

National Health Care Working Group Discussion August 16, 2005

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RICHARD FRANK: Good Evening. My name is Richard Frank; and I'm a professor here at Harvard University and a member of the Citizens' Working Group on Health Care. I'd like to welcome you all to Boston and to Harvard University for this public forum. I am pleased to introduce Randy Johnson, who is the chair of the Working Group, who will, also, serve as the host for this public forum tonight and will direct traffic and keep us on track. Randy?

RANDALL JOHNSON: Thank you, Richard. I'd like to add my welcome to those of you who are in the audience this evening, as well as to those of you who are listening via webcast to this beautiful Harvard Medical Community Forum and facility--this amphitheatre. It's a beautiful opportunity for all of us; and we're so grateful, Richard, that you and others have made us able to be here this evening. In addition to you who are here, we will be webcasting--we are webcasting this event; and you'll be able to see it later at www.citizenshealthcare.gov.

This evening, we're going to have three presentations. The first will be by Richard Frank, the second will be by Catherine McLAUGHLIN, and the third by Dottie Bazos. When you came in the meeting this evening, each of you should have received a card on which you can ask questions. And, as we're going through the three presentations, we invite you to write

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your questions and share them with those who will be collecting them in the aisles. And, we're going to have a sizable portion of our discussion this evening dedicated to answering your questions and hearing your comments.

Briefly, our Working Group is a group of 14 people who have been appointed by the comptroller general of the United States; and we have four or five major functions over the next year and a half. We're in the process, right now, of conducting hearings; and, shortly, we're going to be publishing the *Health Report to the American People*.

We'll follow that report by the commencement in, probably, November, of community meetings on a nationwide basis, in which we'll actually listen to people in community and town hall types of meetings. We'll follow that up with preliminary recommendations that will be published on the Web site—recommendations that would be intended to be sent to the president and to Congress. And then, once we hear information from you, the public, we'll put those recommendations into a final order to give to Congress and the public.

We have a lot to be appreciative of here in the United States; a health care system that, in the minds of almost all of us, it is the best in the world—the envy of the world. And, we are pleased with the care that we receive in most cases.

But, the data shows that there are serious problems with our health care program. And, we have costs that have

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been, basically, running away. We have unaffordable care and, for many, unaccessible coverage. We have uneven quality. In fact, here are some numbers that cause most of us to really tighten our grips on our chair and ask the question, "What can we do with our American health care system?"

The average spending per person is \$6,400, according to a CMS report for 2004. And, it's expected that the cost will grow to \$11,000 per person by 2014. This is not per family; this is per person. So, if you're from a family of four, and you were just average, you'd have a \$44,000 health care bill by 2014. The data shows that approximately, give or take, 45 million Americans have no health care coverage. And, 45-percent of Americans who receive health care do not get the recommended care—do not get the right care at the right time at the right place.

The data, also, shows that we have up to 98,000 deaths per year just due to medical errors in the hospitals. And, private consultants indicate that we have an opportunity to take almost 30-percent of the current health care dollars out of the current spending, because of efficiency. So, we as a health care community as representatives, and many others who are in the public setting, understand that we can't continue this.

So, the president and Congress have asked the Citizens' Health Care Working Group to make recommendations that will

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result in health care that works for all Americans. Not going to be easy—we'll have to face tough choices; but that's what this Working Group is all about.

And, I'm going to, actually, introduce our three speakers. But, for those us who are not speaking in a more formal setting, I'm going to ask, starting with Mike Grady [misspelled?] to just give a brief introduction of himself. And, we'll go right down the line regarding our location, and so forth.

MICHAEL O'GRADY: I'm Michael O'Grady. I'm from Chevy Chase, Maryland. I'm the secretary for Planning and Evaluation in the Permanent Health Industries Services.

FRANK VALMIESTER: I'm Frank Valmiester [misspelled?]. I'm a physician from Portland, Oregon.

CHRIS WRIGHT: Chris Wright [misspelled?] I'm a registered nurse from Sioux Falls, South Dakota.

JOE HANSON: Joe Hanson [misspelled?] from Rockville, Maryland. I'm president of the United Food and Commercial Workers Union.

MONTY CONLIN: Monty Conlin [misspelled?] from Orman [misspelled?] Beach, Florida.

ROSIE PEREZ: Rosie Perez [misspelled?] from Houston, Texas. I'm a registered nurse.

AARON SHIRLEY: Aaron Shirley [misspelled?], physician from Jackson, Mississippi.

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DEB STEER: Deb Steer [misspelled?] from Lakeview, Iowa. I'm a family caregiver and health care advocate.

TERESE HUGHES: Terese Hughes [misspelled?], Centas [misspelled?] Family Clinic, California.

GEORGE GROVE: I'm George Grove [misspelled?] and I'm the executive director.

RANDALL JOHNSON: Well, this evening, your input, and that of many others, is going to be needed; and we hope this presentation will help lay the groundwork for your input. It describes the health care crisis that we face, how it affects us all, those without insurance, what's being done now to fix the problems, and what else we must do.

To lead us in our discussion, I'd like to introduce Richard Frank. Richard, as he's already noted, is a professor of Health Economics here at Harvard, the University Medical School. His recent research is focused on very significant issues in the health care world, the economics of mental health care and substance abuse, the economics of pharmaceutical industry, and the organization and financing physician group practices. Richard is, also, in the esteemed position of serving as a member of the Institute of Medicine and serves on the Behavior Sciences Board. So, Richard, let's turn our discussion back to you, if we may. And, we'll proceed from there.

RICHARD FRANK: Thank you, Randy. I'm going to try to

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set a little bit of the context in terms of economics. As Randy mentioned, the U.S. Health Care System has produced some rather dramatic advances. And, I just want to give you one example, which is the case of heart disease. And, this shows you the progress that we've made, roughly, over the last hundred years.

As you can see, I've identified when the Surgeon General's first report on smoking came out—the introduction of antihypertensive medicines, and the spread of invasive technologies, bypass surgery, PTCA [misspelled?]. And as you can see, the dramatic declines in mortality that we've experienced are very closely associated with these important break-through technologies, which are also driving up costs. And so, this really does illustrate both the dramatic benefits and, also, the dramatic expense that had been created by our advances in technology.

There are other examples as well. We've seen dramatic improvements over the last 50 years in what happens to low birth weight babies, reductions in infant mortality, tremendous improvements in the treatments of depression, breast cancer, and HIV/AIDS. In each case, these break-throughs have been driven by new drugs, new technologies, new knowledge that helps us manage these illnesses.

At the same time that we've had these great advances, we, also, have a system that can be disappointing at times.

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And, we seem to struggle with the challenge of taking the advances in science and the break-throughs in medical technology and delivering them to the people who are sick when they need it. And, so, what we see is that millions of people in this country don't get the care they need when they most need it and when it would benefit them most.

As Randy mentioned, a little over half the people in the country get the treatment that is most appropriate for them and based on medical science. And, that is a source of great disappointment and, finally, the about 45 million people have not health care insurance coverage at all.

Now, there are many ideas about how to improve access, cost, and quality of care in the United States. Washington is filled with proposals; and over the last 20 years, there have been many struggles trying to find the right proposals that will work for Americans.

The Citizens' Working Group on Health Care has been charged with expanding the conversation still further. And, in order to have a constructive dialogue, one of the things that we're doing in our reports in our initial work is to start a conversation based on information and facts that we can have a productive and informative dialogue. And, my job is to start talking about the economics side of things.

This graph shows you that health care spending is growing and growing fast. Today we spend about \$1.8 trillion

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in the health care system. A trillion dollars is big money. And, it represents a seven-fold growth over the last 25 years. And, if trends continue, what we'll see is, over the next ten years, a doubling of what we spend, from about \$1.8 trillion to about \$3.6 trillion by 2014. And again, along the bottom, you can see some of the numbers that Randy showed you, which is the growth and spending per capita from \$6,400 to \$11,100 a year.

Now, we can think about health care spending in two ways. And, one is what does it do to our pocketbook, what does it do to our income overall? And, then, what does it do, in particular, to the ability of the government to play an active role in helping to solve the health care problems? And, I'm going to talk briefly about both.

