U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR HEALTHCARE QUALITY AND RESEARCH
(AHRQ)

CITIZENS' HEALTH CARE WORKING GROUP

MEETING

WEDNESDAY,
MAY 11, 2005

The meeting was held at 8:30 a.m. in the Cherry Blossom Room of the Crystal City Hampton Inn, 2000 Jefferson Davis Highway, Arlington, Virginia, Randall L. Johnson, Chair, presiding.

PRESENT:

RANDALL L. JOHNSON, Chair
CATHERINE G. McLAUGHLIN, Vice Chair
FRANK J. BAUMEISTER, Jr., Member
DOROTHY A. BAZOS, Member
MONTYE S. CONLAN, Member
RICHARD G. FRANK, Member
JOSEPH T. HANSEN, Member
THERESE A. HUGHES, Member
PATRICIA A. MARYLAND, Member
MICHAEL J. O'GRADY, for Secretary Mike Leavitt, Member
ROSARIO PEREZ, Member
AARON SHIRLEY, Member
DEBORAH R. STEHR, Member
CHRISTINE L. WRIGHT, Member

ALSO PRESENT:
PETER CUNNINGHAM, Center for Studying Health System Change
GEORGE F. GROB
JOHN IGLEHART, Project HOPE
CAROLYN J. LUKENSMEYER, Ph.D., AmericaSpeaks
WILLIAM J. SCANLON, Health Policy R&D

STAFF PRESENT:
LARRY T. PATTON, AHRQ Liaison

AGENDA

P-R-O-C-E-E-D-I-N-G-S

8:33 a.m.

CHAIR JOHNSON: Good morning, everybody. Welcome to Washington, D.C. and Arlington, Virginia and Crystal City area. We're glad that you're here this morning. Thanks for making the trip in.

First, we're looking forward to a good three days of discussion and briefings and hearings. May I just invite your attention to the agenda and we'll walk through it real quickly?

Starting this morning, we will have a foundational briefing, as you requested, as a working group and John Iglehart from Project HOPE will be sharing his thoughts and understanding of the American health care system.

Later today, Bill Scanlon will be discussing the Medicare, Medicaid and SCHIP program. Our final session today will be where we have a building the foundation briefing on the uninsured.

We'll get into some working group business toward the end of the day and then if you'll take a look at the agenda for tomorrow, you'll notice that we'll have a foundational briefing again regarding the

private health care system, followed by a hearing of top public sector initiatives to expand coverage.

Now, the foundational briefings are intended to provide, as you recall, education regarding each aspect of the health care system. The hearings are intended to get at some of the issues that we have in these particular areas and current initiatives to deal with some of those issues.

Following the first hearing tomorrow, we'll have a second at 1:00 and that will be private sector initiatives to expand coverage and we'll also have a section for working group business tomorrow afternoon.

On Friday, another foundational briefing on health care costs and you may recall, as a working group, that the legislation requires a series of topics to be covered in hearings and we've asked the Congressional Research Service and CMS to talk about some of those cost issues and lay a foundation of knowledge for us there.

We'll follow that with two hearings, one on public sector initiatives to control cost, and the second, private sector initiatives to control cost.

We have a full three days of business. It

would be our expectation to adjourn on Friday no later than 3:00, so that you who have scheduled flights can make the flights.

That's our agenda. Are there any questions regarding that? While you're potentially thinking of questions, just a word of thanks to the hearing subcommittee, which includes Catherine McLaughlin, Pat Maryland, Dottie Bazos, and Mike O'Grady.

A special word of thought also to not only our full staff, but in particular, Caroline Taplin, who's worked an awful lot to help us put our hearings together, so thank you very much, Caroline.

I think without further ado, what we'll do is we'll get right into our first topic for the morning. John Iglehart, we're pleased that you're here with us. Mr. Iglehart has served as editor of *Health Affairs* and earlier, he served as Vice President of Kaiser Foundation.

