

**Annual Conference:
National Health Policy Conference 2005:
Media Perspective on Health Policy
February 3, 2005**

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DAVID: I have the opportunity now to interrupt your wonderful conversation. I think from all of the conversation that I have had with you in the halls throughout these last two days, we have really had a very exciting conference. I want you to stay tuned and be ready to answer questions for our next two sessions.

I am first going to introduce Diane Rowland, Executive Vice President of the Henry J. Kaiser Family Foundation. I want to thank Diane for her support and for Kaiser's support of the National Health Policy Conference since its inception. You should know that Diane served on the initial planning committees and has helped through the years with helping us get excellent plenary speakers and she is instrumental for making this conference and its plenary sessions available through the Kaiser Network.

As all of you know, the Kaiser Family Foundation is devoted to providing reliable information to policy makers, the media and healthcare community and the public. We are benefiting today from Kaiser's ongoing work with the media and their strong ties to the health press and it is now my great privilege to introduce Diane Rowland, who will introduce our luncheon speaker.

DIANE ROWLAND: Well, thank you David and thank you all for being here. I remember all too well when we started

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planning this conference and we said would anyone come in the middle of February to a health policy conference in Washington? Would they come the first year and then think the topics are so old that they aren't coming back the next year and I think what we are learning is that the topics may be the same year to year, but the information is always new and the insights are always useful. Today, I am really pleased to be able to introduce both a good friend and a great colleague, Susan Dentzner of the NewsHour with Jim Lehrer.

Susan leads the unit dedicated to providing in-depth coverage of healthcare, health policy and Social Security. We can count on Susan to go beneath the 30 second sound bite to delve into an issue to look at all the angles, interview key stake holders and bring the story to us with a depth that is not found elsewhere in television reporting. In fact, that in-depth coverage is the hallmark of Susan's journalism. Prior to joining the NewsHour in 1998, Susan was the Chief Economics Correspondent and Columnist for U.S. News and World Report where she reported extensively on the debate over reforming and partially privatizing Social Security. Now that may sound a little familiar and I think it really does speak to the fact that many of these issues come around again and again and each time, hopefully, we bring new insights to them and on a few, like Medicare drug coverage, we seem to finally move on to get legislation enacted.

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This issue of Social Security is on the minds of many today, especially after last night's State of the Union address, but Susan's real expertise is in bringing the health issues we all work on and care about to the American public through her work with the Lehrer NewsHour and that to me is the hallmark of Susan Dentzer. She is always out front on the issues and thorough in covering them and does them in-depth. That set of characteristics is what I know Susan will bring today to the remarks she is going to share with us – an upfront and in-depth assessment of the tough issues in healthcare we are facing. Also, I know that she will bring with that a real understanding of both our complex healthcare system and probably more importantly, through this policy conference, of the complex political system in which these health issues will play out. So I am very pleased that Susan agreed to come today to share her insights and observations and know we will have an engaging plenary session. So, Susan welcome and we look forward to your remarks.

SUSAN DENTZER: Thank you so much Diane. Diane ought to have said that we would not be doing what we do at the NewsHour but for the support of the Henry J. Kaiser Family Foundation which has underwritten our show devotion to health coverage these last 6½ years. So, Diane, from the bottom of my heart and my pocketbook, believe me, thank you for making that possible.

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It's a great to be with you today with a select group of health services and health policies walks on whom I so regularly and completely depend. I may be the only person in television who tells you I desperately need your data, but I do – I desperately need your data. To me you are prophets in your own land and I regularly read your prophecies and analyses in your "bible" – Health Affairs – as well as some other publications that you include in the canon and I depend mightily on that.

This nice invitation to speak to this group today came with a suggestion that I speak about "the critical health policy issue of my choice." So, after looking at my own personal list of the top 200 or 300 that I try to follow, I decided to talk about what I described and is what is billed in your program as "The Real Crisis." I use the phrase real crisis to distinguish this from the many other things that get attached to that "C" word, the crises word these days. The speech you heard last night, for example, had a few "c" words in it – Social Security being one of them; we also heard about the crisis of the growing number of totally frivolous medical malpractice lawsuits that we know are causing the nations entire cadre of healthcare professionals to think about living medicine and become wedding planners and commodities traders. So, there are those crises, but I am going to talk today about what I view as the paramount real crisis. More importantly,

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about my hope in engaging you all in a further effort to explore the contours of this crisis, to report its particulars and I'll talk about all of that for about 20 minutes and I hope we will have a few minutes left over for questions or perhaps a withering critique of the news media or whatever else you might have in mind to share with me today.