As you can see here, in 1980, we were spending about a little under 8-percent of the nation's income on health care. Today, in 2005, we're spending a little under 16-percent—15.6-percent. And, by 2010, we're slated to spend about 17.5-percent of our income on health care. Now if current trends continue, by 2040, we're going to be spending a third of our income on health care. And, when I was growing up, my parents used to always tell me some simple rules about budgeting, like, a third goes to housing, a third goes to food, a third goes to fun. Well, a third is going to be going to health care; and you can start to think about what that's going to do to the other pieces.

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Another way to look at the impact on our overall income is to think about what's happening to health insurance premiums. And, what you see on this graph is the growth rates and premiums. And, you can see that they've been somewhere in the range of five to 14-percent since 1999.

On the other hand, if you look at the bottom line of this graph, you see that that's the growth rate in earnings. And, that's been under 5-percent since 1999; and it's been, sort of, continuing at a fairly flat rate. And so, taken together, you can see that this has to be starting to cause squeezes on households, on budgets, and on our national income.

So, the implication is that, historically, we've managed to spend more on health care; but because income has grown enough, we've also been able to spend more on everything that we want. Under the recent trends that I've just shown you, our ability to spend more on non-health care goods and services is now being threatened in a fairly serious way.

Let's now turn to the Federal budget. Health care spending today is about a little bit under 20-percent of the Federal budget. You can see that these are the—I've got two sets of projections on the slide for you. One is if current trends continue, and the other one is if we slow spending by about 60-percent. And so, we'd still be growing a little bit faster than national income, generally, but much less than we have been over the last few years.

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So, if you look at the "if we do nothing" column, you'll see that we're slated to go from about 20-percent of the Federal budget going to health care. So, over a third, 36-percent going to health care spending by 2040. Even if we slow spending, we're going to be just under a third of the Federal budget going to health care.

So, the implications of this are several. If we continue along the path, or even somewhat less than we've been going on recently, we're going to have a very difficult set of choices. We're going to have the choice of much larger deficits, thereby, changing the economic opportunities we're going to be offering our children, large tax increases, and a much larger role for the government in the economy, which to some is a difficult prospect. Or, third, very large cuts in the activities of government that are outside of the areas of defense, social security, and health care. In fact, it's projected that a very large portion of our growth and productivity in the coming years are going to be increasingly taken up by health care.

So, the bottom line here is that in order to address the set of problems that Randy talked to you about, and which my colleagues will talk to you about in a moment, we face doing so in the context of economic circumstances that are tougher than they've ever been. And, it is really, in that context, that we need to start our conversation of how to make the tough

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choices, how to solve the problems, but do so in a realistic budget context. Thank you very much.

[Applause]

RANDALL JOHNSON: Thank you, Richard. Again, you should have received cards when you came in this evening; and if you didn't, we'll have some available to you when we get into the question and answer session in just a little bit.

Next, we'd like to introduce Catherine McLAUGHLIN. Catherine is the vice chair of the Working Group, a health economist with more than 21 years of research experience, currently professor in the Department of Health Management and Policy at the University of Michigan. She serves as the director of Economic Research Institute in their initiative on the uninsured. Previously, she served on the faculty of TUS [misspelled?] University. She's a member of the Council of Health Care Economists and Policy and Executive Committee of the American Society of Health Economists. "Special Interests, Special Knowledge in the Area of the Uninsured." And, she'll come to share that at this time.

CATHERINE McLAUGHLIN: As Richard said before, there are a variety of problems that we are facing—when we were asked to look at what kinds of decisions that we, the American people, have to make in order to reform the health care system to make it work for all Americans. In addition to cost soaring, another important issue is the uninsured.

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What to do with the uninsured? And this has been a problem that has faced this country for quite some time. As Randy said, I have spent several of my—a lot of my time the last several years focusing on the uninsured, and would like to share some of the information that I have garnered about the uninsured with you tonight. And, I'm posing it, not to try to threaten David Letterman with Top Ten—so, I didn't do ten. But, I did organize a few of what I call common myths about the uninsured. And, in part, this is to start the information exchange with you about who really are the uninsured? How many are there? And, what are some of the issues?

The first myth is "We know how many uninsured there are in a given year at any given point." Most of you have probably heard that there are 45 million—44.7 million uninsured Americans in the year 2003. And, this came from what is known as the CPS estimate—the Current Population Survey, which is a national survey that is done every year and has for quite a long time.

The good news about this survey is that it has been done for a long time; and so, therefore, we have nice information over time about what's happening to the number of uninsured Americans. The bad news is that we're not really sure what it's capturing and what that number means.

In part, it's because the survey is conducted in March and they call a random set of households in the United States

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and say, "Were you uninsured last year?" And then, "Did you have private insurance last year? Did you have Medicare last year? Did you have Medicaid last year?"

And so, in theory, they can tell from their answers to those questions whether the individual was uninsured for all of the year. And then, they say this is the estimate; and in this case, approximately 45 million Americans answered no to all the kinds of insurance coverage and answered yes to "Were you uninsured last year?"

Unfortunately, when people are called in March and asked this question, it's often hard for them to think about the calendar year, 2002, and think through, "Gee, did I have Medicaid at the end of the year? When did I get on Medicaid?" Or, "When did I lose my private health insurance?" Or, "When did I get a job with health insurance?" And so, it's really not clear what that measure is getting.

Other studies, that have looked at this more specifically, have found that the CPS estimate understates the number of people who lacked insurance for a period of time shorter than last year, and overstates the number of people who are uninsured for all of the twelve months, because of this connection and, also, misses details on how many people are uninsured for how long, and what the trends are for different population groups.

Two other federally sponsored surveys that are, also,

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based on national estimates are known as MEPS and SIF [misspelled?]. In this case, they also have a national sample; but they interview the same set of people every few months—in the case of MEPS, over a two-year period, and in the case of SIF, over a four-year period.

When they go back to that person in two or three months, they say "All right, since we last talked to you, were you uninsured at any of that time?" Or, if they had been uninsured before, "Did you gain insurance?" And then, they ask them, "Month to month, what was your insurance coverage?" So, even though over a two or three-month period, you may have some lack of clarity in your memory. Some of us, that's a bigger problem than others. Exact— "Was it March that I had that happen?" Clearly the measurement error is going to be much smaller than when you're asking someone for the previous calendar year.

What those estimates found, for example, the MEPS, is that one out of four non-elderly persons was uninsured for some period during 2003–63 million. That's a much larger number than the 45 million—the understate/overstate. But, only 34 million were uninsured the entire year.

So, you can see that the CPS estimate, the one that is in the newspaper most often, the one that is thrown around most often, is somewhere in between those two estimates. If we look at the two-year period, you see that 25 million were uninsured

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for two years—continually uninsured over those two years.

And, the SIF panel actually gives us a four-year window, in which we found that ten million Americans were what we may call chronically uninsured. They were uninsured for four years.

The kinds of people that fall into these different patterns vary as well, where we have some populations uninsured for much longer periods of time. Children are much less likely to be uninsured for an entire year. And in part, that reflects SCHIP [misspelled?] and Medicaid—two state and federal programs that are designed to providing insurance to low-income kids who can't have access to privately sponsored health care.

So, we do have this difference between the different groups; and when we're looking at policy changes, we should be aware of people who are chronically uninsured versus those who move in and out of insurance. The average spell, over those two years, in the MEPS for those 25 million—excuse me, for 34 million was eight months.

Well, what we don't know very well is, okay, how serious was it that they had a short spell of no insurance? In other words, how many of them got sick or injured during that spell and, then, didn't have financial protection for medical care and having either postponed getting care or received insufficient care. We don't have good information about that. And, some people dismiss it and say, "If you're not chronically

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uninsured, it's really not a problem." But, the reality is, we're not sure, because we don't have good information tying when the accident occurred, when the illness was discovered, and when they actually were without insurance.

And, for people of chronic health conditions, we suspect that even a two or three-month period without insurance for someone with chronic mental illness, for example, or diabetes, and lack of financial access to medications and treatment, could be quite serious. So, the transitions—who it happens to, who's experiencing, and how long are important for us when we're deliberating what to do next.

The second myth is that "The uninsured are all alike." And, primarily, people think the uninsured are poor, non-working, and sick. The reality is that the uninsured are a very heterogeneous group. While 25-percent are, in fact, in families below the federal poverty level, the majority of members of working families. Two out of three uninsured persons are in a family with one or more full-time workers.

