

FEDERATION OF AMERICAN HOSPITALS (FAH)

2008 FAH PUBLIC POLICY CONFERENCE AND BUSINESS EXPOSITION

WELCOME:

KEITH PITTS, VICE PRESIDENT,
VANGUARD HEALTH SYSTEMS;
CHAIRMAN, FEDERATION OF AMERICAN HOSPITALS

MODERATOR:

CHARLES N. KAHN III, PRESIDENT, FAH

PANELISTS:

KEITH HENNESSEY,
ASSISTANT TO THE PRESIDENT FOR ECONOMIC POLICY;
DIRECTOR, NATIONAL ECONOMIC COUNCIL, THE WHITE HOUSE

SENATOR ORRIN G. HATCH (R-UT)

SENATOR JOHN D. ROCKEFELLER (D-WV)

HEALTH POLICY AND THE PRESIDENTIAL CANDIDATES? WHERE DO THEY STAND?

PANELISTS:

JOSEPH R. ANTOS, WILSON H. TAYLOR SCHOLAR, HEALTHCARE
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*Transcript by
Federal News Service
Washington, D.C.*

(Music.)

ANNOUNCER: Ladies and gentlemen, please welcome Chairman of the Federation of American Hospitals Keith Pitts.

(Applause.)

KEITH PITTS: Good morning, thank you all for being here. By the way, for those of you coming in over on this side, there are plenty of seats over here at the other end, so if you're looking for a place to sit. I'm Keith Pitts. I'm the chairman of the Federation of American Hospitals this year again. Thank you all for coming today. We have a very impressive program this morning. I think you're going to be very, very pleased. We have some great speakers. We're going to get to them right away. And right now, though, I want to thank our sponsors first. Our plenary session this morning is sponsored by Baxter Healthcare, Press Ganey Associates, along with Trane. We are very grateful for their support to the federation. Please join me in giving them a round of applause.

(Applause.)

Great. Well, without further ado, I'm now going to call on Chip Kahn, president of the Federation of American Hospitals, to come up. He's going to be the master of ceremonies for today's session. Chip?

(Applause.)

CHARLES N. KAHN III: Well, thank you, Keith, and good morning to all of you. We're going to have a terrific program this morning. But we had a great start yesterday with Tony Snow. I hope you all enjoyed it. And I also appreciate many of you going to our healthcare reform panel. It was a very insightful, a little scary, but very insightful discussion.

Before I get started here this morning, let me proceed by acknowledging that we have kaisernetwork.org in the back recording our session. Kaisernetwork.org sets the gold standard for producing webcasts of important healthcare events here in Washington and around the country. We are delighted they are with us at the meeting. Their webcasts and the transcripts for our plenary sessions will be available on their website www.kaisernetwork.org, so you can go there if you'd like to see some of the production that we have this morning after this morning.

The federation also will put links on our homepage to the webcasts and transcripts on their website. And our website is www.fah.org. I will add that if you go to our website, we also have links – we'll have links to the Healthcare Passport proposal materials that we made public yesterday at our news conference, a survey on public opinion about healthcare coverage, as well as a new cost estimate of our health coverage proposal that I mentioned yesterday. That cost

estimate is for 2010, and also a description of the proposal in more depth, obviously, than the pamphlet we handed out. So I hope you'll go to our website and look at the Health Coverage Passport details. And if you have any comments on it, you know, let us know.

We have a full agenda this morning, and I'm confident that you'll really enjoy the lineup. So let's get started. Our first speaker this morning is Keith Hennessey. Keith is assistant to the president for economic policy with the White House. He also is director of the National Economic Council. In this role, Keith advises President Bush on a broad range of economic issues and coordinates the development of economic policy at the White House. Previously, from August 2002 until November 2007, when he took his current post, Keith was deputy assistant to the president and deputy director of the National Council under three directors.

Keith also served on Capitol Hill. He worked for five years for Senator Majority Leader Trent Lott. And he has held a number of other key budget positions on the Hill. Keith is, frankly, one of the most knowledgeable people at the White House on economic affairs generally. But specifically, he is an expert on health and an expert on entitlement. And it's a real pleasure for me to introduce this morning Keith Hennessey. (Applause.)

KEITH HENNESSEY: Good morning. See if that works. Boy, this looks like a college lecture. Sort an early morning lecture, lots of students here, not sure if everyone is awake. I think I see a couple guys in back who were at a frat party last night, so I'll try and keep you all awake.

My name is Keith Hennessey. I have known Chip since 1995, when I first started on Capitol Hill. He was one of the most knowledgeable and, frankly, most powerful staffer on the Hill now. And it really is great to see him running the federation. He is a fantastic guy, a brilliant – really knows policy, plus how Washington works, and you all are lucky to have him running the federation.

What I thought I'd do this morning is first of all, since my job – my portfolio is a little broader than health care, what I thought I'd do is give you an economic update, and just talk just for a few minutes about what is going on in the economy, what we see going on, what we think might be happening. I want to talk just for a couple minutes about housing, both because it's the hot issue right now in terms of what is going on in the economy, and I think it can be instructive in talking about health care because rather than talk about the details of any particular health policy issue, what I want to do is I want to zoom out a bit and talk about decision-making in health care and about the philosophical choice that the president likes to talk about. It will give you a sense of how we have thought about health care during the Bush administration, how we're thinking about it going forward, dealing with legislative issues over the next 11 months. And what I'm hoping is that it can help frame your thinking for the upcoming health policy debate that will occur with the next president and the next Congress. And I think maybe that can be a little bit more useful to think for a moment about how we make these decisions, how we make these tradeoffs, and about the ideas underlying the president's philosophy.

First on the economy, we're in a period of short-term economic uncertainty. In the long run, our economy is strong. We feel good about where it is going in the long run. The

fundamentals, the underlying structure, the underlying fundamentals are our economy are very good. We have the most flexible economy in the world, the most flexible labor markets, the most flexible capital markets. And that word “flexibility,” it’s a key word that we use often because what you need in a strong economy over the long run is you need an economy that can adapt. Bad things are going to happen. Shocks are going to occur, whether it’s the economic effects of 9/11, whether it’s the corporate governance shocks that hit in 2002, whether it’s the stock market bubble bursting in 2001, whether it’s \$100 oil. Those things are going to hit the economy. They are going to have bad effects. You can’t always prevent them from happening. What you can try and do is have an economy that is able as quickly as possibly to adapt to those shocks, to deal with them, to adjust, and to make the pain as small as possible so that you can move on and keep growing.

Our economy – you might not know it if you were reading the New York Times or just watching the news, but our economy is in fact growing. It’s growing very slowly. The latest data we have suggests that the economy grew about six-tenths of a percent in the last quarter of last year. We expect roughly the same situation for the first quarter of this year. Best guess is, is that fourth quarter of last year and first quarter of this year are probably going to be the two slowest quarters. That is if we have the projections right. In a strong time, which you would hope for, is growth somewhere in the 2.5 to 3.5 percent range. We had that earlier in the recovery. Things are slowing down right now.

There are three big short-term economic challenges that have led to the slow growth. One is housing, one is the financial market shocks and the volatility, especially in the credit markets, and the third is \$100 oil. What I want to do – and let me talk for a little bit about the housing problems. And you might not know it, again, if you just read the papers, but we actually have two housing problems, not one. The one that you have been reading about since August was the mortgage problem. Actually, let me back up. When you buy a house, you buy three things. You buy land, you buy a building, and you buy a financing arrangement. Now, all of the focus since August has been on that financing arrangement on mortgages and the mortgage markets, the innovation that occurred in the mortgage markets, and some of the problems that have flowed from that.

You have read a lot about sub-prime mortgages. You have different factors there that have caused a lot of people to be facing the difficult situation, where they are having trouble keeping their house. But there is another problem that is less well-covered and possibly even more serious in terms of what our economy looks like in 2008 and 2009, and that is the housing supply. That is the stock of buildings themselves. In addition to the innovation that we had in the mortgage markets over the past several years, you also, especially in some states, had a building boom. You had builders who were just building like crazy because housing values were increasing. Four states, in particular, come to mind: Florida, California, Arizona, and Nevada really saw very strong building booms, where builders were just building on spec.

Prices were going up. It was a great business. Let’s just keep building because by the time I’m done building this house, the value of it will be higher; I’ll be able to sell it and keep making money. And basically what you had was a housing bubble that built in those four states. After a while, that bubble started to accumulate a stock of inventory, and that is what we have

right now. In certain parts of the country, you have a lot of houses unsold. You have a large stock of unsold inventory, okay? When you have a stock of unsold inventory, you need that supply and demand to adjust, and that is what we are going through right now.

That is why the economy is not growing so quickly is because builders aren't building because they have a lot of unsold houses to sell. It's knocking a little more than a point off of GDP growth for the second half of last year. And we're hoping that will taper off going forward. But until those markets, in fact, adjust; you would expect that builders are not going to be building as many houses. And so the housing sector, which is a very small part of the economy – it's maybe 4 or 5 percent of the economy, but that shrinking, and as a result, that's dragging everything down.

Now, we have done a lot to address the first housing problem, the mortgage issues. We have tightened the rules working with the banking regulators and the Federal Reserve so that borrowers are getting good information on their mortgages up front. And Secretary Paulson and Secretary Jackson helped create a voluntary alliance of lenders and non-profit housing assistance groups – it's called HOPE NOW – to help troubled homeowners figure out refinancing options that allow them to, we hope, keep their homes. The president also proposed and later signed into law a tax change that makes it a little easier for some people to keep their homes.

Now that we have taken action to address those mortgage problems – some of those mortgage problems, we are facing a housing oversupply and price decline problem. Now, it's hard for a lot of people in Washington to accept this, but sometimes the best policy is not to interfere when a market is adjusting. We think that is the case here. There are bills that have recently been considered in both the House and the Senate that would, we believe, slow down the painful market adjustments that must eventually occur. Slower is more painful and it hurts the overall economy more. Now, we think that a lot of these changes – they are well intentioned, but they are, in fact, harmful.

And what I'd like to do, and I'm going to use this to segue from housing into healthcare, just to go through a thought example here. So I want to talk about one provision in this housing bill having to do with bankruptcy. What this provision would have said – this was in the Senate bill – is that a bankruptcy judge has the right to come in and write down the value of your mortgage. If you are in the process of declaring bankruptcy, the judge can step in and say I know that you owe \$300,000 on your home, but clearly you can't afford it. And so instead, I'm going to write it down to \$200,000 or \$150,000 and write down the value of your home. Now, that is how it works for sailboats, for vacation homes, for a lot of other property. But that is not how it works for housing. The Senate bill, in fact, would have allowed a judge to come in after the fact, after you had your mortgage, and write down the value of that mortgage.

Now, it is true that this would allow some people who would otherwise have to declare bankruptcy and lose their homes – it would allow some of them to keep their homes. But the key point is that there are costs. And those costs are – the principal one is higher borrowing rates going forward, right? If the lender thinks that they may lose some of the value of their loan going forward, and that loan is going to be written down, then the interest rate that they will

charge goes up. So you're creating a bad incentive, and you're raising the price. There are bad incentives. You create moral hazard for some people to say, you know what, I can take the chance, get a bigger mortgage than I otherwise would because worst case, maybe I can get a bankruptcy judge to write it down. And then there is a fairness question. Eddie Lazear, our top academic economist in the White House, talked about the teacher, who the day the homework assignment is due, hears from a couple of kids who said, you know, I just didn't have time to finish my homework. And so the teacher gives everybody another week to complete their homework assignment.

Now, that is good for those people who were not able to complete their homework, and in some cases, some of them may have had legitimate reasons, real good excuses why they weren't able to do it, but for everybody who stayed up all night finishing their assignment to make the deadline, they are not feeling that it's fair. And so that is one of the questions that you have got to deal with here is the equity of do you bail someone out after the fact when it is creating inequity for people who are, in fact, making the hard choices every month to try and stay in their homes.

Okay, what I'd like to do now, I want to switch to health care and talk about, sort of, on the individual level some of those questions about decision-making and about who is best able to make decisions about health care. What I want to do is I'm going to start with a quote from the president from this year's State of the Union address, in which he said, "To build a future of quality health care, we must trust patients and doctors to make medical decisions and empower them with better information and better options. We share a common goal: making health care more affordable and accessible for all Americans. The best way to achieve that goal is by expanding consumer choice, not government control." The best way to achieve that goal is by expanding consumer choice, not government control. And that is what I want to focus on here.

Now, our goal here is high-value health care. It is the best health given a certain amount of resources. And the first thing we need to do is we need to acknowledge that there are limited resources. Now, there can be a debate as to – at what level those resources are limited, but there can't be a debate that at some point, the resources are, in fact, limited. That is part of what the federation does here is it engages in that debate in Washington about how much of the federal taxpayer resources should be dedicated to health care versus education versus defense versus highways. But at some point, there is going to be a tradeoff, there is going to be a budget constraint. And then people are going to have to make decisions about how to get the best value health care for that limited amount of dollars.

Chip said I spent a lot of time working on entitlements. I started off at the Bipartisan Commission on Entitlement and Tax Reform in 1994, where we identified the long-term growth of Medicare and Medicaid spending as one of the principal long-term budgetary challenges that we face. Where we are right now is Medicare and Medicaid, federal and state Medicaid spending, combined to be about \$880 billion this year. And they are projected to grow somewhere between 6 and 7 percent per year over the next 10 years. Simply put, that is unsustainable. You cannot have a budgetary program that is costing \$880 billion a year grow 7 percent per year forever. The arithmetic eventually will not work. Now, I'm not talking about

the next year or the next two years. But as a matter of long-term policy, you can't have something that big growing faster than the economy. It will eventually eat everything up.

So at some point there are going to be changes that have to be made, and there are going to be tradeoffs. And the question is who is best suited to make those tradeoffs given a limited pot of resources? There are three levels of possible decision-making: the government, an intermediate level, and then the consumer. Now, that intermediate level is the locus of where a lot of the decisions occur right now. And in there, I'm grouping both health plans, I'm grouping providers to a certain extent, and employers. They are making the tradeoffs in our current system for a large majority of the people receiving medical care as they make decisions about how to allocate compensation into wages versus health insurance, what kind of health insurance package to offer their employees. Within a health plan, they are making decisions about how to manage care, how to trade off to get the best care for a large number of people for a limited number of dollars.

One of the president's contentions is that that system is not sustainable in the long run and that we are able to come to a fork where we go toward one of those two other levels. Either healthcare decision making is going to move more up to the government level, where the government is going to be making resource allocations. Or it's going to be moving down closer to the individual based on advice from their physician. We think that that change is already starting to occur. We think it's going to accelerate over the next several years. And we think that it's going to be a major part of the policy debate over the next two, three, four, five years. We saw a little bit of it back in the SCHIP debate, back in November and December, whether you should be having more resources allocated through the government or through individuals. We think that that choice is going to keep coming up.

What I want to do, obviously, the president has made his choice in that he thinks that the decisions should be made by the individual, not by government. But what I want to do is I want to walk through just a few of the elements of that decision-making and talk about why they are important. I'm going to talk about six things. I'll go fairly quickly. One reason is preferences. People are different, but they are not all different. We have different bodies and we need different medical care for different situations. We have different views on medical care and doctors. Some people feel the need to go to the doctor or to the hospital because any time there is something wrong. Other people have an aversion to it. And there are different tradeoffs that people make between health care between other needs: housing, education, whatever it happens to be. And so when you have a government making decisions, what it's doing is it's setting up rules to try to apply to 300 million people or maybe tens of millions of people.

Rules are not going to fit everyone's preferences well. And so one of the questions is if you want to go to a rule-based system, if you want to have government making decisions that involve people's preferences, is that the best thing for those people? You may get it right a lot of the time, but you may get it wrong a lot of the time. And so as you're choosing between government and individuals, one of the things you have to address is to the extent that people are different and they have different preferences about medical care. A rule-based system, basically, where decisions are made by people in Washington for people hundreds, if not thousands of miles away, is you're going to have some imperfections. You're going to get things wrong.

Now, my former boss at the NEC, Al Hubbard and I, we used to debate incentives versus information, which was more important? We ultimately concluded that both are important, and let me talk about both. On incentives, who can more precisely align incentives? We happen to think that the individual can because the individual, when they have control of the resources, is making decisions on the margin about the marginal benefit and the marginal cost of whatever the service is that they are receiving. Now, I'm not talking about the information yet. I'm going to get to that in a moment. But in terms of who has got the best incentives if they have control over the resources, we think this is a clear winner for the individual. This is one of the reasons why the president pushes consumer-directed health care, why he thinks high deductible health plans and health savings accounts are the right way to go. We have seen the studies which suggest that when people start to control their resources, they start to be more conscious of the decisions that they are making about their medical care. They have the incentives to spend their money the right way, to maximize the value that they are getting for the dollars that they are spending.

