but overcoming these barriers, of course, is one of the central tenements about getting something done. So let me say this, like Bill I'm new to this area, I'm new to health and health policy. I've never seen or worked on an issue where the stakeholders and everybody who is involved is more stereotyped and maligned than in this arena. And I say that because it will be relevant to what I would like to talk to you in a few minutes today which is from the perspective from a state foundation that is trying to create the environment to get a state universal healthcare law passed, given the focus of our work and the fact that bringing these stereotypical people of each other maligned

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

folks together is the greatest challenge that we face in getting something done.

But let me just say a little bit, very briefly, about the foundation so that my comments can be put in some perspective. We are a 50 million public charity, a conversion foundation. When Anthem Insurance brought out Blue Cross Blue Shield there was a lawsuit, consumer activism, organized labor and others brought a lawsuit that eventually lead to the creation of this foundation. Needless to say I don't that if people look at us today that we would be confused with the Heritage Foundation in terms of our focus and our approach. But I will say this, given the conversations we just heard between the point, counterpoint with Jim and with Len, we like to think that, in fact, if you look at our board and most of us like to think that we think a lot like Jim and we think a lot that that's the ultimate vision, but you know what, our approach is a lot like Len's. Actually that conversation to me they are not mutually exclusive. I think for us and from our standpoint, both things can co-exist.

But let me say this, I think the bottom line message I want to leave with you today is we've heard in the last couple of days for me some of the sort of most articulate exposition of policy, policy design and it's connection to our healthcare system. But to us ultimately it's about the process, about getting us there that ultimately I think will make a

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

difference. That in turn, is even better than the politics of this whole process and for us it's a bottom up, top down approach. And when I say bottom up I'm talking about it is about building public knowledge and public will and demand for change. It is about building movement, it's about organizing it's about communications, and I'm going to come back to communications in a minute. And it's top down because in order for us to move ahead we have to be cognizant of the design of the different options and the different plans that could be put in play and actually for us, we have Jonathan Gruber who has been heard from over the last couple of days and we have Stan from the Urban Institute, we are working with them on some modeling for the state of Connecticut.

But ultimately beyond the design then, it's about coming together around one solution and let me just say about the top down piece this idea of being able to use research to bring different stakeholders together and bring, whether it's business, doctors, organized labor you'd be surprised if you put folks together in a room how you find more commonalities than not. Now, there's no question that there's a long ways to go, but we found, for example, seven chambers of congress and we've gotten together and I was talking to Christine about we are working with the Connecticut Medical Society, there is room. There is room for conversation and we are seeing that play, we are actually seeing that at play.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I just wanted to mention something quick about the docs that I was mentioning to Christine, it's hard to imagine having an ultimate solution to this conversation without having the folks that are in the trenches delivering healthcare to the population. Now I say that because yes, for us ultimately it is about bringing the practitioners together with the business folks. And look, we can now articulate, I think a very precise economic argument. Universal healthcare is the smart thing to do, but we should not let go of the moral underpinnings of this and I say that because in our approach that's why we have the clergy involved in this whole work in the state of Connecticut. They more than anybody else can carry that banner.

And when I talk about the bottom up in relation to these constituencies it is really ultimately about us getting to the middle class in the state of Connecticut and having the middle class of the state of Connecticut really pound the table of the man in their legislature, whether they are state reps or state senators and ultimately the governor. And to do that you have to be competitive in terms of getting out a message and being able to have ideas that percolate and turn ultimately into action and so for us that means we fund quite a bit of organizing at the regional level, but it also means that we've invested quite a bit in also communications, whether you are talking about message mapping, smart thing, right thing, the

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

right time to do it, or whether you are talking about paid media.

