

THE FEDERATION OF AMERICAN HOSPITALS

**2007 PUBLIC POLICY CONFERENCE
AND BUSINESS EXHIBITION**

MONDAY, MARCH 5, 2007

**8:25 AM – KEYNOTE ADDRESS:
COMPTROLLER GENERAL DAVID WALKER**

**9:15 AM – CONGRESSIONAL STAFFERS PANEL
ON THE UNINSURED**

**MODERATED BY SUSAN DENTZER,
“THE NEWSHOUR WITH JIM LEHRER” (PBS)**

*Transcript by:
Federal News Service
Washington, D.C.*

TIM MARLETTE: Good morning, everyone. Welcome to the opening session of the Federation 2007 Annual Public Policy Conference and Business Exposition. I'm Tim Marlette with Community Health Systems and it's been my honor to serve as chairman for the Federation's Exposition Advisory Board this past year. (Clears throat.) I'm sorry; I'm a little under the weather, so hopefully I can get through this.

The Federation is the national representative of investor-owned managed community hospitals and health systems throughout the U.S. The Federation plays a prominent role in shaping congressional debate on many important issues such as Medicare and Medicaid payment structural reform, rural health issues, development of compliance and quality guidelines, and confidentiality of patient records. This week our program features a broad range of policy experts, business and health care leaders, elected officials as our outstanding faculty, and they will share with us their ideas on how the health care industry is evolving and what we as health care providers must do in order to ensure the continued delivery of high-quality and more affordable health care to our patients.

It has been an honor this past year to serve as your expo advisory board chairman, and I'd like to recognize the hard work and dedicated efforts of all the other members of the advisory board. At this time, if you're a member of the advisory board, if you'd please stand up and be recognized, I would appreciate it. (Applause.) Their diligent work and planning have made this program one that will be especially rewarding for all of us.

Time is short, but I do want to mention some of this year's sponsors who underwrite the educational efforts of the meeting. The officers and members of the Federation wish to thank all of the sponsors for their generous support of the Conference. You'll find a complete listing of the conference sponsors in your program. We gratefully acknowledge their contribution. Today's session has been underwritten in part by our good friends at Cardinal Health, GE Healthcare, Hill-Rom, KCI, Medline, Roche Diagnostics. We would also like to thank at this time Foley & Lardner for sponsoring last evening's welcome reception, Abbot for sponsoring the Wall Street Journal, Medquist for sponsoring our hotel keys, Ansel Healthcare for their contributions for the conference floral decor, Siemens Medical Solutions Diagnostics for underwriting the buyer directory, McKesson Corporation for sponsoring the registration portfolios, and Broadlane for sponsoring the supplier directory, Toshiba American and Johnson & Johnson Healthcare for sponsoring the conference program, and Merck & Company for underwriting the conference. Thanks for your patience while we recognize our sponsors.

At this time, it's my pleasure to begin a presentation for the First Annual Corris Boyd award. Anyone who's ever met Corris Boyd knew that he was an exceptional person and we were saddened by his untimely passing in December of 2005. Corris

served on the Federation's Expo Advisory Committee for many years, serving twice as chairman. The FAH Exposition Advisory Committee has established the annual Corris Boyd Leadership and Diversity Award to honor Corris whose vision of building a better way to live and work through leadership and diversity was embodied in the many accomplishments for which he's known. The award honors an individual or company that has made an outstanding contribution in fostering leadership and workplace diversity in the healthcare industry.

And now on to the first recipient of the award. And I would like to mention that our recipient was nominated by two individuals from different organizations. The nominee is a senior level management responsible for all facets of supply chain operations for his company. His team ensures that the company's hospitals' alternative sites have pharmaceuticals, supplies, and equipment they need to care for patients. At no time have the nominee's impressive leadership skills been more evident than during the days following Hurricane Katrina.

Surrounded by flood waters and without power, a hospital had to be evacuated and needed help from the company's headquarters. While the team at the hospital worked fervently to care for patients and plan evacuations, the company's corporate office tirelessly coordinated the massive effort to rescue at least 1200 people, including dozens of critically ill patients as well as employees, physicians, and family members. The nominee is credited with leading the effort to get stranded people that needed food and supplies and marshalling several of the helicopters and flight crews that participated in the four-day air lift.

The relationships the nominee has cultivated over the years with vendors help the company provide the hospital the necessities to sustain hospital operations. The result was a successful evacuation in the midst of a challenging environment and city. The nominee's commitment to and passion for improving diversity is also well known throughout the company. The nominee has served on the company's diversity task force since it was established. The company's diversity task force serves as a primary resource for the company's senior leadership to develop a strategic vision and priorities for increasing diversity and fostering a culture of inclusiveness. In addition, the nominee plays a leadership role in the company's supply chain and supplier diversity initiative, which was created to develop and support business relationships with minority- and women-owned businesses.

Ladies and gentlemen, please join me in honoring the memory of Corris Boyd by presenting the first annual Corris Boyd Leadership and Diversity Award to Ed Jones. (Applause.)

Ed, if you're here, please come up. (Pause.) I think Ed's supposed to be here. Is he here? (Applause.)

I just want to read the inscription on the plaque. The Federation of American Hospitals' 2007 Corris Boyd Leadership and Diversity Award presented to Ed Jones,

Vice-President, National Accounts, Health Trust Purchasing Group, in grateful appreciation for continuing Corris Boyd's vision of building a better way to live and work through leadership and diversity. His outstanding leadership, knowledge, experience, energy, wisdom, and integrity have been instrumental in promoting awareness, changing behaviors, and empowering others to join the ongoing efforts to address diversity in healthcare. He has earned widespread respect and appreciation from his peers in the healthcare community, all of whom have benefited considerably from his selfless commitment. Ed?

ED JONES: Thanks, Tim. To say that I'm a little bit in shock – extremely humbled and honored to be standing here and accepting this award. Like too many other things, you know, people – it's not just about one person; it's about an overall team, and for me I've been extremely blessed to work with some incredible people within HCA and Health Trust and within the industry, and it makes my job a lot easier to do that, and it starts really at the top, that when you look at HCA, the CEO, Jack Bovender, made a commitment to diversity about seven years ago to the entire management team that this was his initiative, it was his goal to create it as part of the culture and the fabric of HCA, and that really makes the area of diversity and the successes that we've had much more possible.

Second to that, Jim Fitzgerald, who is the presidency of Health Trust, started this initiative many years ago within Health Trust and HCA, worked side by side with Corris over the years to really put a program together that was something that we're very, very proud of and something that, again, has made my job a lot easier in that respect. And so too oftentimes one person gets more credit than they deserve, and really it's a team that really deserves the credit overall.

And then finally, I want to thank Corris, who was a good friend and somebody that I'll really miss every day, and I appreciate the friendship that we had and the things that I learned from him as it relates to supply chain and diversity. Thank you very much.

(Applause.)

MR. MARLETTE: Just to echo that, I was a good friend to Corris as well and I certainly miss him every day as well. At this time, I would like to introduce Chip Kahn who does an outstanding job of leading the Federation on a day-to-day basis. Chip has served as president of the Federation since fall of 2001 and he's going to serve as your moderator for the remainder of the morning.

Chip?

(Applause.)

CHIP KAHN: Well, thank you, Tim, and good morning, everyone. And I want to express my deep appreciation for Tim, his efforts and the efforts of the entire Exposition Advisory Board, and, of course, all our sponsors who helped make this

meeting possible. During the next two days, we'll obviously be identifying you individually, but we really do appreciate the help that we get from the sponsors.

Now we have a great program this morning, but before we get onto it, I'd just like to highlight a few other items in the program that I'd like you to focus on. First, at 9:30 today, from 9:30 to 10:45, we have a session in the Cotillion Ballroom, "Covering America's Uninsured: The View from Capitol Hill." As many of you know, the Federation members have set out as a goal covering all Americans. We have a proposal; it's our priority. And this session is part of the process, the national conversation. We want to get going to get focused by policymakers on covering all Americans.

Second, tomorrow morning – I was glad to see everyone here bright and early this morning. Tomorrow morning you can get here at 8:00; we're going to start promptly at 8:10. I'd appreciate it – we've got a great program – Chairman Rangel of the Ways and Means Committee, Senator McCain, Senator Wyden, HHS Secretary Leavitt, and Labor Secretary Chao. It's going to be a great program, we're going to get started right on time. Come, listen to the good presentations, bring questions, and we'll have a good session.

Now, before I begin, there are still some seats over here, so if any of you in the back want to move over, we have more seats over here. I really appreciate you all coming this morning. We have a great crowd.

Now it's my pleasure to introduce David Walker, comptroller general of the United States Government Accountability Office. David is the seventh comptroller general of the United States. He began his 15 year term in November 1998. As comptroller general, he heads up Congress' governmental Accountability Office. David has extensive experience in both public and private sectors. He served as a partner and global managing director of the Human Capital Services Practice of Arthur Anderson from 1990 to 1995. He was a public trustee for the Social Security and Medicare programs.

Some of you may have watched "60 Minutes" last night during the program. David gave an unflinching assessment of our nation's fiscal situation and particularly as it regards the entitlement programs and the future. It's part of his stop on the Fiscal Wake-Up Tour – today is an official stop on the Fiscal Wake-Up Tour. We're going to hear his remarks about the country's fiscal situation. But I think it's important to say that we should look at these remarks as important and as difficult as they are to listen to, they are simply a wake up call. They are simply saying that we need to take on these issues, look for solutions, look for resolutions. And the wonderful thing that David's doing and going around the country and making his point is that if we take these issues on now, if we cope with them, solutions will be easier and we can move on into the future and look forward to a better future for our children.

So, with that, let me give you the comptroller general of the United States, David Walker.

(Applause.)

DAVID WALKER: Thank you, Chip. It is a pleasure to be here with you this morning. You can see me; I can't really see you with the lights, but the important thing is for you to be able to see the screen because I'm going to use a PowerPoint format to be able to convey some very important information.

Let me start by saying that as comptroller general of the United States and as head of the GAO, I'm the nation's de facto chief accountability officer, and at GAO we're in the facts and truth business. Our job is to provide the facts and state the truth in a professional, objective, non-partisan and non-ideological fashion, and our job is not just to focus on today, but to help the Congress and other policymakers be in the position where they can try to deal with issues before they reach crisis proportions and to help prepare for a better tomorrow. And that's what this is about.

If I can, let me start by talking about what the composition of the federal budget was in '66 and how it's changed in the last 40 years. So I'm going to talk about the past, the present, and the future, and a possible way forward, with an emphasis on health care.

In 1966, the U.S. budget at the federal level was comprised, as you see here on the far left pie chart: 43 percent for defense; 1 percent for Medicare and Medicaid because, as you know, these programs were created in 1965 and '66 was the first year that we had expenditures. Fast-forward 40 years. Defense has gone from 43 percent down to 20, and that counts Iraq, Afghanistan and the global war on terrorism; Medicare and Medicaid has gone from 1 percent to 19 percent, and discretionary spending has gone from 67 percent to 38 percent. You don't see that here, but I know those numbers by heart.

By the way, discretionary spending includes national defense, homeland security, education system, judicial system, transportation, other infrastructure, and of course GAO, very importantly. The fact is, is that entitlement programs and other forms of mandatory spending are squeezing discretionary spending, and yet, when you look at the preamble of the Constitution of the United States, some of those discretionary spending programs are in the Constitution, and some of the programs that are vital programs that need to be reformed, not done away with, are not in the Constitution of the United States.

And if you look in the last year alone, interest on the federal debt has gone from 7 percent to 9 percent. Why? Because we're adding debt at or near record rates and interest rates have started to go up. The compounding effect when you are a debtor is not a positive factor. When you are an investor, the miracle of compounding works for you. When you're the world's largest debtor – AKA the United States of America – the miracle of compounding works against you.