One point that should be very obvious is that when you are talking about one of those intermediate organizations or the government as a whole, there are other stakeholders. Whether those other stakeholders are shareholders, whether they are elected officials, whether they are bureaucrats interested in keeping their jobs, whether they are other interested groups that are lobbying Washington, those other stakeholders in the decision-making process, when decisions are more centralized in Washington, you have other people who are able to influence the decision-making for reasons that are different than helping the person get high-value health care. I don't mean that as a pejorative statement. I just mean it as a statement of fact that people are going to look out for their self-interest, and they are going to participate in whatever level of decision-making exists.

All day, every day, we are dealing with various groups who want to come to see a mess and explain why a certain type of treatment is the right way to go, why the CMS reimbursement rates should be done a certain way. We think that in that case, you are not having a proper alignment of decision-making incentives that is focused solely on delivering high-value health care for the patient. There is a bit of a tension there.

Finally, with the incentives, when the individual is, in fact, making those choices, when they have control over the resources, we think they will not only make better decisions, but they will take more responsibility for their health. Medical care is, of course, only one input into health. And we think that when you have the incentives, when you're starting control your own resources, what you're doing is you're giving people incentive to be healthy. And some of the preliminary evidence for HSA suggests that people do start to care more, take more responsibility about the health of their bodies and about the decisions that they are making.

And I want to talk for a couple of minutes about information because it's one of the most important underlying questions here. If you get the incentives right, but people don't have information about the medical care that they are getting, then people can't make good decisions. First point on information is who knows more about your particular medical situation? Is it you with your doctor? Or is it an NIH research expert who has done a lot of studies about it? Now, the NIH research expert or the person who is writing in JAMA may have a lot better information,

a lot more expertise, and years of research background about the general medical condition. You happen to know and your physician happen to know about your particular situation. This one is not a clear winner for one system or the other because there is a tradeoff. You and your physician are the closest ones to you and to the particular medical situation that you're facing. And so you can say, you know what, what is going on in this medical study doesn't precisely apply. But neither you, nor your doctor may have the advantage of all of this research, of all of this knowledge that is out there.

And so part of what we want to try and do is we want to try to encourage that information to get to the doctors to where it can be most effective in helping people make decisions. But if you try and say in Washington, based on the following medical study, here is the rule that we are going to set up for what kind of treatment should be reimbursed by Medicare or by a government-run health plan, you run into the same problem as you did with preferences. The rules are imperfect and they are not going to work in a lot of cases, so that is the tradeoff that you have got.

One of the other principal arguments about information, one of the principal arguments against consumer-directed health care is complexity, is that people can't possibly understand all of the complexity involved in medical decisions, and they are just not able to make decisions about medical care. What I want to do – I want to give an example to try to contradict that. Could everyone who has purchased a computer, a home computer, in say, the past five years raise your hand? Okay, most of the room. Okay, I want to read you two specs for a home computer. The first one is an Intel Core 2 Q6600 Quad Core with 8 megabyte L2 cache, 2.4 gigahertz processor, and a 1066 FSB. I can go into the memory parameters and the speed of the hard drive as well, if you'd like. The other one is an Intel Celeron processor 420. Let's see, it has got 2 gigabyte dual channel DDR 2D Ram at 667 megahertz. Now, I'm going to guess that not many people in this room could make the choice here. The first one, by the way, is \$2100; the second one is \$800. It's probably hard for a lot of people here to figure out which is a better value for the dollar.

Well, what I did this morning was I got on the Dell website, the first one, I said I want a computer for my home business. I want Microsoft Office Professional. I need a big screen, a fast hard drive. I'm going to be doing PowerPoint presentations and also listening to my music library. And it built that system for me. The market figured out a way to help me buy this computer even though I had no idea what a SATA 3.0 gigabyte per second hard drive means, it was able to help me make that complex decision, okay? In this case, Dell makes money by helping people figure out how to translate their needs and wants into purchasing for a complex decision. We believe that markets can and will solve this informational problem. We think that they can help explain complex decisions to people.

And, in fact, we see that right now as federal employees. We can buy the checkbook guide to health plans, which compares the various health plans that we have and let's us make decisions as to what health plan is best for us. This is one of the reasons why Secretary Leavitt is working so hard on health information and health technology, on electronic medical records, is we believe that if we make the information available that participants in the private market are

going to figure out ways to make money to help people make those complex decisions about their health care.

One other point – it's a counterargument as to why people say that individuals cannot make decisions and should not be making decisions about their medical care and shouldn't have to make those tradeoffs in those resource decisions. It's the ambulance problem. You get hit by a truck, you're in the ambulance, you're on your way to the hospital. It's not the time for you to start negotiating over the price of your medical care. It's an excellent example, but the argument is actually a little bit misplaced because the situation here – it's not the severity of the medical treatment that you need. That is not why you can't negotiate. It's the urgency. And I think what happens is that this ambulance example is used to argue that for serious medical conditions, for serious medical treatments that people do not have the ability and should not be required to make those tradeoffs, to make those evaluations as to what medical care makes the most sense for them and how they should be allocating resources to do this.

But the fact is it's not the severity of the fact that the person was hit by a truck. It's the fact that they are in an ambulance and they need the care now. The same is true if you cut your arm and you're bleeding and you go to the emergency room. That is probably not life threatening, but that's also not the time that you are going to be negotiating for medical care or for the best value for the dollar. When you do have a serious condition and you need to get it treated sometime in the next three months, what most people do now is they shop around for the best doctor, the best hospital they can find so they can get the best treatment. So people are shopping now. We think that they can shop. We think that markets can help develop to provide them with the information to make that decision. And we think that the number of cases where, in fact, it's inappropriate to having the individual make those decisions is limited to the cases where it's urgent rather than something where it's very severe.

Finally, I want to talk a little bit about equity because that is one of the principal arguments for elevating the decisions to the government level. And I think that it's a little misleading. The first kind of equity, when economists talk about it, they talk about horizontal equity. Two people in a similar position should face the same sort of government conditions. And that is one of the problems with our system right now is we don't have that kind of horizontal equity. If you are fortunate enough to get your health insurance through your employer, you get preferential tax treatment through the tax code. If you work maybe for a small business or if you're self-employed, if your employer is not able to provide you with that health insurance, then you have to pay for your health insurance with after-tax dollars. That is a basic fundamental inequity in our system. It makes it harder for people to afford health insurance when they are not fortunate enough to be working for generally large employers. It hurts small businesses and small business employees. And we think it's fundamentally unfair.

This is why the president proposed what we call a standard deduction for health insurance, which creates a level playing field. It treats everybody the same. No matter how you buy health insurance, whether you get it through your job or you buy it on your own; you get to deduct the same amount, \$15,000, from your taxes. You don't have to pay taxes on it. We think that it's fair. We also think and the outside experts agree that it will, in fact, significantly reduce the number of uninsured. There was a lot of debate late last year about how best to help the

uninsured get health insurance. Well, the director of the Nonpartisan Congressional Budget Office released some slides yesterday, in which their analysis shows that the president's proposal would increase the number of people with insurance by about 7 million in 2010. That is bigger, a bigger positive effect on the number of uninsured than the proposals that were advanced by the congressional majority last year.

So when you hear someone say we need to cover all of the uninsured, ask them, of the bills that were advanced last year, did any of them match up to the president's proposal? Would any of them have had a concrete proposal that was budget neutral over 10 years and would have increased the number of people with health insurance by 7 million – is that everybody know (?), but it's a very significant step.

Now, we have some outside estimates, which suggest that the number could be higher. We had numbers around 10 million for our proposal. The president has signaled his openness to discussing the idea of a flat tax credit, where the estimates range from 14 million to 20 million additional insured people. We think that these are ideas that, frankly, demand consideration. We are disappointed that the Congress did not consider them last year. But we think that they are going to be a major portion, not just of this year's health policy debate, but of the policy debate going forward. We think that they are fairer to the people who want to buy health insurance. And we think that they will result in decisions being made more by the individual, moving things away from the government. And we think that it will result in an increase in the number of people with insurance.

I want to leave you with one little exercise. I see most of you have pads and pencils in front of you. So just something to discuss over lunch. In front of your pad, if you could make a little two-by-two grid for me, just two boxes. There is no right answer here, so there won't be a quiz. For each column, I want you to label the columns. The left column, let's label that rich; and the right column, let's label that poor. Okay, now we're going to label the rows. The top row, we're going to label healthy, and the bottom row, we're going to label sick.

And what I want to just encourage you to think about today and maybe discuss over lunch is if you're in the government and you have a limited pool of resources and you want to help people, how are you going to order these boxes? I want you to put a one, two, three, and four in the boxes. Who are you going to help first? Who are you going to help last? I'm going to help you out. Most people put a four in the top left box. Most people say if I have a limited amount of resources; I'm probably not going to use that to subsidize rich healthy people. I'll give you a little more help. Most people say that if they are just making a value choice that they would put a one in that bottom right box. That if I'm just making this value tradeoff, the first people I want to help are the poor people who are sick. There is no right answer for where the two and the three go. But I want to encourage you to think about it, and then discuss how our current system works because our current system does not have a four in the top left box, and it does not have a one in the bottom right box.

Depending on how you measure it, a lot of the dollars are going to rich healthy people or rich sick people before they are going to poor healthy people or poor sick people. Now, some of you are going to have different choices here than others. But most people end up with a ranking

here, with a preference list that is very different than our current system. And it's something to think about. We are using taxpayer dollars to subsidize people, and the way that those subsidies are generally designed by the way we do Medicare, Medicaid, and the treatment in the tax code, generally tend to be different than the way that most people would prioritize it.

I hope you found this useful. I thought it would be a little more instructive and maybe a little more helpful to talk about this in a little bit more of a philosophical way. I think that these underlying questions are going to be part of the debate that you're going to see throughout 2008 and 2009 and 2010. And I hope that I maybe have been able to do a little bit of a good job in convincing you why the president thinks that decisions need to be made by the consumer, by the individual based on advice from their doctor, not by centralizing more decisions in government. Thank you very much and enjoy the rest of your day.

(Applause.)

MR. KAHN: Thank you, Keith. And that was a great start to the morning. And now it is really a unique pleasure for me to introduce our next speaker, Senator Orrin Hatch. Senator Hatch has been a very special senator since he joined the chamber 30 years ago from the state of Utah. He has always been a leader, he has been a doer, and he has made a difference. His contribution to improving health care and expanding coverage is unquestioned. And so I look particularly forward to his message this morning. He has made a mark in the Senate and does so every day. He is one of the few senators of his generation who has made such a mark every day and will be remembered far into the future for his contribution to this nation's greatness.

But for me, in many ways, and even more importantly, I have always found him to be a very personally kind and thoughtful person. And that is a rare quality in Washington. So it is my special pleasure this morning to introduce our next speaker, Senator Orrin Hatch from Utah.

(Applause.)

SENATOR ORRIN HATCH (R-UT): Let's see, they told me this thing will go up a little bit. Well, Chip, thank you for that wonderful introduction. I have known Chip for a long time. And let's put it this way, we both had a lot more hair back then. He was one of the best health staffers on Capitol Hill and brings a lot of insight to the federation. You all are fortunate, in my opinion, to have such a talented and knowledgeable person as your president. And he has certainly assembled a very capable staff. Conwell Smith, Jeff Cohen, and Jayne Hart have all done an excellent job representing your interests here in Washington.

I also want to introduce Kevin McGuinness, my former chief of staff and good friend, who now represents the federation. You can't find anybody better than Kevin. Finally, I also want to acknowledge Keith Pitts, the chairman of your board of directors and vice chairman of the Vanguard Health Systems. I would also like to thank you and Chip so much for inviting me to speak to your membership.

And I saved the most important people for last. I want to extend a warm welcome to Washington my fellow Utahns who are in the audience this morning. Brent Johnson, vice

president of the supply chain, Intermountain Healthcare; Mark Probst, CIO and vice president of International Healthcare; Steven (sp) Prendergast, national accounts manager of CR Bard, Inc.; Bill Kethler (sp), health system accounts director, Merit Medical Systems, Inc.; and Todd Oldroyd, vice president of national accounts for Merit Medical Systems, Inc.

You're here in Washington at a very exciting time. The results of today's primaries in Texas, Ohio, Vermont, and Rhode Island could be a turning point for the Democrats. There may even be a turning point for Republicans. They will finally know – the Democrats may finally know who will be their nominee. And the way things are looking this way, could be the first presidential campaign that Bill Clinton has lost. (Laughter.) And he wasn't even the candidate.

Tensions are certainly running high in Texas. Over the weekend, a cowboy friend of mine from Texas attended a social function that Hillary Clinton was also attending. She was trying to gather more support for her nomination. She and my friend talked a little bit, but when she discovered that he was a Republican and wasn't going to change his vote for her, her tone changed. Things got a little bit heated when they started talking about universal health care.

And as they were debating the pros and cons of the healthcare reform plan, she kept swatting at some flies that were buzzing around her head. My Texan friend finally asked her, ain't you having some problem with them circling flies? And she stopped talking and said, well, yes, if that is what they are called, but I've never heard of circle flies. Well, ma'am, he replied, circle flies hang around ranches. They are called circle flies because they are always found circling around the back end of a horse. (Laughter.)

Oh, Hillary replied. But a moment later, she stopped and bluntly asked him, are you calling me a horse's rear end? No, ma'am, the cowboy replied. I have too much respect for the citizens of New York to call their senator a horse's rear end. That's a good thing, she responded. And after a long pause, my friend in his best Texas drawl said, hard to fool them flies, though.

(Laughter, applause.)

But seriously, I get along well with Hillary. I like her a lot. (Laughter.) But I just couldn't resist telling that story. Now, I will share my impressions about the upcoming presidential election a little bit later. Now, I will update you on the healthcare crisis before Congress this year.

Since it is a presidential election year and the entire House of Representatives and one third of the United States Senate is up for reelection this year, it is going to be extremely difficult to get anything done this year of consequence. And I know all of you are nervous about how hospitals will be treated especially after reading the president's Health and Human Services Department's budget for fiscal year 2009. Trust me, with all due respect to President Bush who I deeply admire, I do not believe that the cuts in the president's budget will be seriously considered by Congress this year.

It is highly unlikely that a Democratic Congress would approve a Republican president's budget during an election year. Even when the Republicans were in charge, we in the Congress

wrote our own budget. Let me take a few minutes to talk about the status of the Medicare legislation that all of us expect to be considered by Congress this spring. Congress approved Medicare legislation last year that protected physicians' Medicare reimbursement rate from being cut by 10 percent until July 1st, 2008. In order to prevent physicians' Medicare reimbursement rates from being cut by 10 percent from July 1st to December 31st, 2008, Congress must simply pass Medicare legislation before June 30th. Cutting doctors' Medicare rates does not go over well back home during any year, but not taking care of physicians during an election year is simply bad politics.

And the chairman of the Senate Finance Committee, Max Baucus, who is up for reelection this year, understands the politics. Last fall, he worked with the ranking Republican member of the Senate Finance Committee, Senator Chuck Grassley, in the hopes of developing a bipartisan Medicare bill that could be marked up by the Finance Committee. Unfortunately in the end, a compromised Medicare bill was never seriously considered by the Finance Committee. This year nothing has really changed. Senators on both sides of the aisle want to take care of both Medicare beneficiaries and their doctors. We also want to take care of rural healthcare providers and continue to the moratorium on therapy care for Medicare beneficiaries. But the chairman of the committee and many of the Democrat committee members want to go beyond these provisions and pass a more comprehensive 18-month Medicare bill.

Many want to include payment reductions to the Medicare Advantage program, which are simply unacceptable to the administration and to us Republican members of the committee. There also is an effort to increase the low-income subsidies for low-income Medicare Part B beneficiaries, which would cost between 2 to \$5 billion every five years and maybe more since the Congressional Budget Office is currently recalculating the budget baseline. Most Senate Finance Committee Republicans do not want to address the issue unless Medicare Part D premiums are means-tested. This is pretty much a non-starter for Democrats on the committee. In addition, the Democrats want to remove any beneficiary copayment for current and potentially future preventive health benefits in traditional Medicare. In principle, I think it would be a good idea, but I feel that there needs to be some beneficiary responsibility.