When I think about the real crisis in healthcare, I often think instantly about how I can bring these down to the level of real stories – 8 minute stories, 10 minute stories and maybe we don't have the 30 second sound bite, but we probably don't have much more than the 45 second sound bite to deal with in television. When I think about these crisis, I am drawn to stories such as those that encapsulate these issues very well and I think one of the ones that I came across recently, and I hope it had been one of my own stories on the NewsHour, but it wasn't. It was a story that I read on the front page of the Washington Post back last October. The story started out as one of these, by now familiar, tales of a person without health insurance. This person having been a 53 year-old carpenter from North Carolina, named Howard Staub. Howard had learned last summer that he suffered from a life threatening heart condition and that he would have to undergo surgery to replace a heart valve, so he went to his local hospital in Durham, North Carolina and, as you know, there are a couple of large hospitals there, which told him that the surgery and attendant

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hospital stay would cost him somewhere between \$50,000 to \$200,000 depending on how it all went and that the hospital would happily perform it for him once he put down \$50,000 in cash in advance of the surgery. Now, the Post reporter who wrote that this was obviously an impossible sum for a self-employed carpenter without health insurance, but here the seemingly familiar story takes a bit of a twist because the Post reporter said, Staub decided faced with this situation that he had no alternative but to outsource the job to India, "taking his queue from cost-cutting businesses, Staub in September flew about 7,500 miles to the Indian capital of New Delhi. There he was met by a car and driver who took him to the rather implausibly named Escort Hospital – something in the translation doesn't quite carry there. The Escort Hospital, however, was founded by an Indian cardiac surgeon who had trained in the United States and practiced for years New York and then returned to set up the state-of-the-art facility in New Delhi. There doctors replaced Staub's bulky heart valve with one harvested from a pig. The total bill was about \$10,000 including the round trip and the planned side trip to the Taj Mahal.

Now, I was really struck by this story, mainly, because it came just weeks before a Presidential election, which I was frankly floored at how little health issues got. I tried desperately to persuade our show and others that they were the

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hidden issues that deserved everybody's focus, but obviously against Iraq and everything else it was a hard sell and I was very struck by the difference having covered the election race in 1992 versus the election race in 2004. When you look at every indicator, everything told you it should have been as much of an issue as it had been in 1992 and obviously it was far from that. As I said, I was so struck by this story that I turned around and wrote a tongue in cheek opt-ed piece for the Post suggesting that at last we had the solution to the uninsured crisis, which was simply to outsource the care for all of the uninsured to India. We could start by having call centers in Bangalore. You could call up if you have some problems, just the way you do with your Dell computer if it doesn't turn on. (I have personal experience in this realm.) I have developed a great relationship with some people in Bangalore over the last year or so. So, what's the difference - you would call them up and say I've got the sniffles today - oh! Thank you for calling! So, then through the miracle of the tele-medicine anybody who really needed to be seen by a doctor in India could go to a place stateside and then through tele-medicine, you could actually be examined by a doctor in India and then if you needed a prescription, you could place an order and one of the Indians in the off companies that is knocking off brand name publications of prescription drugs in India, which is what we used say until the patent laws change in a

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year or so. You order those and then, of course, if you had to be seen or operated on in India, I thought that these airlines that have, which are all going bankrupt, could be paid to do shuttle services of the uninsured and 45,000,000 is a big market. You could fly the people back and forth between Boston and Bombay and probably it would be cheaper than loan guarantees for the airlines. So, it seems to me that it would solve a whole lot of problems domestically. We would have no more overcrowded hospital emergency rooms choked with uninsured patients, no more worries about a nursing shortage because we no more overcrowded hospital emergency rooms choked with uninsured patients, no more worries about a nursing shortage as well because we would have all of these Indian nurses working to take care of our patients, hospitals would be freed up to do what clearly makes the most sense for them economically, which is to treat the well insured at steep prices, even giving them care that they don't need in many instances. So, this could solve a lot of difficulty. Just think about it, if we got to the 95 percent discount that Howard Staub got, we could cover all of the uninsured in this country for about \$10,000,000 per year. That's about what we spend in one month on the war in Iraq, so all the way around it would be an incredible bargain.