This is something that most of the American public does not know. They really think that if you work, you have insurance; and, if you are poor, you have insurance, because you have Medicaid. Neither of those myths is true. We do have a group of what are known as the "young invincibles" in the insurance industry. Some of you in the audience are "young invincibles." Most of us up here are not. Those are the

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people between 18 and 34, primarily. And, the insurers say these are people who are young and healthy - they don't go to the doctor, they don't need care; and, therefore, when faced with any kind of trade-off to buy health insurance, they will choose not to, because they think they don't need health insurance.

And, we do see that people in the younger age groups are disproportionately without health insurance. We also see, however, these "tweeners," people who we feel as though should be able to afford health insurance and should be getting jobs with health insurance. One in five of the people who are uninsured are in a family where the primary workers earning between \$15 and \$25 an hour. That's not rich - \$25 an hour or full-time, full-year is \$50,000. But, people often think \$30,000 to \$50,000 a year—why should I be subsidizing that person? Why should the government with our tax dollars be subsidizing that person? They really could afford it. Why aren't they taking it up?

So, again, when we're trying to think about policy recommendations that we want to make, we need information about what are the pockets of people without health insurance? When are they uninsured? And, what are the consequences of it? If we look at some of the other information I give you here, we see that there is variation in terms of who are, what might be considered, chronically uninsured versus those with

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transitions.

And, sort of, the summary here is that age and wage are protectors. You see that younger people—the kids—are less likely to be uninsured. And, again, that's because of Medicaid and SCHIP. And, also, higher-wage workers are less likely to be uninsured, because they're more likely to either be able to afford the care on their own or to have a job that provides subsidized care coverage through their employer.

We, also, see that Hispanics are much less likely to be covered and much more likely to be without insurance the entire year. The recent MEPS data just came out two or three days ago; and we see that's still the case that one out of three Hispanics goes without insurance at some point every year. And, one out of two-half—are uninsured chronically over time.

This is something that obviously has to be taken consideration of; and some of it is due to the fact that they're non-citizen immigrants, and they're not eligible for Medicaid or SCHIP. And so, we have this gap in coverage for them through the public system. Some of it is that they're more likely to work in the service industry, migrant farmers, in jobs that are transient, and which there is no offer of employer-sponsored insurance.

The third is "Coverage is coverage is coverage." All right—that the only thing we have to worry about is "yes, no, you're insured." Well, that's really not true. There are a

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lot of people who are what are known as "underinsured." They really do not have financial protection against a very high cost illness. They may have a limit to how much their insurance will pay. Or, it may be someone earning \$30,000 a year who has a \$10,000 deductible. Well, once you look at \$30,000 a year and what it can buy, a \$10,000 deductible - if you, then, get very sick, it's not going to protect you.

A very simple way to think about this is to say, all right, let's decide that this country--when we're finished talking to everyone--says "We want universal health insurance coverage. We want every American to have coverage." And, we go to the president and to the Congress and say, "The American public has spoken loud and clear that they want universal coverage and they want everyone to have health insurance." Congress could pass a bill that says "We will provide every American with a \$100 of coverage. We have universal coverage."

Well, this is somewhat facetious, obviously, but that, obviously, would not solve the problem. We wouldn't be in any better situation than we are now. So, we really do need to think about what kind of coverage is appropriate.

The fourth is, "Those individuals without health insurance choose to be so." Well, in some ways, as I said, this myth is true. Those "tweeners," in theory, could afford to turn it down--I mean to accept it, rather than turn down the offers.

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And so, the question is, why? Well, affordability is a very personal concept. We all have a different view of what our risk is against financial consequences of being sick. And, we all have our own set of values of what is affordable. For people in that "tweeners" situation, what is it that we're going to ask them to give up?

If you're looking at a family of four, you're talking about 6, 7, \$8,000 a year just for a basic health insurance plan. If you're earning \$30,000 a year, \$40,000, \$50,000, what is that you're going to give up? Are you going to reduce housing, food, transportation?

And so, affordability is a concept that we really need a much better measure of in order to understand what is affordable and what is free choice and what is, in fact, people just hoping for the best, saying "I really can't afford to give up anything else. I'm just going to hope we all stay healthy."

The fifth is that "Health insurance would improve the health of all the uninsured." This is a common belief. And, often people look at disparities in health status and say, "If we could just get those immigrants health care. If we could just get those people with lower health insurance coverage health care, then those disparities would go away." Well, unfortunately, we really don't have good evidence that that's the case.

And in some, it's because we don't have a nice trial in

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which we just randomly say, "Okay, you guys don't have insurance. We're going to put you in the uninsured bucket. And, you guys are going to be the insured bucket. And then, we're going to see. We're going to see at the end of the year whether you guys are healthier after a year of insured health care and you guys are sicker. Because, when you guys get sick, we give you care. And, most of us, I think, are happy we live in a country where that's true. We're not willing to do that kind of clinical trial.

But, for researchers who are looking at it, it puts us in the statistical position that we're not really sure which came first. An example could be you could see a woman who is uninsured and low-health status. Either one of these two scenarios could hold. It could be a woman, who is uninsured, got sick, got injured, and then, did not get the care that she needed and was in lower health status than she would be if she had had insurance.

Alternatively, it could be someone who was insured, got sick, got injured, was forced to stop working, because of that injury or illness, and as a consequence, lost their insurance. We don't know which occurred. So, we can't rely totally on providing universal health insurance coverage to get rid of many of the disparities that we witness in this country today.

The final one is about the emergency room, that, the myth is "The uninsured are flooding the emergency rooms and

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causing us a lot of problems." We all see this in the paper all the time—people claiming half of our patients in the emergency room are the uninsured; and they don't need to be here. If they only had health insurance, they would go somewhere else.

Well, that, actually, is not supported by data. If we look at ER visits, at time of the visit, only 14-percent were uninsured. Fifteen-percent of the population is uninsured. What this suggests is that the uninsured use the ER proportionately. They use the ER at the same rates as those of us with private health insurance.

So, really, big users are those people with some public coverage. And, this is particularly true for children and for people who are disabled. They're the people who are using the ER, and I would say that most of us think it's not inappropriate—it's because they need it.

Tied to that is if we got them out of the ER, it would free up all this money. Well, the assumption is that they're costing us a lot of money in the ER. The problem is that if, in fact, they're there for inappropriate care, almost by definition, it doesn't cost very much. You hear the doctors complain that they come for a sore throat. They come for a bad bruise. They come for a rash. If they had a medical home, they could go and do that in a clinic.

Well, if that is, in fact, the case, the cost of

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treating any of that is quite low. And, because emergency rooms, like fire departments, have to be staffed for what the surge demands, the big accidents, a big crisis, the flu epidemic. Those extra costs of treating the uninsured, that 14-percent, are really not very high. It would not free up a lot of money in the system.

And then, the last is, and it should be clear where I'm headed here, this myth that "If we extend coverage to the uninsured, it will result in sky-rocketing costs." Well, again, if the uninsured are going to the emergency rooms for urgent and emergent care—appropriately going, then, they're already getting that care. And, we're all paying for it already. If they are going for inappropriate care, that's not going to be very expensive care. And, what the uninsured, we find, are postponing is preventive care, treatment for chronic conditions, and things that, in fact, in the long run, should actually save costs.

A recent estimate was that if taking this into account, what the system is already paying for, for the uninsured getting care, was that if we provided a basic plan to all the uninsured, it would result in a 3-percent increase than what the country pays for health care. So, it's sort of good news/bad news. I felt like Richard was giving us all the bad news about high costs. I'm giving you some bad news that there are a lot of people who are uninsured.

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There are a lot of people who go in and out of insurance coverage. But, the good news is that it appears as though they are using the system appropriately, and that there are solutions that we as a community could talk about and try to do something about.

[Applause]

RANDALL JOHNSON: Thank you, Catherine. You've certainly shared with us a perspective that most of us don't have regarding the uninsured, and we appreciate that and look forward to hearing more in the Questions and Answer period.

Our next speaker is Dottie Bazos. And, Dottie is going to cover some of the initiatives that we have seen across the country, as well as what actions and what steps will the Working Group be taking between now and the time we make our recommendations to the President and Congress.

Dottie is a registered nurse who works as a health care policy consultant and adjunct professor at Dartmouth. She's, also, led a project in New Hampshire for the children with chronic health conditions to maximize access and payment. She has a PhD from Dartmouth. So, we'll ask her for her comments at this time.