This provision, too, has the potential to cost a lot of money and, as you all know, money is very tight. So you can probably read the writing on the wall. Passing such a bill is going to be extremely challenging, especially by June 30th. To help you understand what we are up against, let me share with you the new obstacles – or at least some of the new obstacles that we are now facing. First and most important, this week, actually next week, the Senate Budget Committee – well, this week, the Senate Budget Committee will consider the Senate budget resolution for fiscal year 2009. We expect this year's budget resolution will include reconciliation instructions. Essentially, this means that certain committees will be asked to find savings and programs that fall under their jurisdiction.

Medicare, as you know, is under the jurisdiction of the Senate Finance Committee. Last week, Chairman Baucus indicated that Medicare provisions, including the Medicare physician reimbursement fix will be part of the budget reconciliation legislation. Senate Republicans previously had been told that the Finance Committee would work on a bipartisan Medicare bill this spring. So this latest news to us was quite a disappointment. It may be a smart move by the

Democrats because it is easier to pass a budget reconciliation bill than a bill moving on its own. A budget reconciliation bill only needs to pass by a simple majority in the Senate. However, in order for a Medicare bill to move through the Senate on its own, it would need 60 votes in order to be considered on the Senate floor – and not only in the motion to bring up, but on the bill itself.

Now this is due to the cloture rules. And the Republicans felt that moving an independent Medicare bill through the Congress meant that we would be able to work out a deal with Democrat members that also would be acceptable to the White House. Moving Medicare legislation through the budget reconciliation process indicates to me that the administration will probably not be consulted during this process. And for that matter, neither will the Senate Republicans. Let me repeat. In order to prevent doctors' Medicare reimbursement from being cut by 10 percent, the budget reconciliation bill will have to be signed into law by June 30th. Typically Congress does not even discuss budget reconciliation legislation until late spring or early summer. So needless to say, Finance Committee Republicans are very disappointed by these latest developments.

Secondly, there is limited money available for the Medicare provisions. And the broader the Medicare bill, the more offsets Congress will need to find because the Democrats have committed themselves to a pay-go situation, although they find some very ingenious, actually ridiculous ways of getting around it. Keep in mind, they also have some other problems as well. I briefly mentioned that the Congressional Budget Office currently is recalculating the budget baseline, so these provisions may be even more expensive this year. The obvious target, and I think the Democrats would be very straightforward on this, is the Medicare Advantage program. But other providers will be on the chopping block as well. And while you're in Washington, take the time to see your senators and House members to educate them about hospital budgets and how certain Medicare reductions could really hurt – well, really could hurt the hospitals in our respective states.

Now, when we are talking about the Medicare package, value-based purchasing is a high priority of the administration. You just heard from Keith Hennessey, and I am certain that he told that the White House wants to include value-based purchasing and e-prescribing in any Medicare legislation. I know that federation has been working very closely with the American Hospital Association, the Association of American Medical Colleges, and other hospital groups including Premiere to develop an industry position. Please continue those discussions because it makes our job a lot easier. It has been made clear to me that your biggest concern is that you do not want a value-based purchasing program to be used as an offset for the Medicare bill. And please know that my door is always open to you to hear your ideas and suggestions.

Now, it is great that the federation will be participating in the Senate Finance Committee's roundtable on Thursday. And my advice is to be completely honest with the committee members on how you believe value-based purchasing should work. I also know that the federation strongly supports including legislation in the Medicare bill on the National Quality Forum. I am very interested in having my staff sit down with your Washington staff because, naturally, I want to be helpful to you, as I think I have been throughout my 31 years in the Senate. Again, I believe that it is going to be tough to add new issues to the Senate Medicare bill

this year. However, I recommend educating Finance Committee members on both sides of the aisle on this legislative language. I look forward to being educated on this issue.

Another important matter that certainly will be discussed during this year's Medicare debate happens to be specialty hospitals. There is support among several committee members to include language similar to what was included in the House-passed Medicare bill last year. Now, I recognize that it is important to all of you that self-referral to physician-owned hospitals be banned and that you also strongly support a moratorium on the construction of future specialty hospitals. There are several members of the Senate Finance Committee who have concerns with this provision. However, you have the support of both the Finance Committee chairman and the ranking Republican to include this provision in any Medicare bill.

Now, as a senator from a rural state, I briefly want to mention the Medicare rural DSH payment issue. This is very important to hospitals in my home state of Utah. And I strongly believe that hospitals serving a disproportionately high number of uninsured patients should be reimbursed appropriately. You have my assurance that I will do what I can to assist you on this issue. Rural DSH hospitals have every right to be compensated appropriately. Now, many of us were extremely disappointed that the SCHIP reauthorization bill was not signed into law last year. As one of the original authors of the program, I am still quite frustrated by last year's turn of events. But please know that I have not given up, and I will continue to push until SCHIP reauthorization legislation is signed into law.

You probably also know that last year's Medicare bill reauthorized the current SCHIP program until next March. I know that you're going to hear from my good friend, Jay Rockefeller, next on the agenda. Jay and I, along with Chairman Baucus and ranking member Grassley, went through last year's wars in both Houses and with constant repetitive meetings with the leadership in both Houses.

Along with Senator Ted Kennedy and the late Senator John Chafee, we were the original authors of the SCHIP program back in 1997. So we took the president's veto of our legislation very personally. I truly believe that President Bush got some very bad advice when he vetoed our SCHIP legislation. However, let me just say in all honesty that when we went into it, we had an agreement across the board that we would put a 30-percent cap. And I considered that a cap on everything. And as you know, some have been using Medicaid combined with SCHIP and two states, really two areas, Missouri – or was it New Jersey, I can't remember – and the District of Columbia already have Medicaid SCHIP at 300 percent of poverty. That is \$64,000 for a family of four, which I think is ridiculous. I would never have gone over 200 percent of poverty. But we had an agreement that we would put a 30 percent – we would put a cap on 300 percent of poverty.

Well, the Democrats said, yeah, that agreement was only on SCHIP; it wasn't on Medicaid. I said, well, what argument can you make that Medicaid should be 300 percent of poverty or even be more? And they couldn't and they admitted that they couldn't. And I said, well, then why not have the 300 percent? And the argument was we do not ever want to have a lid put on an entitlement program. So you can see what we have to face. And the House members were not completely wrong in raising that issue. The fact of the matter is, is that I said,

okay. Since before you go into SCHIP, you have a 57-percent match from the federal government, why don't we, if we hit 300 percent, drop that back down to 57 percent? We couldn't get that done either. They wanted to get the higher match from the SCHIP program, which is a higher match.

Well, I had one more issue to raise with you regarding the Senate Finance Committee. Chairman Baucus intends to hold several healthcare hearings in the late spring and early fall on healthcare reform. At some point this year, he will conduct a full-day healthcare summit for committee members and outside groups to discuss healthcare reform. To me, it is very important that you offer to testify and participate in these hearings as much as possible. Your own president, Chip Kahn, has done a lot of work in this area with strange bedfellows' health reform campaign.

In addition to the Senate Finance Committee, I also sat on the Senate Health Education Labor and Pensions Committee, better known as the HELP Committee. I used to chair that committee back in the early '80s. The HELP Committee has jurisdiction over the Public Health Service Act, the Food, Drug, and Cosmetic Act, and some areas of health insurance. Briefly, I just want to thank all of the federation members for all of your help when Senators Kennedy, Enzi, Clinton, and I wrote the Wired for Healthcare Access Act. Please know how much we all appreciated the federation's assistance on these important issues.

As some of you may know, this bill was approved by the Senate Health Education and Labor Committee last year. There were some jurisdictional issues that the Senate Finance Committee had to work out with the Health Committee on this bill. And once they were worked out, we truly believed that this bill would be approved by the full Senate. Unfortunately, in the Senate, even one senator alone has the power to prevent a bill from being approved by the full Senate under certain circumstances. And that is exactly what happened.

One senator has a hold on this legislation. And while we all tried to work with this senator and hoped that the bill would be passed by the Senate, its future is currently uncertain. Now, as you know, by a vote of 51 to 48 on June 26th, 2007, the Senate failed to invoke cloture on a motion to proceed to the Employee Free Choice Act, also known as the Card Check Act. I was honored to join my colleagues Senators McConnell and Enzi and lead the Senate fight against the Card Check bill. This is a very bad piece of legislation and it deserved to be defeated.

Keep in mind, the unions can come into your hospital or come into your system and if they can get 50 percent of your employees plus one to sign a union card, you are unionized against your will. And that is in spite of the fact that our unions fight for secret-ballot elections all over the world. Now, that is what you are going to face if we get a Democrat in the presidency and they win more seats in the United States Senate. The only thing to stop that so far has been the Rule 22, our cloture rule or filibuster rule. I know all about that because I led the fight back in 1978 against the so-called Labor Law Reform Bill, which would have unionized America against its will. Had that bill passed, at least 50 percent of American workers would have been unionized.

It is estimated – for those of you who are Republicans or independents or conservatives, it is estimated – or even Democrats – it is estimated that had that bill passed, the unions would become so powerful, they would have been the single most powerful entity in our country today. They are almost that anyway. The unions spend between a half billion and a billion dollars every two years in local, state, and federal politics. Almost all of their employees are dues-paid political operatives, the best in the business. Think about that.

When I run, I have to raise enough money to get out my vote. The unions do it for the Democrats in almost every case. And with that amount of money going into politics, you can imagine – and, by the way, not a dime of that is reported anywhere, where all of mine has to be reported. Had Labor Law Reform passed, we would be a much different country today. If Card Check passes, which is even worse than Labor Law Reform, and Labor Law Reform is terrible, I can't begin to tell you how the downgrading of American will occur. And I happen to be one who believes in collective bargaining. I'm one of the few members of Congress who ever earned a skilled tradesman's union card. I went through a formal apprenticeship program.

But the reason this country has survived well is because we have an almost equal balance between labor and management. The unions have a little bit of an advantage as perhaps it should be, but if that bill passes, that advantage is going to go like that. And if that happens, you're going to be in a totally different situation. Well, I believe that if this bill were enacted, it would dramatically diminish the rights of workers in union organization process and shift power away from individual employees into the hands of employers and union bosses. Now, I oppose this legislation because I believe it promotes neither freedom nor choice for employees when it comes to the union representation. Rather the card check certification, the binding interest arbitration, and the penalty sanctions of the so-called Employee Free Choice Act would deprive employees of their freedom and choice in union representation that the National Labor Relations Act guarantees them and that the National Labor Relations Board secures for them.

Now, some believe the current system is broken and that the so-called Employee Free Choice Act will correct its deficiencies. Well, I adamantly disagree. There is no free choice when an employee is bound by signatures on union authorization cards instead of votes in a secret-ballot election made after an employee can learn about the advantages and disadvantages of union representation. There is no free choice when government-appointed arbitrators decide the terms of a union contract that is binding for at least two years and employees are denied the right to vote on whether to accept the union contract.

In a recently released study of statistics for 2006, the win rate of unions in secret ballot elections supervised by the National Labor Relations Board has increased for the 10th consecutive year. That's correct. Unions have a rising win rate in secret ballot elections over the span of the last 10 years. But they have had to earn that right. For example, in 2006, the unions win rate was 61.5 percent of all representation elections, which was up from 61.4 percent in 2005. Since 1996, unions have won more than 50 percent of all NLRB supervised elections in each year. Thus, secret ballot elections supervised by the National Labor Relations Board are effective in time-honored avenues for employees to express their free choice on union representation. More significantly, unions are winning well over 50 percent of these secret-ballot elections. Yet some now want to cast aside this effective system and give unions the

ability to increase membership dues by a forced card check system and a guarantee of a government-imposed initial union contract.

Now, this is easily one of the worst bills that I have seen in all of my years in the United States Senate. And I want to thank you for your efforts last year to assist in defeating this horrible bill, but that battle is not over. This presidential election is very important. We will most certainly see this bill or one very similar in the next Congress, and I hope that I can count on your continued support in opposition to this bad bill.

Now, finally, I'd be remiss if I didn't talk to you a little bit about the elections that we are facing in the fall, and maybe even as early as tonight. The entire House of Representatives is up for reelection this year along with one-third of the Senate. Today the Senate is composed of 49 Republicans and 49 Democrats along with two independents who both caucus with the Democrats. This year, 23 Republican seats and 12 Democrat seats are up for reelection. If the Democrats are able to win 60 seats in the Senate, it will have a dramatic effect on how the Senate operates due to the cloture rules. Cloture has been used in recent years to protect the rights of the minority. When cloture is filed on a motion to proceed on a specific bill and there are less than 60 votes, the bill is essentially dead.

Therefore today, if the majority party wants a bill to pass, it is in their best interest to address the concerns of the minority. If the Democrats win 60 seats this fall in the Senate, that incentive goes away. And while any senator has the right to put a hold on a bill, the majority party will have less incentive to address the concerns of the minority party when drafting and negotiating legislation. So that is one reason why this election is so significant for the Senate this year.

The presidential race is extremely interesting as well, especially the ongoing contest between Senators Hillary Clinton and Barack Obama. It's hard to watch the evening news, the Sunday talk shows, or now even Saturday Night Live without seeing some story about the Clintons' fury about the kid-glove treatment the press is giving Senator Obama. Oh, my goodness. As many of you know, Senator Clinton herself was on Saturday Night Live this past week joking about the most recent debate with Senator Obama. As luck would have it, the members of the band that appeared on the show that night, Wilco, are big supporters of Senator Barack Obama. Poor Hillary. She just can't get a break.

As far as our Republican candidate is concerned, I've known John McCain for his entire career in the United States Senate, and I will say this: He has never let an unkind word go unspoken. (Laughter.) And I love him for it sometimes. (Chuckles.) I'm sorry, I shouldn't have done that. (Laughter.) Seriously, John is a good man. And while I was originally a Mitt Romney supporter, I believe that John will make a good president, a great president. In fact, the other day I was quoted as saying that if John McCain is elected president this fall, his motorcade won't need training wheels. This is a slow crowd is all I can say. (Laughter.) Oh, boy, did I get some calls on that one. I'm sure I'll get a few from you.

I know some of you who really aren't dumb enough to be Democrats, but I hope not too many. (Laughter.) I was in a debate a number of years ago against – it was a very tight race

against a very popular mayor of Salt Lake City. And we were before 2,000 people at this debate at Brigham Young University. And he was talking about how important it is to be a Democrat, and I said, well, you know, I used to be a liberal Democrat. I went all the way through BYU as a liberal Democrat. I said, then I learned how to read and write, and I became a Republican. (Laughter.) Everybody laughed. The next day, I think it was the Ogden Standard-Examiner came out and said Hatch demeans with an editorial, Hatch demeans every Democrat in Utah as being incompetent and illiterate. And I thought, oh gosh, they don't have a sense of humor. Well, I hope you do. (Laughter.) And Senator Obama did call me and tell me that I was being unfair. Lawyers got involved. So now when it comes to Senator Obama, I will simply say, he is a man unburdened by experience. (Laughter, applause.)

Now, I have to admit, I like all three of them. Hillary has worked very hard for New York. She is a tough senator. I have worked with her on a number of health issues, and she has been willing to come to the center, which has meant a lot to me in some of those issues, bio being one of the important issues. But there are others as well. Barack is a very decent honorable person, in my view. But if you want a leader, I gotta tell you, McCain is that. You may not always agree with him, but at least he'll speak his mind and tell you what he believes, and he has got guts.

Well, I'm going to end my speech on a somber note regarding the presidential elections. When it comes to November, I do hope you remember this. The question is not how you feel at the end of a speech. If that is the test, then let's elect Sean Connery and be done with it. No, the issue is how you feel at the end of the next four years. Will you feel safer? Will your children's future look brighter? Will your paycheck be yours or something that has to be shared even more with the government? Will your day be spent helping your hospital treat patients and save lives? Or will it be consumed filling out an infinite number of forms for an endless number of regulatory agencies? Then again, why should we change things? (Scattered laughter.) I think it's ridiculous. Will you be able to tell your family what I've left you is more than what was left me? Will the promise of tomorrow be brighter than the expectations of today? That is a challenge we face and that is the decision before us. And yes, that is our blessed opportunity.

Well, I can't end without at least some element of humor. And being from Utah and being a Mormon and watching Mitt Romney go through that election with all kinds of prejudice against my faith and his, even though the Constitution said there should be no religious test, I just gotta tell you, Mormons have a great sense of humor, too.