Part of the problem is the government has at least three ways to keep score on deficits. These are in billions of dollars, so you need to add nine zeros to the right of these numbers in order to appreciate the magnitude.

In the last two fiscal years, yes, it's true that the deficits, whether it's the unified budget deficit, which is the lowest number and the one that politicians and the press tend to focus on, it's gone down from 318 billion to 248 billion, or the cash-based operating budget deficit, or the so-called un-budget deficit, which excludes the Social Security surplus – in other words, we spend all that money every year and we have been – that went down from 494 (billion) to 434 (billion) – or even the financial statement number, which is an accrual basis, went down from 760 (billion) to 450 (billion).

Well, obviously, smaller deficits are better than bigger deficits, but we haven't been in a recession since November of 2001. We had strong economic growth, and only about \$100 billion of these numbers had anything to do with Iraq and Afghanistan. This is imprudent. And this is the good news because the future will get worse if we don't start getting serious soon.

If you look in the last six years alone – and the only reason I picked six years is not because of who might have been in office for six years or who might have been in control of the Congress for six years; it's because these numbers have only been maintained for the last six years and publicly reported – some of these numbers. In the last six years alone, the total liabilities and unfunded commitments of the United States federal government – and those unfunded commitments include Social Security and Medicare, the difference between how much we promised over the next 75 years, and the dedicated payroll taxes and premiums that we have to deliver on those promises, the funding gap discounted back in current dollar terms – stated differently: how much money you would have to have today invested at Treasury rates to deliver on that promise.

When you take the total liabilities and unfunded commitments, they've gone from 20 trillion to 50 trillion in six years. Now, a trillion has 12 zeros to the right of it, and I don't know about you, but most people have difficulty with billions, much less trillions and tens of trillions. So let's take these numbers and translate them into terms that you and I and others might be able to related to.

Fifty trillion dollars is 95 percent of the total net worth of every American household, including billionaires. Fifty trillion dollars is 440,000 per American household. The median household income in America is about \$47,000. Therefore, on our present path, if we do not make fundamental reforms, in order to deliver on our existing promises, the typical American household has an implicit mortgage of nine-and-a-half times their annual income. But unlike most mortgages, this one is not backed by a house. The only asset that Americans have in order to be able to deliver on this obligation over future years is their citizenship in the United States, which is valuable and which does provide unparalleled opportunities to earn and to maximize one's potential, but they're just like in the Social Security and Medicare trust funds: there are no hard assets backing that obligation.

By the way, as we all know, in Washington words are used that don't necessarily mean the same thing as Webster's Dictionary, and one of which are the terms "trust

funds.” There are no trust funds; there are sub-accounts in the General Ledger. And by the way, if you looked at the financial statements of the U.S. government, the bonds in those trust funds are not deemed to be a liability of the United States government. That is wrong. That needs to change. And I’m going to try to change it.

Six years ago, this is what our fiscal future looked like. The bars represent federal spending as a percentage of the economy, so inflation is taken out. The lines represent federal revenues as a percentage of the economy, so inflation is taken out. If the line is above the bar, that’s called a surplus. We used to have those, but those days are gone. If the bar is above the line – which you don’t see here, but you will on the next one so just wait – that would be a deficit.

In January of 2001, when I testified before the House and Senate and people were so concerned that we were going to pay off all the federal debt – now, frankly I thought about three nanoseconds about that, but people were really allegedly seriously concerned about that – this is what our fiscal future looked like. We had fiscal sustainability for 40-plus years. This is what it looks like today. If you assume that all tax cuts are made permanent; if you assume that something is done with regard to AMT; if you assume that federal revenues stay at roughly the same percentage of the economy that they have historically; if you assume that Social Security and Medicare are not reformed; if you assume that we continue to debt finance; and if you assume that discretionary funding, which includes national defense, homeland security, et cetera, et cetera, grows by the rate of the economy, then this is our fiscal future. Rather than having fiscal sustainability for 40-plus years, the model that generates these simulations blows up in a little over 40 years.

Now, part of the problem – in fact, the major problem – is represented by entitlement programs: Social Security, Medicare and Medicaid. This represents the projected spending on these programs as a percentage of the economy. By the way, this does not include interest on the federal debt, which I can assure you we will pay; we will not default, in my view. Therefore, if you look at these programs alone, you can see that we’re headed to a future whereby the entire historical level of federal taxes will be consumed by these three programs alone. As they say in Texas, that dog don’t hunt. This ain’t going to happen. And the sooner we recognize reality, the more options we have, the more time we have to phase it in, and the more time that individuals have to be able to make adjustments because the facts are clear and compelling.

If you look at our nation’s tax expenditures, tax expenditures represent the foregone revenue as a result of deductions, exemptions, exclusions, credits, et cetera. In Fiscal 2006, the single-largest tax preference in the Internal Revenue Code, related to the fact that no individual pays income tax on the value of employer-provided and paid health care, irrespective of how wealthy they are, how much money they make, and how lucrative their health care program might be. That alone loses 125 billion a year.

If you add payroll taxes on top of it – which most Americans don’t pay unless you’re a small business, sole proprietor or certain type of situation like that, then it gets

close to 200 billion a year and rising rapidly. I would respectfully suggest that one of the things that we need to do is that we need to put tax preferences on the radar screen. They're not part of the budget process. They're not part of the appropriations process. They're not part of the financial statements of the United States government. We need to change that because if you're trying to stop the bleeding on the bottom line, you need to look on both sides of the ledger. We need to make sure that spending programs and tax policies are generating positive outcomes, and right now, in many cases, we just don't know.

If you look at the trends, the green line represents mandatory spending in inflation-adjusted dollars – so these are real dollars, not nominal dollars – if you look at the red, that represents the tax expenditures, and if you look at the blue, that represents discretionary spending – you'll see that mandatory spending is on a march, an unrelenting march, which causes the numbers that I've talked about before to occur. And you can see that in some years, tax expenditures accumulated more money than discretionary spending. So we've got to look at all dimensions.

What's the bottom line? The status quo is not an option. There is no way we're going to grow our way out of this problem. Anybody who tells you we're going to grow our way out of this problem, number one, hasn't studied economic history, and number two, is probably not very proficient at math. Faster economic growth can help, but we're going to have to start making some tough choices, and we need to do it sooner rather than later.

Now, what's a possible way forward? First, we need to provide more truth and transparency as to where we are financially and to where we're headed fiscally. We need to engage in a public education program to help the American public understand the need for dramatic and fundamental reform, and what the consequences to our country, our children and grandchildren will be if we don't mend our ways.

I am a baby boomer. Many of you may be. The baby boom generation is on a track to be the first generation in the history of the United States not to leave the country better positioned for the future. That is unacceptable to me. That is a failure of our stewardship obligation, and it's something that needs to be changed, and I'm going to try to do my part to do that.

Public education is essential such that the first three words in the Constitution come alive, and they're the three most important words in the Constitution: "We the People." We the people are responsible and accountable for what does and does not happen in the capitals around this country. We need to bring in performance metrics to understand which programs and policies are working and which ones don't. This country spends close to \$3 trillion a year, issues tax preferences of close to a trillion a year, issues thousands of pages of regulations a year, and for the most part, it has no idea whether those programs and policies are working or not. Other countries have them; we need to have them, and we at GAO are working with the National Academies, the Organisation of Economic Co-operation and Development, and others to make that a reality.

We need to bring back tough budget controls that expired in 2002. But guess what? We need tougher budget controls because we're in worse shape and the tsunami of entitlement spending is closer to hitting our shores. The first baby boomer reaches 62 and is eligible for early retirement under Social Security next year. The first baby boomer reaches 65 and is eligible for Medicare three years later. Seventy percent of financial analysts recommend that people take Social Security at the early retirement age, irrespective of whether or not they're retiring or not.

The wave is on the horizon and will start hitting our shores soon. We've got to bring back tough budget controls on both sides of the ledger. We need to reform our legislative processes such that Congress has to consider not just the one-year, five-year and 10-year cost of both spending and tax proposals, but the discounted present value dollar cost. In the case of Medicare prescription drugs, that number was \$8 trillion – \$8 trillion – not disclosed, not discussed before the bill was enacted into law. At that time, the unfunded obligation for Social Security was several trillion less. What type of credibility do you have going to the American people saying, we need to reform Social Security – which we do and we need to do it sooner rather than later – when you just add a new benefit that costs more than the one that you're trying to reform? There's zip credibility in that, and it's time that people change their ways, and that is a nonpartisan statement. The system is broken.

We need to reexamine and transform government for the 21st century. A vast majority of the United States government is based upon conditions that existed in the United States and in the world in the 1940s through the 1970s. For example, the definition of disability, 1947; the organizational model classification compensation systems of most of the federal government, 1950s; the tax preferences for employer-provided health care, 1940s, early 1950s; some of the weapons systems that we're building, Cold War era.

We need to step back and reengineer government for the 21st century. That will take us 20 years, but we need to get started now. Time does not allow me to go through all these details. I will post these slides on our website, which is www.gao.gov under the From the Comptroller General section within the next day or two, and you, when you have more time, at your leisure, can take a look at these specific possible ways forward with regard to the three elements that I've talked about. I mentioned a few already. That's for financial reporting.

On the budget and legislative processes, here are some of the things that I think we need to be debating, and in many cases we need to be enacting, sooner rather than later: In my view, if you bring back tough budget controls, if we improve truth and transparency about where we are and we're headed, if we have these legislative reforms, we then need to figure out a way that we don't just balance the budget within a reasonable period of time – and in my view we ought to be balancing the operating budget, not the unified budget. No country – no college and no country can afford to run

large, growing structural operating deficits with impunity over time, and no family can either.

So we need to bring back those controls and we need to not just have a balanced budget within a reasonable period of time; we need to make a down payment on that \$50 trillion imbalance, and we need to figure out how we can end up chipping away at the balance of it over a number of years, and it's going to take us probably 20 years to do that. But we need to get started now because that \$50 trillion number is going up 3 to 4 trillion every year on auto pilot.

With regard to fundamental reexamination and transformation, these are some of the thoughts that we need to engage in. And, yes, we need to try to figure out how we can close the tax gap, the roughly \$300 billion between what people should be paying and what they actually do pay, but we'll never make that zero, and we need to recognize that we need more fundamental reforms, including fundamental tax reform that will improve economic growth, improve equity and fairness, and generate more revenues over time.

This document is on our website. It's called "21st Century Challenges: Reexamining the Base of the Federal Government." It is a foresight document. At GAO we're in three businesses: oversight, insight and foresight document. It raises over 200 illustrative questions that need to be asked and answered to reengineer government for the 21st century. These are the areas that are covered, and you can see health care is there. As I said last night on "60 Minutes," there are a number of things driving our long-range imbalance, but health care is number one. And if there's one thing that could bankrupt America, it's health care.

These are some of the illustrative questions that are included in the document, dealing with Medicare and Medicaid, dealing with the need to reexamine our health care system. Again, at your leisure you can look at it. I want to make sure we have time for Q&A. These are the key dates for Medicare Part A. We're already running a negative cash flow in Medicare. The projected date of exhaustion of the trust fund for Medicare is 2018.

This is the growth in health care spending – an unrelentable and unsustainable path.

This is what health care spending has done in a five-year period. The red represents health care spending per capita. The green is CPI for medical. The black with the delta is the GDP. And the blue is CPI for urban consumers. And you can see that health care is growing much faster than the economy.

This represents a scattergram of what percentage of our economy, as compared to other nations, that we spend on health care. We spend 50 percent more of our economy than any nation on Earth. It's not a money problem; there's plenty of money there.

This is the non-elderly uninsured population and the trend in that number. We have the highest uninsured population as a percentage of the population of any industrialized nation on Earth.