I want to actually use my last minute to show you an example of what that paid media looks like. The two commercials that I'm going to show you are 30 second commercials that we aired in the state of Connecticut three weeks at a time using communications as a way of getting attention to the issue and creating the environment. They are designed to try to be memorable, of course, and to be provocative in certain ways. So with that, let me just say that in the first commercial you are going to see was a version of three different commercials where we had docs and nurses and providers as part of the messenger and we also had a second set with business folks. So you are going to see the provider one. We can roll them. [VIDEO BEING SHOWN]

DAVID COLBY, PH.D.: We pushed our time, so for people who want to ask questions, why don't you come to the mics and I will start with - okay. Why don't you identify yourself and ask the question.

DIXON AWAR: My name is Dizon Awar, I work for the Men's Health Network, I heard panelists speak on this issue from yesterday up to this moment and when I came to this country a few years ago one of my first graduate classes I took I heard about the issue of social insurance in the United States or at least Medicare and one of the myths, I mean, I was

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

made to understand it was a myth that this problem, I mean, some people do say if they fix it, people are going to use it, so they don't want to fix it. My observation at this point is that I've heard so many talks about a lot of recommendations made and I've been made to understand that there are so many options on the table that there is just one option which I also think that maybe considered and that option is also something which I learned in this country in one of my strategic management classes and it had to do with the fact that if something is not working, one of the options is reengineering. Meaning that if it does go to a point where we do feel that this thing cannot work anymore let us council it all together and make a new beginning.

And when I heard all the conversations that were had and how healthcare cost has been going up over the years I've seen these talks in schools, in presentations and everything, so my question, my first question is, is there a point where we think that this cost has to reach before we believe that the system is not working and that we can get rid of it and kind of look for a new, an entirely new system, because the cost of fixing of problem right now, the way it is growing, it is getting to a point where it will be more than the cost of restarting a new system altogether. And if we can maybe consider starting a new system that may be great. And some of

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the barriers which I kind of thought that were not mentioned were the fact that—

DAVID COLBY, PH.D.: Let me let some people respond to that first question.

DIXON AWAR: Okay.

DAVID COLBY, PH.D.: Leonard, you raised the issue about the cost of the system and I think in some ways the question is do we have to really reform all of the pieces and you mentioned reforming quality, reforming cost before we reform the whole system.

LEONARD SCHAEFFER: Well, I mean the fundamental reality is there is no system, so you can't reform a system, you have to look at pieces of it. I think that for maximum political doability you want to change as many pieces as you would if you were to start from scratch. So you begin where people are familiar with a couple, but there are a couple of things that we can change that are very straightforward and that are part of our culture and the first thing is we can say that we are going to buy, all the financiers are going to buy things that either work, it's demonstrable that they work, identify the output or the outcome, or we'll say the universal process evidence based medicine approach that out to be used and if evidence based medicine approach isn't used or the [inaudible] pay for it and that's what I meant earlier about that kind of flies in the face of some of the notions of our

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

professionalism, unsupervised expert, you can be smarter purchasers in the government and private sector.

I think we should also take a look at the incentives that we put in. [inaudible] service medicine creates an incentive to do more and break things into pieces that are inconsistent with a medical home or a medical businesses. So we've got to change the incentives. I also think we can invite everybody in. The problem is some people are in and some people are out. We need everybody to be a participant and we can do that a number of ways with universal health insurance. But I think you go after pieces. One of the things that's increasingly popular is the notion of Medicare being expanded so that the amount of public who can join it certainly because everybody knows what Medicare is and the other option is people who get the health insurance from private health insurers will be able to do that. If you did that within this context of saying here's how much we'll buy, here's how much we'll pay for it, here's our expectations. That's probably an adequate solution. To start from scratch is physically impossible.

DAVID COLBY, PH.D.: Christine.