Around the turn of the last century, we had about 25 general authorities in the church, people who ran the church. And they one day called this old mule skinner to become a general authority. His name was J. Golden Kimball. He was 6'-4"-inches tall, 147 pounds, tough as nails. He was very spiritual, but the only thing wrong with him was he could never quit swearing having been a mule skinner. He would stand in the Salt Lake Tabernacle and just swear a blue streak when he gave a speech. And the president of the church would be pulling out his coattails saying, Brother Kimball, Brother Kimball. And he'd say, don't worry, president, he said, you can't get too mad at me because I repent too damned fast. And he'd say things like that – (laughter) – that just about drove the leaders in the church mad, but they all loved him anyway.

Well, one day the president of the church called Golden and he said – Golden, he said, we have a special assignment for you. We're going to send you to this congregation down in central Utah. Well, believe it or not, there may be a case of adultery. There may even be a couple cases of fornication. And even worse, there may be a couple of people drinking spirits – because you know Mormons don't drink alcohol. They don't use tobacco and they don't even drink tea or coffee. It's called the Word of Wisdom.

And so old J. Golden, he gets in his Model A Ford and he drives down to this congregation and he gets up in front of this congregation and, I mean, with a sheath of papers in his right hand, he just blasted them for an hour, calling them to repent, swearing at them all the way through the meeting. I mean, people came from miles around just to hear him speak, and just blasting them in his high falsetto voice like this. And finally he gets near the end of his speech and he says, I bet you're all wondering what I have in my hands in this sheath of papers. He said, well, I'm going to tell you. It's the Lord's shit list and you're all on it. (Laughter, applause.) Thank you for inviting me here today to speak with you. Take care. Great to see you. (Applause.)

MR. KAHN: Well, I expected to bring you political speeches and policy speeches. Didn't necessarily expect a stand up but you sure got it this morning with Senator Hatch. Thank you very much, Senator Hatch, that was wonderful. Our next speaker is Senator Jay Rockefeller of West Virginia and it is quite a pleasure for me to introduce him. The senator is among – among the senators, many responsibilities in the Senate. He is a member of the Senate Finance Committee and chair of the committee's Health Subcommittee. He is part of a very small cadre of members of the Senate and the House that are leaders and experts in health care.

Over the last two decades, he has helped shaped the Medicare program and with great energy done his best to expand health coverage to those who need it the most. He is known for getting things done, for accomplishments, and I look forward to his message this morning. Whether it's this year for Medicare or next year, hopefully, for health reform, he will be at the center of the progress that will be made by the Congress. And we are fortunate to have his wisdom and his thoughtfulness as well in that process. Join me in welcoming Senator Jay Rockefeller. (Applause.)

SENATOR JAY ROCKEFELLER (D-WV): Good morning. I thank you for the invitation, and, Chip, thank you very much. I think you could be a senator or a congressman or human being from anywhere and understand what the healthcare problems are in this country.

Some of you heard me tell this story before but it never stops me from doing it again. But I got my – I found my meaning in my life, so to speak, when I was about 26- or 27-years-old. I'd done a lot of stuff over in Asia and it's like I didn't particularly want to make my life out of that. So I signed up to join VISTA and then I went to a small mining town in West Virginia and I spent two years there working on people. Nobody went to school because the county deemed it unimportant as a place and therefore never sent a school bus. It's tough to get to school without a school bus.

And there was no health, care and just focusing on that, it really pounded into me, at the age of 26 and 27, the power and the tragedy and the agony of not being able to see a doctor, not be able to get to rural health clinics, growing up at the age of 14 or 15. And I remember I used to pile teenagers in my Jeep and we'd go down to a free dental clinic. And I didn't even understand it at the time that it was already too late because what happens to the baby teeth is going to determine what happens later on and it was already too late for that.

And so I learned a lot of lessons about people who are also afraid of health care. They have so much bad news in their life that they're – in Appalachia. It's not Appalachian, sonny, it's Appalachia. That's true. And they have so much bad news in their life any way, they don't particularly want to go get an MRI or some kind of screen pap smear test or whatever because that may bring more bad news and they don't want more bad news. They can't take more bad news. So they sort of hold back from the healthcare system, which means the end – and this is back in the '60s so that the interaction of the healthcare system and people, I don't think, has changed all that much. People that don't have it and the system itself.

I think, as nation, we've always done what's – tried to what's right by our most vulnerable populations, especially when it comes to health care. But it hasn't worked and it isn't working for a lot of other people too. So I want to talk about that this morning and I'll be frank about it. We've always recognized that we have a moral commitment to do health care and we always say that and nothing changes enormously. You pursue what you can as you watch the money dilute. And you come to Washington and you talk to us and you're unhappy about it. You're angry about it. You should be. And yet, nothing really changes.

I think in recent years the better natures that we have been shouted down by the crass voices of special interest. And really, what I mean by that is self-interest. We all know the sobering statistics. There are 47 million Americans that don't have it. Some people 43, some people say 46. I think it's 47. Nine million children don't have it, 2.7 million veterans don't have it and I don't need to tell you where the millions of Americans who are uninsured go to get their health care if they in fact have the courage to go get it there, and that's the ER rooms, which is the most expensive part of your operation. And I can remember back during the Pepper Commission, we made a visit out to Chicago and already in something like the last year, six emergency rooms in Chicago had closed simply because they couldn't afford to stay open. And that was in the late '80s for heaven's sakes.

So you see it every day in your over-crowded emergency rooms and this resulted in huge and growing uncompensated health care. It's a burden to you the increasing frustration. It must be just wild for doctors and for nurses and for administrators, people pouring into your ERs having to wait five or six hours or more. And it's not because they're being kept there; it's just because that you don't have the space, you don't have the personnel for it. In the meantime, Medicare and Medicaid is going down. You're getting less money to do a more responsibility. So one only has to turn into the nightly news to understand why the American people are also so disgusted with the state of health care in this country.

When you say young children die because of lack of access to dental care, people say, oh, I hadn't thought about that. Think about it's true and you know it's true. Hardworking, middle-

class families having to declare bankruptcy because of one catastrophic healthcare event, the elderly having to choose between their Medicare premiums and the cost of utilities and food, older children losing access to health insurance because they're attending college – they don't think they need it. If they're wrong, they're really in trouble. And I could go on forever.

In short, our current healthcare system is one of competing interests, not of sort of the universe that you represent here. It's of competing interest, overlapping bureaucracies, and shortsighted considerations, and a lot of politics. I'm not going to talk about presidential elections and things of that sort. I am going to have a few words to say about some of the cuts that have taken place.

It doesn't provide comprehensive coverage for our most vulnerable population. It doesn't coordinate care. It doesn't manage chronic disease and it doesn't services to the vast squats of the nation. There's no way that it can. For me, for the first time in a long time, the American people really are focused on health care. They're really angry. I've been out on the trail a tiny bit. I don't have to be out on the trail. I can just be in West Virginia or I can be here. I could be talking to you, listening to you, and people are mad. Some are mad at the housing crisis, the general uncertainty about the economy, the loss of manufacturing base, the war, whatever. But both family and businesses, small business, all businesses, more and more are focusing on the insufficiency of the healthcare system and the unwillingness or the inability of the government to do anything about it to the extent that the government would be involved with it.

We need to embrace this moment, I think, and not squander this chance with political posturing or finger pointing, which is what we do. And I'll talk about that in a minute because it's not an evil thing sometimes. It's just that people with different points of view really get mad because they really want to see something happen and so you don't sort of sit back and just say, well, I guess it's not going to happen. You speak out about it. You have to.

Now, Republicans and Democrats have come together on health care before. Now, I have to go back a ways but, you know, Medicare-Medicaid. But then I don't have to go back very far on the children's health insurance program. I mean, that was passed and I worked on it with Orrin Hatch and John Chafee and others. And that was absolutely – it just roared right through and it was actually what – in the finance committee where really most of the health care is done, we kicked all the staff out of the room. We've never done that before because we were so hung up on technicalities in the children's health insurance program.

And we kicked everybody out so there was just us around a table. And your previous speaker, Orrin Hatch, actually felt so strongly about it that he got up and he gave a – he didn't have to stand up. It was just a little table. But he stood up because he felt so passionately about children having health insurance. And then Al D'Amato, who hadn't talked a lot about healthcare that I could remember, got up and did the same thing. And then Frank Murkowski did it and all of a sudden, lo and behold, you know, we were writing a children's health insurance bill and it was bipartisan and it was emotionally, powerfully, professionally bipartisan. And it was a wonderful, wonderful moment but the current environment has left many Americans wondering if that bipartisan commitment is a thing of the past. It's left me wondering about that.

So now with the presidential campaigns in full swing, we're going to hear a lot about – are hearing a lot about health care in the coming months. One thing is clear, no matter which party gets elected to the White House in November or holds a majority in Congress, the problems plaguing our healthcare system are going to have to be addressed – not all at once, and I'll talk about that. We must get back to a broad-based health reform momentum. A momentum thing in which we try to fix a broken system, which is hurting our country desperately.

We're behind the world in health care for our people and those investments that we do make do not provide the same results as other countries are getting. It has nothing to do with the nature of you and with people who care about healthcare in this country. But it, nevertheless, it nets out to be a fact. It's like being 16th in broadband, right next to Croatia. That doesn't make me proud but it's a fact and that's our with broadband. That's what we're meant to be really good at.

So I believe that we should embark together on a different path, one that involves our policymakers from the states to the federal government, listening to our healthcare professionals and their patients, and understanding that health care means preventing chronic disease. It's the old thing about Medicare and I can remember Jack Danforth. You remember him from Missouri. We started working on advance directives back in 1989 because even back then, we knew that about 50 percent of all Medicare was being spent in the last six months of life and what could we do about it. And then it was very controversial. It got this sort of religious, political overtones and it was very complicated but it's right there.

My mother died from Alzheimer's over a period of 10 years. It was awful. And she had to make the decision by biting down on her feeding tube in a hospital that she didn't want any more care. That this was not what was meant to happen. And so we took her home and she died three weeks later listening to Handel and Bach and Mozart and the music that she loved. But she wasn't draining money out of the healthcare system. And there was, you know, there were four of us who were siblings. We all agreed on what should happen with her but often you get children – maybe one child that doesn't disagree then the hospital is in a terrible situation.

I can remember a doctor from the hospital coming to our house, in her house in New York and, you know, she was getting just things that kept her from being in pain and she was way beyond the state of consciousness and all the rest of it, and he was sweating bullets because, you know, the Hippocratic Oath. And he was really sweating bullets because he didn't know what that meant to be stopping care for somebody who was still alive, technically. And that kind of thinking, of course, is what means that people decide to extend life, you know, forever when it's not going to be possible and it eats up Medicare like crazy.

So I think until we're prepared to put aside our differences and work together towards meaningful change, then we'll only be paying lip service to real healthcare reform and we're capable of doing that. We're all capable of doing that. So year in and year out, you'll come to Washington and you'll tell people like me about your problems. Washington will get bogged down in partisan solutions and bureaucracy and the American people will be disgusted with all

of us. They blame me. They blame you. They blame everybody and they have every right to. Me more than you. But we can do better and we can start today by doing four things.

First, rejecting reform just for reform's sake. It's so easy to talk about healthcare reform and then not actually connect all the synopsis, I guess, I would that word. Now, there's all the entanglements so that it becomes a workable solution. Second, and I think very easily, taking the children's health insurance program and improving it. I think that will happen in the next administration, regardless of who wins the presidency. But it was a very, very difficult solution. I mean, Orrin Hatch and I worked together with Max Baucus and Chuck Grassley very hard for six months this year. Our staff working 24 hours a day, seven days a week. And the question was, well, I mean, obviously we're going to do this. We've got 6.6 million (dollars), we can go to 11 (million dollars) but the problem was we had to raise taxes to do it and you can't raise taxes under this administration.

Well, we raised the same taxes that we paid for for the first one, which were the cigarette tax, which is sort of a sensible thing to do. It's kind of like doing a kid a favor by raising cigarette taxes. And it passed. It passed in the Senate. We got 69 votes for it. It passed in the House overwhelmingly. The president said he was going to veto it four times and did veto it twice. I don't understand that. I don't understand that. Was it the taxes? Was it the fact that the Congress might get something done? I mean, we were right on the cusp and I was in the negotiations all the way and there were 15 Republicans that we couldn't get in the House and we had to meet with them every day. Baucus, myself, Grassley, and Hatch would meet every afternoon for months from five to seven. And then the staff would meet all the time and we discussed how can we overcome this problem?

Well, we couldn't – we'd meet with the House members. Only 15, we only needed 15 votes more to be able to override the veto. And every time we seemed to come closer, we'd come closer and then it would drift apart. And that was maybe some blind loyalty to the president. I don't know but I've never been through a more frustrating experience in my entire life. And predict that whoever is elected we will get that done. And it'll be great because it'll be something like 20 percent, 21 percent of the uninsured in this country and that's a start. It helps.

Third, standing rock solid together against the president's misguided budget cuts. And fourth, continuing the success with experience with bringing health care to our nation's most rural area. You'd expect me to talk about that because I come from West Virginia but there's no state in this country, including Rhode Island, which doesn't have rural sections. So rural is every state. Rural is every state. We're just all rural so it hurts more.

First and foremost, we cannot be taken in by calls for reforms that are not really reforms at all – that appear to be reforms. I don't care if the candidates are sort of general in their plans as they present them to the public during the campaign. I don't expect them to get totally specific because, frankly, people stop listening because once you get into the weeds on the campaign trail, it's just amazing to watch people start nodding or getting angry because you're not talking about manufacturing or something else. But deep in their hearts, they're terrified. But you get into the weeds and you begin to disconnect so it's just a concept of people dedicating

themselves, to promising it. I will take that for now and for the most part, at least on my side of the aisle, people do have.

I mean, people – you know, Hillary attacks Barack and Barack attacks Hillary on their healthcare plans but they're 95 percent the same; they're 95 percent the same. And you know that if one of them were to get in that they would work it out and they would come to us and they'd come to us in a different way than back in the Clinton healthcare time when they did it sort of – and they did. And I was very much a part of it. George Mitchell and Tom Daschle and Ted Kennedy and myself were the foot soldiers, so to speak, in the Senate for that. But the problem was that it was done – and I remember the American Medical Association said that they were being excluded. They actually had 60 fulltime professional doctors working full time on the program but the problem was that it was topped down. And you can't do that in America. It has to be more bottom up and people have to feel a part of it, just psychologically as well as, I think, literally.

Okay, I'm going to say something, which maybe not all will agree with but that's okay. I think we have to insist that all patients have access to high quality health care and therefore, do away with Medicare reimbursements for physician self referral. It has to happen. (Applause.) Not much applause but I'm very certain of my position on that and, you know, it's going to hurt some people but it's the right thing to do, especially hospitals where sometimes corrupt – and I don't mean that in the, you know, worst sense but corrupt and ill thought through. Clinical decisions are made and inappropriate care is delivered in order to increase profit margins. And I think we can all agree tinkering with the tax code will only reward those who can afford healthcare insurance in the first place and do nothing to do those who really need our help.

And finally, no matter how many times President Bush says it, the emergency room is not, cannot, and will not be the solution for our healthcare problems, especially for our children. Depending on the ER is like putting you out of business slowly. Secondly, in 2005, the number of uninsured children increased for the first time since the creation of it back in 1996 and it sort of started a little bit after that. The trend has continued every year, the increase and it's likely to get much worse if the economy gets worse, which it will. So more people, more children, more people in general, more pressure on you, more inability because of cuts to you to be able to deal with all of this. And then your frustration, your anger – you're in the business for the right reasons. You want to cure people, help people, and the government is undercutting you.

But I go back; SCHIP has always had a broad, bipartisan backing. And we can do that so that's a hopeful sign. Adding to the nation's growing healthcare crisis is not a solution, having more people uninsured. It will surely lead to greater cost shifting to taxpayers and healthcare providers, including our nation's hospitals. So that leads me to my third point. Instead of giving you greater federal resources to deal with our nation's complex healthcare needs, the current administration – and I'm not being political; I'm just mad about this, okay. I could be Republican, I could be a Democrat, and I'd say the same thing. It's busy. You always have to defend the president of your party.

I remember when Bill Clinton was president and he was doing stuff on trade and stuff and I was furious and I was attacking him all the time. And he'd come up and he'd say, why are

you attacking me? And I say because you're wrong on what you're doing. And that's what this system is meant to be about. We don't just – we're not just Republicans and Democrats and can't deviate. We're that but then we call it like we see it.