Well after that opt-ed ran, I got an unexpected deluge of calls, e-mails and letters from people. Some were, not surprisingly, from uninsured people who wanted the contact

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information for the Escort Hospital. One e-mail was from a young woman in Florida who actually had health insurance; she was in her 20s and had already a heart valve replacement and she just wanted to take down some information in case she ever wound up without health insurance by the time she needed the next heart valve replacement as she probably would in the next 10 or 15 years time. So, she was just lining up the options for the possible uninsured future.

Not surprisingly, of course, the Physicians for a National Health Plan posted my article on their website. Somewhat more surprisingly to me was that I got some calls and even one visit from an Indian businessman proposing that we go into business together. Since it certainly didn't strike him as an outlandish idea at all that we would do this.

Well, my purpose here today is not to talk about that article, although I now have done that for five minutes and I apologize. My purpose is to talk about this real crisis and in conventional terms we often describe it, obviously, as the crisis of the uninsured, but we all know that it is much, much, much bigger than that. It is so big that it needs one of these long Germanic words to encapsulate everything that is in it. It is not just that 45,000,000 people do not have health insurance and that at the, as the Institute of Medicine has indicated, that 18,000 Americans die prematurely every year as a result. It is not just that healthcare is expensive and that

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the cost and the aggregate are seemingly out of control. It is not just that health insurance is becoming increasingly unaffordable, not just for individuals but obviously for employers, as the employer based coverage system it seems is slowly coming apart. It is not just the fact that the only idea we have about what to do about this at the moment is consumer directed healthcare or as Ann Morrison has memorably called it now – “consumer deflected care” – and it is not just that our healthcare safety net appears to be at risk as we contemplate the further reduction in the growth rate and spending in Medicare and Medicaid. It’s not just that Americans pay the highest healthcare prices across the board, not just on pharmaceuticals, but on everything else: hospitals stays, medical devices, you name it. And it is not just that we do all of this and pay all of this, but that we do this without any sense of confidence that we are really getting our money’s worth and purchasing as much as we need to be needed appropriate quality error free healthcare. So with all of that, why not go to India. Well, you can easily see why I have trouble coming up with a single word for this crisis. I think of it as THE healthcare and health coverage crises. In this same way, I am sad to admit that it’s the same story that I’ve been covering in some way shape or form for about two decades. I am just in a later and more mature phase of the coverage than when I first got into the game.

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What I cannot get out of my head is that it is facing so many more people now and so many more lives and so much more money is at stake. Now, for us in the news media, one part of telling this story is very easy. We can find the stories of the people like Howard Staub. They are frankly falling out of the trees. What we don't know and what we increasingly need more in terms of research provided by people like you is what all of this means and where it is heading. So, what I would like to do most today is make a plea for you to keep on doing what you are doing - which is generating health services and health policy research that is relevant to this crisis that has no easily condensable name. I assume that you not only want to do this, but that you have some vocationally calling to do this. I assume that you did not go into health policy research because it is paying the big bucks, but rather that you feel that you might help contribute to some constructive solutions to social problems. Just between you, me and the wall, there are a few of us in journalism who feel that way as well, so I am hoping that we can work together on a new partnership to produce data and research that is applicable to us in covering this story of a huge crisis with no name and putting it into more digestible chunks that public and public policy makers, in particular, can understand.

So, here is my short list of things I could really use from you. Let's talk about the uninsured. Do we really know

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the whole story about what caused the lack of health insurance to exact on our population in terms of excess mortality? The IOM in 2002 came up with the estimate of 18,000 excess deaths among those ages 25 to 64 based at the time on 40,000,000 uninsured. A newer estimate, based on the health and retirement survey data suggests 13,000 excess deaths alone among the population aged 55-64. I have to admit when I first read the estimate of 18,000 excess deaths a couple of years ago, I said to myself is that it? You can just not insure 40,000,000 and only 18,000 per year people die as a result. Now, I admit this is the mark of a truly hard bitten and cynical journalist, but seriously, 18,000 is fewer by 4,000 than say the number of Americans who die every year of leukemia which is not among the most common form of cancers. So, is that really the entire cost and mortality of not insuring such a big slot of your population even for a while or is it that we are not counting the numbers were the effects right or if we are counting them right, why are numbers so low? Is it that people really are churning out of the uninsured ranks faster than we think and therefore becoming insured quickly enough that sooner or later they do get the healthcare they need or does it turn out to be the case that only getting about half as much healthcare as you need, which is what we think the uninsured get isn't as bad as we sometimes think? Maybe you are exposed to half as many medical errors, for example. Half as many hospital staff

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infections, half as many medication screw-ups. Whatever the case we need your helping answering more of these questions, because if we do harbor the suspicion that going without health insurance for prolong periods is a bad idea, and does manifest itself in worse health and greater death for the population, that is a story that we need to continue to keep front and center for policy makers in the public.