CHRISTINE CASSEL, M.D.: I just want to take Leonard on as he knew about this issue of professionalism. Professionalism has been seen as a smoke screen to prevent accountability in the past. But your experience is really from the experience of trying to deny claims and I'm very

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

sympathetic with that and in part what I'm saying is that - and I will send you some of this, look at the new literature on professionalism because the new literature on professionalism including this charter and including what our board and now all 24 specialty boards require of physicians to do as they maintain their certification overall lifetime, is to be accountable. It includes measuring the quality of care. So the word professionalism may have a bad taste because it is that old model and maybe we need a new way of talking about it, but from the physicians perspective, I want to also say that Hertslinger and Porter aside, there will never be the ability to measure everything to get a perfect accountability of the sort that you are hoping for and regardless of how successful or not paper performance might be the issue of a complex patient and the accountability for managing personalized, what the IRM calls patient centered care is going to require some degree of not having everything be a widget and everything be a nail and a hammer. You are going to trust the professional.

LEONARD SCHAEFFER: Some things can be identified.

CHRISTINE CASSEL, M.D.: Right, that was AHIP that did that.

LEONARD SCHAEFFER: I think the Definition of Professionalism I think is terrific, I read that. It is a massive cultural change, a massive cultural change.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

CHRISTINE CASSEL, M.D.: I would argue not, I think most doctors out there and this is from our surveys are frustrated with the fact that they aren't trusted and that they are nicked and dined to death and that actually going back to a model where there was a more comprehensive payment system that wasn't this fee for service hamster care would in fact, so I just want to urge everybody who was thinking about restructuring payment to take that into account that you are not hearing from a lot of the doctors who are really looking for some other options.

LEONARD SCHAEFFER: I think it applies also to academics, it's a bigger problem there.

DAVID COLBY, PH.D.: Let me give some other people opportunities here. So switch sides.

KIMBERLY SURE: Thank you, my name is Kimberly Sure and I'm a resident physician still in training and I've gone back to school to get a master's in public health and I've done some work recently volunteering with the Universal Healthcare Foundation, Juan's group and my volunteer work and coming to these meetings and a lot of other classes I've gone to this year is really almost made me feel so depressed, like we've been trying to get to healthcare reform since, what 1919, 1920 for our country. I want to see it in my lifetime and in my career. And the other thing I want for my career is I don't want to have to come to meetings like this anymore. I really

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

just want to stay in the office or the hospital and to take Cybele's comment, I want to take this part of my work and eliminate that job.

So my question is, all of you have talked about barriers, so how do we generate the public force to overcome this change and in Washington, because I think it may have to come at the federal level as well, how do we rise above the noise, that was another phrase said on this panel today. How do we get all these groups who are currently fighting for a piece of the pie or cream skimming and say we are talking about the wrong things, we are fighting about the wrong things how do we get there. I really want to know because I have a long career ahead of me. Thanks.

DAVID COLBY, PH.D.: Who wants to start on this?

CHRISTINE CASSEL, M.D.: How about Cybele?

DAVID COLBY, PH.D.: Well, I didn't want to put her on the defense.

CHRISTINE CASSEL, M.D.: What would really work in your perspective?

CYBELE BJORKLUND: Well, I think it's a difficult thing. I feel like in my remarks I was, for me, uncharacteristically Pollyannaish and trying to give a good we can do this and followed by Len who made me think well, maybe we can't. But I want to go back to my comments because that's what drives my members and after all they have votes and Len

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

doesn't and I don't, and that's what matters. I think, I guess there's a couple of things, I also do need to say that some members do know something, a lot of them don't, but some members have a long deep knowledge, more than most of us in this room on these issues and fortunately at least one of my bosses and the other one has other kinds of perspectives surrounding these things are in that camp of having knowledge, having driven reforms in the past, having been beaten back in the past, but a real understanding and commitment. I guess one thing I was thinking about is that even on a political level, and I really think of myself as a policy person who operates in the political world, so you have to take my political speculation with a grain of salt, that in some ways a lot of the redistricting that's occurred over the last decade or plus has made it so that there are very few swing seats but a lot of very safe seats and it means that if members, that's a big if, if members at large can be convinced of the need for change and the need to do it there's a smaller population of them who are more easily threatened.