DOROTHY BAZOS: Thank you, Randy. Richard and Catherine's presentations beg the question of whether we as a society can make quality health care more accessible and affordable for all Americans. Issues of rising costs,

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uncertain quality, and uneven access have put pressure on all of us to find solutions to address these complex issues. So, for that I thank every one of you for coming tonight to join us in this conversation.

For the next few minutes, I want to talk about solutions. First, and I will talk very briefly, I just want to tell you a little bit about what's going on across the United States to find solutions. Second, I want to introduce you to the Citizens' Health Care Group and tell you why we were formed and how we fit into finding solutions. And, third, I want to describe how you can get involved and how you can help us tonight by helping us to take the first step to listen to the American public about what you think should be done to actually improve the health care system in the United States.

Communities, business, labor unions, insurers, governments—we're all trying—we're all seeking new ways to achieve affordable quality health care. Lots of different types of initiatives have been focused on us, on consumers. For example, right now my own health insurance pays for me to go to the gym three times a week. So, health insurance organizations are embracing or helping us to embrace healthy lifestyles.

Some initiatives are focused on helping us to become better consumers of health care, providing us data, teaching us how to actually compare the quality and costs of different

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health plans, doctors, and hospitals. Still other initiatives are focused on empowering us to share in the decision-making processes about our care with our doctors; so that we can be better consumers; so that we can actually look at the cost, quality, and outcome of the care that we're about to purchase.

Information technology, including the electronic medical record that we've all heard about, has been touted to be able to reduce medical errors, increase the portion of patients who receive appropriate care, improve communication between doctors and patients, and enhance coordination with different doctors and hospitals, and enable tell-a-medicine [misspelled?], which is very important in rural areas.

More and more physicians' offices, hospitals, governments, including Medicare, are now adopting and using the electronic medical records. But, IT as a solution is not just about electronic medical records.

A few weeks ago, we were at the LDS Hospital in Salt Lake City; and there I was fascinated with the way that Brent James, one of the Working Group members, and his colleagues have built a true learning organization, in which information is used to not only prevent errors from happening in hospitals, but, also, to develop new knowledge about patient illness and feed that knowledge back into the solutions about how we can improve health care.

Pay-for-performance is also one, of the other

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solutions, that has been brought about recently. Pay-for-performance efforts are possible now, because we have much better data on utilization and outcomes in health care. Some health plans are now starting to pay physicians to actually do what we know works.

We're going to hear tomorrow about some of these initiatives, and one of them that's been widely publicized is the "Bridges to Excellence" program. This program was started by a group of employers, physicians, health plans, and patients, and was created to realign everyone's incentives, so that the physician can do what he knows is best for the patient, so that the patient knows that he's getting good, quality care, and so that the insurer knows that he's paying for what really works.

Government is also developing new and expanded programs to help us take care of the issues of the uninsured. For example, the State Children's Health Insurance Program is being expanded. Prescription Drug Coverage under Medicare is being expanded. And, there's money now in the president's budget to expand federally qualified health centers.

Another initiative for finding solutions is one that's focused on small and medium-sized businesses, in which they're beginning to pool their dollars with communities, with employers, so that they can actually cover the people who are working for them. We're going to hear about one of those

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initiatives tomorrow about a nationally recognized initiative called the "Access Health Model." And, in this initiative, there's this, called the "Three Share Model." It distributes the benefit costs equally between employers, employees, and communities, and enables small and mid-sized businesses to provide a comprehensive mainstream benefit for employers of small business.

But, there is one big missing piece in all of these solutions. And, that piece, actually, I think, is us—the public. Congress wants to hear from the public. And, we want to hear from the public. While each of the solutions and approaches that I talked about are all important on their own, we know that there's no silver bullet out there for improving our health care system or for reforming it.

We know that we're going to have to use a combination of several different approaches to address the problems that we have in our health care system. And, solutions will require trade-offs and a national consensus on what those trade-offs should look like. To this end, Congress has asked to hear from the public. Thus, as a way to hear from the public, they created the Citizens' Working Group.

The Citizens' Working Group was formed by legislation under the Medicare Modernization Act. There are 15 citizens sitting here before you. We're users of the health care system just like you are. The Secretary of Health and Human Services

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sits on this commission with us.

We were all appointed to be on this by the Comptroller General of the United States, who represents many regions of the country. You heard where everyone is from. We're from 14 different states across the United States. And, we represent a broad range of health care perspectives.

Some of us on this commission are uninsured. Others of us have chronic health conditions ourselves or disability. Some of us are recipients of Medicaid or Medicare. We all use the health care system. Some of us work in the health care system. And, some of us, like Richard Frank and Catherine, are experts at studying the health care system. But, all of us, each one of us here, really believes that health care can work for all Americans.

We have a really big job to do. We've been mandated, through legislation. That means we have things that we have to do. We have an outline; we have a work plan; we have to do what the legislation tells us. And, it tells us that we need to take the problem of health reform to the public, to you, tonight. That's why we're here. We need to walk the public through the issues of costs, quality, and access, and through the tough choices of reform.

We need—we're charged to discover what Americans like and what they don't like about our current health care system and to give your guidance back to Congress. We're charged to

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build a national consensus on how best to improve the system of health care in the United States.

This is a really, really big job. And, how are we going to do this? We do have an outline. We can't just sit around and make this up. We're charged to hold hearings—regional hearings across the United States. And, those hearings are really meant to inform us and the public who attends about what's going on in health care now in the United States. We've already had four hearings. We've been to Crystal City, Maryland, to Jackson, Mississippi, to Salt Lake City, Utah, to Houston, Texas; and tomorrow, we're having a hearing right here in Boston.

With input from the hearings, from the literature, and from all of the commissions that went before us, we are going to take this information and draft a report called "The Health Report for the American People." And, we're going to disseminate that report widely.

Now, that report is going to be used just as the framework for a discussion. It's, sort of, going to be a status report to bring everybody up to speed about what really is going on in our health care system. Where is the money coming in? Where is the money going out?

Once we disseminate that report, and we will write it in several different ways, we'll have a large report on our web, we'll have a report that researchers can read; but we're

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going to, also, distill this report down into a ten-page report, so everybody in the United States, no matter what level they read at, no matter what interest level they're at, will be able to get it very quickly and join the dialogue with us.

We will also have the report on the web. The report will also be disseminated in a hard copy.

Once the report is out, we will begin the most important part of our work, which is, actually, to have a public dialogue. Let me go back to this. We will hear from the United States. During the public dialogue, we will go across the United States, listening to as many community groups as we can.

Once we have heard from consumers, then, what we do from the public—then what we will do is take that information and develop preliminary recommendations. Those will be put up for public input again. Once the public responds to the preliminary recommendations, we will get our final recommendations together; and those recommendations will go before the president of the United States and before Congress. The president is mandated to comment on these recommendations. Congress is mandated to hold hearings on the recommendations.

Now, when we go out into the public and tonight, we're going to focus our dialogue with the public on four important questions. And, these are the questions that Congress asked us to focus on: What health care benefits and services should be

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provided in the United States? How do the American people want health care delivered? How should health care be financed? And, what trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

Our dialogue is, also, going to focus on making very tough choices. The last question about trade-offs will be the most difficult question for you, the public, to answer. We already make tough choices about health care everyday for ourselves and our families. Now, we really need to work together to make tough choices as a nation.

So, tonight, I invite you to join us in the dialogue, help us to answer the tough questions, help us to find ways to get to the place where we can say that health care really does work for all Americans. And, with that, I'm going to return the podium to Randy Johnson. But, I'm going to leave our four questions right here for you to think about. And, I hope that's what you'll help us answer tonight. Thank you.

[Applause]

RANDALL JOHNSON: Well, thank you, Dottie. These are four questions that are very important. And, you have heard Dottie mention this evening, and we started off our discussion by saying that, we're hear to listen to you, the American public. And, we've been saying that all along. So, tonight, we have formed few, if any, conclusions regarding the

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recommendations that we'll make. We're still in the process of listening. That allows us to keep an open ear, an open mind to your thoughts and input.

We'll try to take some of your questions and answer them to the extent that we can; but the reality is, we might end up saying, and we'll need to learn more about that before we make a recommendation or we're able to answer your question. We have some microphones that are in the aisle, and we'll invite your comments at the microphones if you'd like. And, for those of you who are watching via the webcast, again, we invite you to share your input with our website, which is citizenshealthcare.gov. And, we'd be happy to take your comments or questions at any time.