You all have his bio in front of you. It's a brief bio, but I would just like to say this in introducing you that when our hearing subcommittee gave thought to who might best be prepared to provide a foundation of knowledge regarding our health care

system, you were one of the two or three whose name rose to the list, to the top, and so we're glad you're here and we'll look forward to your discussion.

John, however you wish to proceed over the next couple of hours or so, actually an hour and a half or so, we'll welcome that.

MR. IGLEHART: Thank you, Randy. It's a pleasure to be here. This is a small group and I have somewhere between 20 and 30 minutes of remarks and I don't mind at all being interrupted during the course of them, so feel free to interrupt.

I had prepared a PowerPoint presentation, but then I thought about it and thought you'd be PowerPointed to death before this is over. I really only have three slides and I came across these three slides recently and I was struck by them.

I think, as the title on the first one says, America's Thinning Social Contract, I think this is one of the issues, questions that our society faces that you'll be grappling with over this two-year period.

As you can see in this first slide, people that were asked by the Harris organization, please tell us whether you agree or disagree with the

following statements about health care and you can see, over the period of 12 years, some erosion in the majority view of the people who are unemployed and poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes.

Then, if somebody could move me to the second slide, I'd appreciate that. The second slide, over the same period of time, please tell us whether you agree or disagree with the following statements about health care.

The government should do whatever is necessary, whatever it costs in taxes, to see that everyone gets the medical care that they need. You see there also some erosion in the majority view.

Then thirdly, and the last slide, please tell us whether you agree or disagree with the following statements about health care. The higher someone's income is, the more he or she should expect to pay in taxes to cover the costs of people who are less well off and are heavy users of medical care.

Here, you see substantial erosion in the majority view from agree 66 percent to agree 51 percent. I am going to leave this last slide on the

screen because I think - I really want to embed it in your mind, as you go through this long and undoubtedly very interesting process over the next two years of trying to figure out ways that the financing and delivery of medical care in America could be improved.

As we all know, America is an exceptional country in many respects. In some respects, in fact, many respects, it's exceptionally good. There are other respects where we could certainly improve things for people.

One of those, I think we would generally agree, is health care. I, at the opening, really would applaud Senators Hatch and Wyden for sponsoring the legislation that led to the authority that created this citizen's commission.

I think it's a timely creation of a body because we're really at a lull in Washington in terms of a way forward on changing or trying to improve our system.

One of the ways that the U.S. system is exceptional is that unlike most other industrialized nations that concentrate their resources in one health insurance system that provides universal or near-universal coverage, the United States falls short

on that measure.

Its array of public and private programs, when totaled, are the most expensive of systems, outstripping by more than half any other country and you'll hear more about that, I'm sure.

The number of people without health insurance continues to climb slowly, reaching upwards of 45 million now, about 15 percent of the population. By many technical standards, U.S. medical care is the best in the world, but leaders in the field of quality believe that there is an urgent need to improve it.

I would like to quote briefly from really our most eloquent advocate in this pursuit of quality, Dr. Donald Berwick, a pediatrician in Boston, who really has a world-renowned reputation in working with systems, not only in the U.S., but around the world in terms of improving quality.

Don said recently in an interview that was published in *Health Affairs*, and I quote here, "There is a deficiency of will and ambition in the major centers of power and the delivery of health care in America. We do not have a shared aim to raise the bar in performance. That's the problem."

As I said, I think the creation of the Citizens' Health Care Working Group is timely, not only because of this lull, but because the facts I have just underscored indicate that there's really a profound ambivalence in society about whether medical care should be considered a social good of which the costs should be borne by all or a benefit that employers should purchase voluntarily on behalf of their employees with government-sponsored insurance for people outside of the workforce who find these services unaffordable.

An objective observer, it seems to me, would have to conclude that at present, there is little appetite for expanding government's role in health insurance and much more support for encouraging the purchase of private health insurance through tax subsidies of one sort or another.

At different times, Americans have answered this or similar questions in a variety of ways, the question of whether health insurance should be available for all or whether it should be more like a good in our competitive market-driven system.