We turn to the cost of healthcare on my list here. Most of us have a grasp on the very basic story that the big drivers of growing healthcare costs are, obviously, technology and utilization. Most of us grasp the story that in healthcare, unlike other sectors of the economy, technology tends to be cost enhancing, rather than cost reducing. Most of know that that is somehow linked to insurance and the fact that insurance makes pricing sticky on the downside. But now that we have grasped that basic storyline, is it true? Are there technologies that are cost reducing as we suspect there are in healthcare and with information technology among them? Then, do we just fail somehow on healthcare to reap the rewards. Isn't that a question of never or just not yet? For example, we are only on the cusp of getting an electronic medical record and other important IT (Information Technology) tools. We recently have done a story at the NewsHour on the VA Health System that, as many of you know instituted the electronic medical record system wide. That system cost more than \$1,000,000,000 for the

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VA to build, but it just costs \$78 per year per patient to operate and the VA, moreover, will give you a copy of that software for \$60. You stack that up against the estimates that 1 in 5 lab tests in this country have to be repeated because the medical providers who wanted the results of those tests can't find them at the VA because these things are all available on electronic medical record just by managing to do one fewer lab test per year per patient, they can cover the cost of an electronic medical record. So, now we are now talking about maybe, just maybe, getting an electronic medical record nationwide by 2010. Well, you are all going to have to study what happens and if so, help us answer the question of why it is taking so long.

On cost containment, whether you call it consumer directed or consumer deflective healthcare, how is this movement going to play out. Is it going to lead us into the snarl of adverse selection or a brilliant new day of savvy shoppers looking for healthcare bargains on E-bay? Will the arch of this story look like the arch of the managed care story from, say, the early 1980s to the early 2000s – starting with wow and brilliant new innovation in controlling health costs and utilization. Everybody is starting to do it. Whoops! There are some down sides. Hmm, there are some real problems. Oh my gosh, it's a national scandal. Everybody hates it, let's get serious and have some federal laws against it and now there's a

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Hollywood movie about what bandits they are and then forget about, it's dead. Is that going to be the arch of the consumer directed care story the way it was for managed care. If it is, I'll be counting on you to tell me that over the next several years.

What about healthcare prices and healthcare pricing. Do we really understand how much of U.S. healthcare costs is related to U.S. health commodity pricing or are high prices the price we pay for having the most successful and largest capitalist economy that also happens to be the one that imposes the fewest reins on healthcare? How necessary are these high prices to keep the whole machine humming along. Like the familiar story that we hear that we need to pay higher pharmaceutical prices in the U.S. because every other industrialized country insists on paying lower ones and without our high prices, industry could not at all afford to undertake the R&D to develop new products for the world. Well, how true is that story. I ask because I once spoke with a securities analysis who covers the pharmaceutical stocks. Now, this is a guy how follows this industry for a living and he's bought big time into capitalism. He told me that every number that he had ever gotten out the pharmaceutical industry other than what they reported to the SEC turned out to be fiction with a little probing. So, what is the truth here and what is not? To bring up a specific case, starting next year, we will honestly need

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your help to tell us what the effect is on U.S. pharmaceutical prices of the new Medicare prescription drug benefit. What prices will the PBM and PPOs and PDPs serving these beneficiaries be paying for medications? Will these prices be consistent from region to region? Will Medicare's larger presence now in the pharmaceutical market have a dampening effect on prices or not. What, if any, new trends will emerge in utilization of drugs among those on Medicare. And, of course, the big question is will there be offsets as many claim as more Medicare spending on drugs reduces expenditures for other aspects of beneficiaries' care. Also, maybe there is another big question: How many beneficiaries who enroll in PPOs and PDPs will actually understand what he heck it is that they are doing?