We're going to spend the rest of our evening—our time together this evening with questions that you are bringing to our attention. And, again, if you'd like to make comments, feel free to share those in the aisle mic.

We've already had a question that's come from the Web site; and Dottie, if we can ask you, potentially, to respond to this one. "Will you be proposing any health care coverage for family caregivers of terminally ill or severely disabled relatives?" And, the follow-up question is—it's a two-part question. "Do you think the taxpayers could designate up to \$10.00 for stem-cell research on tax forms?" We're starting out with very easy ones, Dottie, you notice, and we'll look

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forward to your comments.

DOROTHY BAZOS: Thank you. As I said, when I was talking, our charge is to listen to the public. We have no—we do not know today—we honestly do not know what we're going to propose.

RANDALL JOHNSON: The question for those in the sound booth has been that the microphone may not be turned up loud enough for everybody to hear. Thank you.

DOROTHY BAZOS: Okay. Is this better? Okay. How about this? Okay. [Laughs] Okay. I'd just like to repeat the question: Are we going to propose—Randy, could you just repeat it, please?

RANDALL JOHNSON: Sure. The question that came to us from the Web site was: "Will you be proposing any health care coverage for family caregivers of terminally ill or severely disabled relatives?"

DOROTHY BAZOS: When I was talking, the piece that I really wanted to make clear to you as the public is we, as a Working Group, are not ready now to propose anything. We are beginning the dialogue with the American public. What we really want to know, and this is a wonderful question, about what is not working for you in America.

So, for the person who asked this question, obviously, care giving is a very big issue. So, we want to listen to that issue. We want to put it next to all of the other issues. And

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then, once we hear from Americans, and we listen to you about how you think care should be delivered, and what you think we should be paying for, then we'll begin to develop our recommendations.

So, what I can say is that this is a wonderful question. It certainly will be considered; and I'm hoping that it will be brought up again and again, and that we can hear from the American public about how they think that these types of issues should be addressed.

RANDALL JOHNSON: Mike O'Grady, who serves as Assistant Secretary of Health and Human Services representing Secretary Mike Levitt [misspelled?] is with us and serves on our committee and would like to add another thought.

MICHAEL O'GRADY: Yeah, there is a program—there is a program out there called "Cash and Counseling." It's done through the Medicaid program; and right now it's a demonstration. Often the way Federal Policy is developed, is you start out—you, sort of, do your research, and you start out with a demonstration, try it in a few states or in a few communities. And then, you see if you can ramp that up. You see how well it works, you evaluate it, and then you, in effect, take it up to scale—take it up nationally.

Now, that's a joint project between the Department of Health and Human Services at the Federal level and the Robert Wood Johnson Foundation [misspelled?]. It's been—I think four

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states it's in right now. And, I don't believe Massachusetts is one of them.

But, it's basically the idea of where you have a situation where they are talking about where you have—it's through the Medicaid. So, we're talking about disabled, we're talking about some children, we're talking some elderly in terms of that.

But, it is the idea where you don't always have enough workers, whatever they are, whether they're occupational therapists, whatever—enough people to provide the services. And, this allows a cash amount to be made available so you can do—hire your daughter-in-law to help take care of you or come in and dress you and some of those sorts of issues.

Again, there are always policy concerns about that. So, it's being very carefully evaluated to make sure this doesn't turn out to "I'm just going to give money to my son-in-law, or whatever." But, the initial evaluations have been very, very positive in terms of just this sort of situation. Can't you get the sort of care you need? It keeps people out of the nursing home. It seems to do quite a nice job.

RANDALL JOHNSON: Thank you, Mike. A comment from the audience:

MALE SPEAKER: I'm a physician who, in fact, focuses on care for patients with chronic illness. And, I think one of the problems is that we're trying to find a solution for two

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very different questions. For one of them, insurance is probably the correct term; and that's the healthy patient in whom our major concern is the risk for something that's unlikely to happen this year. And, for that patient, we focus on prevention, we focus on diagnosis, and we focus on the unexpected risks, like a car accident.

I don't think we can have the same approach that's going to cover the patient who has a chronic condition, which is what we spend a lot of our money for. For those patients, what we need is disease management. It's very expensive, it's not a question of treating a risk—they already have the disease; although, they have increased risks for other diseases. And that, for instance, I think may be inappropriate to tie to employment. Whereas, for the healthy person, I think, it may be reasonable to tie the insurance to employment.

RANDALL JOHNSON: Thank you very much. Another question for the Working Group deals with a person who asks from the perspective of not having employer coverage but would like to address the individual coverage market. And, maybe, Catherine, if you would like to respond to this, "Has anyone in your group looked at regulations regarding insurability of self-employed persons?" And, may I ask on top of that, or along with that, to what extent are there thoughts and recommendations for coverage for self-employed, for individuals who would like to purchase coverage?

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CATHERINE McLAUGHLIN: Thank you, Randy. When we were in our first public hearing in Crystal City, we heard from a woman who has been studying the individual market for a number of years. And, she did present us with some information about the variation across different states in terms of regulation for the individual non-group market, as well as the variation across states for premiums.

And, so we have, in fact, received some information about that, which we are putting in—some of it into our report. One of the problems, of course, is that every state is literally different when it comes to the individual market. And so, it's very difficult to summarize in any meaningful way, what that market looks like. But, one of the things that she did stress with us that the premiums are high, they're unaffordable for many people who don't get employer-sponsored health insurance, and there is very little regulation of the quality of the benefits that is provided.

And, there have been a number of states that have tried to address this issue through regulatory policies to ensure that individuals don't pay premiums, and then when they get sick, that company was just a fraud or they go belly-up—they go bankrupt, and they no longer honor that obligation. So, we know that—we know from listening to this particular researcher, that this is a difficult problem; and we look forward to, as Dottie said, in our community meetings hearing more and more

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about that variation across states and getting recommendations from all of you of what seems to be a reasonable way to approach this and what kind of solutions can the American public come up with that will fit those different needs.

RANDALL JOHNSON: Catherine, would you keep the mic there for another question on the uninsured?

CATHERINE McLAUGHLIN: Okay.

RANDALL JOHNSON: And that is, "To what extent or what is the age distribution of chronically uninsured?"

CATHERINE McLAUGHLIN: Oh, that's a good question. Because of the Medicare program, the elderly population has a very low level of lack of coverage. And, because of SCHIP and Medicaid, the children 18 and under have a relatively low level. So, we don't see a chronically uninsured in the children group or in the elderly group.

Most of the chronically uninsured occurs, then, in the non-elderly adult population. And, it is highest among those people between 25 and 34 years of age. It also—the real difference is, as I showed in my earlier slide, that Hispanics are much more likely to be chronically uninsured and low-wage workers. So, more important than the age distribution for the chronically uninsured are those two factors.

RANDALL JOHNSON: Thank you very much. At the microphone on our right.

ANN ELDRIDGE MALONE: Thank you. My name is Ann

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Eldridge Malone [misspelled?]. I'm a community health nurse. I do home care nursing in the inner city with the Boston Visiting Nurses Association. And, I teach as clinical instructor in hospitals and other health care settings. And, I do a lot of health care reform advocacy work. Also, a family member and, as all of you are, so I have a lot of different roles in relation to this topic; but, I just would like to, first of all, say I'm grateful you're undertaking this effort, but give voice to what the American people have been saying in many nationwide polls that the health care system is very broken.

It's not working well for many of us. And, that it's really an immoral situation that in the wealthiest country in the world, we have so many of our people without health insurance coverage, which is the ticket for access to care. And that, the American people have been asked and have said that health care should be treated as a right, that we, as a civilized wealthy society have the means to do it.

So, why do we allow this increasing trend towards treating it as a commodity in talking about the 5,000 different kinds of insurance policies that you could buy if you are fortunate enough to have the money to buy it or fortunate to work for an employer that helps you pay for it, when the people say it should be a right.

And, here in Massachusetts, I'm actually proud to be

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part of an effort to amend our state constitution and that answers your first question, "What health care benefits and services should be provided?" When we complete this—it goes before our legislature's schedule next Wednesday, August 24, for its second vote in the legislature, then to the state-wide ballot in November, '06. And, the language that we are inserting will say that "Every resident shall be ensured health insurance coverage that provides them medical care that is preventive for preventive, acute, and chronic conditions" - so, that's medical care—and that also articulates "and mental health care and prescription drugs and devices."