When you look at outcome-based statistics, which we need, and you look at the OECD numbers for its member countries, of which we are one of 30 member countries, you will see that for life expectancy at birth, we're 23 out of 30 in 2003. It hasn't changed dramatically since then based on data that I've seen, but I wish we had more recent data. One of the real problems that we have in health care is the data is dated. When I was a trustee of Medicare, I was shocked and appalled at how old the data is, given the amount of the budget represented by Medicare and given the percentage of the economy represented by health care: infant mortality, 25 out of 30; potential years of life lost, 23 out of 26. And by the way, all 30 countries aren't major industrialized nations.

The administration, to its credit, has changed its position of late. Two years ago it said, deficits don't matter. Then it said, deficits matter, but they're coming down. Now it says, deficits matter and they're coming down, but we've got this large and growing imbalance over the long term; we need to balance the budget within a reasonable period of time; we need a down payment on that \$50 trillion, and we need to figure out, where do we go from here. Does that sound familiar? That's within the last two years.

These are some of the things that they've been proposing in the health care area: First, to reduce the tax preference for employer-sponsored health care – not the employer deduction, which would be one of the dumbest things you could do because employers would get out of the business of offering health care, but the exclusion to the individual in certain circumstances. And I think it's inevitable that that exclusion is going to have to be limited at some point in time in the future, for a variety of reasons.

Secondly, to slow the annual growth of Medicare spending – and we've heard this before – through reduction in provider reimbursements; to increase Medicare revenues through expanding income-related premiums for Part B and Part D; to slow the growth in Medicaid spending with regard to reimbursements and a restructuring; and to reauthorize the CHIP program for five years with some modifications.

Now, there are pros and cons to what they're proposing. There are some things that you like and some things you don't like. But I will tell you this: They deserve credit for putting something on the table. And if this was enacted – and I do not expect that all of this would be enacted into law, for a variety of reasons – it would represent an \$8 trillion-plus down payment on our fiscal imbalance. So at least they deserve credit for putting something on the table. And what I would suggest to you is this: It's not a matter of if there are going to be dramatic and fundamental changes in health care; it's a matter of when and what. The status quo is unsustainable and unacceptable. It's very important that when you see proposals that you don't like, that you start coming up with options, because the status quo is not sustainable.

These are some of the health care bills that are up on the Hill now by various members. And I know you're going to be hearing from one or more of these members over the next several days.

Now let me give you my perspective on health care and GAO's as of today.

In my opinion, for any system to work, a corporate governance system, a tax system, a health care system – you fill in the blank – you have to have three things for it to function effectively and be sustainable over time. Number one: incentives for people to do the right thing. That doesn't necessarily mean tax incentives. Behavioral incentives. Secondly, transparency to provide reasonable assurance that people will do the right thing because somebody is looking. A consumer is looking, the government is looking, a not-for-profit or independent sector organization is looking, the press is looking. There's a lot of people who look. And thirdly, accountability if people do the wrong thing. Incentives, transparency, and accountability. And with all due respect, I would say in health care we're zero for three. Baseball season is upon us; that's called a strike out. We can, we must, and ultimately we will, do better.

Ultimately we're also going to have to address four key dimensions, in my view: access, cost, quality, and personal responsibility. And on personal responsibility, let me note that one of the areas that we're number one in in the world – in addition to spending on health care, is not a good indicator of future health and future health care expenditures – and that, where we're number one and nobody's even close, it's called obesity.

These are some of the things that we believe and I believe need to be discussed and debated. There are short-term actions and there are long-term actions that need to be considered, and some we're going to have to do over a period of time and therefore require both short-term and long-term actions. You're going to see debates about whether and to what extent the government should be able to leverage its purchasing power. You're going to see debates about whether or not the state should have more authority to serve as experiments, which is what the founding fathers intended. You're going to see debates about whether or not there should be limits on direct advertising of prescription drugs and whether or not there should be limited reimportation of prescription drugs. You're going to see discussions about the need to improve transparency in connection with health care costs and outcomes because 85 percent-plus of the costs are paid for by somebody who doesn't receive the service and the disconnect that can occur there.

You're going to see debates about how incentives can be created to encourage physicians to use prescription drugs in appropriate ways, and other products and services, but right now what we have is a system that encourages more and does not have adequate checks and balances as to cost and as to outcomes. And my wife had a personal health experience within the last year that was a case study in that where she had thousands of dollars of tests done and where the physicians ended up doing every test that they could think of, and on the last test we asked a simple question: How much does it cost? They had no idea and they said, don't worry about it; your insurance company will pay for it.

And my answer was, Doctor, you don't seem to understand how insurance works. They may pay today, but we pay tomorrow. And in many cases, what's going on in this country, nobody is paying today and we're expecting our grandkids to pay tomorrow with compounded interest.

We need to encourage more case management approaches, which is done in the private sector but not done by federal government programs to the extent that it should. We need to reexamine the design of entitlement programs, including more income-related approaches. There is a difference as to whether or not you should have an opportunity to be covered by Medicare and how much you should pay for it. The government historically has not decoupled those. We're going to have to look at those, and looking at income-related approaches to a much greater extent.

We've got to re-look at the tax preferences. We need to encourage preventative care and wellness services in circumstances where it's clearly beneficial, both from a health as well as from an economic and a cost perspective. We need to promote more personal responsibility for health care, and there need to be consequences if people do not take care of themselves. They should not be able to exercise an unlimited put option on their children and grandchildren.

We need to ultimately limit the growth of government-sponsored health care programs. States will limit the growth because they have constitutional balanced budget requirements, they have rated debt that is not presumed to be the safest rating, and therefore they will ultimately control their costs. Corporations will control their costs because they'll go out of business if they don't control their costs. The only entity that does not have effective cost controls is the federal government because it charges the credit card. It has an unlimited credit limit as of today, and it just passes it on to future generations.

We need to develop a set of basic and essential health care services that every American would have access to – basic and essential. Those words are chosen carefully.

We need to develop a set of evidence-based national practice standards to help avoid unnecessary care, improve outcomes, and reduce litigation, done by professional physicians and those in the health care industry, not by those in Washington. And we need to make sure that we are pursuing multinational approaches to investing in health care R&D, as we did in the case of defense in years past.

In summary, four things: We need to assure universal access to some basic and essential set of services over time. That might be in lieu of – in fact it would be in lieu of some things that we're doing now for certain segments of the population. Secondly, we need to control costs. We need to have a budget at the federal level. Thirdly, we need to have above-average outcomes for an industrialized nation. And fourthly, individuals have to assume more personal responsibility for their own health, and there need to be consequences if they don't.

In closing, America has four serious deficits today. We have a budget deficit. We have a balance of payments deficit, of which the trade deficit is a subset. We have a savings deficit. For the first time since the Great Depression, Americans spent more money than they took home for two years in a row. And the most serious deficit of all: we have a leadership deficit. Whether it's the public sector or the private sector, people are living for today, and many families are living for today. We can't just generate positive results today; we have to prepare for a better tomorrow.

And with regard to leadership, we need more leaders in the public sector, the private sector and the citizen sector who exhibit four key attributes, and hopefully you are one of these: courage to state the facts and speak the truth and to do the right thing, even though it may not be popular, even though it may be counter-cultural; the integrity to practice what you preach and to lead by example, to recognize that the law is the floor of acceptable behavior, and who strive for a higher calling; creativity to find new ways to solve old problems and to help others to see the way forward; and stewardship, last but not least, to recognize that our responsibilities as leaders is not just to generate positive results today, not just to maximize value and mitigate risk today, not just to leave things better off when we leave than when we came, but most importantly, and the heaviest lift, to leave things better positioned for the future.

And when I go on the Fiscal Wake-Up Tour, the last slide that I show, which I don't think I have it here today, is a picture of my three grandkids. They did not cause our problems, but it is their problem. They will pay the price. They will bear the burden if we don't get our act together sooner rather than later. They're too young to vote; they don't have a voice. I am their voice.

I'm more than happy to answer any questions you have. Thank you for your time and attention. (Applause.)

I have to do like this in order to be able to see, so if you come up – I think there are microphones here, down all the aisles. I can't imagine this is a shy group, although it is early in the morning. We've still got about another 10 minutes, nobody has any questions? Yes, sir, can you – yes, sir, if you could just go right here on the aisle, there's a microphone right there. Well, I'm glad you asked a question, because I give lots of speeches and I've never had a situation where no one had a question.

Q: Thank you for your presentation. One thing I didn't see in there is what impact does illegal immigration have in terms of the education, Social Security, Medicare?

MR. WALKER: Good question.

Q: I don't know if it's a large problem or a small problem.

MR. WALKER: No, no, good question.

Q: Just common sense says something doesn't seem to add up. If you're not paying taxes, why should you get benefits?

MR. WALKER: Sure. Well, first, we have about roughly a million legal immigrants a year coming into this country and that's what's assumed in the Social Security and Medicare projections. We also have an illegal immigration problem which we're all aware of and which is probably beyond the scope of this session, but we do do work on that and I do have views on that. The bottom line is this: when you look at the structure of our economy, when you look at who we're competing with and the basis under which we have to compete, we have to compete based on skills and knowledge; we can't compete on wages. We have to compete on innovation, productivity, quality, etcetera, et cetera. And when you look at the structure of many federal government programs, you know, they are indexed to wages, they are affected by inflation.

And so, when you get right down to it and you cut all the way through it, what the bottom line is, over the long term, if immigration is comprised of individuals with above-average skills and knowledge as compared to our population, over the long term it will be a net plus. If it is comprised of people with below-average skills and knowledge as compared to our population, over the long term it will be a net minus. And so one of the things that we have to recognize is that whether we're debating immigration or Social Security reform or Medicare reform or tax reform, we can't just look on the short term. We have to understand, what are the long-term consequences, because our real problems are over the long term.

We're in pretty good shape today with regard to normal economic measures but we're not going to be if we don't mend our ways.

Next question. Yes, sir?

Q: Your comment was interesting about the doctors saying, you know, don't worry about the insurance is going to pay for it. You're a government employee and I understand – or I think I understand – that the government employees have a pretty good healthcare program. Is there anything we can learn from that, first of all? And second of all, I do worry a little bit about that because I'm not sure they feel the pain that most Americans feel the folks are putting –

MR. WALKER: Well, several things. First, in the particular example that I gave, it didn't deal with a federal government health program. It dealt with a health program for Delta Airlines. My wife worked for Delta Airlines for about 30 years; she retired early. And it had to do with Delta's healthcare program. You are correct in saying that the federal government has a generous healthcare program. The federal government has generous benefits. There's no doubt about that. It may not pay as well with regard to cash compensation, especially with regard to certain skills and knowledge – and believe me, I didn't come into government to make money and most people don't come into government to make money.

I think your point is well taken in that the government needs to lead by example. The government should practice what it preaches. The government should make sure that its programs and policies are reflective of where we need to be, not the present or the past. And it's not just with regard to, you know, plan design, administration, and cost incentives and quality outcomes. It's also with regard to things like electronic medical records and I'm pleased to say that, at least from what I've seen so far, the VA probably has about the best electronic medical records in the country. And so there actually are a few areas where the government does lead by example and I would hope and expect that we can have more as time goes on. Here, and then I'll – go ahead, sir.

Q: Good morning, Mr. Walker. Thank you very much for your comments today. They've been very enlightening. Many of us in this room today deal with the medical products and supplies device category. From your estimation, as you look at the inflation of healthcare costs, what implication for the medical supplies, products, devices industry should we be considering? Should we be expecting – do you think this is going to be effective or affecting in the coming years?