The current administration has consistently proposed doing less. Last month, the president submitted his fiscal year 2009 budget after we got over the shock over the 2008 budget. And he proposed \$183-billion cut in Medicare and \$18-billion cut in Medicaid over five years, a total of \$200-billion in cuts in services that you rely on and the people who come to see you rely on. I don't have to tell you what it would mean for American hospitals. These cuts are irresponsible. I don't know why they're done. It's a very interesting thing. And you may know this or you may not. But I've given Mike Leavitt – and I remember I took Mike Leavitt to West Virginia with me. And his 16-year-old son – he's never been to Appalachia and he came from Utah, different state. And we had a wonderful day. And he's the only person I've ever taken to where I was a VISTA volunteer, which is sort of sacred ground to me, because I wanted him to talk, sitting on a swinging porch bench, and talk with our people about health care.

Then we went to a rural health clinic in Lincoln County, and he talked with them. The press never knew anything about it. That was part of the deal, and they still don't to this day, but I guess they will after this speech. (Laughter.) But he was very sympathetic, and I liked him. I had been a governor for eight years and he was a governor. But what people don't know is that when a member of the cabinet or a sub-member – in other words, right on down the line – comes to testify before the Finance Committee or any other committee of Congress, they do not say what they really think. They're not allowed to by either Democratic or Republican administrations.

All of their speeches – and I always do this. I say, all right, now, did you write this last night and stay up till 3:00. Did you put this – start working on this a week ago and then take it out, work on it a little bit more, or did you simply hand your speech that you wanted to say to OMB and let them correct it? That is what happens with every single testimony from the administration to Congress.

So it's like you're not being told what they think. I don't think Mike Leavitt believes what he was saying, but he has to say it, and that is the deal. OMB determines what you're going to say. Well, what is OMB? Office of Management and Budget, so they don't let you wander very far.

All right, here's another thing. The president proposes these ill-advised cuts to hospitals at the very same time that he has refused to address the gross overpayments to Medicare Advantage. If we were going to get more money, and we had agreed on it, for the children's healthcare program that we could get from tobacco, we were going to go to Medicare Advantage. There is an enormous resistance building up in Congress to Medicare Advantage.

And let me just say a few words about Medicare Advantage. When these plans were created, Congress was told that they would be much more efficient than traditional Medicare. But just the opposite has happened. We pay these private plans 112 to 119 percent of traditional fee-for-service Medicare. The public doesn't really know about it because it's in the weeds. The

press doesn't cover it much because it's in the weeds. And newspapers are sort of like television these days; you can't do anything very long because people won't pay attention.

And so in 2006, they got \$64 billion more than they should have gotten, Medicare Advantage. Now, I don't know why you'd be very happy about that. I'm not. I think it's something that, you know, the MedPAC and CBO have recommended for quite a while eliminating them all together. We cannot continue to allow Medicare Advantage plans to regulate themselves. Medicare is a public trust and unfortunately this public trust has been squandered in recent years. Medicare Advantage has preyed on the poor. It's preyed on the elderly and the disabled, and without consequence. They don't pay a price for it. Yet they continue to be rewarded with billions of dollars in Medicare overpayments, overpayments that can be used – could be used to lower Medicare premiums, to improve the quality of low-income subsidy or add to greater preventive benefits for Medicare. And prevention is the secret to the whole thing.

So these are the types of things that would truly help the elderly and the disabled in all of our states, and there would be much better use of the billions of dollars that MedPAC and CBO say we are now wasting on private plans. These overpayments are indefensible. They must be ended immediately. Not only is it irrational for the president to protect the profits of these private plans, it's also, in my judgment, immoral.

Finally, we must do away with the two-tiered healthcare system that we have – easy to say, hard to do – that discriminates based upon geographic location. Now, I understand that urban areas are more accessible to health care than are rural areas, but all people are born equal and, you know, as they say, we can get to the move, but we can't insure our people. And that just doesn't make any sense at all. We must offer people living in rural areas the same access to high-quality, comprehensive care that we do to those living in urban areas.

Hospitals in rural areas have to be adequately reimbursed, though we must also think outside the box sometimes. You know, the technology of Medicare, the data – we're starting up something in West Virginia that the foundation is – I mean, it's sort of – it links all rural health care. It actually comes out of the Federal Communications Commission, if you can believe it.

You know what e-Rate is, right – connecting classrooms up to Internet. And that was meant to do three things. One is to, you know, break down the walls of cities and rural areas, and it was meant to be able to make people computer literate. And it has; it's been extraordinary. Well over 90 percent of Americans – now you go into an elementary school and they are doing things on the computer which are unbelievable.

But also in the e-Rate was a mandate to do this for rural healthcare systems, healthcare centers. And now that has started. And in West Virginia, we've just gotten a grant that allows us to connect up not only with our consortium of WVU and Carnegie Mellon, and Ohio State, and all of the rest of it, but also plugs us right into NIH, to the Library of Congress, the whole thing, so that there is even less excuse for us not to be able to reach out to rural hospitals now because of the state of technology, and what can be done with it.

Now, some people just say, when I bring up healthcare reform – I get two responses basically. The first response is that healthcare reform as an initiative died 10 years ago with a reason: It was too much change all at once – presenter (?) from the top down. People didn't participate. And I do think that the partisanship that has driven the Congress, that this has been part of the problem. They came to the Congress and said this is what we've got to do. Congress had never been included in the process. You can't do that in American democracy. That's what today is all about. People get to vote what they want to do. It's going to be very close, and how people vote will decide what's going to happen, and that's the way it should be regardless of the outcome.

Now, my answer to that is that we must show people why broad reform is necessary, and we're not very good at that because we complain about our cuts, and, you know, people that come to my office all of the time and see me and my staff, they complain about cuts, they want more of this, and they are segmented. Everybody's segmented. And you have your thoracic surgeons, and you have your ophthalmologist, and you have your durable medical equipment. Everybody wants their own fix. So the whole concept of what is general reform, as opposed to what is fixing a specific part of the healthcare financial puzzle is what gets lost.

We have to help the people understand not just – they understand that they're in agony over health care and they're terrified of it, but we have to understand what healthcare reform really can mean, and they have to be involved in this process. And I hope that the presidential candidates, whoever wins, will do that. What are the goals of our healthcare reform system? We don't do that. We just say what it's going to be, and then we complain about what's going on, but we don't bring them into the process of how do we do this together. What is your role as a responsible parent? What is my role? All of the rest of it.

So together, we have to make policymakers think beyond addressing the immediate systems to focus on the longer-term solutions. Until then, sometimes you have to make progress piece by piece. Well, nobody wants to do that; you've got to do the whole thing all at once. It isn't going to happen that way. And it's fine for the presidential candidates to say they're going to – they've got a complete system, but it's not going to happen that way. Congress can't absorb that, the American people can't absorb, the budget can't absorb that.

And so there is nothing wrong with, one, trying to bring them into the process, and then taking your so-called – not make it easy on myself – the children's health insurance approach, which can pass because who's going to be against children? Children really don't start any wars. Most people are for them, like them, have them, and they want it to work for them.

The second major response I get when discussing health reform is that we don't have the money for it. Technically that's true. Technically that's true, particularly if we keep on doing what we're doing. And, yes, it's – there's a huge federal deficit. We have a \$9-trillion deficit. When President Clinton left office, there was a \$5.6-trillion surplus on the table. And I blame myself and I blame him and I blame all of us for not saying, okay, take 4 trillion of that 5.6 trillion and fence it. Fence it, and say that it could only be spent on the renewal of America, which incidentally has to be happening at all areas, from research and development, to infrastructure in the literal terms, to the way we – you know, do we teach to test or – you know,

all of that stuff. It all has to – there is so much reform that has to go on in this country, and it just happens to be hitting right now when our lowest point in terms of having resources.

So does that stop us? No. Federal funding is a question of priorities. And that our current failing healthcare system has a better chance of easing our debt if we fix it. Now, I'm going to throw something very radical at you – not in my speech. One of the ways that President Bush has been able to pay for the war in Iraq and the war in Afghanistan is that you never see it in the budget; it's never in the budget. Why? Because he borrows it from China, South Korea, and Japan.

And I got up in a Democratic Caucus one day and sort of made the pitch that – you know, and global warming, which I'm huge on, is going to be hundreds of billions of dollars. And I think we have the window of 20, 25 years. I have grandchildren that live in Baltimore; they live in New York, Washington. Those tend to be fairly close to the ocean. And if the warming takes place the way it is, I want to have grandchildren. I really want to keep my grandchildren.

And so the question is, if you borrow from the Chinese, they're going to take us down because they own so much of our debt that if they – if we go down, they go down. So they're not going to. The Japanese won't because they're friends. The South Koreans won't because they're friends. So that it may be that we need to on a couple of subjects – health care, and let's say climate change – that we have to borrow from other countries to do this for a period of 10 years or so.

And the Democrats have taken this particular opportunity to become rigid, fiscally responsible. Pay-go: You can only spend what you've got or you take it from something else. Well, I understand that. It certainly is responsible. It makes people nod with approval, but it sure doesn't help you in your problems, and it sure doesn't help Medicaid in its problems or Medicare and its problems. And we're broke.

So if we're going to do universal health care without borrowing, then we're going to have to take it from something else, some other program. Pass on your suggestions on pieces of paper to me, and they better add up to a whole lot of money.

So in any event, let me just close by saying I tremendously commend you for the enormous difference that you make with the care and attention that you give your patients. I understand you're hurt. The state I come from, West Virginia, is not large. I know our hospitals well and our hospital administrators and CEOs very well. Your community is an incredibly important part of health care in our country especially in rural areas, in underserved areas, and everywhere. We know what the challenges are ahead of us. We know that overcoming them will be difficult and will require us to take a serious approach, and maybe go outside the box, and maybe do some things which will displease the Federal Reserve. But we've got to solve certain problems and health care and global warming on two of them.

You saw what happened when an enterprising reporter wrote in the Washington Post about what was happening at Walter Reed Hospital, the veterans. I've never seen anything like it in Congress, and I've been there 24 years. It was like all of a sudden, all of Congress – it was a

volcano of explosion of anger out of determination of commitment, and budgets went shooting up – \$2 billion more than the president suggested. The same thing will happen – traumatic brain injury, post-traumatic stress disorder.

All of those things became – they were at the top of our cerebral cortex and our moral cortex. We hurt. We had failed, and now it's being driven home by a very different kind of warfare, where you couldn't tell who the enemy was. And these horrific agony of what PTSD really means and what traumatic brain injury really means, and the number of suicides. I never thought I'd be on a suicide bill. Well, I'm on the Omvig Suicide Bill because there's a lot of that going on, and I suspect there's a lot of it that we don't know about.

But it was fascinating because it was a profoundly moral problem involving people who had gone of at the age of 19 and 20 because those are the kids that are willing to take the risks, and then they – as long as they are on their tanks, Humvees, whatever, with their 50-caliber machine guns, and going off into the sunset, we think that's great. Great television. But let them get wounded, and traditionally Americans tend to forget about that. It's not my point. My point is that that story changed the Congress forever, and we will fund veterans forever, for what it takes. (Applause.)

Look, I'm glad you clapped, but I didn't want you to because my point is that if – what is the difference between that, which is more tragic – or is it – than the person who can't get to a hospital and has no health insurance and watches their child die and nobody can do anything about it. If we've got to go out of the box, let's go out of the box and pick two important subjects, and do what we have to do to cure them. Thank you all.

(Applause.)

MR. KAHN: I don't like to think of myself as vertically challenged, but compared to Senator Rockefeller, I clearly am. I always thought 5'9" was okay.

The next part of the program is on health policy and the presidential candidates. Where do they stand? I could say it was hope that we would have presidential candidates here today to speak to you. We have over the last year actually had – the last few years had Hillary Clinton and John McCain speak to this group, but obviously the presidential candidates are otherwise occupied. So we'll have to give you second-best, but I think you'll find it quite good. And may fill the gap better than if the candidates were here themselves personally.

We're going to do it in two parts. The first part, I'm going to show you a film, which I'll describe in a moment, that is uniquely connected to the Federation of American Hospitals and the federation's members' decision over a year ago to make a commitment on the issue of covering all Americans. And, second, we'll have two experts representing more of a Republican viewpoint and more of a Democratic viewpoint describing to you where the candidates and the parties will probably be. And I think you'll really get a lot out of that session also.

But first, let me start with the video. Between Labor Day and Thanksgiving of last year, the Federation of American Hospitals and a consumer group, Families USA, got together and

organized presidential forums. We had six presidential candidates participate. Our purpose was to further discussion about health insurance coverage, as well as to help create an environment in which this subject that we feel so strongly about would be discussed in depth, not simply at the superficial level that so frequently it is dealt with in the political campaigns.

So we had these forums. Each forum lasted for an hour. Each forum was identically structured. Each forum allowed an opportunity for the presidential candidates to speak, give their positions, and then be questioned by four of the nation's leading healthcare journalists.

The forums were extremely successful. They were webcast live. Most were on C-SPAN. They were all run live by XM radio. They were covered by many a media outlets. The forums were sponsored by the California Endowment, the Ewing Marion Kauffman Foundation, and the Kaiser Family Fund provided a great deal of assistance. And we conducted most of the forums at the Kaiser Family Fund Center here in Washington, D.C.

From the forums, our moderator at the forum was Susan Dentzer of the "News Hour with Jim Lehrer" on educational television. And she put together the film that you're going to see now. Part of it was part of a report on Christmas Day that the "News Hour" did that featured our forums. The rest of it was added to make sure that all of the candidates that needed to be covered were covered.

So without further ado, I'm going to give you the film, and I'll be back in just a few moments to introduce our next panel. But I hope you enjoy the film because it will set I think a good context for the discussion you're going to have between Ken Thorpe and Joe Antos. Thanks. Roll the film.

(Begin video segment. Includes several clips)

SUSAN DENZER: (In progress) – top domestic issue for voters and for those running for president in 2008. So candidates were invited to discuss the topic in a recent series of forums at the Kaiser Family Foundation in Washington, D.C.

SENATOR HILLARY RODHAM CLINTON (D-NY): (In progress) – is that all Americans should have quality affordable health care.

MR. : We must have a universal healthcare system.

SENATOR JOHN MCCAIN (R-AZ): But I thought we ought to have some straight talk to begin our discussion.

MS. DENZER: The forums were organized by the left-leaning Families USA, an advocacy group, and the right-leaning Federation of American Hospitals, which represents for-profit investor-owned hospital chains. Along with Arizona Senator John McCain, the sole Republican who agreed to participate, were five Democrats, New York Senator Hillary Clinton, former North Carolina Senator John Edwards, New Mexico Governor Bill Richardson, Delaware Senator Joe Biden, and Ohio Congressman Dennis Kucinich.

A panel of journalists, including me, probed the candidates for roughly an hour a piece on a range of health issues. But most of the discussions centered on two key ones, expanding health insurance coverage for those who don't have it, and reigning in health costs for everybody. The candidates were unanimous in responding to our first question.

MS. DENZER: Do you believe all Americans should have health insurance coverage?

JOHN EDWARDS: The answer is yes to the question. I'm proud of the fact that I was the first presidential candidate, Democrat or Republican, to come out with a comprehensive, truly universal healthcare plan.

MR. : We have a federal government that hasn't made a serious effort on healthcare reform in over a decade.

SEN. CLINTON: We have a healthcare crisis in America – 47 million uninsured. We have to act, and it appears as though there is a growing consensus to do that.

MS. DENZER: But after that note of agreement, the candidates diverge. Ohio Congressman Dennis Kucinich favored the most extreme change, moving from America's blended system of private and public health coverage to a completely government-financed healthcare system.

REPRESENTATIVE DENNIS KUCINICH (D-OH): I'm the only candidate running who's talking about a single payer not-for-profit healthcare system, Medicare for all. We're already paying for it; we're just not getting it. Sixteen percent of our gross domestic product is spent for health care. That's about \$2.3 trillion a year. If we took all of that money for health care, we'd have enough to cover everyone.

MS. DENZER: Kucinich was the lone Democrat to say his plan would also cover an estimated 12 million undocumented immigrants. And he added his plan would put the private health insurance industry out of business and require all for-profit entities engaged in health care to convert to non-profit status.

Laura Meckler of the Wall Street Journal asked him about that.

LAURA MECKLER: How would you compensate the shareholders who have invested in these for-profit companies and which are now just going to go away.

REP. KUCINICH: There would be a market-value compensation that would be involved to the company.