Speaking of prices and markets, what about the old "saw" that I've long heard that healthcare isn't a single national market, but largely a series of local markets gone together since most people get their healthcare relatively close to where they live. Clearly, there are very disparate local markets who work with my good friends at the Centers for the Value the Clinical Sciences at Dartmouth and have demonstrated clearly through the Dartmouth atlas that the wide variations in care exist among states and within states in these local markets. That these happen to be local markets heavily driven by the numbers of providers in them and the

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whims of the providers in them seems fairly obvious, but how much of that is changing or is likely to change is more of a national or even global market for healthcare development. Arab sheiks have always gone to the Mayo or Cleveland Clinics for high cost and high quality healthcare. Now we see uninsured carpenters like Howard Staub going to India for the low cost, high quality version. Is a global market in healthcare likely to evolve, at least in some extent and will global pricing help to drive down U.S. health prices and maybe even rash of quality. Just as competition among steel producers or auto manufacturers or computer chip makers or almost any other aspect of manufacturing did over the last several decades.

It may not be as strange as we think, but I heard the story of a CEO who came into a meeting holding two seemingly identical heart pacemakers made and marketed by the same manufacturer, but one was bought here, in the United States and another that was bought in India, again, at a fraction of the cost. This fellow announced that he wants to import all of his devices from India and is pushing to figure out how to get the FDA to allow it. What happens if a tidal wave of lower prices emerges, not just for health commodities, but for health services and that hits the U.S. market.

Well, as you can see I could go on and on and on today, but I won't. We have a lot of work cut out for us, you and I,

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helping ourselves and the public understand what is driving this huge crises and what, if any, means are available for getting out it. The uninsured issue in particular having fallen as much off the radar screen as it has since 1992, forces our renewed attention on this issue.

The comedian, George Carlin, as you know gave a rather pessimistic take on Americans in saying that "I don't believe there is any problem in this country. No matter how tough it is that Americans when they roll up their sleeves can't completely ignore." Now, George Carlin makes me laugh, but I still want to prove him wrong and I bet you do as well. Thank you very much.

DAVID: You want to take some questions?

SUSAN DENTZER: Sure. I'll take some.

DAVID: We want to try for some questions. I would encourage you again to go to the microphones. As you may be moving to those microphones, I am going to turn to Diane and see if she has a question.

DIANE ROWLAND: So, Susan, if we need to get this issue of the uninsured back on to the agenda, what can the media do to help get it back there?

SUSAN DENTZER: The news media, particularly, the television news media, especially, can do a really good job of finding the people who are most affected by this and impacted by this and in the end – what was George Bernard Shaw – it is

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the mark of a truly educated person to deeply moved by statistic, but more people, frankly, in my experience are not moved by statistics like 45,000,000, but by the stories of individuals how have had to contend with lack of healthcare coverage and the burden it has on their families. We can do a very good job and will try to do a good job of that. It certainly, as I say, would be helpful to always have heads to hang this on and that is often in the form of new research, new data, etc. I can guarantee you if the IOM were to come out tomorrow and say we were wrong about that 18,000, it really is more like 70,000, I'd probably be able to sell the NewsHour on the story. It is the kind of thing that will help drive our coverage if we can continue to point to newer data, newer information and a newer set of understanding about what the impact is on people. How over and above the anecdotal coverage which we are able to get. We know we can go out and find uninsured people.

DAVID: I am going to ask Susan a question. (This is fun for me). One of the interesting things over the last two days is how much on the minds of this group and even certainly the governor from Kansas, Mark McClelland himself, the congressional panel that was here, how much for them Medicaid is an issue and yet the President and, at the top here, we don't see as much attention to this issue, so if we have some fundamental issues with restructuring of Medicaid, what we do

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about long term care and who should really be paying for that long term and then the important progress we made with S-Chip and not losing it as that gets renewed this year, how can the media help the policy-watts like us get the Medicaid story up a little higher on the media meter.

SUSAN DENTZER: Let me tell you how we are going to approach it. In my experience when I do a story on Medicare, I can make a first reference to Medicare followed by the phrase, the Federal Health Insurance Program from the aged and disabled and that's all the explaining that I have to do, then the rest of the time I can go on and talk about whatever the particular point of the story is. I cannot do that with Medicaid. With Medicaid, I have to insert an entire paragraph that usually goes – and you can imagine how thrilled my producers are when I try to form this into my story, but I find it is really necessary. Medicaid and how the program originally set up is a federal and state partnership to cover the core, but is increasingly morphed into a program covering the disabled elderly that now covers almost 51 million Americans more than Medicare and covers everything from uninsured moms and otherwise uninsured moms and kids, pregnant women accounts for almost 40 percent of the births in the country every year pays the bill for those and also pays at the other extreme one-half of all nursing home expenses. As I say, they just love getting that paragraph. But that is really the gist of the problem