MR. WALKER: Well, it's tough to get – I mean, obviously, that's – medical devices and supplies is a very big area, you know, and making a general statement is difficult. Let me just talk about several things that you know and I know are driving our challenge and then you can figure out yourself about how you think it might effect.

You know, healthcare costs are going up for a lot of reasons. You know, they're going up not just because of inflation, not just because of medical inflation. They're going up because of utilization and intensity. We also have a situation where because of our payments systems and because of our litigious society, there are – we encourage people to do more. Because if you do more, then you'll make more money, you'll mitigate risk unless you mess up. And we have, you know, a circumstance in which everybody wants unlimited healthcare as long as they don't have to pay for it. And 85 percent of the costs are paid for by somebody other than who gets it and even the people who are covered by employer sponsored programs, they don't pay income tax or payroll taxes. So, they don't even realize how valuable this benefit is.

I think we're going to have to go to a system where, as I talked about before, everybody has access to a set of basic and essential services. And let me talk about what that might be and you figure out how it fits to medical devices. It could be something along the following lines. Certain inoculations in preventative and wellness services coupled with protection against financial ruin, which varies based upon your means, based upon unexpected and catastrophic illness or accident where you are not performing heroic measures in ways that otherwise do not make sense. Now, that gets you preventative wellness, that gets you the catastrophic – which, if you talk to the American people, those are the things they're most concerned about.

That leaves a big middle, a big middle which employers, which, you know, industry associations, professional associations, trade associations, states, communities, and others can fill in various ways through various choices maybe along the lines of the

Federal Health Employee Benefits Program, if you will. So, you think about what the impact would be.

I will tell you this: There is an over-proliferation of some medical equipment. There's no question about it, which also serves to fuel more use in circumstances that may or may not make sense.

Any other questions? Well, I hope you have a great conference and I'm sorry to have you have such a tough message early in the morning but, you know, there's never a good time to get it. And sooner or later you need to get it. Thank you very much. Have a good conference.

(Applause.)

MR. KAHN: Thank you, David. That was great. Thank you, David. I hope you all found the presentation useful. I think the great thing about the presentation was on the one hand, he painted the picture of the problems but then he offered a number of solutions and hopefully that'll provoke conversation, provoke action eventually, and we can alleviate the issues that David raised this morning. So, that's a start. And now we go on to the rest of the conference.

As I mentioned when I began this morning, in a few minutes, at 9:30, we'll have our session on Covering American's Uninsured, the View from Capitol Hill. It's in the Cotillion Ballroom for those of you that want to go. Following that session, we will have the Board of Governors meeting for the Federation members, following that session in the same room. So, for those of you that plan to go this morning to the "Covering America's Uninsured," please work your way over in the next few minutes over to the Cotillion Ballroom. We'll start at 9:30 sharp.

So, we start the meeting generally. I hope you all have a good meeting and I want to thank all of you for coming this morning. We now adjourn to the rest of our sessions. Thank you.

(End of session.)

CHIP KAHN: Elvis is in the building. Elvis is in the building. If everybody could move to their seats. I hope we have enough seats in the back. I know they were bringing in extra chairs. Our last two panelists – if everyone could come to their seats. Our last two panelists are in the building and will be coming down the stairs in just a few moments. So in order to catch up, I think I'll begin and filibuster a minute until I see them walking down the stairs – Deb Mizeur and Bridgett Taylor.

Let me first say that I appreciate, and the members of the federation appreciate, all the attendance this morning. This is a great crowd for probably the most important session at our meeting, a discussion by those who really make a difference of what this association considers the primary healthcare problem in this country: access to care and

access to health insurance. And we appreciate your interest in this and look forward to the panel that we're going to hear in a few moments.

As you know, a few days ago the federation launched, rolled out its proposal, its addition to the developing national conversation on healthcare coverage. This morning, we look forward to hearing from the observations of key Hill staff in a conversation with Susan Dentzer about this issue of health coverage and the progress that we hope will be made in the near term and clearly over the next three or four years.

So, now that we're all here, I'll begin with dispatch. It is an honor to introduce to you one of the most preeminent and respected journalists in the United States today. Many of you know Susan Dentzer as an on-air correspondent with "The NewsHour with Jim Lehrer." At the "NewsHour," Susan heads an awarding-winning unit that provides in depth coverage of health policy, healthcare, and Social Security. I'll dispense with the other accolades. She has so many. And I'm just going to give the top line on each of our panelists and then pass the baton to Susan and let her get into the discussion. Again, I really appreciate all of you coming this morning to this very important session.

We have on the panel Bridgett Taylor, the professional staff member, chief health finance advisor to Chairman Dingell at the Committee on Energy and Commerce in the House of Representatives. Deb Mizeur, Democratic professional staff Ways and Means Committee, Subcommittee on Health. She advises Congressman Stark and Congressman Rangel on many healthcare issues, including issues related to access.

Billy Wynne is the health counsel for the Senate Finance Committee, where he advises Chairman Max Baucus. Chuck Clapton is professional staff member with the Ways and Means Health Subcommittee. He advises Mr. Camp and Mr. McCrery. And finally, John O'Neill, policy director for the Senate Republican whip, Senator Lott. Really appreciate the panelists coming out this morning. Look forward to the discussion.

Susan, you're on.

SUSAN DENTZER: Thanks so much, Chip, and good morning to all of you. I don't know how many of you were at the earlier session this morning with David Walker of the GAO, but after I listen to David Walker, I always feel like I need about fifth of scotch to get through the rest of the day. (Laughter.) So, as an antidote to that, we're going to try to have a somewhat livelier time this morning as we talk about, oh, light problems like 47 million uninsured and things like that.

Let me just give you a little sense of the format this morning. We're going to have about 45 minutes of conversation among all the panelists. And then we'll open it up to about 15 minutes of Q&A – hopefully as lively as the panel discussion will have been, I'm sure.

And now, my fellow journalists in the room, I come to you this morning with a heavy heart. Because of the fact that these are staff members, we're going to

unfortunately play – unfortunately, in my perspective, play by the normal rules, which is that this will be a not-for-attribution, off-the-record conversation for the journalists present. However, they have all agreed, if they can, to stay after and if you want to come up to them individually and see what remarks could be attributed to their bosses or whatever, they will make that happen.

So, with that, let us get going. The topic, as Chip said, is access. And we know that access is once again in the air. According to a recent survey undertaken for the federation by American Viewpoint, a stunning 86 percent of voters want the president and Congress to act sometime between now and the next election to address coverage for the uninsured.

In recent weeks, as we all know, a number of coalitions from a variety of perspectives have come forward with coverage expansion plans. Chip mentioned the Federation Zone and Health Coverage Passport Plan. We have more than a dozen states – most notably, Massachusetts, California, and Pennsylvania – at varying points along the way of coverage expansion plans. And of course, now we have two announced presidential candidates, Barack Obama and John Edwards, who have actually gone out and called for universal health coverage. So the universal language is back.

So, the question I'm going to start with the panelists on is, are we, as a nation, not only back to talking about expanding coverage but are we back to talking about universal coverage? How do the folks you work for see this and what kind of a timetable do you see us proceeding along? And, Bridgett, I'm going to start with you.

BRIDGETT TAYLOR: Well, thank you, Susan, and thank you to the federation for having me here today. That's a big question. I actually – you were speaking of the press – was asked the question about where the Democrats were going to be right after we came into power on this. And I said, well, probably going to be a gazillion flowers blooming because there's so many people who have been harnessed in and not allowed to run and do what they want to do, in terms of trying to do healthcare. As you know, it's such a priority for all the Democrats.

I work for John Dingell. And for those of you who don't know, he's the longest-serving member of Congress and has been in the Congress for 52 years. And Mr. Dingell has always been for covering the uninsured and has introduced every year since he came into Congress HR15, which is a universal coverage bill paid for by VAT tax. And he is in the process of putting together a Medicare For All bill that he and Senator Kennedy introduced in the last Congress. We're making a few revisions and that will be introduced shortly.

I think that the issue of universal coverage, there's no question that there's a lot in the air right now to do that. I think one of the things that's holding back, to some extent, is this awful word called PAYGO. I'm sure that if you heard from David Walker this morning, he probably talked about that a little bit. But it means that we have to pay for

anything that we spend. And because universal coverage is so important, it also means that you have to spend some money to actually make it happen.

And so we're stepping back a little bit, I think, and at least in this session of this Congress, looking at doing things like covering all children. And I think that that is where we're beginning is with children.

MS. DENTZER: Okay, and we will be talking about SCHIP reauthorization, shortly.

Let me skip over to John for a Republican perspective here. John O'Neill, you work for Trent Lott. What do you see? Is universal coverage coming forth on lips on that side of the aisle?

JOHN O'NEILL: I think my own view is that the goal of, I think, most members of Congress, just like most Americans, is to have universal coverage. And by that I mean to have everyone have access to health insurance in this country and hopefully have health insurance. So, I think the goal is not as wide a divide as you sometimes see reported in the media or it appears from the outside. I think members on both sides of the aisle want Americans to have health insurance coverage.

They want them to have good health insurance coverage. I think the question is, is the political environment such that you can kind of get to a broad compromise? That's the challenge, I think, will all legislation. And the more you get into an issue like this that touches people's lives day in and day out, actually the harder it is to get a deal. You see that in various other areas – entitlements, Social Security – where if you took a poll of the American public, you would probably have 95 percent of the American public say we need to deal with that.

The members reflect that. On both sides of the aisle, they believe that too. It's just a matter of can you get people on the same page and in a mode enough to compromise, you know, to get an agreement? Personally, I think – it's somewhat counterintuitive, but I think the more time I spend working on the Hill or in politics, the more it seems true. I think that divided government is a time – and when you look at it historically – where you have a higher opportunity, quite often, to accomplish big things because people are forced to compromise. That's the only way to get something done, and you usually have two parties that are kind of jockeying for position. I don't know – and that would mean that now it would be a good time to do that.

I think the one other big obstacle that is out there, though, is you have a big election coming up where you're going to have both parties nominating brand new people. So it's a big presidential election. It's obviously a big congressional election. It seems like every two years is turning into, you know, the election of the millennium. So, that's already beginning, as all of us are well aware of from watching TV everyday. The campaign is on, and will that be an additional impediment that makes it impossible to get an agreement? I think that's the key thing to look for.

MS. DENTZER: Okay.

Deb, John talks about the need to get members, on both sides of the aisle on the same page. You work for somebody, Pete Stark, who is often on his own page – (laughter) – not to break any news here. What do you think about the prospects for moving to the same page on an approach?

DEB MIZEUR: Well, I agree with John that we would be hard pressed to find anyone on either side of the aisle that would suggest that being uninsured is an acceptable state of being. And I think the people in the audience would also agree that from the perspective of providers, we need to find a way to get people insured so that we can actually afford to provide care for them.

But, again, as John mentioned, the real challenge is going to be finding a way to reach agreement on both sides of the aisle. I think one of the reasons why we're faced with the issue of expanding coverage is not only because of the number of uninsured, but it's also because those people with insurance are facing challenges of rising healthcare costs. And there's a very famous chart that was done a few years ago about the way that public policy affects healthcare costs and spending, and it points in our history where healthcare costs are perceived to be rising to a level that are unaffordable.

We have a discussion about whether or not we should move to a universal coverage system. This most recently happened, obviously, in '93, '94. And I think those costs are rising again to a level where we need to have another discussion about bringing down healthcare costs. So, not only expanding coverage, but really reining in cost growth. And there are a number of ways that I think that we will be looking at over the next couple of years to rein in cost growth: gaining efficiencies through health information technology, improving quality, those kinds of things; lowering administrative costs, for example.

But from our perspective and the perspective of Congressman Stark, you need to build on what works in the existing system. And clearly Medicare is one of those things that has been a pretty consistent partner in our healthcare system. We'd like to see Medicare's payment policies improved so that Medicare continues to be a partner going well into the future. And we can make some improvements to Medicare that really show Medicare's leadership ability in the healthcare system writ large.