That is what health care consists of. That is what—and you know, and preventive care could be meant to include things like acupuncture or massage or your gym membership, as Dottie mentioned, because, we're not doing nearly as much as we should with health prevention or disease prevention and health promotion.

So, that is what we need to include in what we're talking about, what should be provided. And, excuse me, we already pay, more than enough to provide that to every person in this country, if we had a mandate that health care dollars go to health care. [Applause] And, how many studies do we need? [Applause] You know, showing how much is spent on misuse or overuse; and let's not forget to point the finger towards the incredible amount of waste that the insurance industry

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creates in our health care spending.

You know studies show that anywhere from 20 to 30 to 40-percent of every health care dollar in this state, the legislature commissioned an independent economic analysis, you know, a quarter of a million of our hard earned tax-payer dollars went to this study. And, how many studies do we need? And, show that \$0.39 of every dollar in this state on health care doesn't go to care; it goes to administration overhead. And, it's very similar to that across the country.

So, again, poll after poll shows that the American people support and answer to question number two, a government-run health care system that could guarantee that health care dollars go to health care; it doesn't mean that every provider, such as myself, a nurse, or doctors, or others would work for the government. But, they could collect the monies, and then, have regional budgets; and the care could be privately delivered.

I mean, we're the last industrialized country in the world, that doesn't have some kind of National Health Insurance program for its people. It used to be the U.S. and South Africa, when they had the Apartheid system. When they did the right thing and abolished Apartheid, they did the right thing, and established a National Health Care program.

So we stand alone with this immoral situation. It's really on all of our shoulders, and I'm so disgraced to in a

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country that allows this.

How should it be financed? I think to really make sure that health care dollars go to care, so we could all pay in according to ability to pay. So, it could be a tax base for individuals, and then employers could pay in, say 8-percent payroll tax, because they've been paying; so, we don't want to all of a sudden have that benefit for a worker not be there any more.

So, they could pay in a portion of payroll tax. And, we could spend less than we spend now and give comprehensive coverage to everyone if we had better stewardship of our health care dollars.

And that leads me to the last question, what trade-offs? I mean, that kind of infuriates me that we're told that we have to give up some kind of care, that the patients that I see, shouldn't get the counseling around their diabetes prevention, or access to the best treatments, because we can't afford it. Yes, we can afford it, if we mandate that health care dollars go to care.

So, I really hope that you might try and reframe that part of your conversation with the American people. If we look at what the facts are; you say you want to bring the facts to the people.

We're spending, on average, two times more than any other industrialized country in the world, per person on health

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care; and yet the world health organization ranks us 37th in the world, in the effectiveness of our system and the care that we give to our people and their health outcomes. So again, I'm very grateful you're undertaking this. And, I think that we have to address the issue of where the health care dollar's going now, and does that part of the health care industry insurance and pharmaceuticals companies that over charge—are they willing to give up that money so that that can go to care of people that we can not have an honest discussion, without really talking about those facts. Thank you, and good luck.

[Applause]

RANDALL JOHNSON: Thank you. One of the questions that we have had, right from the beginning is, "Is the United States spending enough?" And, we've had some feed back on that, so thank you for your comments. A question for those of you who are on the panel, here's one that asks, "What can be done about the costly bureaucracy that interferes with the delivery of health care and drains overhead money from the system?" And, Richard, you've looked at quality and costs, do you have a perspective on that, you'd like to share?

RICHARD FRANK: Clearly, there's a significant amount of waste that I think we tend to kid ourselves a little bit and pretend that [Interposing] yes, [Interposing] Okay, how's that? [Interposing] Okay, how's that? [Interposing]

All right. I think that, like any large enterprise,

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and we have a \$1.8 trillion enterprise in this country, you need management, then an administration, to run a health care system that's that big. And, I think there's a tendency for us to kid ourselves to think, well gee, you really don't need anybody to manage it; you don't need anybody to keep track of the dollars. And so, I think there's a tendency to overstate how little administration we can get away with.

Having said that, I also think that there's clearly a tremendous amount that we do that's sort of over the top and not as productive as it might be. And, getting the right number and figuring out what that is, is difficult work; but, for example, I think the Medicare program, in many respects, may not be our model for efficient administration. We may be spending too little on administration there, just because of the amount of waste there is.

On the other hand, the private insurance market, we may be spending somewhat too much on administration. So, I think that one of the things that we're really going to focus on is trying to get what the facts really are here, because there is a tremendous amount of propaganda on this issue.

RANDALL JOHNSON: Thank you, Richard. Before we go to you who are in the aisle, I'd just like to ask that you try to limit your comments to two minutes so that we can hear from everybody who would like to make a comment and respond to all the questions. So, unfortunately, our time doesn't go beyond 7

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o'clock this evening; but if we could do that, that would be helpful. And, I think this side of the aisle is next, so we'll go to you, sir.

MALE SPEAKER: Thank you. And, I'll try to keep it short. Based on the question, a few questions ago, when we talked about self employment, the problem with self employment is the self-people that are self employed often fall in the group of the uninsured. And, people look at the uninsured as people that do not want to pay for insurance. And that can't be further from the truth. Myself, I'm paying-I've had more than 300-percent increase over the last four years in my insurance. We are currently paying \$18,000 per year. We can't afford to pay for this type of insurance. We can't-we're not getting great insurance either-this is for very poor insurance; but it's just insurance.

The problem of trying to have it be in the state control-I'm from New Hampshire, and you can understand how important it is for me to come down on a Tuesday, from New Hampshire, to discuss this with you. In New Hampshire, we are left with only three insurers in the whole state and the reason that we only have three insurers, currently, is because the other insurance companies moved out, because the state tried to regulate the insurance companies to the point where they didn't feel like being put under the thumb of the state control. So, they moved out; they just went.

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This is where we need the federal government to come in and stamp down regulations that are enforceable. We're not looking for pie in the sky; we just want affordable insurance. It should be a God-given right, like that elegant [Laughs] elegantly put—the woman on the other side of the aisle, earlier said, this is not something that we should wonder or not whether we can afford it, or what we should have or what we shouldn't have—this should be a God-given right.

And, when you are self employed, you are already paying through the nose for everything. And, to be put into the group of the uninsured, simply because the insurances cost so much that you either have to eat or get insurance, even though you are working is just absolutely ridiculous in a country like ours. Thank you.

RANDALL JOHNSON: Thank you. [Applause] We have a question on the uninsured, Catherine. And here it is. "My kids are not 'Tweeners'" is the statement, and there's a relatively longer introduction, but the question is, "How do you plan to suggest that we adjust the system to help people like my children? Both children," and this is from a retiree, "Both children want health insurance, why can't I add them to my coverage like I could when they were dependants?"

CATHERINE McLAUGHLIN: I think that the previous comment about the self employed is very consistent with much of the information that I've presented; and it is definitely

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a problem, there's no doubt about it. From the insurer's perspective, individuals who aren't a part of large groups, who come to them for insurance, they suspect they know something about their health care use that I don't know. They know they're going to have a baby this year, or they know that they have a particular illness that runs in the family, or they already have some kind of condition that they're not disclosing. And so, they charge very, very high rates.

Their solution from a theoretical perspective, of course, is to pool across those different risks. And then, have everyone be average. In order for those pools to stay stable, however, the lower risk people have to be willing to subsidize the higher risk people. And, that is a problem that the American public is going to have to talk about.

So, the woman who was talking about trade-offs, that's one of the trade-offs that we have to think about. Will people who are lower risk be willing to be part of that large pool and not pay according to their risk but pay according to their ability to pay? That's a conversation that we hope to have with the American public over the next six months. And, those kind of trade-offs are ones that we have to talk about as a society, because some people are going to be losers, and some people are going to be winners in that kind of arrangement. And we have to talk about

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willingness to do that.

In terms of the dependants, it's that same issue that insurers are going to be worried that those particular adult children, again, have some kind of health care condition or expect to have babies or to have some kind of life decision that is going to cost money, and it's going to be difficult for people to do.

So, any of these kinds of changes in health insurance market—in the private market are going to require some kind of governmental reform; and that's one of the things we want to hear about. We want to hear what do people want? What do you want? And, it's not what we want; it's not what we think; we are really supposed to go out and feel the pulse, as they say—have you guys feed the canaries in the mine shaft, so that we can then report back. And, the hope, as Dottie said, was if, in fact, we do that, the President and the Congress will have to listen to what we said, because we will be representing you.