MS. MECKLER: Who will be paying that? I'm an investor who's invested in this hospital –

REP. KUCINICH: The national healthcare plan repays that.

MS. MECKLER: So the government is going to be paying all of those people.

REP. KUCINICH: The government – the government pays that; that is right.

MS. MECKLER: How could the government possibly afford that? It's got to be in the billions.

REP. KUCINICH: By amortizing the cost with Treasury Bonds over a period of time, just like you pay for a lot of other capital expenses, period.

MS. DENZER: By contrast, other Democrats emphasized that they would not replace the current health insurance system but would instead build on it. The offer plans to expand both public health coverage like Medicare and to facilitate access to private health insurance plans.

SEN. CLINTON: I have proposed the American Health Choices Plan. Here's how it would work. You have private insurance, nothing changes. You keep that insurance. If you like your doctor you have, you keep him. But if you don't have health insurance or if you don't like the insurance you have, you can choose from the same wide variety of private plans that members of Congress get to choose from.

MS. DENZER: Clinton said the new menu of options that people could pick from would include a public plan like Medicare. We asked her about that.

Well, a lot of your critics say including a public plan in that approach is really single payer through the back door, that it would create a new federal bureaucracy, it would saddle taxpayers with huge new costs and probably produce overwhelming pressure to clamp down on healthcare prices.

SEN. CLINTON: Well, that's a either misunderstanding or misrepresentation of what I've proposed. I've included the public plan option because a lot of Americans want it. I believe in choice and competition. You know, what see what happens. For all of those people who believe that the private system is by far the best, they're going to have more than 250 options to choose from, and for those people who like the fact that Medicare which insures private choice only has a 3-percent administrative cost, they'll get to make that cost.

MS. DENZER: Responding to David Muir of ABC News, Edwards said he had proposed an almost identical plan several months before Clinton proposed hers.

DAVID MUIR: Even your wife said it's John Edwards' plan as presented by Hillary Clinton, or along those lines. Can you help the people at home who are watching this know what the key differences are then between your plan and Senator Clinton's plan?

MR. EDWARDS: Yes. They're in the weeds. (Laughter.) There are some differences but they're not significant. I should be flattered I guess, but I think for America, this is a good

thing, that we're having a debate about health care and universal health care, and the differences between the major candidates are fairly nuanced.

MS. DENZER: One of those nuance differences was over who would be compelled to contribute to coverage; in other words, mandates. These include requirements on employers to contribute a certain percentage of payroll to workers' health coverage, and a mandate on individuals that they purchase health insurance.

Edwards, Clinton, and Richardson agree that both types of mandates were needed. They all said the individual mandate would be coupled with subsidies for people who could not otherwise afford coverage.

MR. EDWARDS: And the reason is mandate is necessary is because you cannot have universal healthcare without it; it does not exist, and anybody who pretends it is not being straight.

MS. DENZER: Taking a different tack, Senator Joe Biden of Delaware said he had deliberately omitted any mandate from his plan.

SENATOR JOE BIDEN (D-DE): One word Americans don't like: mandate. I don't want to make this hard; I want to make this simple and not susceptible to what some of the insurance company and the right wing will argue this is: a mandated socialistic system.

MS. DENZER: Instead, Biden proposed having government pay all healthcare bills for any individual that topped 50,000 a year, a so-called reinsurance program. He said that would make coverage cheaper and more attractive to both employers and individuals alike.

SEN. BIDEN: So that is the incentive to keep them in. And I do not believe that it is instinctive instinct of American people that given affordable access to health care, they're going to deny it. Now, if it turns out I'm wrong and it becomes a problem – I don't believe it is – then I would adjust it.

MS. DENZER: Senator Barack Obama of Illinois turned down our invitation to participate in the forums. But on the campaign trail in New Hampshire, he defended his decision to omit an individual mandate from his plan even though he would impose a mandate on large employers, and would also require parents to obtain coverage for their children.

SENATOR BARACK OBAMA (D-IL): In terms of this debate about the mandate, look, this is a manufactured issue. I have committed that I will make sure that every single American in this country has health care they can count on. I think the problem and the reason people don't have health care is not because they're running away to avoid getting health care; it's because they can't afford it. If we make it affordable, which my plan does more effectively than any other plan out there, then I'm confident that people will buy it.

MS. DENZER: With the exception of Kucinich, who had replaced private health coverage with a public system, all of the Democrats said that private insurance companies would have to operate under new national rules.

SEN. CLINTON: Whatever you choose, you will have the following guarantees: First, you will never be denied coverage because of pre-existing conditions or risk factors. Second, your coverage will be guaranteed. Third, your coverage will be affordable. Fourth, you will always have an option that is fully portable.

MS. DENZER: The Democrats also said their plans would all require 80 (billion dollars) to \$110 billion a year in additional federal spending and proposed similar ways to come up with the money. Julie Rovner of National Public Radio pressed Senator Clinton on –

JULIE ROVNER: Can you give us some more clear idea of how much more in federal outlays you'd be willing to put on the table for this?

SEN. CLINTON: I have put forth a list of savings and spendings that add up to about \$110 billion. And about half of that would come from not continuing the high-end tax cuts for the wealthiest of Americans, returning to a pre-Bush administration level, back in the 1990s. And the other half comes from savings that every expert I have talked to believes we can realize.

MS. DENZER: As for savings, the candidates agree that there were real ways to cut health costs, or at least to get better value for the dollar spent, especially for chronic disease.

MR. : Chronic diseases like heart disease, diabetes, and cancer account for at least 75 percent of our healthcare costs. We have got to start taking better care of ourselves as a nation.

MR. EDWARDS: Our chronic care is a mess is because there is no medical home that is responsible for the coordination of chronic care so that you don't have overlapping care, that you don't have unnecessary care. But if you are 75 years old and you have a serious chronic healthcare condition, serious heart ailment or diabetes, you have one healthcare provider that you know you can go to who will coordinate your care among other healthcare providers.

MS. DENZER: All said, they were looking forward to debating the Republican presidential candidates on health reform and if elected, would steel themselves for a long battle ahead.

SEN. CLINTON: I'm looking forward to debating whomever they nominate on healthcare. We can continue with the dysfunctional, expensive, unequal system that lacks quality, or we can begin to say, look, we are a smart country and we can figure this out, and I'm betting that's what we'll do.

MR. EDWARDS: There will be millions and millions of dollars spent on television, in newspapers, on radio to try to defeat healthcare reform. And it will never change unless we as a nation join together and stand up to them.

MS. DENZER: As the sole Republican who accepted the invitation to participate in the forums, Senator John McCain of Arizona laid out a very different approach starting with what he said was the biggest problem with American health care.

SEN. MCCAIN: America has the best-quality health care in the world. We have the most innovation, we have the best hospitals, et cetera, et cetera. But what's the problem? The problem, my friends, is not the quality of health care in America; it's the cost of health care. Unless you address healthcare costs in my view, you're never going to solve the other aspects of the healthcare crisis that we face in America.

MS. DENZER: McCain said that as president, he'd push for an array of measures to reduce costs.

SEN. MCCAIN: Obviously we have to promote competition. That always works whatever we're talking about in the healthcare system. Foster the development of roots for safer, cheaper, generic versions of drugs and biological pharmaceuticals, and obviously safety protocols that permit re-importation, tort reform, and Medicare – excuse me, Medical malpractice reform are vital.

MS. DENZER: McCain said tackling underlying health costs in this way would ultimately make health insurance more affordable and prompt more Americans to purchase coverage.

SEN. MCCAIN: If we can bring down the costs, as I believe we can, through a lot of the measures that I just talked about, including individual responsibility, then I am absolutely convinced more and more of them will take advantage of it. Everybody should obviously have access to affordable health care in America.

MS. DENZER: McCain also proposed a major change in federal income tax law that he said would make it far easier for millions more to afford health coverage. Employers' contributions for health insurance are currently not taxable to employees. But McCain said that under his plan they would be. McCain would replace that tax break with others that would not just go to those with employer-paid health insurance but to everybody, refundable health insurance tax credits of \$2,500 for individuals, and \$5,000 for families.

SEN. MCCAIN: That tax credit more than makes up for the tax burden that they now bear and gives them I think substantially more choices. When it's their money and it's their decision, I think they make much wiser decisions than when it's provided by somebody else.

MS. DENZER: McCain said his campaign had not estimated how many more Americans would be able to buy coverage as a result. We pressed him on that.

Senator, staying on these tax credits – as you said, \$2,500 per individual, \$5,000 per family, the average cost of a family health insurance policy is now upwards of \$12,000. So people who are not getting coverage through their employer, this would really only offset a fraction of the expense of having an overall health policy.

SEN. MCCAIN: If they are low-income people and have no health insurance today, at least now they've got \$2500 or \$5,000 in the case of a family to go out and at least start beginning to have one. It's not a perfect solution. And, frankly, if it was not for the price tag involved, I would make it even higher.

MS. DENZER: Dr. Tim Johnson of ABC News asked McCain who has twice battled melanoma why he opposed new national rules on insurance companies aimed at helping people like him.

DR. TIM JOHNSON: Senator, you referred several times to pre-existing conditions. And obviously as a cancer survivor, you know how tough it is for people with such conditions to buy new insurance, how costly it is, how often they are just flat-out denied. Why not level the playing field, prevent insurance companies from cherry picking and let them compete on a level playing field?

SEN. MCCAIN: Because I think then we would be mandating what the free-enterprise system does. And that would be obviously something that I would not approve of. But I also believe that we should broaden high-risk pools, and that would be a government function, to broaden the high-risk pools that many of them now have, and we need to help people who need it.

MS. DENZER: But McCain went on to make clear that that was one of the few areas where he thought greater government involvement in providing health coverage was warranted. He underscored that he opposed all health-insurance mandate.

SEN. MCCAIN: I don't think there should be a mandate for every American to have health insurance. I think that one of our goals should be that every American own their own home, but I'm not going to mandate that every American own their own home. I feel the same thing about health care. If it's affordable and available, then it seems to me that they – again, it's a matter of choice amongst Americans.

MS. DENZER: All transcripts and videos of all the presidential health forums are available on www.health08.org.

(End video segment.)

MR. KAHN: Great. Well, I hope that all of you found the film helpful and as a good introduction. A lot of went into the production of the forums themselves. And I think, as you can see, with the highlights, that a lot was accomplished and a lot of detailed questions were asked, and a real dialog and conversation was conducted. About the subject, they were going to now drill on, this subject of where the presidential candidates and the parties are likely to stand now and in the fall when we will go through a national conversation about the uninsured, about health reform, and about the future of America's healthcare system.

As I said, the key candidates are pre-occupied today, but you're not getting second-best. You're getting in two speakers two knowledgeable experts who have been involved from their – from both sides in studying and in discussing health reform and health matters, and they really have a deep understanding.

I'm going to introduce Joe Antos first and Ken Thorpe, and Ken will lead off. We'll have each of them making a presentation, and then we'll have the opportunity for some discussion up here and questions from you if you'd like to ask questions of the panel.

Representing the Republican side is Joe Antos. Joe is the Wilson H. Taylor scholar in health care and retirement policy at the American Enterprise Institute. He is also a commissioner of Maryland health service – of the Maryland health services cost review commission. Joe's research focuses on the economics of health policy, including Medicare reform, health insurance regulation, and the uninsured.

Before joining AEI, Joe served as assistant director for health and human resources at the congressional – all-important congressional budget office. He also held senior positions at HHS, the Office of Management and Budget in the White House, and the president's counsel – and a past president's counsel of economic advisors. He is in this area one of the real experts in health care here in Washington among the think-tank community.

Representing the Democratic side is Ken Thorpe. Ken is the Robert W. Woodruff professor and chair of the Department of Health Policy and Management in the Rollins School of Public Health at Emory University. He also co-directs the Emory center on health outcomes and quality. Ken has a long and distinguished career in academia and public policy. He has taught at many universities and held professorships there besides Emory, including Tulane, where I'm an alum of the graduate school. So I'm really appreciative of every – the contribution that Ken made to Tulane a number of years ago.

In government, Ken served as deputy assistant secretary for health policy at HHS under President Clinton. While there, he coordinated all financial estimates and financial impacts for President Clinton's health reform proposal. He also directed the administration's estimation efforts of congressional health reforms proposed during 103rd and 104th sessions of the Congress.

Most important for today's discussion, Ken has worked with several policymakers including Senators Clinton and Obama to help develop their alternative approaches to covering the uninsured.

Two more things about Ken: One, because of the work he has done in his career, he is one of the gold-standard estimators in terms of healthcare reform and healthcare policy. When people produce numbers about the uninsured – we had John Sheils do the numbers at Lewin for our plan. Ken is one of those with John who really is a gold standard and when he says the numbers are X, those who look at numbers believe him.

Second, he is really to be admired, I think, for all of the effort that he is putting into the area of looking at obesity and related illnesses, and his research there I think has really been

critically important in bringing attention to what probably is the greatest health crisis that faces America in the near term.

So with that, please give a round of a applause for both, and we'll start with Ken.
(Applause.)

KENNETH E. THORPE: Well, good morning, everybody. Oh, come on. I'm from the South. We've got to do better than that. Good morning.

AUDIENCE: Good morning.

MR. THORPE: All right. We'll let that go. Chip, thanks for the kind introduction. It's a pleasure to be here with you and Joe. I'm going to do something unusual of being a professor. I didn't bring any slides, so that's not like me. I'm also going to do something a little bit unusual in that I'm going to talk about these plans, but I want to do it in reverse order because certainly on the campaign trail and where people are spending most of their time thinking about this issue, you've gotten a fairly good understanding of what they would do with respect to the uninsured.

And I can tell you after working with most of the Democratic contenders on this issue, all of them have brought away one of the major bottom lines that you just heard from Senator Rockefeller, that, yes, there were a lot of lessons learned in '93 about how not to do this. And I think what you're going to see moving into 2009, not matter who wins this race, whether it's Senator McCain or Obama or Clinton, is that there is going to be a new message, a new strategy, and whatever is done in this issue has got to be bipartisan, that the process matters a lot and how the legislation and proposal moves through is going to be critically important.

Let me tell you a little bit about their proposals in areas you've heard very little about in part because I think they largely agree in these areas, and I think that for the most part, from what I've seen from Senator McCain's plan, that he agrees with key elements of these two plans as well.

One of the things that I think that was really important in the way the plans were laid out, if you go back and look at the way that Senator Clinton presented her plan, she did it in three parts. And she started very importantly I think with the issue about affordability of health care. And that was her first proposal out of the blocks I think for several reasons. One is that the flip side of this issue is that 85 percent of the American population has health insurance coverage. Point two is that in the 2006 mid-term elections, when you look at the data, 96 percent of the people who voted in that election had health insurance. And point three, their number-one issue that concerns them, the main anxiety out there in the business community, in the labor community is it costs too much, the issue of the affordability of health insurance.

And that was a major part of what she proposed. It's a major part of what Senator Obama proposed. And let me give you a little bit of a sense of some of the items that they're talking about.

One of the things that I think that they important did – and you just heard Governor Richardson talk about this issue and Senator Edwards as well – is that they both went to the data, and as Chip mentioned, a lot of the data that we've been working on down at Emory for the last five years – really laying out the issue of how we spend our healthcare dollar and what is driving the growth of healthcare spending, and presented the data in a little bit of a different manner.

The first fact that we presented to these candidates to get them to think about solving this affordability issue, was that about 75 percent of what we spend nationally on health care is linked to patients that have one or more chronic healthcare conditions. If you look at the Medicare program, it's a number that's way over 90 percent. Medicare owns this population of the chronically ill. And if you think about sort of the typical clinical profile of these patients, it's a hypertensive diabetic with elevated cholesterol, bad triglycerides. They're overweight so they probably have some pulmonary issues, likely have some back problems, and they're depressed. Now, that is a clinical management problem of enormous complexity both for a primary-care physician and for the patients themselves. So that was the first point.

The second point is that we know, given the way we pay for healthcare today, particularly in the Medicare program, that we don't provide all of those patients with all of the clinically recommended preventive healthcare services, the ongoing medical management of those conditions. They get about 56 percent of the clinically recommended care.

The third point is that, as Chip mentioned on the obesity front – and I'm doing this before lunch, not during or after lunch – because 34 percent of the American population today is clinically obese. That is double from 1985. And that doubling of obesity by itself accounts for about 15 percent of the growth in healthcare spending. The explosion of diabetes is largely driven by this.