So he actually, Congressman Stark, introduced a bill that would have built on Medicare and also the employer sponsored insurance system. And I think that we would like to see that go forward. One thing you won't see Congressman Stark suggesting is a single payer system. I think he acknowledges that we need to move away from a discussion around the fringes and really talk about some of the more practical approaches. But we need to have a discussion about getting everyone in the mix.

MS. DENTZER: Chuck, let me turn to you. Those of us who lived through the last exercise of health reform, as Deb mentioned, '93, '94, think of it – at least I certainly think about it as the first time I watched the Alfred Hitchcock thriller, “Psycho.” There was a lot of excitement at the beginning. Somebody gets stabbed in the movie. You think that the crazy mother is up in the attic and then it turns out at the end of the movie she’s been dead the whole movie and the whole thing sort of falls apart at the end.

Do you think that we are in that sort of early “Psycho” phase – (laughter) – where there’s a lot of excitement and that as we get down to brass tacks on some of these issues, whether we expand Medicare – we just heard David Walker a few minutes ago say we have to limit the growth of government programs. Well, expanding Medicare would seem to directly contradict that prescription. What do you think about the ability to forge across the gap here?

CHUCK CLAPTON: Healthcare as a Hitchcock movie. I have to admit I’m not sure how to answer that. (Laughter.) I guess I’ll start – I’ll echo Deb’s comment on healthcare spending. It’s a top concern. The CMS actuaries came out, I think, just two weeks ago and reported currently we’re spending \$2.1 trillion on healthcare. In the next 10 years, that’s scheduled to increase to \$4.1 trillion. It’s going to go from 16 percent of GDP to 20 percent. So that means that one out of every five dollars that spent in this country is going to be used for healthcare.

That’s an issue. And it’s not necessarily the bad one. Some people argue that for a country with our economy and our rates of growth, that we can afford that. But, as Deb said, that with increases in cost, it is going to put the issue on the table. But to the point of the uninsured, I’ll just make the observation, echoing all of my colleagues, that there does seem to be a growing interest in tackling the issue of the uninsured. I’d point to two discrete events that have gone on recently that I think have galvanized a lot of public attention and actually could provide a roadmap for where folks may want to go.

Massachusetts Republican governor, Democratic state legislature put together a very bold proposal to cover all of the uninsured – had things like individual mandates but also private health insurance – so taking concepts that may in years past have been anathema to either side – and they came up with compromise that works. It’s not flawless. I know a lot of people have been very critical of the cost for premiums that have increased in the last year since the initial proposal. But, again, it’s a start and it could provide a roadmap.

The second thing I’d point is the president’s proposal on taxes that was in his budget. A lot people have said that proposal is dead on arrival but I think the president did a real service to the country by at least putting the issue back on the table. But if you look at the current tax code, that we have an incredibly regressive system where we reward the wealthiest workers and actually penalize and discriminate against those who lack employer-based-healthcare coverage. If any of us were asked to design a healthcare system, it’s probably the last type of system we would ever want to set up.

Now, the positive news coming out of that, according to the Joint Tax Committee, that they think the president's actuaries got their score wrong. They actually think that proposal the president put forward actually generates \$500 billion in new revenue over the next 10 years.

So, for those who didn't like the president's proposal, in part because it didn't do enough for lower-income individuals in terms of providing subsidies or helping them buy into private health insurance, there could be some real money there that could be spent, and, again, with the goal of moving towards getting, if not universal coverage, getting a lot more of the 47 million currently uninsured into healthcare coverage using a private insurance model.

MS. DENTZER: Okay. Well, let me turn now to you, Billy, because we just heard from your colleagues that there's lots of interest in expanding coverage, dealing with the problem of the uninsured, that it's motivated as much by the problems of the insured as it is the problems of the uninsured, that there's bipartisan support for this, clearly, and that people are moving away from the fringes. Single payer seems to be off the table. It sounds as if people really are trying to find mutually acceptable approaches to this.

So, since you work for the Senate Finance Committee and Max Baucus, and since we all recall the Senate Finance Committee chairman last time around, Daniel Patrick Moynihan was the person who threw a wrench into health reform, and therefore, this is a very powerful position that your boss holds in the whole debate, what do you think is going to happen?

BILLY WYNNE: I think we're going to throw a wrench into healthcare reform. No, I'm just kidding. (Laughter.)

MS. DENTZER: Okay.

MR. WYNNE: Well, Senator Baucus gave a speech at the Academy Health Conference a couple of weeks ago where he outlined some principles that he thinks will be important to moving forward in terms of addressing the uninsured and healthcare in general. And one of those was universal coverage and I think he would say we ought to look at covering kids first, not just because it sounds good but because if you get people on the right track early in their lives and get them the preventative care they need, immunizations, that sort of thing, you've done a lot for yourselves as a country in taking care of your citizens.

It's a moral issue, but it also is a business issue. And we hear just as much as we hear from consumer groups, we hear from business leaders, who say it's time to change the way that we deliver healthcare in this country and it's affecting the ability of our country to compete with other rapidly growing economies like China and others. But I think it is important to note that even if we do achieve the goal of coverage for all, we haven't addressed – and others in the panel have mentioned this – we haven't address

what I think is the heart of the problem, which is the rising healthcare costs. And by insuring more people, you're shifting – let's say, you know, you reduce on the employer side or whatever you do – I'm not saying we should do that – but you will just be shifting the costs around. You haven't done anything about the percentage of the GDP that's going to our healthcare, which I think is probably the biggest and gravest problem that we're facing.

And there are things that we can do, and I was encouraged to see this morning that CBO is going to be studying in earnest some alternatives for controlling costs in addition to what it proposes every two years, its budget options, which is really just kind of cutting off the top. It's addressing the symptoms to, for instance, lower rates for X provider. It doesn't get at the cause. So we're encouraged that CBO is going to look at that. We'd like to think that Peter Orzach, the director, was inspired by the hearing we had on Thursday about physician payment, too. But I have a feeling they've been working on this for a while.

But anyway, there are some steps that we can take this year to control costs. I think we'll be working with our friends in the House and across the aisle in the Senate to get that done. And I think we'll also move forward on covering more people this year. Obviously CHIP – and I know we'll probably talk about CHIP later – is a huge issue this year, probably our top healthcare priority on the Finance Committee. And we're also going to take a look at helping small businesses cover their employees and revisit an issue that was well-worn last year. We're hoping a new approach this year will find success.

MS. DENTZER: Okay. Just before we leave you, Billy, let's go back to Chuck's point about the president's proposal on limiting the tax exclusion to employees for health insurance. Deb's boss, of course, has declared this DOA in the House and we do know that tax legislation has to originate in the House, according to the Constitution, but is it DOA? Should it be DOA?

MR. WYNNE: I don't think anything, in our view, is DOA, so to speak. Senator Baucus was encouraged to see the priority the president placed on healthcare in the State of the Union and in his budget. Yes, there are a lot of proposals, including that one, that we have some concerns about. We're concerned about moving to a more individualized market when we're not sure that the individual market is fair right now. Actually, we're pretty certain that it wouldn't be fair if it were, you know, to be opened up tomorrow. So there are some concerns but, you know, we tend to not call things dead on arrival and take things off the table at this point. But, you know.

MS. DENTZER: Okay. Let's move to covering kids. And, Billy, you brought up, as did others of you, the reauthorization debate over SCHIP, the State Children's Health Insurance Program, which as we know was enacted in 1997, given a 10-year life. That's now up. It's got to be reauthorized by September 30th. But already we can see lots of people poles apart on what they want to do in terms of reauthorizing it. Is it going to be reauthorized as is? Is it going to be reauthorized with changes? What additional

capabilities will states have to expand coverage beyond children – the targeted low-income child population on up or even folding in adults? Will there be a change in the federal match if pertains to adults, et cetera, et cetera, et cetera? A big debate ahead.

Bridgett, where do you see this going?

MS. TAYLOR: Well, actually, I'm more optimistic about what we might be doing on SCHIP because, as many of you know, when it was passed in '97 it was a bipartisan deal. And in the past, we've had problems where the states have run out of money and it has always been a bipartisan working arrangement to put it together. We intend, at least in our committee, to try to work on it in a bipartisan fashion to make sure that we do get the care to children.

As many of you may know, seven out of 10 children who are uninsured belong in Medicaid or SCHIP or could be eligible for it. And so our probably number one goal is to try to do what we can to try to find those children and get them enrolled. In that particular instance, I don't think there is any problem between the two parties in trying to do that. I mean, there are things that we've talked about already like doing continuous eligibility so that when the children are enrolled they stay in their managed care plan for the full year and they can actually be managed, and then they don't drop off and come back on; drop off and come back on.; things like allowing them to be enrolled in hospitals or in schools; things like having a one-stop shopping so that they go get enrolled in other welfare programs but then they would automatically be enrolled in this program. And that's with the goal of trying to find them.

I think you're right, Susan, in terms of the areas where you're going to have some disagreement is that the president put on the table that they would not like to cover any children above 200 percent of poverty. And a lot of the states – Chuck mentioned the Massachusetts experiment; they went up a lot higher than 200 percent of poverty to cover children. They don't want to cover parents –

MS. DENTZER: And got approval from the administration to do that.

MS. TAYLOR: And they got approval from the administration. And in fact, the statute, as it exists, shy of waivers, doesn't allow any enrollment of parents or children. So the only way that parents and children have been getting in have been through waivers. And they've been given by this administration so they have sort of made a turn in a way that is a little bit perplexing to some of us. And what I started to say about the parents is that that's one of the number one ways also of trying to find children who are eligible is to enroll their parents.

So, I do think those are going to be the areas that are of the biggest debate and whether or not we can reach an agreement is unclear. But I don't think there's disagreement about trying to get kids covered. And I actually also have not heard a lot of debate about trying to use the tax code to help children. So that's another area where I think it's good because we're not going to have to have that debate in the context of kids

at least. Maybe Chuck and others on the panels may feel differently but that's my take on it.

MS. DENTZER: Well, let's turn, Chuck, briefly, to the administration's proposal. Nobody's against covering children; you just don't put enough money on the table so that children can be covered. That's the way things work in this town. So the president has proposed what in the view of some is insufficient funding to keep the program, even at current levels, going forward. Where do you think your fellow members are? Sorry, I just promoted you. You haven't run yet. The members you work for are.

MR. CLAPTON: Well, and I'm uniquely sensitized. I have to point out that working at the Ways and Means Committee for Mr. McCrery, I probably shouldn't opine on SCHIP since that's exclusively within the jurisdiction of Energy and Commerce, where I used to work. But because I used to work with Bridgett there I'll feel free to still comment upon it.

I think a big part of it – I don't want to say it all comes down to this, but a big part of it is money. Everyone wants kids to have healthcare coverage but some of the proposals that have been put on the table spend as much as \$60 billion. And the challenge, as Bridgett mentioned before, was we're operating in this brave new world called PAYGO, which means that for every dollar you spend, you have to find an offset. If you want, I can go through the list of offsets and I can assure you none of them are fun, none of them are painless.

So, if we want to spend that kind of money, we're going to have to ask the question, whose ox gets gored? And if we're willing to address that and figure out where those pay-fors can come from, I think it's possible. A couple of concerns, though, I would raise, both from a perspective of equity and also the perspective of how we want our healthcare system to work – SCHIP has been very successful. It is intended as a program to provide healthcare insurance for low-income kids who fell right above the Medicaid eligibility. However, not all states have implemented their SCHIP programs that way. Some states have gone up as high as 300, 350 percent of poverty. You're talking about a family of four who is making over \$60,000 a year. Similarly, states have covered over 630,000 adults.