RANDALL JOHNSON: Thank you. Over here.

DR. PETER HELLUM: My name is Dr. Peter Hellum [misspelled?], a chiropractor. I also want to thank you all for your time and effort. I think it's wonderful that this is being done. I have a couple of quick points, hopefully under two minutes. One is I hope you do consider adding services such as chiropractic and alternative therapy to

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whatever the plan is out there. The other thing, from a personal note, I personally believe that a radical change in the health care system needs to be occurred.

I believe that the financing and the care, maybe—I was listening, actually, to Steve Forbes the other night, and I think he makes sense that maybe we should all consider a flat tax that can be incorporated into a single payer universal health care system that, also, has maybe an opt-out for people that have the money or want to buy a supplemental coverage for additional benefits that are maybe not covered by the initial plan.

And, I think that there is—we have so much duplication that is discussed. We have auto [misspelled?] insurance, health insurance; we have workers' compensation insurance, Medicaid, Medicare, private insurance. We have so many overlaps that is—basically, we're all providing the same care. I'm a provider, and I almost have to go to school sometimes to figure out what everyone's plan is. Wal-Mart people have a different coverage than Costco.

We're all individuals. At some point in time, it might be healthy. But, at some time when they get older, my kid might be sick. So, we—we're all one big pool, in my opinion.

My question to the panel is—and, I have asked this before, because, actually Richard Nixon was probably the

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first person to institute a universal health care coverage that didn't get passed. But, have the panel study the Australian system, the Japanese system, the German system—we all talk about the Canadian system; but has anybody ever studied the systems? When people come to my office and say, "You know, in Australia, we don't have this problem." So, has anybody studied the systems that might be working better than Canada? Let's see what else is out there. And, that would be my suggestion for the panel.

RANDALL JOHNSON: Thank you very much. Appreciate your comments. And, we can certainly, without responding in length to your suggestion, we have looked and heard about other countries' systems; and that has been part of the listening process that we have given to.

We have two doctors on our panel, Dr. Frank Valmiester and Dr. Aaron Shirley. And, if we could ask you both to comment on this just briefly: "What more should the federal government do to promote preventive health, such as prevention of obesity?" Which of you would like to go first? Frank, since you're closest, do you want to do that?

FRANK VALMIESTER: There's no question that obesity is becoming a national health problem. It's a recent discovery or appearance on the health care scene

[Interposing]

RANDALL JOHNSON: Are you able to hear Frank? A

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little bit closer to the mic, please. Thank you.

FRANK VALMIESTER: With the development of Type 2 Diabetes is a consequence of obesity. And, the difficulties of caring for obese people in general, is the difficulties that they have in functioning, and the development of heart disease, and problems of cholesterol, and hypertension. What the federal government can do about it—the way they're situated now is that public monies are, primarily, involved in the Medicare population and the Medicaid population. And, the main thing they can do is embark on an education program and begin to establish programs in the school system. And, it's a primary educational issue at this point.

How the public feels about that, again, we will learn in our dialogue with the public how they want to address the problems of obesity, which is really an individual problem. It's an issue like smoking, it's like alcohol, consumption—it's almost viewed as a risky behavior anymore. And, the question how does the public want to deal with members of the public who become obese and then become problems for the health care system? We'll wait to hear, and we'll incorporate that in our report.

RANDALL JOHNSON: Thank you, Frank. And, Aaron, would you like to comment?

AARON SHIRLEY: My personal view is I don't think the federal government can do anything short of better

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articulating their consequences. Many individuals are obese out of preference. And, you get into fads and other kinds of situations. I don't think the federal government in any way can directly impact on it. But, better articulating the adverse consequences might help.

RANDALL JOHNSON: Thank you. Okay we have a few minutes left. And, if we get one minute comment from each of you, we can get each of you in our discussion. So, that kind of limits you; but, would you help each of those others who are standing? And, we'll start over here; and then we'll go to that side, as we move toward adjournment of our meeting.

TILLIE RUTH TEXERA: My name is Tillie Ruth Texera, [misspelled?] and I represent, from Massachusetts Senior Action Council, 3,000 senior activists. I have one thing to say about obesity. The Feds can subsidize Physical Education in the schools and after school programs for massive participation of children. I have a grandson, who's in Olympic soccer development. My God, the amount of money that goes into that child; it's like two grand a year from a private source.

Okay, we need massive—Phys Ed is being cut out, okay, now I want to reiterate that \$0.39 figure for every health care dollar spent in Massachusetts—our council was part of the advisory council that, for the state, which did that study, and looked at all the sources of health care spending and try—it was supposed to come out with a recommendation about how to utilize that money wisely. But,

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the only thing that came out was the \$0.39 of every health care dollar goes for administration. And, that does not include, let us say, the physical plant, the hospitals and the heavy medical equipment. And, it also includes the very tiny administrative cost for Medicare and Medicaid. So, I think that we—that is where the money is.

RANDAL JOHNSON: Okay. Thank you very much, and, over here?

DEBBIE SOKALAR: I brought a short statement from my husband, who couldn't come, but who spent many years being uninsured and with a serious illness. My name's Debbie Sokalar [misspelled?], his is Robert Stanford, and, just one brief point from his comments.

He was, 20 years ago, admitted to the hospital with a brain tumor and called up his boss at his relatively new job, who said, "We didn't hire you to be in the hospital, you're fired." And, he suggests that nobody should have to go through that, and that that sort of employer's thinking about dumping sick workers for a variety of reasons, including health care costs for those who do have insurance, is one of important reasons it's crucial to make health insurance stop depending on people's jobs.

And, he also talked about comprehensive coverage and cutting costs. For myself, since I'm a person who works on researching health care policy, I would just say, I hope that,

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when you're looking at issues of trade-offs, that trade-offs in designing reform, shouldn't only mean trade-offs in giving something up, who are patients.

I hope you will take a broad definition of the term trade-offs and consider. So, do Americans want a health care system in which a lot of money is spent on advertising or not? Maybe we don't get a lot out of tax. Do Americans want a health care system with tens of thousands of different health insurance plans; and lots of money gets spent moving around the money and checking what's covered on different plans and so on? Do we want payment benefits that allow providers of care to profit inordinately by—and having incentives to provide unnecessary care? The desire to go out and get an unnecessary operation isn't something most of my friends want to do a Saturday night; somebody else makes money off of that.

RANDAL JOHNSON: Okay, thank you. We're going to have to go to the next person. Sir.

MALE SPEAKER: Yes, I've been a [Cough] dental educator for 35 years. And, I'm here to just answer your questions. Benefits and services provided, hopefully, you will cover dental care, as well as medical care in your recommendations. That's extremely needed. Regular delivery as it is today, but the financial aspect, I think is disastrous.

I was around at the time when insurance companies and

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hospitals were non-profit. I think that the switch to for-profit health care has been the worse mistake the government has ever made and should be absolutely [Applause] eliminated. My health care bills have gone up enormously since everything went for-profit.

And, my strongest recommendation was that we get to a fully government funded health care system that provides basic health care for all Americans; and then, if you want frills, go after that later. And, personally, I would be happy to see—to pay higher taxes, myself, if we had to for health insurance. I would love to see a decrease in defense spending, and [Applause] a decrease in government subsidies.

RANDAL JOHNSON: Thank you, over here?

WILLIAM S. COLEMAN III: Hi, my name is William S. Coleman III; I'm a nutrition educator for University of Massachusetts Amherst School of Public Health, Department of Nutrition, the Amass [misspelled?] Extension. I just want to read a brief letter to the editor that I have written; and I've got a package for each one of you, which is comprehensive. And, it lists what Central Massachusetts is doing for the uninsured; and we can study off this.

One thing that I will leave you with is two words, thrift gene—greater research on the thrift gene—it's in our bodies; and if we can learn to understand and control that, I think we'll do well. But, in Massachusetts, there are

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600,000 people without health care coverage—100,000 cannot afford to pay for the plans their employers offer.

Now Governor Romney has released a new plan for affordable health care for Massachusetts, residents, along with center President, Robert Travelini [misspelled?], he's introduced the new plan to the Boston Chamber of Commerce. Now with these plans, we have to be realistic when we communicate with folks in letting them know that even the work that you are doing—nothing is going to happen overnight; but there are a lot of things in place that we can put right to handle.