The result of the answer to policy actions over the years has been that we do provide health

insurance, mostly voluntarily by employers through the private sector, to about 85 percent of the population, leaving many people uninsured, the majority of whom are full-time workers and their dependents.

Taken together, all of the activities that are defined as components of health care make up the most dynamic sector in the American economy as measured by its capacity to grow in good times and bad.

On the other hand, health care expenditures are growing at a rate that is regarded as unsustainable by both public payers and private payers. Those members of the working group who have a lot less gray hair than I do must bear one fact in mind, and that is that this refrain, the refrain of unsustainability, has been voiced for decades.

Indeed, one of the very first articles I wrote as a health policy journalist published in the early 1970s in the *National Journal*, I wrote similar words and here we are, some 35 years later, wringing our hands, but still in search of ways to tame the growth of health care expenditures somewhere closer to the growth of the overall economy.

Because the money that finances medical

care flows through third parties, patients and providers alike have been less sensitive to the rising costs of care than they would be if patients had to pay for care more directly out of their pockets.

Over the last 40 years, out-of-pocket spending has declined as a share of total health care spending. In 1964, for example, it was 45 cents of every health care dollar. By 2004, out-of-pocket spending for the insured made up about 14 cents of every health care dollar.

Over the past 200 years, the provision of medical care in the United States has been shaped by a variety of factors, including pragmatism, political imperatives, periodic health crises, the exercise of power by private interests, a strong belief in limited government, individual freedom, and science and technology.

Periodically, Americans have sought to enact a universal program of health care that would define it, like schools and police protection and the courts, as something that should be available to all citizens, regardless of their economic standing.

These efforts, as you all know, date from the presidency of Theodore Roosevelt in the early 20th

century. They've all failed for many reasons, including Americans' general distrust of government and expanding governmental powers, resistance to these efforts by the medical profession, by private insurers in many instances, and many employers who oppose the expansion of governmental powers.

Another factor has been the absence of a sense of noblesse oblige that reflects our society's belief in individualism and individual freedom, but compromises efforts to promote community. This slide I have up there I think speaks to that and the fact that it's really a moving target within society today.

While there have been many efforts one can point to that the community as change agent is alive and well through, as former President Bush characterized it, "a thousand points of light", there are also other signs that suggest Americans are less willing today to be their brother's keeper than they were in previous times.

Among the 30 member countries of the Organization for Economic Cooperation and Development, OECD, all capitalistic industrialized democracies, total tax receipts as a percentage of the gross domestic product are the lowest in the United States.

This fact has not had much influence on a continuing trend in the United States. Ever since the enactment of Medicare and Medicaid under both Republican and Democratic regimes, the government's role in financing and regulation of health care has grown inexorably.

Public health care expenditures today now are approaching half of the total and this percentage will only grow as the Baby Boom population nears retirement.

Let me turn to the role of employers specifically. Ever since World War II, employer-based health insurance has provided the bulk of coverage for the working population.

While there are many thinkers on the political left and right who believe the employer-based system should be abandoned in favor of empowering individuals or extending Medicare to all, employer-based coverage remains popular among many workers because they understand it and somehow believe that their employer is paying for it, but that is not what most economists believe.

They believe that employees foot the bill of their health insurance as part of their total

compensation. In other words, higher health insurance premiums means smaller pay raises and thus, smaller take-home pay.

One feature of employer-based coverage is its high administrative costs compared to government-sponsored programs, such as Medicare and the Veteran's Administration's medical care system.

Private employers find it increasingly difficult to bear these administrative costs, but they are grudgingly still willing to pay them because they believe a government-sponsored system would be even less favorable to their long-term interests.

One fact is that the insurance premiums that employers pay on behalf of their workers for coverage is a tax-deductible business expense. This tax expenditure, when totaled, amounts to more than $100 billion a year, so it really is, next to Medicare and Medicaid, the government's third largest health care program.

What's troubling about that is that many of those dollars of that more than $100 billion, I think now approaching $150 billion, is distributed every year to people with substantial means.