What is it that we want SCHIP to do? Is it a foothold into having a single payer universal government-run healthcare system, or is it designed to provide healthcare coverage for low-income kids? If it's the latter, I think there will probably be fairly broad bipartisan support if we can find the money.

Now, you had mentioned the cost of that. CBO has estimated that the cost of just funding the current obligations are about \$13 billion. The president put on the table a proposal to raise SCHIP spending \$5 billion, which is still, over a five-year window, a 20 percent increase over its current allocations. But I think folks can legitimately disagree as to whether that's sufficient.

But I guess the point I'll wrap up on is if we're going to spend the money, we have to find out where we're going to pay for it, and also at the same time make sure that whatever we're doing doesn't have the affect of also crowding out private health insurance, which, unfortunately, I think, when you take eligibility levels up to \$60 (thousand) or \$70,000 a year, you do run that risk. So whatever we do, I don't think we should do harm to folks who actually already have private health insurance.

MS. DENTZER: Well, Deb, picking up on Chuck's theme, the administration has in fact attempted to position this. There's a big philosophical debate, as he suggested. Are we going to have more government-sponsored health insurance? Are we going to position as much of the coverage expansion as possible in the private sector? Your boss, again, Pete Stark, has a broad Medikids proposal on the table, which essentially would create a Medicare for children, and that would be the default option. Talk about that and talk about what you see as the prospects for that amid this big philosophical debate.

MS. MIZEUR: Well, Congressman Stark has a long-standing interest in covering all children. And that's why in 1999 he drafted and introduced the Medikids proposal, which, as Susan mentioned, would create a new pool for children, building on the Medicare program. And I think his ultimate goal, really, is to have all kids covered. And he sees that Medicare really is an efficient way of doing that, but I think he would be open to having all kids covered through SCHIP.

The point is that we need to find some vehicle to make sure that children are accessing healthcare benefits in the way that is keeping them healthy and keeping them able to learn and keeping them as potential future taxpayers and part of our overall economy.

So, I think in the context of SCHIP reauthorization, though, the Ways and Means Committee is going to be asked to fund a percent of that reauthorization. And that has piqued Congressman Stark's interest in ensuring that it provides coverage to all kids. I know that Bridgett and others are working on eliminating some of the current barriers that exist to enrollment. I don't know if anyone in the audience realizes, but SCHIP really only covers 40 percent of its eligible population. And that's because there are limits on funding; there are barriers that are created to enrolling kids. And if we really want to make sure that those kids are receiving the coverage that we all feel that they are eligible for and should be eligible for, I think we need to kind of address those issues as well.

I do want to say, though, that it's hard to find anyone that doesn't believe all kids should be covered. And I think that the question really that we need to put to the Republicans is at what level? I think Democrats would want to be more generous at the income level that there would be eligibility for then maybe the Republicans would be.

But, in my mind, there needs to be an acknowledgement that private sector health solutions work for people who can afford them, but at some point, we have to

acknowledge that people have income that's far too little for them to be able to afford a private coverage option and that public programs really do work better in those instances.

MS. DENTZER: Which is what? Which is the case for having eligibility go up to 300, 400 percent of poverty?

MS. TAYLOR: Exactly.

MS. DENTZER: Okay. John, what about that?

MR. O'NEILL: Well, you know, I think – I don't have a whole lot to add to the panel. I mean, I think most members on our side, you know, view SCHIP as a program that was put in place for children or put in place for children in financial need. You know, I think the program, to the extent it has focused on those things today, our members think it has been a success.

I think the more you stray from that core model, I think the more concern they have about it. I think they want it focused very much on children and children who are in need. And so, I think the attention will stronger the further you kind of depart from that core model. What the percentages are and allocations are, you know, it probably varies from member to member, and, you know, across the Senate too, not just on the Republican side of that. I think there's a real desire to keep the program to a core objective of protecting children and protecting children who are in need.

MS. DENTZER: Bridgett, you wanted to make a comment.

MS. TAYLOR: Yes, I just wanted to make one comment to counter Chuck just a slight bit. But the SCHIP program really isn't a government-run program. And it is private sector plans that are being operated here and it is run by the states. In fact, I was on the opposite side when we passed SCHIP, wanting to be an entitlement – or, excuse me, Mr. Dingell was on the opposite side – wanted it to be an entitlement. Instead it became a block grant, which is, by no stretch of the imagination, anything that Democrats usually support, so I don't think it's fair, necessarily to call CHIP a government-run program.

MR. DENTER: Government-inanced probably would have been better terminology. I apologize for that. All right, well –

MS. TAYLOR: No, I though Chuck said it. I was countering him.

MS. DENTZER: Oh, Chuck. Well, I echoed the language.

Billy, let's take this to you. Chuck put, really, the critical question on the table, I thought. Is the reauthorization of SCHIP the steppingstone to universal coverage or is it an opportunity to reauthorize a good program as it is? Where do you think your boss comes out on that?

MR. WYNNE: Well, it's certainly one very important way to expand healthcare coverage. And in the Finance Committee, we have the pleasure of having jurisdiction over both that program and all of the potential offsets for that program. So, it's going to be a particularly fun year for us.

I would say that I think this conversation may somewhat illustrate that – and this is Senator Baucus' view and I think it happens to be consistent with the view of most Americans and probably industry stakeholders too, that they're less interested in an ideological debate about private-verses-public coverage and more interested in rolling up our sleeves and figuring out a way to get things done.

And that's kind of a platitude, but what it means is, in our view, the solution is going to be a combination of public and private sector approaches. And that means there's going to be a burden on the private sector and the government and, you know, pretty much everyone in the country, to expand coverage. It's not going to be easy. The poll that was mentioned earlier, it was encouraging that it indicated not only do most Americans support expanding coverage for everyone, but they're also willing to make some sacrifices to get there. It's one thing to say that in a poll and another thing to actually have it happen. But it was encouraging to show that people are at least thinking in terms of this is not going to come easy and it's going to require serious sacrifices on both the public and private sector side.

MS. DANTZER: All right. Let's do a quick poll. The question is this: When September 30th rolls around, will SCHIP have been reauthorized and will it be reauthorized as is or bigger? Those are your two choices: as is, bigger.

Bridgett, quickly.

MS. TAYLOR: Yes, I think it will be reauthorized because we'd lose the \$5 billion that's there in the program that is – because of the way the system works, we'll just lose that money and I don't think anybody wants to lose that, those dollars that are there.

MS. DENTZER: As is or bigger?

MS. TAYLOR: Huh?

MS. DENTZER: As is or bigger?

MS. TAYLOR: Oh, in between. (Laughter.)

MS. DENTZER: Okay. Deb.

MS. MIZEUR: I would agree with Bridgett; in between.

MS. DENTZER: Okay, Chuck.

MR. CLAYTON: In terms of I think it has to get done for Bridgett's point, that CBO will basically increase the score of a bill to what – is \$50 billion? – if we don't do it. So there's just no way. In terms of is it bigger, my hope would be that if we're going to expand coverage, we could continue the SCHIP program but also provide alternatives to Deb's point of if there are lower-income folks who need assistance, there are lots of other ways we could provide that type of assistance. It doesn't necessarily have to run through SCHIP but certainly expanding coverage.

MS. DENTZER: So, some additional tax credits or something like that.

Okay, Billy: as it, bigger? September 30th deadline met?

MR. WYNNE: Yes, it will pass and it will be bigger than its current form. You heard it first.

MS. DENTZER: Okay, and John.

MR. O'NEILL: I'll be just a little contrarian just to be contrarian. I will say it certainly will get reauthorized but having lived through Congress the last few years I wouldn't be surprised if we have a 90-day extension on September 30th or, you know, some kind of stopgap. And you have to go through one or two rounds of people being at a deadline before they really have the final push to really get a deal of some sort.

MS. DENTZER: John is invoking the tried and true wisdom of Washington, that there's always one more son-of-a-bitch out there that you didn't count on, right? (Laughter.)

MR. O'NEILL: Especially in the United States Senate. (Laughs.)

MS. DENTZER: Let's turn to the area of healthcare costs and quality because all of you have referenced this more or less in some way. The polls clearly show that the cost of healthcare is among voters' top concern. The public is increasingly aware of patient safety issues, increasingly aware of the big variations among providers about how healthcare is practiced around the country. So what, if any, action on this separate set of issues about cost and quality might we expect in the current year or before the election? And by extension, what's the prospect for resurrecting health information technology legislation, which almost made it through the last Congress? And Chuck, let me start with you on that.

MR. CLAYTON: Sure. I wish, as I sat here, that someone could give us the silver bullet that would help us control cost. A lot people have promised a lot different ideas over the years as that silver bullet. Some have been good, some haven't panned out. The answer probably lies somewhere across a lot of different proposals. I'll just

mention some of the ideas that I know some in Congress are thinking a lot about these days.

Quality: Certainly there's a thought that the reporting of greater quality, which eventually could lead to tying payments to greater quality or greater efficiency, could be a mechanism, and that something was set up, going back to MMA, then the Deficit Reduction Act; some at least initial procedures where some providers, namely hospitals, could start to provide some quality data. I thought it was interesting, though – I just saw this morning that from the provision we set up in MMA, we still have 133 hospitals that are forgoing a 2 percent payment differential and not reporting quality data. So again, probably –

MS. DENTZER: None of whom, I'm sure, are in this room –

MR. CLAPTON: Of course not.

MS. DENTZER: – represented in this room. Right.

MR. CLAPTON: Of course, probably not a panacea that's going to fix everything.

Another thing that's been talked about a lot that dovetails with quality is transparency. A lot people have raised the issue of providing consumers, particularly with the advent of consumer directed healthcare like health savings accounts, with more information about price but also quality data to allow consumers to make better informed choices. I think there's no consensus there in terms of how effective that could be or if it could in fact drive down healthcare spending in the long run. As a conservative Republican that generally – I have to believe that empowering consumers in the long run makes for better purchases and might help control costs. But certainly, in the short-term, if our concern is healthcare cost, it's not going fix everything.

Then beyond that there's Medicare payment rates. Medicare is the 800-pound gorilla that drives a lot of healthcare spending. We say just last week the Medicare Payment Advisory Commission came out with a number of recommendations that would include basically freezing different types of payments. Of interest, and I'll just mention one of them. There seems to be a renewed focus on post-acute care with MedPAC making recommendations on inpatient rehab facilities, long term care hospitals and other types of facilities that would produce over \$2 billion in savings over five years. So that might be another way where Congress could go if they're looking to help rein in healthcare spending.

MS. DENTZER: Another one of those recommendations dealt with an issue that I know Deb's boss cares a lot of about, which is payments to Medicare Advantage Plans. Is that part of the cost reduction agenda for the current Congress?

MS. MIZEUR: It certainly is on the table, as is everything in Medicare these days. Basically, research around health spending in the United States demonstrates that we're paying more than any other country because our prices are a lot higher. So, certainly things like negotiating discounts of pharmaceutical industry could help to lower costs, negotiating better discounts with Medicare Advantage proposals, squeezing out some of the administrative inefficiencies that we have in our system. We spend 30 percent of our overall spending on administrative costs. That's pretty astronomical. It seems like there are some efficiencies we can gain there.

I think that the area of quality is going to be an important focus of Congress this year, although I'm not sure we're actually get savings scored by CBO as a result of our efforts. And HIT is clearly a part of the initiative around quality. Congressman Stark believes that the HIT debate in the past couple of Congresses has been somewhat stifled and not very expansive. He would like to see that broadened to actually show leadership from the federal government, both in determining what the interoperability standards should be and also enabling Medicare providers to both use HIT and helping them finance that. So, I think that you are going to see a renewed effort on our part to look at Medicare writ large and also the issues of HIT and quality.