And I present – I start with this because if you think about my opening statement that we've got to have a different message, a different strategy, and a different approach, it's got to be bipartisan. I think the reality is, coming into 2009, no matter who wins, there has got to be opportunities for the president-elect to build a coalition around health reform that draws broad support and is an important element of the overall issue. And I think that the issue of affordability and really reforming our healthcare system is a major part of that.

Both Obama and Clinton's proposals, and I've heard – believe it or not, I thought I was going to fall out of my chair – Senator McCain actually talking about chronic disease on Stephanopoulos on a Sunday morning. But the issues that they're raising are that we have to find ways to more effectively manage chronic disease in this country, is we need to build an integrated delivery model that make some sense. We need to appropriately pay and fund that model, and we need to provide the information technology to give physicians the tools to manage it.

If you think about those types of issues in terms of prevention of obesity, prevention of chronic disease, modernizing our delivery infrastructure in providing electronic medical capacity, those are not partisan issues to me. They are not Democratic issues or Republican

issues. I think they're commonsense initiatives that I would think coming into 2009 could serve as the basis for a broad agreement on major an important parts of healthcare reform.

These are issues that both Senator Obama and Senator Clinton have spent a lot of time writing about and put into their healthcare campaigns. And I raise it only because you don't hear much about the issue because it's the natural inclination, particularly in a primary, to focus on the differences. You know, where do they differ, where do they disagree, and so on. They agree on this issue. And I would think that many Republicans and Senator McCain would agree that there is an opportunity to make some movement in this area to really do health reform.

Talk a little bit – on the quality side, I think the same issue exists there. The CBO has been now for the last several months putting out a whole host of information about why health care costs too much, raising the issue of variations in care, and Joe will talk some about that.

Our information on cost effectiveness research and what the most effective means of treating certain types of patients is I think sorely lacking. We have made a tremendous underinvestment in our public health infrastructure and our research infrastructure that is really handicapping our ability to provide clinicians and patients up-to-date state-of-the-art information. And those are, again, the second whole area of healthcare reform proposals that all of these candidates have put out in some substantial detail, but, again, not so much heard about this on the campaign trail because I think that there is, again, a fair amount of agreement about the fact that we need to make some investment in this area.

Again, I start with these two areas because I really do think, and I'm very optimistic coming into 2009, that on these big structural issues of how to make health care more affordable, how to really do health reform, how to broaden the policy debate on this issue to focus on prevention of chronic disease and obesity and rebuilding our healthcare infrastructure are areas that we can start the debate and discussion about healthcare reform and do something very substantial on it.

Quickly to the third issue, which is obviously what you've heard most of the discussion about, most of the debate between these two candidates on moving towards reducing the number of uninsured. It's an area where realistically their plans overlap probably 95 percent but there are some key differences that have taken most of the debate in that direction.

Let me just start with their similarities. And, again, I think that these similarities are a reflection of what certainly Senator Clinton learned from 1993 and 1994 in healthcare reform. And I think as Senator Obama has learned in his efforts to pass healthcare reform in the Illinois senate.

Redistribution, as you've heard from our previous speakers, is a tough political issue to move. So when you have a lot of redistribution of where people get coverage, how much money is spent, who pays what on health care, the politics of that are very difficult. And that was certainly a major thrust of the Clinton plan 14 years ago was that there was going to be a fair amount of redistribution of insurance arrangements and who paid what for health care.

This time around, both of these candidates have proposed the following: One, for the 200 million Americans or so that have private health insurance, if you've got private health insurance today, you can keep it. Their proposals are just going to try to find ways to make it less expensive and more affordable. So nobody has to change their coverage. You can keep your own private health insurance plan if you so choose.

Point two, that there has got to be an opportunity for people who don't have health insurance coverage through their employer or who are individual entrepreneurs that can't afford health coverage to buy private health insurance. And both of the candidates would make available the plans through the federal employees health benefit program, I think as you heard Keith Hennessey from the White House talk about that this morning. I think all would agree that that is a terrific market-based model with a lot of information on the premiums, the quality, what people expect to pay out of pocket, and so on.

So, again, I think both of these candidates have resolved the issue that they are going to build on the private insurance market, for better or for worse, that they're going to open up more private health insurance plans for people to choose those plans if they so desire. So they pretty much agree on that issue.

The difference is really on the requirement to acquire insurance. I can tell you that both candidates on the Democratic side have proposals that would essentially fully fund, in the Clinton case, people who want to buy insurance at an affordable rate. She hasn't put out tremendous amounts of details on it, but I think as you have heard her talk about, people would be limited to paying a certain percentage of their income on health care. That would be capped, and there would be federal assistance to help people purchase those health insurance policies through the private market.

Senator Obama has the same type of approach. In fact, he has – the amount of federal assistance available to people who earn 20, 30, 40, \$50,000 in income are virtually identical. There really isn't much difference there in terms of what people would pay for health insurance coverage, at least in terms of the support they get from the federal government.

The big difference is of course the requirement to acquire coverage. Remember, this is getting a lot of play now because this is a Democratic primary. This is a big issue for Democratic voters. It goes to the core of the Democratic base. So of course it's going to get a lot of tension at this point in time in the discussion.

Obviously Senator Clinton feels strongly that individuals should acquire coverage and have universal coverage. Senator Obama in my discussions with him on this issue wants to move in that same direction. However, he thinks, as you've heard, that the main reason people don't buy coverage is because they can't afford it. His notion is let's see what happens. Let's provide – let's open up the private insurance markets. Let's provide some federal support. Let's get the pricing point down. And let's see how many people show up and purchase insurance.

And I think he would be very open to taking an assessment of that after three or four years and see whether or not we need to redouble or change our efforts about how to proceed.

But at least from the get-go, he was not comfortable in requiring that adults acquire insurance, but he did obviously want to have kids covered, and there is a requirement that kids cover their children.

That is the thrust of the difference. It's a huge philosophical difference. They approach this problem slightly differently. I think their goals are very similar. But if you really look at the broad structure of these healthcare reform proposals as they would affect 300 million Americans, the most important parts of it that are common really deal with the issues of health reform, and not just health financing reform.

So I would encourage you, if you get a chance, to look at all three of these candidates' websites. There is a fair amount of detail talking about the issue of affordability. I do think that coming into 2009, no matter who wins this election, that – and in particular I guess if a Democrat wins – that you will see them lead with this issue of affordability because there's got to be some way for them to get out of the blocks and build a bipartisan coalition around health reform that can really engage Republicans and Democrats and Independents, liberals and conservatives around a common set of initiatives.

And I think, given up the way they've teed up their plans on the affordability issue, there is an opportunity in 2009 to really do something major on this, that's important to all of us, which is improving the quality of health care getting better value out of healthcare system.

So with that, I'll turn it over to Joe.

(Applause.)

JOSEPH R. ANTOS: Thank you, Chip, and thank you Ken. When Ken and I get on the stage together, we usually agree with each other about what the problems are, and this is no exception. Let's see, can I – can we have the slides please. I hope I don't have to do anything. Okay, great. Thanks. Okay, well, so let me start of here. I'm going to try to talk about the – kind of the Republican stance on this and try to distinguish where the Republicans are compared to where the Democrats are.

Every day many persons of faith start their day thinking about the challenges that they will be faced with, and they ask themselves, what would Jesus do, WWJD. Similarly every day, Republicans, not all of whom of faith ask themselves – (laughter) – WWJD – what would John do.

John McCain is not your average Republican. I think Senator Hatch made that point pretty clear. (Laughter.) And it's not just his manner of expression; it's his ideas as well. The – you know, the fact is that he holds many stances, policy stances that deviate substantially I think from the standard Republican rhetoric, and indeed, in health care, there are a number of positions that he has taken so far, which certainly will serve as friction points between him and his own party. So let's continue.

You know, we always have to start by talking about the problems that confront us, and clearly, as Ken said, cost and affordability is one of the biggest problems. The number I want to point you to – everybody knows about the \$2 trillion health spending bill in this country, but fewer people realize just how rapidly that spending is growing. Since 2000, health spending has increased by a third, yet the economy grew by about half of that much. Clearly, you can't continue on in that fashion and hope to have a sustainable health system with those kinds of growth rates.

Coverage – coverage is the big issue that we hear especially from the Democrats, and, again, it's not the number; it's the growth. Since 2000, the number of insured has increased by almost a quarter and the economy has been doing pretty well up until this past year. So that's not an economic phenomenon; that's a health system problem. And then finally, quality in value – again, people in this room are very familiar with this issue. We spend a tremendous amount of money. We spend it in ways that can't be explained very easily by the data, by science, by patient condition or anything else, and yet, there is a gnawing concern that the money we're spending is not producing the value we want.

And here, you're probably all familiar with this chart from the Dartmouth (ph) that demonstrates just how variable medical practice is in this country. This shows that depending on where you live, you're more likely or less likely to get very expensive treatments for the same, the very same condition.

So let's move on to Republican themes. And I'm going to focus my remarks really on the McCain stance. He is the frontrunner; he doesn't have the nomination sewn up yet, but it's looking pretty good, and the other major Republican candidate, Governor Huckabee, has not provided us as much information as McCain, so I'm going to stay with McCain by and large in this discussion.

Clearly the huge difference between Democratic candidates and Republican candidates is the relative importance of cost versus coverage in what they talk about. It's true that the Democrats, especially Senator Clinton, has made a – emphasized affordability and cost. But both she and Senator Obama of course have gone back time and again to talk about universal coverage, whereas the Republicans uniformly, all of the past candidates and the current ones, have emphasized that cost is the principal problem. If you don't cut healthcare costs, then universal coverage is not sustainable for very long – hence, the Republican stance that we should strive for universal access to insurance, universal access to health care rather than universal coverage per se.

This is also part of the theme, the Republican theme, that people need to make their own decisions. We can make it easy for them to make the right decision, but in the end, people should be in charge of what they do and not be directed forcibly into something that they might not agree with. Instead of mandates, Republicans tend to support financial incentives including, and especially, changes in the tax treatment of health insurance.

Obviously, they wouldn't be Republicans if they didn't talk about competition. They wouldn't be Republicans if they didn't talk about personal responsibility. But as Ken said, the

solution to a lot of the fundamental health problems in this country – health, not health insurance, not health financing, really does boil down to personal responsibility. People have to take ownership of their own bodies, not just of their health insurance.

Transparency, clearly an important part of individual decision-making. And then a particular focal point of the McCain campaign is his emphasis on looking at the sickest patients, and having patient-centered health care. That's been a theme of his that I think has distinguished him from his Republican counterparts.

Okay, since McCain's most well-articulated policies involve taxes, I thought I'd spend a couple of minutes talking about tax policy. Now, the tax exclusion. When you buy health insurance through your employer, all of your premiums, unless you're working for an employer who hasn't figured out how to do this yet – all of your premiums, the part that the employer pays and that part that you pay directly are excluded from income taxation, excluded from the calculation of your adjusted gross income.

This is a product of wage-and-price controls in World War II. It was a way of allowing employers to provide additional compensation to their workers when they couldn't raise their wages. And it has had a powerful effect in this country. Last year, the latest available data, 177 million people had employer-sponsored coverage, taking advantage of this enormous tax break, which amounted, again, last year to over \$200 billion of subsidies.

Furthermore, and maybe more importantly – again, it's the growth that matters. And in this case, the tax exclusion automatically increases federal subsidies to people for health insurances by something like 15 to \$20 billion without any discussion on the floor of Congress. It's automatic; it happens instantaneously, and nobody on the Hill has addressed this since probably the early '50s.

These are good things. We have a lot more people with insurance through this mechanism than we might have had otherwise. However, there are also some perverse impacts from – oh, my goodness – okay, there are some perverse impacts from this kind of preference. The preference is regressive. It tends to favor high-income people in high-marginal tax rates. It does not help people who don't buy insurance through their employers. It does not help people who are low income and don't have a good job.

It's highly regressive. It's discriminatory. It promotes cost growth. And the reason it promotes cost growth is that the true cost of health insurance and true cost of health care is really hard for most people to figure out. They might know, probably some time in October or November of every year what their insurance premium is, but they probably don't know by now. And they are confused probably about how much their employer puts in and whether that's their money or not. It is their money, thinking as an economist.

But, also, if you're not directly paying for the insurance, you're more inclined to buy more generous coverage. That generous coverage basically means that you're paying less attention to the cost of the services as well. That promotes cost growth because of this general lack of understanding of where your dollars are going. It increases the number of people who

don't have coverage because as costs spiral up, more and more people can't afford the coverage. Because it is run through an employment system, many people do not have a choice of health insurance. And finally, people tend to be locked into their employment simply because they don't own the coverage.

Okay, McCain's health tax reform, he would replace the exclusion with a refundable tax credit. The key point here is that under McCain's credit, low-income people will do much better than under the exclusion. The average person, who is the 15-percent income tax bracket, for example, gains, or has a value of the exclusion right now buying a family policy. This is the average full cost of a family policy in 2007: \$12,000. The exclusion is worth a little over \$3600 to that family, if they are average workers.

Under the McCain tax credit, they get a flat \$5,000 regardless of how much insurance they buy. So clearly lower-income people would do better than they are doing now.

Furthermore, interestingly enough here – it took me a while to figure this out. The McCain campaign hasn't provided much information on their proposal. It turns out that the amount of money you could shelter from taxes through health insurance is actually lower if you're in a higher income tax bracket under the McCain tax credit proposal. Again, the average worker could shelter up to eight – a little over \$8,000 if they're single filers or a little over \$16,000 if they are family coverage in essence. That is what the \$5,000 credit would be worth under – is the equivalent of in the exclusion. However, at the 35-percent tax rate, there is only about \$13,000 worth of tax sheltering.

So this is a strange Republican plan. It's highly progressive. There is a lot of leverage with tax reform. It promotes more efficient insurance. It promotes lower premium coverage, and it promotes greater cost sharing. It promotes greater awareness of what it costs to get health care. It put – it would put pressure on employers and unions to offer more basic plans. Prior to this past year, I could have said the auto industry would finally catch up with the rest of us and realize that health care is expensive and begin to offer more sensible plans. They've begun to catch on although they're still 20 years behind everybody else.

A couple of issues though: Indexing this tax break for inflation is always a challenge. If you're going to save money, you can't index it according to the increases in the costs of health care. You have to index it for something lower. Most people talk about the consumer price index. But what that means is that the value of that subsidy over time would diminish. It would begin to lose its value in terms of how much health care or how much health insurance you could buy. That's an issue for anyone who proposes tax policy of this sort.

There is also a concern that I think is not well-justified about this sort of thing destroying the employer risk pools, upsetting the current system we have. The fact is that under McCain, this tax break, this tax credit would be available to everybody wherever they bought their insurance. But the fact is also that employers offer insurance because it is a great way to attract good employees. It's an even better way to retain the ones you want to keep. That's an important bargaining tool in the labor market. I don't think the larger employers will drop out.

Impact on higher-need patients – I think this is perhaps the biggest challenge. If you have a flat tax credit and you are a relatively healthy person, you can buy a lot of coverage with that flat tax credit. If you are a person with multiple chronic conditions or you've had a heart attack or you're diabetic, or other indicators, that you're going to spend a lot of money in health care over the next few years, you're going to have difficulty paying for health insurance.

The McCain campaign is aware of this. His advisors have been thinking about this. There is some thought about trying to risk adjust, but this is a challenge for this kind of a tax – flat-tax treatment of health insurance, which we obviously did not have with the current tax treatment.

Okay, other McCain issues. He wants to expand competition. I'll go over this very quickly. With insurance, he wants a national insurance market. He wants people to buy insurance that is portable across state lines. He wants to promote the purchase of insurance through all sort of mechanisms, not just employers, although he wants to keep employers in the game. And for those high-cost individuals, he wants to encourage the states to develop bonus subsidies to help out high-cost low-income families with the purchase of insurance.

With the delivery system, he wants to see more competition. He supports innovations such as walk-in clinics at retail locations, something that has shaken up the physician establishment but promises to offer convenience and maybe even more immediate health care to people for at least routine conditions. He wants to see expanded roles for nurses and others to take more responsibility. He would promote tele-medicine. And an interesting and challenging idea: He thinks that providers of all sorts ought to be able to cross state lines and practice, something that could cause the AMA some difficulty, I'm sure.

I'm sorry. Didn't do that right. Okay, may for value. His other major theme in Medicare – he wants to change the way we pay for services. He wants to pay for results. He wants to pay for bundled episodes, not just individual services. He supports CMS's stance that we should not be paying for preventable errors or mismanagement; however, that's easier said than done, as most of the people in this room know. And he wants to focus on the small number of people who spend the most money for health care.