Now it goes back to gauging what you are seeking to do and back to some of my comments and everybody else's about managing expectations and such because if you do stuff too far even those safe seats will be threatened. But I guess, and again, I'm a not a political scientist, but I was kind of thinking of things that also are different, materially

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

different, from the last go around and I think that hopefully is one of them. But I think overcoming the noise a lot of it has to bubble up from a lot of folks who have stayed around, between your planes and your trains as somebody, I think Bill said, and are willing to sort of work through foundations like yours and through the other national advocacy groups and going and demand change.

I do think that the industrial complex, I love Bill's term, the health industrial complex benefits from the status quo spends a lot of money and energy here in Washington to try to prevent change. But five or ten people wandering into a district office of any sort of rank and file member and demanding something is a voice that breaks through ten lobby visits. Thirty, forty, fifty people doing it, wow, 100 people showing up getting flooded, but it takes the honest brokers from the advocacy communities who the only thing that they have at stake is better coverage for people to be the truth sayers in it and I just thinking, the ability to obfuscate on this knows no bounds and my favorite version of that in which I'm trying to go back to my boxes if I can identify which one it's in, and pull it out for the next go around was during the last go around, the litany of postcards we got saying keep the government out of my Medicare. Big government, stay out of my Medicare.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So that to me is sort of a perfect example of how easy it is for someone to try to change the debate, but I think with people's eyes being opened that there has to be more of a demand this year and I think there is. I think even people with insurance are really worried. We have this whole huge class of people that's even greater than the number of uninsured who have coverage that doesn't work for them and that's not going to work for long.

DAVID COLBY, PH.D.: Let's have questions from the two people who are up there now, two new people. I think we are running close to time here and I will get pulled off the stage. So would you introduce yourself?

STAN DORN: Stan Dorn from the Urban Institute and thank you for a wonderful panel discussion. I'd like the panelists reaction to the following pessimistic perspective that I don't want to believe, but I've heard expressed. The kind of grand health reform that we saw in '93 and '94 and that appears to be a potential for next year is doomed to fail. It's been tried over and over again, we are talking about a seventh of the U.S. economy. No matter how you slice it somebody is going to get hurt. The combination of this, as Cybele put it, it's an easy target in terms of obfuscation and our political system is set up to make it easy to block things, so given all that, some people say, we shouldn't contemplate grand reform, we should contemplate one of two things. One we

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

should contemplate giving states increased authority to experiment and we've heard this view expressed from people from the historic right and historical left on the theory that let's try things in the states, once Americans experience it and kick the tires maybe would be more willing to do something nationally.

The second counsel that I've heard is to say let's be more like, nationally, let's be more like Minnesota or some other states that have pursued incremental strategies where in Minnesota for example first they did kids and then they did parents and then they did childless adults and now they have the lowest rate of uninsurance of any state in the country. So I'd like the panelist's response to that sort of pessimistic diagnosis and prescription because I don't want to believe it.

DAVID COLBY, PH.D.: Very quickly from my perspective we are doing 1993, 1994, whatever happens. Number two, you tell me what's going to be the outcome of the elections this fall, that may have a lot to do with it. And number three, I think the approach, what we are talking about here is universal coverage, expanding coverage to the uninsured. I think that incremental step in that direction, I think there are solutions on the table, I think it's very possible, I think still the issue will come okay how do you expand coverage, but how also do you control costs. Until that cost issue is addressed I

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

think you do run into a problem. Juan, did you want to say something?

JUAN FIGUEROA: Yes, Stan, my sense is that I wasn't deeply involved in '93 or '94, at the time I had some involvement, but not certainly nearly as much as now, but my sense is that things are different today in a sense that the crisis is a lot worse. Cybele talked about the middle class and the insured. This is something that's resonating a whole more and people are willing to talk about it who are insured. But because of either high deductibles or higher co-pays, etc., etc., they are worried, they are worried about their health security. So my sense is that the circumstance is different than '93 or '94. I think there is more hope for optimism.