MS. DENTZER: Bridget, there's a school of thought that says if we are about to go down the road of expanding coverage, the worst thing we could do is expand coverage on top of the current healthcare system, that we really can't have a coverage debate without this cost and quality reduction debate. What does Congressman Dingell think and how active do you think that will be a part of any universal coverage legislation that is eventually put forward either before or after the election?

MS. TAYLOR: Well, I think that – just to echo the comments of my colleagues, there are all the different things that they elaborated on that are things we need to continue to look at. Quality has certainly been something that you all have been faced with in terms of getting the data reporting and areas like that. We're looking at it right now in the context of physician payment and seeing if there's ways in the context of paying them more to get them to do some reporting in the same fashion that you've been doing. But, and I don't – I guess the concern I have a little bit is that it has been very, very hard for us to determine ways to truly save cost, short of doing things like reducing provider payments.

And I don't – I mean, I think there are a couple things like – one that jumped into my mind as everybody was talking, and it probably seems to be the simplest but could be provide quality and savings is ePrescribing. There are so many different things that happen in terms of safety issues, some of the things Susan mentioned, that ePrescribing is one of the few things that I think we could get savings if we can manage to tie up CBO and stuff a rag in their mouth and actually make them give us a number on that, but they've been a little bit hesitant on that. But I definitely think that we're going to see all of this being a part of the debate on health reform.

MS. DENTZER: And, Billy, what about from your perspective and from Senator Baucus' perspective? How much does this have to be part of the debate on health reform?

MR. WYNNE: We think it has to be central to the debate and there are some things I think we can try to move forward on this year, and one of those is comparative effectiveness research, investing in that. I think the statistic we have is that of the \$2 trillion or so we're spending on healthcare, only about one-tenth of 1 percent of that is spent on figuring out which treatments and products are cost effective compared to comparable treatments and products. So, that I think is a high priority for us this year. Also, we've talked about giving providers feedback on their resource utilization. GAO has a study coming out fairly soon along those lines of – a lot of people are familiar with the Dartmouth studies on the variations in resource use among physicians, and one theory on tackling that is to, at the very least, let them know if they are overusing resources at least as compared to their peers when treating comparable patients. So, that's something that is interesting that we're going to be looking at this year.

Another thing, people have talked about paying for quality, and Senator Baucus feels pretty strongly about that. It's not easy, as I think everybody in this room knows. It's not easy for anyone to do, much less the government to do. And it's our view, though, that we kind of need to get those creaky gears grinding to bring people to the table and encourage, you know, the development of efficient ways to encourage and incentivize quality. And one of the major focuses thus far has been on sort of process – you know, did you give the aspirin when the patient complaining of chest pain, or whatever it is? And where we'd really ultimately like to go is outcomes, and saying, you know, did that patient die, or did he – you know.

That's the goal of all of this and that's even trickier to do than the process measures but we think that if you focus on outcomes – especially for the chronically ill, the patients who are really driving a lot of the costs in, at least in Medicare – then you may find some savings.

Senator Baucus was basically pleading with Peter Orszag at CBO in our hearing last week to show – you know, everybody says, oh, this is will help to cut costs, but when it comes to, you know, when the budget wonks get their hands on it, it inevitably costs more to do these things. So, you know, so it's not – we have to look long term, I think, in implementing some of these things and we have to trust that ultimately they're going to –

MS. DENTZER: Some kind of dynamic scoring as applied to healthcare? What's he talking about?

MR. WYNNE: Senator Baucus?

MS. DENTZER: Yeah, for the CBO.

MR. WYNNE: Well, he – well, it was kind of a sort of a facetious conversation, actually – but I mean, what he’s saying is the current scoring mechanisms in some ways tie the hands of CBO and how they look at these things, but I think it’s also fair, which is sort of their view, that the savings from a lot of these initiatives are long term, in many cases outside of the budget window that they’re analyzing. So, you know, I don’t think we’re talking about directed scoring or overhauling how CBO does their scoring. But I think what we are talking about is getting a real sense from them of which of these initiatives are going to work in the long term to save costs.

MS. DENTZER: John, I want to ask you specifically about health information technology because your boss is from the Gulf and as everybody said after Hurricanes Katrina and Rita, a lot of the situation that the victims of those two disasters experienced would have been ameliorated had we had electronic health records. Does he have specific views on how to move this legislation forward?

MR. O’NEILL: This is something he’s been very interested in. I think he tends to, on the committee, defer to the chairman and ranking member on a lot of these issues and has a lot of confidence in their ability to get things done. I think Chairman Baucus knows how to get things done. So, I think that’s an issue that is probably one of the low-hanging fruit type of things that we can get done this year and there’s a lot of support on both sides of the aisle.

And I think that you’re hitting on the key point about cost and the reality is why don’t people have coverage? It’s pretty simple, as everyone in this room knows: People don’t have coverage because they can’t afford it. And if we don’t deal with the cost side of this equation – and there’s a whole menu of ways to do it; as everybody’s been saying, it’s not an easy thing – but if we’re going to really reform health care, I think Senator Lott would say that first and foremost, you’ve got to get a system in place that controls costs better. And that also – I think that’s part of looking at the tax code, too. That’s then a tool once you control costs to help make insurance more affordable for people, and the reality is today we’ve got a tax system that is skewing all the benefits to people who need it the least and we need to even the distribution of those tax benefits as part of affordability, too.

MS. DENTZER: All right, we’re going to open it up in just about a minute to questions from all of you, and let me just point out there are two mikes in the center. I hope you will come to the mikes to ask your question. Please identify yourself by name and affiliation when you do that. While we’re waiting for questions to come forward, let me stay on this question of the low-hanging fruit and what is potentially achievable this year or certainly between now and the election. Do all of you agree, HIT? Is that one that’s – probably to use that unfortunate phrase – a slam dunk for this Congress to put through? Do you agree? Anybody disagree? Let’s put it that way.

MS. MIZEUR: I have to say no.

MS. DENTZER: No, you don’t agree?

MS. MIZEUR: I don't agree that it's a low-hanging fruit. I think that when you look at the HIT discussion, clearly we might be able to reach some agreement on how interoperability standards come into play, what Medicare's role might be. But the question that is looming out there is what do we do about privacy standards to protect the information once it's collected? And that's not been part of the discussion so far. I think a lot of people are reluctant to talk about privacy because it gets us into this very serious marshy territory. But it's an essential part of the discussion and it hasn't been addressed thus far. And I think that HIT isn't going to move forward without a discussion on privacy.

MS. DENTZER: Which would lead to what?

MS. MIZEUR: We don't know because we haven't had the discussion (Chuckles).

MS. DENTZER: Do you agree, on the Republic side, John or others? Chuck?

MR. O'NEILL: Chuck, go ahead.

MR. CLAPTON: Uh, thanks John. (Laughter.) I think the core if you look – taking out the self-referral, the so-called Stark pieces we did from last year, which, assuming in this new Congress aren't going to be going anywhere – the other provisions in the bill were fairly innocuous and may, at the margins, have been helpful. I think Deb is right that folks are going to want to put privacy on the table. The challenge, however, is that we already have huge obstacles and roadblocks that are impeding the adoption of HIT.

And unfortunately, I recall the debates we had in the mid '90s over the so-called HIPAA legislation which mandated privacy that was a huge fight that took many years to work out, led to rules that were eventually held up and reissued. So, unfortunately, if we do start to get into the debate of what is a privacy protection, I think it actually stands a pretty good chance of impeding the ability to adopt HIT legislation, at least in the short term – which, not a comment on the merits, but just through a lot of different stakeholders out there who have very vested interests and this has a real impact on how they do business.

MS. DENTZER: Okay, in a moment I want to ask you all about some other potential candidates for low-hanging fruit – maybe, maybe not – mental health parity, FDA regulation of tobacco. But let's take a question here; I believe we have one. Welcome.

Q: Thank you and thank you for coming. My name is Tony Fahem (ph) with Capella Healthcare. I don't know if you were privy to the presentation this morning by David M. Walker, but he talked about a \$50 trillion hole over the next 40 years in terms of increasing entitlement spending and relatively flat revenues. Is Congress going to

tackle that kind of strategic problem this year, or is that likely to be something for after the next election?

MS. DENTZER: And that was a reference to the present value costs of a number of programs, \$32 trillion of which was Medicare and Medicaid.

Chuck, cost is your favorite tar baby.

MR. CLAPTON: Can I pass this one to John and return the favor?

MS. DENTZER: Okay, John.

MR. O'NEILL: Yeah, I think definitely, just frankly – I mean, this is probably not necessarily what Senator Lott would want me to say because I think he has an interest in tackling these issues as soon as possible, but frankly, I think no chance of seeing anything in the next two years. And these issues are tough. I mean, it's no accident that when, you know, Republicans tried to pursue Social Security reform last time – I'm sure my Democratic friends would say, well, the president handled it completely the wrong way or whatever, but you know, even if you handle an issue flawlessly, you know, one of these issues, it's just very difficult.

I'm very cynical about the ability of, you know, people to get very big things done in this country. I think it's what the members, most of the members, really truly actually do come here for. They believe in doing big things and I think a lot of them want to, and we're going to have to deal with the entitlement issue at some point. But frankly, I would – my own view is, you know, it could be another five or 10 years before it really gets dealt with, or, you know, what tends to happen is legislation in crisis. I mean, that tends to be when Congress actually acts on some of these big issues where there is serious political downside for whoever puts them on the table. So, sorry for the gloom and doom; hopefully somebody will say something more optimistic.

MS. DENTZER: Deb?

MS. MIZEUR: I actually do want to be a little bit more optimistic. Congressman Stark recalls the last time he was chairman that he worked hand in glove with his Republican counterpart, Congressman Gradison, on efforts to improve and sustain the Medicare program over time, and he wants to return to that kind of a model where Republicans and Democrats are working together toward the long term future and sustainability of Medicare. And I think we are going to be taking a serious look at Medicare policy this year, driven partly as Bridgett said by the need to address physician reimbursement.

But there's been a neglect of the Medicare program for a long time, from Congressman Stark's perspective, and he wants to return to that. So, I think we are going to be examining the program and its payment policies to make sure that we're extracting the greatest efficiency that we can in partnership with the Medicare providers,

understanding that we also need to balance that with the need to ensure access for its beneficiaries. So, I do think that there's going to be a concerted effort in looking at that. And on the Medicare Advantage side, I have to just point out that CBO recently scored Medicare Advantage overpayments at \$160 billion over the next 10 years, and that is, I think, something that we definitely will be taking a look at.

MS. DENTZER: Well, and, Chuck, comment on that quickly because many Republicans, when the Medicare Reform law was put through in '03, objected to these perceived overpayments to plans. Are people ready to say, yes, these are overpayments or not?

MR. CLAPTON: I can't say categorically, but I know just in the context of some of the hearings we have had that when you talk about the \$65 billion that the Congressional Budget Office identified as going towards Medicare Advantage plans, a significant portion of that isn't overpayments to plans. What it is is actually additional benefits that are provided to Medicare beneficiaries.

The way Medicare Advantage works, plans submit bids, and to the extent that those bids are below what are known as the benchmarks – and that's what CBO looked at, the regional and national benchmarks – they're required to provide 75 percent of the difference between the bid and the benchmark back to beneficiaries in the form of greater benefits. So, that means that Medicare Advantage enrollees get access to dental, they get access to preventive services, they get access to greater cost-sharing. So, if we're talking about reducing the benchmarks that Medicare Advantage plans get paid off of, what we're talking about is reducing the benefits to those populations.