In other words, it's not distributed

equitably. That's an issue that has been discussed on Capitol Hill for at least ten years, perhaps 20 years, and there's never been much headway made about it.

Individuals who believe in a competitive based system consider that one of the great obstacles to moving to a more market-based system. Nevertheless, the business community, although they continue to favor the employer-based system, are of many minds regarding what the future role of employers should be in providing health insurance to their employees.

One need not go any farther than reading the daily newspaper over the last several weeks and listening to the expressed concerns of the CEO of General Motors and understand what sort of a plight a company like that faces. In fact, I heard GM described recently as a health insurance company that happens to make cars.

In any event, I think the role of the employer, and certainly Randy Johnson, among others around the table, will weigh in on that and have concerns about that and will have questions about that as you go around the country listening to a lot of people talk.

Well, there are many supplements to the market-based system that dominates the American system. At different times as policymakers have recognized the limitations of the market-based private insurance, supplemental systems have been designed to accommodate people considered worthy of receiving publicly-financed care.

These programs, as you all know, include Medicare, which serves some 40 million disabled and elderly beneficiaries, and Medicaid, which, with a total of federal state expenditures nearing $300 billion, has surpassed Medicare as the largest publicly-sponsored health insurance programs.

These two programs, enacted in 1965 by Congress, grew from very different traditions, one far more acceptable to the American people than the other. Medicare, as you know, is a contributory program that is financed by the working population.

That is, all workers, except public employees, are required to pay a tax assessed as a payroll deduction with the understanding that once they retire, they will be entitled to the medical services covered by Medicare.

Medicaid, by contrast, is means-tested.

That is, a beneficiary must prove that he or she is impoverished before being declared eligible on the basis of economic need.

As you have read in the newspaper over the last few months, Medicaid is really on the griddle again in terms of what its future should be. I think at root, the issue there, while there's lots of bells and whistles around it, the issue is what level of government or whether a level of government should provide care to a variety of different population cohorts.

That is really the hot potato that's being tossed between states and the Federal government today and employers obviously have a strong role in it, as well. One of the great concerns of the Medicaid directors today is they see a continued erosion of private employer-based coverage and more of these people enrolling in Medicaid.

They wonder what the future of the program is and how it will continue to affect the money they have for other worthy state-based projects, mainly education.

One of the supplements to the market-based system in this country, or another one, is medical

care for veterans. The Department of Veteran's Affairs, and particularly its tax-financed, centrally directed medical care program, embodies a brand of socialism that is unusual in this country.

The program relies heavily on physicians with affiliations to medical schools who provide care to veterans, teach, and conduct research. Despite the uncharacteristic nature of the VA system of medical care in the American context, it enjoys enormous support among politicians of every stripe and has escaped largely unscathed from the competitive struggles that have engaged the private sector in recent years.

The VA has its share of problems for sure over the quality of care delivered in its facilities, but it has made strides in improving quality and particularly, exploiting the power of information technology to better the medical services it provides to veterans.

The uninsured. The existing private and public health insurance programs, as I've already said, falls short of covering the entire U.S. population. Now we have somewhere around 45 million uninsured people. It's a debatable number, but it's a

large number, whether it's 45 or 40 or even 35.

People without health insurance must rely on visits to emergency rooms, to physicians' offices, or clinics, where they are treated as charity cases or have to pay out of pocket.

There's no magic formula for transferring the cost of covering the uninsured from individuals to government or business. If the American people want to extend coverage to people without health insurance, they are going to have to pay for it through fees, insurance premiums, or taxes, or if taxes are levied on businesses, higher prices.

Three decades ago, economist Victor Fuchs wrote a little book that remains as relevant today as it was in 1974 when it was published, entitled *Who Shall Live*. Fuchs labeled one its chapters The Physician, the Captain of the Team.

Of every $100.00 spent on health care, only about $20.00 goes for physician's services, but the dominant role of the physician is particularly important because doctors control the total process of care.