In our communities in Central Massachusetts, we offer several free health care options to people who do not have health care coverage. I know that when people present at emergency room, it's a difference between \$1,500.00, and not only does it present \$1,500.00 bills that could ultimately follow you, it can destroy your credit ratings, if somehow or another you get your life together. Now people don't think of things like that.

But I do want to say that the health care clinics that are provided around the country, and we have two great health care clinics in Central Massachusetts—we have a great Pro-Family [misspelled?] Health Center and we have the Family Health Center. And, those are provided in your package that I've provided for you. They—to support these programs, to

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continue to market these health care options for folks who have health insurance and might be able to buy more affordable pharmaceutical products, is something that I hope your committee may say let's look at around the country of the health care programs that we have in existence, and how can we help to provide those? And, just leaving you with those thoughts, you look in your package; and I am grateful to see that one of our greatest health care advocates in the legislature, Former Governor Mike Dukakis, is with us today, thank you. [Applause]

RANDAL JOHNSON: Thank you very much. [Applause]

Ma'am.

KATHLEEN BRIDGEWATER: Hello, I'm Kathleen Bridgewater, [misspelled?] and I'm a public schoolteacher. And, I have seen the difficulties that my students and their families have suffered for many, many years and it's time to call a halt to this. I deeply appreciate your four questions and suggest that universal single payer health care would save money, provide comprehensive care to everyone, and not involve divisive, morally objectionable trade-offs.

My question is how willing is your committee to vigorously champion the only solution that fulfills all five principles of the health care reforms set out by the Institute of Medicine. Will you defend the only solution that saves billions in the health care system as a whole and saves

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American patients hundreds of billions of dollars, while providing universal high-quality comprehensive care?

Having 45 million or between 25 million and 84 million people without health coverage in the United States is a national disgrace and a public health time bomb. Chronic worry about health care is typical for both the uncovered and for those with inadequate coverage. When serious health emergencies arise, most people, even those with health insurance, have their physical problems compounded by medical bills that can easily overwhelm their ability to pay.

Unlike other industrialized countries, only in American do we allow two-fifths of every health care dollar to be drained away for non-medical purposes, while many of us have sub-standard care. Any right-minded observer knows the current arrangement of paying middle man in order to get services is a form of highway robbery that we have condoned for far too long.

The pernicious links between wealth and health subvert medical providers' solemn pledges—solemn oaths to provide quality care for all. We need to stop asking who is worthy of comprehensive health care? The system that posts gate-keepers between the sick and the caregivers is as expensive as it is morally corrupt. The common sense solution to the health care crisis is the single payer system.

Multiple studies and 40 years of Medicare give clear evidence that it will work. With single payer as the funding

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model, all four questions you are deliberating are easily answered. A single payer system would guarantee funds for comprehensive care, all medical services, including all dental, eye care, mental health, long-term care, hospitalizations, medical devices, and pharmaceuticals to everyone by certified providers of their choice.

High-quality health care would be affordable to individuals, families, and to society. Health care would be based on medical need and not the generosity of an employer. In Massachusetts we spend more per capita than any other state. Our population of 6.5 million would save more than a billion dollars a year by instituting the Massachusetts Health Care Trust under our State Senate Bill 755.

Single payer bills are filed in other states and are gaining support. A notable example is the Pennsylvania Balanced Comprehensive Health Care Reform Act of 2005. I strongly recommend you read it.

Were we to pass the federal single payer bill, the U.S. National Health Insurance Bill, HR 676, our nation's total household medical expenditures would drop from \$326.7 billion to \$65.9 billion annually, greatly reducing the barriers to care. My question to you is will your committee serve the people or follow in the footsteps of too many elected officials who have easily given over to serve the medical and pharmaceutical corporations? Will citizens through this

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process of the Citizens' Health Care Working Group finally regain the power to improve our physical and financial health?

And, I also want to say, please make sure that you read Debbie Sokalar's "One Billion a Week is Enough." Her research is phenomenal. I hope you make sure you read it. Thank you.

RANDALL JOHNSON: Thank you for your input. [Applause] Sir.

KENSI AVISBAR: Good evening. My name is Kensi Avisbar [misspelled?] I'm a physician and I'm a fellow in FYDC [misspelled?]. As for my fellowship, I'm now doing Mass [misspelled?] of Public Health at Harvard. And, I have a comment, probably a question, that's comments regarding Dr. McLAUGHLIN from University of Michigan.

In one slide, she mentioned that uninsured use the system appropriately. And if that's what she means, I was somewhat shook, based on my experience in American hospital, I found quite opposite. The system we have now for the uninsured is very, very difficult. It's just opposite, and is a somewhat shameful system for uninsured. When insured people—they don't like to go there saying that they are uninsured. First of all, they are being discriminated against.

This is—again, I'm not bringing you fact, but my intuition, what I have witnessed, is the fact that people who work in the hospital emergency rooms, without health insurance, they are being stigmatized. They are not being given

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[Inaudible] of care, even though that's what they should do, but the reality is they're not getting the specialties as fast as the people who have the high insurance. There are these - some kind of double standards.

So, I don't think they use the system appropriately. In fact, I have met many elder as many people that say they don't go to emergency room or the doctor, because they don't have insurance, because they are afraid that they will be treated by [Inaudible] over and over again, even if they have conditions that's not life-threatening.

So, I find quite the opposite. And, also, I think that the system that—the basic universal health system will realize the notion of dignity, which is missing now. [Applause] Dignity, as opposed to charity—when those people who are without insurance goes there and you say they use the system appropriately, which I don't think they are, is like charity. Even the medical staff, many people know—they know they don't have insurance, they treat them differently. They don't care to as special, as I said before.

And, I don't think that the system work right now. And, even when they go, even when, we said that tax payer would pay for them, they still—we send them bills for many, many years that can treat in their future, and then the credit history, and everything. So, I think you need to review this thinking and see what the reality is.

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RANDALL JOHNSON: Thank you very much for your comment.

[Applause] And, our last comment—right here.

KATHERINE ARROT: My name is Katherine Arrot

[misspelled?]. I serve on the board of three non-profits involved with the community in long-term care of the elderly. I, also, serve on an IRB. And, my prior career was in supportive medical research computer science. I have three comments to make. I feel this country is too big for one total universal system. I would suggest for those who are looking at a totally government-run system that we study the Veterans Administration.

What has that caused per patient? What are its successes? What are its failures? And, how did the Veterans feel about that system?

The second question is, I remind everybody, that even though we have Medicare, it has to be supplemented by private insurance. So, that's something to be understood, that even that government program is not complete.

And third, Medicare—the Medicaid budget, at least in this state, and probably in most other states, that three quarters of that budget goes to paying for long-term care, mostly for people who suffer from dementia. And, unless we get a handle on that program, that is something that is going to sink the ship. And, I think people in the younger ages have no clue that long-term care is not financed by the government

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until you run out of your assets.

And, this is a huge iceberg. And, I hope you are considering this and looking at research to reduce dementia. Otherwise, we've got another huge iceberg that's not being mentioned tonight. Thank you.

[Applause]

RANDALL JOHNSON: Thank you very much. Thank you very much for your articulate comments. And, to you who have been here in the audience and shared your perspective, we thank you as well. You might suspect that the people on our Working Group have some passion regarding this health care subject. And, we sense your passion as well. And, so, we appreciate that.

Now, we have other comments and questions that have been raised that we haven't been able to get to this evening. And our Working Group will be here for 15 minutes or so, if you would like to approach any of us directly. Meanwhile, just a reminder to you, as to those of you who are on our webcast, that you can still submit your comments to citizenshealthcare.gov.

Secondly, you're able to review this proceeding that we've just gone through for the last hour and a half on the same Web site, www.citizenshealthcare.gov, should you wish to do so in the future. And with that, again, we'd like to thank you, Richard Frank, for your hospitality this evening and

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earlier today. And, the hearings that will be conducted tomorrow at 8:30 will be right here in this building. And, in those hearings will be—we've extended invitations to those who are of a special expertise to come and share their perspective with us. But, if you'd like to attend and listen, you'd be welcome to do that, too. With that, we'll adjourn our meeting for this evening. Thank you very much for coming.

[Applause]

[END RECORDING]