And, you know, that's certainly a decision Congress can make. But when you look at the overwhelming – I shouldn't say overwhelming, but the majority of Medicare Advantage enrollees are low-income and minority populations, that might not be quite as attractive as some people have initially thought when they first saw that number. So, I wouldn't say it's necessarily a slam dunk that we're going to be able to just hit Medicare Advantage payments and that's going to be the cash cow that will be used to fund everything that we want to spend money on this year.

MS. DENTZER: All right, John?

MR. O'NEILL: Could I just make one real quick comment? I also – I kind of was taking the gentleman's question to be talking about a broad, you know, very comprehensive entitlement reform. I mean, certainly I wouldn't be surprised if there's incremental Medicare legislation just like, you know, we typically have. But even big numbers, you know, \$160 billion over 10 years, you know, even if you could capture all that – I mean, compared to the type of numbers that, you know, people are talking about, that's a very small piece of a puzzle.

MS. DENTZER: What I'm taking from this is none of you see an action-forcing entitlement commission like the entity that put through the changes to the Social Security system in the early '80s coming up in the next two years.

MR. O'NEILL: That's what I would say.

MS. DENTZER: Don't hold your breath is what I'm hearing.

MR. O'NEILL: Right.

MS. DENTZER: Okay, question here please.

Q: Hi, I'm Pat Ball with Triad. Thank you for coming today. Just have a question. Many of us are concerned about all the talk about cost reduction because that translates to us as payment reduction, and I'm just wondering what your predictions are for reconciliation.

MS. DENTZER: With respect to provider payment in particular?

Q: Yes.

MS. DENTZER: Okay, let's see; let's talk to our tax folks here on ways and means. Deb?

MS. MIZEUR: Yeah, well, I think to clarify, there's going to be an examination of Medicare's reimbursement policies across the board. It's not just going to be aimed at hospitals. We're very aware that MedPAC has recommended a full update for hospitals this year. But we also are aware that some hospitals are doing much better than others. And so I think we're going to need to look at refining Medicare's payment policies to make sure that those that are kind of at the margins are taken care of, but maybe we can extract some of the efficiencies out of those that are doing much better. And I think that our challenge is really going to be identifying what the differences are and why there are differences and crafting a Medicare reimbursement policy that actually takes those differences into account.

MS. DENTZER: Any ideas as to how that could be done?

MS. MIZEUR: Not right now.

MS. DENTZER: On the drawing board.

Okay, Chuck, just quickly on that?

MR. CLAPTON: I guess to follow up on Deb's point that I think the easiest and most typical way that Congress produces savings in these programs is they go in and hit provider payments. So, again, I made reference earlier to the MedPAC

recommendations, a couple of them – while hospitals will get a full market basket update, skilled nursing facilities, nursing homes would basically get a zero percent update. And this kind of goes back to the earlier question that was asked, what can we do in the long term to better control Medicare spending growth? One of the biggest cost drivers within both Medicare and Medicaid are chronically ill populations and those who are in institutions. And if we were to do something substantive in those areas – actually you do have the chance even by making a minor differential in the rate of growth over 10 or 20 or 30 years – you’re talking about hundreds of billions of dollars.

However, I would argue simply just arbitrarily cutting payments to nursing homes or home health agencies probably is not going to get you the policy outcome you want, which is you want better coordination, you want better management, ideally for some institutional populations you want to get them out of the institution because the only reason they’re in there is that’s the only thing Medicaid pays for right now, get them into a home setting where they can get home health services. But all of that takes a lot of time, a lot of effort, and an initial investment of money up front.

So, that might be a pathway we can get at some of the long term spending issues, but unfortunately I think Congress will probably revert to form and look at individual payment reductions only because it’s what we’ve done both under Republican and Democratic controlled Congresses over the last few years.

MS. DENTZER: Billy, would you agree that that’ll be the outcome?

MR. WYNNE: Yeah, I’d just – I’d like to weigh in on sort of the two issues that have been discussed. And one, Medicare Advantage, I think part of the problem there is we’re not sure what it is that we’re getting with that money. So, I think we’re moving from this presumption of success to putting a little more burden on the insurers participating in the program to show Congress, you know, what they’re doing. Are they in fact transferring all of that money over to their beneficiaries and what are those –

MS. DENTZER: Or the providers for that matter.

MR. WYNNE: Excuse me?

MS. DENTZER: Or the providers.

MR. WYNNE: Right. Anyway, so we’re going to have some stepped up oversight of the Medicare Advantage side of the ledger and part D, just to mention. In terms of budget reconciliation, I think that the PAYGO rules and the renewed emphasis I think on budget austerity sort of decreases the impact, you know the stakes of whether or not we go down the reconciliation path. And I truly don’t know whether or not we will and it’s not our call. It’s the Budget Committee’s call. But, you know, I know when you hear the word reconciliation the provider community tends to get faint, but I guess what I’m telling you is you should probably be faint anyway – (chuckles) – because whatever

expansions we had this year, you know, we're likely going to have to find some offsets for them whether it's a reconciliation vehicle or not.

MS. DENTZER: Okay, I went – I got my mechanical fruit picker out a couple of minutes ago and asked you for the low-hanging fruit and I didn't get any takers on HIT legislation. So, mental health parity, FDA regulation of tobacco, anything you want to put on the list any of you as low-hanging fruit that maybe because there's at least a bipartisan consensus forming around a couple of those issues that maybe that could gel into something passed? Bridgett?

MS. TAYLOR: Well, I definitely think mental health parity has possibilities. I'm not quite sure it's ripe enough for falling off the tree yet, but I think it's getting there. I think there's a bipartisan agreement in the Senate between Senator Kennedy and I think Senator Enzi – but you'll help me if I'm wrong about that – that those of us in the House are starting to look at. The House has always been where the problem has been anytime you do any changes to insurance reform because there is a big difference of opinion. But I'm hopeful that because there is bipartisanship in the Senate and comes over that we're going to be able to move it. But we are actively looking at it.

MS. DENTZER: Okay. Anybody else? Deb.

MS. MIZEUR: Our committee is going to be looking at – and I know Bridgett's committee as well, I think – at genetic non-discrimination. This is a policy that's been hanging around for a really long time that would prohibit the use of genetic information in setting insurance policy premiums or in denying coverage altogether. And so, I think that this month we're going to be taking a look at that bill and maybe finally passing it after 10 years.

MS. DENTZER: And since genes have apparently been distributed equally among Republicans and Democrats, maybe that has a chance of being passed?
(Laughter.)

MS. MIZEUR: There's some potential. It has bipartisan co-sponsorship and so we're hoping that we can work with our Republicans on passing it.

MS. DENTZER: Okay. Let's just briefly take a moment to sum up what we've heard this morning. Is universal coverage back in the lexicon with a lot of talk, maybe action? We heard yes. Is SCHIP going to be reauthorized? Yes, by deadline, except I think John was the one skeptic. And the majority said bigger than the current program in many respects, whether it's on the outreach side or what have you. We heard entitlement reform, don't hold your breath before now and the election. And we heard a couple of faint possibilities for low-hanging fruit: mental health parity and genetic non-discrimination. That sounded like about it.

So, let's look forward for a moment. I'm going to close this by asking all of you to make predictions. Now, as Yogi Berra said, predictions are very difficult, especially

when they involve the future. But looking forward, let's try to think about what might happen after 2009 when either Rudy Giuliani is president or Hillary Clinton or Barack Obama or one of the others we haven't yet mentioned. What do we think will happen? We do know what the American public says. According to the most recent federation poll, 79 percent of respondents said a candidate's position on addressing health coverage for the uninsured will be "extremely" or "somewhat" important in their vote, and 35 percent of those people said "extremely," the others said "somewhat." But that's a big core of people now putting that at the top of their agenda.

So, tell me what happens as of January of 2009, Chuck, when president whoever it is takes the oath of office and what happens on universal coverage or whatever else. Chuck, start with you.

MR. CLAPTON: Thanks. Okay, let me caveat: My crystal ball cracked a long time ago. I think expanding access to coverage, that it's not sustainable in the long run to have 47 million uninsured people in this country. And as a component part of that, going to Billy's point earlier, I think we need to make both individual and small group markets work better to provide an affordable health insurance product for working Americans. So, I think that's going to have to be on the agenda in 2009.

MS. DENTZER: Okay. Deb.

MS. MIZEUR: I think that health reform has been on the agenda for the last century and periodically when we have these discussions something happens. We start debating health reform and there's push back on the provider side to decrease costs to a level where people are comfortable again. I think nothing is going to happen in 2009 if we don't actually lay the foundation and frame the issue in a way that we can make the American people comfortable with making some pretty significant changes.

We were burned in '93-'94 most recently by making assumptions that the American people were supportive of health reform. They clearly weren't, after people even in this room helped to defeat that policy. And I think nothing again is going to happen in 2009 unless we really work over the next two years to figure out what they mean when they say that.

MS. DENTZER: Okay. Billy.

MR. WYNNE: I totally agree with what Deb said and Senator Baucus is actually – we're working right now on a series of hearings this year and into next, before we get drowned out completely by the presidential candidates, to lead a discourse in Congress, at least in the Senate, on what the best path forward ought to be. And actually very soon, in the next couple of weeks, we'll probably have the first of those hearings. So, I think we're very serious about moving forward in the next two years.

I mean, I think – I share the skepticism, I think, of the other panelists, but I do think it will take a fresh White House – no offense to the current White House – but to

really look at broad-paced healthcare reform and expanding coverage in a really significant way. And I do think – I mean, I just started my job in November, so my naivety is excusable, I hope, but I’m pretty confident that we’re going to see some major reforms in the early parts of the next presidency, whether it’s a Republican or a Democrat that gets elected.

MS. DENTZER: John, fresh White House?

MR. O’NEILL: Yeah, I think that’s key. I think there is going to be a window of opportunity after the next election. I think absolutely the panel’s right that the groundwork needs to be laid over the next two years in terms of the background. I think it will have a much better chance to succeed if we have some form of divided government, if we have the president, particularly if it would be a Republic president that is willing to give Congress a leading role – I think that was one of the mistakes in ’93-’94 was not letting it be as organic a Congressional product as it could be.

And in the Senate, I’d keep a very close eye on what Senator Baucus and Senator Grassley are doing. When they lock arms, they are a force, in the Senate at least, that is very difficult to stop and they are capable of running over their respective caucuses in a good way for the American public, I think.

MS. DENTZER: Mowing down their grandmothers, right, on the way?
(Laughter.)

Bridgett, last word to you.

MS. TAYLOR: I’ll just be brief. The one thing I would say definitely is we have some hope because Chip no longer works for HIAA, where he’s running “Harry and Louise ads.” (Laughter.)

MS. DENTZER: No “Harry and Louise,” right.

MS. TAYLOR: And so I think we have hope. I would just say a lot depends upon who the president is who’s elected and how much of a risk-taker he is in wanting to get out there and how much the American people send a signal that this is what they want as a result of that election because I think that there will be a lot of it going on in Congress as the next two years progress. So, it could be ready if we just had the right leadership.

MS. DENTZER: Okay, well, it is often said that Washington is a town where the facts, although interesting, are irrelevant. (Laughter.) But I think you can hear this morning that one fact is that there are a lot of smart and caring members and a lot of smart and caring staff working very hard on some of these issues. We don’t have a clue where it’s going to come out but it’s very interesting to discuss and very interesting to watch. And join me now in thanking this terrific panel for giving us an overview of all that. Thank you.

(Applause.)

MR. KAHN: And on behalf of the federation, I'd like to thank the panel and thank Susan, and we'll continue with the meeting now in a few moments. Thank you, guys.

This is now, in the next five minutes, time for the federation meeting. If everyone in the back would move to their next session elsewhere in the building, we will begin the Federation Board of Governors meeting promptly at 10:55. So everybody has got five minutes, but please come back at 10:55 if you're a Federation BOG member, and we'd love to have you sit here for the panel.

(End day one.)