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which is giving people an understanding of just how enormous this program is and how important this program is and increasingly how, but for the growth of this program, we would not be here today talking about 45,000,000 uninsured in the most recent census bureau survey, but at least 2,000,000 more. So, we are going to start by that, I am actually headed down next week to do a piece on 10 care because as all of know that is a program that is front and center or in the eye of this storm currently and we are going to tell people that 10 care has been an anomaly, of course, because it was the target of one of the earlier 1115 waivers in expansion population which now may lose its coverage, but we are going to start by explaining at least what Medicare and 10 care mean in that context and go on later in the course of the year to do more including probably talking to some governors to come in and talk on the show since they come into town at the end of February for the National Governors Association meeting. I think though, by and large, we are going to try to bite this off, at least on the NewsHour, story by story by story and hope over time to achieve a greater understanding of what is at stake in Medicaid and again, that is another one where many of you can be helpful to us. If in fact, we come out of this year with something like an agreement on how to restructure the program that is going to be one we will want to follow very closely. I am going to be highly dependent upon your research

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to tell us what the results of that effort will be. A question here.

CHRIS KOLHLER: Hi, Chris Kohler from Rhode Island. The prospects for focusing on the uninsured, for whatever long Germanic word we want to call it and given the language of an ownership society and the conversation that we had yesterday at lunch around the nature of personal responsibility and the no end of it and the way the consumer driven health plans can foster that sense of – you make bad choices, it's your own consequence. So you have a tide that is running the other way. There are signs of hope. We had this conversation at lunch: we don't let our Emergency Room doctors turn patients away. Medicare and Medicaid are growing and are kind of the signs of a collective responsibility, but yet all the stuff about ownership societies and personal responsibility seems to run against paying attention to those sorts of folks. So, are there specific strategies using the media and public relations to change the conversation a bit, because that whole scenario forces it off the screen in the way that you are talking about.

SUSAN DENTZER: I'm not sure that I know how to be completely responsive to that question, but let me say this. There is another piece that we have been working, which is looking directly at consumer directed healthcare. In our conversations with some of the people in the employer community themselves, a lot of them are nervous about this. No benefits manager wants to not do this if the CEO is reading in the Wall Street Journal everyday that this is the

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way is that Rome is working folks and you have to get on this bandwagon. So, every is exploring. Also, if you look at the surveys of employers, 99 percent of them say, yes, we are thinking about a health savings account or what have you in future years.

Privately, which is not great for television, they do say that they have a lot of misgivings about this. This one CEO told me years ago on a different context, when I was actually writing about employee training programs and empowerment groups that were very popular at the time, and in particular, manufacturing circles and I was writing a column about what a nifty idea this was and the CEO said to me, you know Susan, there is one problem with this: about half the people want to be empowered and the other half don't. So, if you talk to some the benefits people, they will tell you much the same thing. About half of their labor force really doesn't want the responsibility of deciding what to do with their healthcare dollars. It is the same group of people who went along with some of the Kaiser folks a number of years ago to a focus group of elderly individuals and this was the time of the Medicare Commission back in 1999 and, of course, what was in the ether then was the notion of choice again, competition private plans and gee wouldn't it be terrific if you could have 25 private health plans to chose among for your Medicare coverage and in the focus group I went to, one lady got who was in her late 70s and said, how about one good plan. That is a perspective for part of the population and so, I tend to think going forward that not everyone will come back five years from, let's say,

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and find everybody with an HSA or consumer directed health plan and therefore I think, and this the long way of saying it, there are limits to the ownership business and certainly the sense that I get from people purchasing healthcare from a corporate perspective is they do to. They think fundamentally, particularly some of the largest companies where there has been a very active effort to try to understand the source of health costs growth to make selections and assessments about quality providers, to institute paper performance programs, etc. They don't think that the same energy can be exerted by a bunch of individuals acting individually there, who are ironically the individuals who don't have that much confidence in the individual marketplace so much as they have confidence in the collective actions of the employer. As I said, that was probably not completely responsive, but at least I talked for 3 minutes on the subject.

Thank you very much, I enjoyed talking with you.

DAVID: You have already expressed your thanks to Susan and Diane as I add my personal thanks again and let them move on to their days.

[END OF RECORDING]