And pharmaceuticals – here's an important area where he deviates greatly from the Republican Orthodoxy. He thinks that we could save money by importing drugs from Canada, and he strongly supports follow-on biologics or generic biologics as a way of introducing competition to lower prices for new classes of drugs that are about to enter the market.

Of course he supports better information of all sorts for everybody, not just consumers, but for physicians as well. And tort reform – he would put a cap on damages. And interestingly, he would provide a safe harbor for doctors who follow established clinical guidelines – again, not necessarily what every Republican would see as the right way to go because who establishes the guidelines?

So there's the dream but in fact, what could Republicans accomplish if a Republican were in the White House next year? Well, the fact is that a Republican president would be sorely

limited by politics and the budget. Obviously the Democrats will be in charge of Congress. They will have a very strong majority in the House. They will certainly have a majority in the Senate – maybe not 60 votes. There's the economy – the deficit will be worse. The economy will be the worse. That means there will be less money to spend. Of course, that's true for a Democratic president too. And then a particular problem for a Republican: health is not a Republican issue and so there will be some challenges there to push forward.

Nonetheless, things will have to happen. There will be a federal push on cost reduction. Next year won't – I think for any president, Democrat or Republican alike, next year in many ways won't look different from this year, last year, or any other year. Tighter price limitations in Medicare. That's the easy fix. That's a short-term solution and hospitals, you know what I mean. However, under McCain, I think there would be a strong push for new payment systems, as I mentioned earlier, to pay for value – a big pressure on the pharmaceutical industry through Part D to lower prices and to make concessions at least to Part D. I think there will be some expectation that would be spill over in general. I'm not sure I believe that. And then a big question, where's McCain on comparative effectiveness analysis? He talks a lot about coordinating care and knowing what's the right thing to do but would he go that far? I think that's a big political question.

Finally, as far as federal program expansions are concerned, they would be limited. And I think this really depends on the level of bipartisanship and the level at which the Democrats on the Hill are willing to go towards the McCain position. But I strongly suspect that he will push for filling in the holes at the bottom of SCHIP and the Medicaid program rather than trying to fill in the middle. He will certainly push for better targeted income tax subsidies. But if he's successful, there won't be any new money. It'll be redistributive. And if all is lost, we'll do what we always fall back on, if you can't solve the problems at the federal level, well, kick it to the states. Maybe they can do something about it. Thanks a lot. (Applause.)

MR. KAHN: Maybe I'll emcee from up here. And I have a couple of questions and then if anyone in the audience has questions, we can ask them. One – and I guess I'll ask this of both participants but probably Ken first – which is in terms of problems with delivery regarding chronically ill particularly, which is what you're raising, and diffusion of health IT. There's a consensus. On the other hand, what troubles me, and I guess my question to you is – and I'm on the commission at HHS that has been working with Secretary Leavitt on setting or encouraging standards and other advances in HIT and the problem I see is I don't see it. I mean, yes, some hospital systems were able to buy systems but basically we're proceeding at a snail's pace and it's not because we don't have standards; it's because, as far as I can tell, we really haven't figured out how to get our cottage industry physician world to accept it.

And so I guess my question to you is – I'm not arguing about health IT or arguing about disease management but what public policy do you think could be implemented from or enacted by the Congress that will actually move the dime here? And I'll ask the question of both because if you listen to Senator McCain or his people, they actually talk about the same thing but I don't know what the policy looks like to actually get the delivery system changed.

MR. THORPE: No, it's a good question, Chip. I can give you an example of a state that has done this, which is – and it's one of the reasons why I'm more optimistic of healthcare reform than I was 14 years ago, which is the state of Vermont. That state passed not only a universal coverage bill that kind of looks like what Senator Obama is talking about, voluntary with some subsidiary to buy private insurance. But at the same time, they are building a statewide delivery model community by community, changing the way that they pay for that not just in Medicaid, but in the private sector as well because they're all collaborating on it. And to your question, they recognize that you really can't do this right until you have a much faster diffusion of electronic technology, particular in the primary care physicians' offices.

On that front, what they have done is they empower their local REO (ph) there to basically coordinate the standards and establish them, working with the hospitals and the physicians in the Vermont medical associations. So they've come up with uniform standards. Two, is that they're paying for the implementation and adoption of information technology in physicians' offices. So in both the Obama and Clinton plan, they recognize that to do this you're going to have to have more money in the system to provide assistance for physicians that are working, you know, one and two person practices than to acquire and train those doctors on how to use this. So they put in \$7 to \$10 billion for a short period of time in order to fund and accelerate the diffusion of the technologies.

Vermont is doing the same thing. So depending on their financial situation, three to four years out, all primary care physicians in that state will not only have electronic technology, but it will all be interoperable within that region, including Dartmouth. So it's a good case study. It's a small enough state, obviously, to do this. But I think there's some lessons learned on the leadership, in terms of establishing the standards. They selected out five different information technology systems, the lower cost, the higher costs that gave the physicians the confidence, that they put them in place, that they would be interoperable. And they provided some of the financial support and training community by community to really do this. So I think all of those things would have to be part of this policy solution but we've got to put somebody behind it.

MR. KAHN: Joe.

MR. ANTOS: You know, I think one of the biggest issues is that health IT is not a good business proposition for doctors and hospitals and other providers. Or at least if it is, it's not very clear how good a business proposition it is. Everybody here has a personal computer or has a computer at the office and the world's worst statement that your IT department can give you is you're going to be upgraded. This is the one of the great fears of this system because, of course, we see in the computer world all sorts of technological improvements. And that doesn't sync up with what most people want in their lives or in their health system, which is some stability of the computing platform and some chance to get used to it before it changes on you. So that's a problem.

But in addition, who stands to make money from health IT, if we really implement things very well and we use that information to eliminate unnecessary tests and fine tune the kind of treatment that we give people? In other words, if we use our healthcare resources more accurately, who stands to gain?

Well, it's probably more likely to be the insurance companies and the government than it is the providers because if you don't do something as a provider, you're not going to get paid for that. So we need to look beyond these technical issues, which are very important and I agree with Ken, leadership at the local level, not just at the governmental level, but also among hospitals is critically important since hospitals tend to be the hub of the community in terms of health care. But we have to go beyond that to really think again about the financial relationships in our health system in this regard. I could see Medicare, for example, in the next couple of years paying for the use of health information technology. That would be the first step to requiring the use of health information technology. That might be painful but we'd get there that way.

MR. KAHN: Joe, let me ask you a question and I hope this isn't perceived as a trick question – and Ken pipe in after I finish but I think you'll pile on probably with this question. None of the Republicans and even Senator McCain has suggested they would support universal cover per se. Actually, in our forum Senator McCain was quite specific that it was not something he thought could be accomplished and he didn't see government as having a role there, albeit that he was for changing the tax code and providing more subsidization.

At the same time, not Senator McCain per se, but at least the current administration and others on the Republican side can sort of beat on the hospitals about transparency and about being competitive. And yet, we have uncompensated care at the 15- or 18- or 20-percent level and the question is if we're going to move away from the Byzantine financial system we have now, where some years Medicare is a contributor, some years there's cost shifting from the private sector to Medicare and there's always cost shifting from wherever hospitals get revenue to cover the cost of the uninsured. So there's all this indirect subsidization that goes on. If we don't have everyone covered, we can never move away from that so it is, in a sense, the hospital are caught in jeopardy and others in that system are too when they're expected to compete on price. And yet, without full coverage, you got to rob Peter to pay Paul. How do you respond to that?

MR. ANTOS: Okay, this is me not Senator McCain – (chuckles) – or probably anybody else in the Republican Party. When the Democratic candidates talk about universal coverage, whether they're talking about mandates or not, I think most people interpret that as meaning instantaneous universal coverage. And I think a sensible position is to recognize as some of the earlier speakers did this morning, that nothing happens instantaneously. Senator Rockefeller made that very point, you can't do it top down. It's got to come bottom up. And so, while I don't want to put words into any candidate's mouth on this subject, I think a more reasonable view on this is that you have to attack all of the problems as well as you can at all times and unfortunately forever. And that includes the uninsured. Even if you had a mandate as Massachusetts is proving to this very day, without substantial subsidies – or the road they didn't take, substantial reductions in the cost of insurance, you're simply not going to pick people up.

So I think, fundamentally, that's the issue that you have to deal with. That's the hard issue. In a sense, talking about universal coverage is the easy political policy that frankly has to be based on a lot of harder things to do.

MR. KAHN: Ken, do you have any comments on that?

MR. THORPE: Yes, I don't think I disagree with much of that. And again, probably for full disclosure, just so there's no confusion, I'm obviously here speaking here on behalf of anybody but myself. But to Chip's points, yeah, the uninsured generate a lot of uncompensated care. I mean, this year alone, when they show up, albeit too late in the stage of their illness, there's about \$50 billion in money floating around out there. A piece of it gets funded through Medicare and Medicaid dish, but you're right, it's make as make can; it gets floated into private insurance premiums. It takes away from operating margins. You know, the financing strategy doesn't make any sense. So I think part of the discussion is really to make it more explicit, and to a certain extent, honest about how we're paying for this and to the extent we can make it fair in terms of how the subsidies play out in terms of the taxpayers. That makes a lot of sense. So I think that to that issue, you know, we're fooling ourselves to think that we're not sort of paying for a lot of this right now. We are.

The second point, I think to Joe's issue, in terms of the timing of this, you know, again, is part of a Democratic primary. You are going to hear Democratic presidential candidates talk about a vision of universal coverage. I think the realities are that they would pursue this, perhaps, at different speeds. You know, tactically, I think they both recognize that in their first six months, they'd have to find ways to build coalitions on this issue of health reform. I personally believe that they would start – at least my guidance would be to start on areas where you have mutual agreements and then move towards universal coverage.

You will be limited by the financial costs of this. That's going to be a major issue. But at the end of the day, I think as you heard Senator Rockefeller talk out about, it is going to be a matter of priorities. Where do we allocate federal dollars? What role do the budget rules play in terms of pay-go rules in this debate? Is the money there? Sure it's there. But it's an issue of how you prioritize federal spending and how quickly want to move the ball down the field. I think they both agree that you want to put federal money into making health care more affordable. The approach it slightly different but at least there's agreement that we've got to do something to get these numbers down.

MR. KAHN: Before we close, any questions from audience for the panel? If you could state name and where you're from that'd be helpful.

Q: I'm Gill Rico (ph) and I'm from Boulder, Colorado. I have more of statement than a question. I found Senator Hatch's comment a little disturbing when he says because of this being an election year, nothing will get done. I guarantee you that everybody in this room approached their boss or their boss approached their boss and said I can't get anything done because it's an election year – (chuckles) – you'd get fired, you know. (Chuckles.) And what I also find is that I'm really glad that Apollo 13 called out, "Houston, we've got a problem," because if they had called out to Washington, they'd still lost in space. When Senator Hatch said about the circling flies, you know, there is circling flies around and over Congress. And what I'd like to impart, because you guys are very influential and you have access to our elected officials,

I'd like you to maybe share this proverb, a Chinese proverb, that says, "Talk is like bubbles, deeds are drop of gold." (Chuckles.)

MR.KAHN: Well, thank you.

(Applause.)

MR. KAHN: That was great. I don't where to go from that. (Laughter.) Keith, maybe we to adjourn while we're ahead. Well, I want to thank you for the comment.

MR. : Hold, Chip.

Q: One more question.

MR. KAHN: Oh, another question.

Q: Yes, hospitals and physicians are paying an enormous amount of money for auditors and consultants to make sure that they are compliant to all the regulatory requirements and I never hear any discussion about this as a part of healthcare cost reduction. And I'm just wondering if our legislators are even aware of the tremendous impact that the regulatory requirements are having on our facilities in physician offices form a cost perspective?

MR. KAHN: Who wants to take that?

MR. THORPE: Well, if they don't they should. I mean, if you look at, you know, just at a physician's office and look at gross revenue coming into a physician's office 40, 45 percent of it is administrative costs and, you know, not related to actual costs of taking care of patients. I mean, that's crazy.

So I think as we go along in this discussion about simplification and administrative streamlining that that's got to be part of a commonsense solution. I mention the Vermont example. Part of the Vermont legislation was to find ways to reduce the administrative costs of running a physician's office, to simplify it so that you're not dealing with duplicate reporting requirements across different health plans. You're not dealing with duplicate reporting requirements across HEDIS-type measures and so on. And that was sort of the quid pro quo, again, to try to get physicians engaged in doing something that's tough for them to do, which is bring this technology into place. But, you know, we've got to recognize that we've got find ways to pull the cost base out of the hospital and physician industry. And a lot of these things really do produce little, if any, value.

MR. KAHN: Any other questions?

Q: (Off mike.)

MR. KAHN: Sure.

Q: One thing that's a little bit confusing for me and it's probably an over simplification but this discussion of making the government insurance plan, if you will, available to the private sector on the surface seems to make a lot of sense. And I don't know why something like that wouldn't be done. It seems to create a competitive environment and the government, in a sense, is competing with the private sector. But if it's good enough for government employees, why isn't good enough for the rest of us?

MR. ANTOS: Well, since you probably agree with that Ken, let me demure on this point. I'm a retired feds. I'm very familiar with the federal employees' health benefits program and I'm delighted that the taxpayers are willing to subsidize my health insurance. By the way, decision about which coverage made by my wife not by me, so we have the most expensive plan. But I'm delighted that the taxpayers are willing to pay 75 percent of the cost of this really Cadillac plan. And that's the problem. You know, again, you have to be realistic. It is not financially feasible to give the uninsured, and shortly thereafter, everybody else the same health plan that the senator has because it's too expensive. So –

Q: (Off mike.)

MR. ANTOS: Right. However, where the truth is, I think, has to do with, I think something that Ken said earlier, if I'm not mistaken, that that's a system that makes it easy to buy insurance. It's an organized market. That's what Massachusetts tried to do. Some other states are trying to do the same thing. But to make it possible to fulfill that Republican dream that you can buy insurance anywhere, you better not have to force people to go to the Yellow Pages because they won't be able to do it. So that part of the system, I think, makes an awful lot of sense.

MR. THORPE: Yes, I think, you know, that part I'd agree with. I mean, the advantage is that it's a national, ready-made system that already is up and running. And I think to the generosity point, the thing that's kind of intriguing about the program is that it includes everything from health savings accounts and consumer-driven plans to more extensive Blue Cross plans and HMOs and everything in between. I think it's an incredibly diverse program in terms of its product offerings. Joe's right that, you know, the most popular plan are the two Blue Cross plans. In part, they've been there the longest but, you know, there is a lot of diversity of product offerings in this program. And just as a side note, I'm happy to pay for Joe's health insurance.

MR. ANTOS: Thank, Ken. By the way, that diversity, though, is at a high level. That's the point. I agree with you. There's a lot of diversity but we're talking up here not some somewhere in the middle.

MR. KAHN: And we're also, at least in terms of the federal employees' plan, talking about a plan even though, albeit, 9 million or 10 million participants, it's a plan designed as an employer plan to bring in individuals. And open that plan creates a tremendous amount of problems because the issues of risk selection come in that are not current when you have a plan that includes employees and even retirees. And actuaries know how to deal with it. That's the first issue.

The second issue is, in terms of an actual public option, on the one hand you can argue, well gee, all you got to do is put people in Medicare, maybe change the benefits a little bit, and there you go. And the problem from our stand point there is there you go and presumably you'd use the administrative pricing system that's used under Medicare. So the doctor 10-percent reduction that's coming July 1 and probably will be funded but is coming under Medicare payment would then be experienced by everyone that was in the Medicare plan.

So the problem is if you try to retrofit these reforms on top of existing systems, you're going to tend, I think, either to have a misfit in terms of taking a system that's really an employer-type system. And assuming that you can just throw the risks in or taking Medicare system and expanding it, which ultimately would probably be really difficult for the private sector to deal with and compete with because they can regulate prices. And at the end of the day, sure, they can ratchet down on the providers through the price controls but that's going to cause problems. So I think – I'm not criticizing either approach, I'm just saying it's a lot more difficult than, with all due respect to the candidates, it sounds on the campaign trail.

And with that, I'm going to take the privilege of having the podium and say thank you all for participating. Thank you, panelists. I hope that you found the whole session this morning and yesterday worthwhile. And the plenary session is now adjourned. (Applause.)

(END)