And look, my perspective is sort of bias as the state as you know, to get things at the state level, but it is true that notwithstanding all the conversation that we are hearing at the national level with the democratic candidates or the candidates of presidents in terms of health care, it's not stopping the political leadership at the state of wanting to come up with something that's creative, that's new, that expands coverage, that tries to put people together in a room with people that need to be put together.

So my sense, and we are seeing this in the state of Connecticut, the last session there were two authorities that were created that are due to come up with a recommendation to

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the legislature on a universal healthcare plan by December of this year to be taken up as a top issue in this coming session in 2009. So I think all those factors are different. I think they put us in a different stead than I think '93 and '94. So there is reason for optimism.

DAVID COLBY, PH.D.: Go ahead.

BONNIE OHM: Bonnie Ohm with AARP. My question is for Cybele. I'm interested in what's on your agenda for this year given that we have mental health parity that's gone through a couple committees, we have GINA, we have physician doctor fix that needs to occur, what do you think is going to actually pass out of the congress, could you be a future seer for us?

CYBELE BJORKLUND: Well, we'll fast forward through this year to get to the meat of it for next year, but I think GINA is pending in the senate, it's passed out of the house. There is one senator who opposes it and the senate needs to call him on it and roll him, let him chat about it for as long as he wants to and have a 99 to 1 vote and get on with it. Mental health parity should come through the house floor, people are hoping, in February. There are some differences to negotiate with the senate. On Medicare, we'll have a Medicare bill this year. I don't know yet how large or small it will be. We are all cheerleading from the sidelines hoping that finance will be able to produce a good compromise and will go and negotiate from there.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I think the real thing came back to sort of panel in what we are talking about today in terms of the future that I hope for our committee is to have in a very limited calendar and I say that because between January and the March recess my committee has some total and some of these passed already of ten legislative days to work. They are in for votes more days, but that includes days that they come in at 6:30 because of all these primaries going on right now and then they are here on a Wednesday and maybe a Thursday and then they are gone again on Friday and so it leaves you very little time for committee business. That notwithstanding in my committee, Chairman Stark has talked about, we've outlined with him a series of laying the groundwork for health reform hearings. There's a lot of education that has to be done in all of the committees.

There's been so much turnover since the last go around and he was here and produced a wonderful bill that JAMA said was the best bill at the time, but there is a knowledge level that has to be built and we want to try and build that among our members this year so that when they get into the discussions and the meat of it next year we don't have to be going over even mundane, but important things like risk selection and risk clueing and things like that. There are varying degrees of knowledge there. So we've got sort of a series of public hearings and probably a broader series of seminars to try to educate both sides of committee again, going

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

to Bill's point that this has to be a bipartisan exercise and we hope it will be. There's been a tremendous amount of turnover on the republican side of our committee in terms of what happened last congress and then the retirements announced for this congress. So, we'll be looking at it in terms of prepping for healthcare performance and sort of an education year, getting people sort of up to speed and defining the problem and then really sort of what's going on to move forward.

I will say we went back and polled - I was not on this committee then and so I've gone back and pulled the prep work that our committee did in '93 and '94 and it was two hearings a week plus seminars. The intern I had had to go back because it was before things were on-line and pull out of our library the front page and the witness list and the topics for all of the hearings. It's a ream of paper, I could put it in a copy machine. Our members, often times it was just Pete and his then ranking member Bill Gradison at those hearings. They didn't all come to all of them, but there was a real appetite and a lot of groundwork laid. We don't have that kind of time this year, but we are going to do what we can to prep them for it. And I think all of the major committees have some of that planned. I think health does, finance, energy and commerce.

¹ kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

DAVID COLBY, PH.D.: Please join me in thanking this panel. And before you leave Chris O'Flynn has an announcement at the end, one of the co-chairs.

CHRIS O'FLYNN: Well, I just want to say on behalf of the co-chairs of the conference, Jonathan Gruber, Marsha Lilly Blanton and myself, thank you very much for attending and please we hope you found it useful. Please join me in thanking the NASI staff who put the conference together for us.

[END RECORDING]