The actual delivery of care is frequently in the hands of other health professionals,

pharmacists, nurses, technicians, and allied personnel, but for the most part, they take their direction from a physician and report back to a physician.

Today, many physicians engaged in bureaucratic and political struggles that sap their time and energy and exhaust their patience for treating uninsured people, wonder whether they remain, as Fuchs labeled them three decades ago, Captain of the Team.

But physicians have had a difficult time persuading Washington and more broadly, society, that their discontent taken to an extreme is having a deleterious effect on the care they render to their patients.

In short, the medical profession, in my view, has been unable to harness the enviable stature that most physicians enjoy in their communities where they practice into a commensurate level of influence in health policy making. In short, physicians have been no more successful than other stakeholders in moving the dial on health care reform.

The road to reform, briefly, many individuals who make up the broad health policy

community look to various approaches to reform as the road to redemption for health care.

However, again, as you know, there is no one approach that comes anywhere close to achieving a consensus. There are three broad types of reform that have drawn both enthusiastic support and strong opposition from different interest groups.

One relies on the individual responsibility of consumers to face limits and curb spending by making cost benefit trade-offs. The latest incarnation of this approach is consumer-directed health care which, advocates argue, will enable enrollees to save money tax-free that they can use to cover out-of-pocket expenses associated with health care and also provide consumers a greater choice among physicians and plans.

A second approach to reform relies on government to impose price or quantity controls on medical providers, either in its existing programs, or through global budgeting or single-payer plans.

Government, however, is not well-positioned to weigh costs and benefits across innumerable health care trade-offs, particularly for new technologies.

A third intermediate approach would have third parties accept fixed budgets or vouchers and then create effective limits on spending through capitation of providers, price limits, and utilization controls. But the public backlash against managed care demonstrated the limits of people's patience when third parties come between them and their medical preferences.

One whole subject that someone in this - in my lead opposition could devote the entire time to, really the determinants of health and how influential in any industrial society are things that are non-medical in terms of determinants. I'm thinking here about social determinants, personal behavior that affects health status so profoundly.

The estimates are that medical care, for any given individual, really only makes up about ten percent of that person's health status and if you smoke or if you drink excessively or if you engage in unprotected sex or if you are poor, an economic dimension, and there are a variety of other things, all have a profound, and really substantially greater, impact on the health status of any given individual than his or her access to medical care.

That's a whole different subject. We at *Health Affairs* have worked closely over our almost 25 years now of publishing with the Robert Wood Johnson Foundation and for many - the foundation now is about 35 years old, I believe, and for at least 25 of those years, when you looked at where they put their money in terms of grant-making, about 95 percent of it went to efforts to improve medical care and five percent went to this broader population health subject around non-medical determinants.

In the early 1990s, a light went on on the head of Steve Schroeder who, at the time, was CEO of the Johnson Foundation, and before he retired in I think about 2003, the foundation had changed its grant-making strategy from one that was 95 to five in favor of medical care to one that's now 50/50, health care in one 50 and health - in other words, public health, population health, and these other more socially determined factors, the other 50 percent.

The government has not made that kind of shift, obviously, although there is a lot of activity and I think there's a growing body of research and perhaps a growing body of researchers, although still rather small, that are focused on this subject.

As you go around the country, you should be aware of this non-medical set of factors that bear so heavily on the health status of an individual.

I'd like to finish up really by - no one asked me to do this, but I'll do it anyway - and that is what role would I think the Citizens' Health Care Working Group could play over this next few years?

As I said initially, I do think it's very well-timed. We're in a lull in terms of Washington making any great headway, broadly speaking, in health policy, and so there is this period.

The literature is replete with task force reports and recommendations from a wide variety of stakeholders, both governmental and private, about which way to reform, but as I said earlier, there is no consensus there.

What we lack, it seems to me, is the political will to move in one direction or another. It's not simply a Republican problem or a Democratic problem. I mean, I think it's a societal problem.

What I would like to leave you with and point to is something that we discovered at *Health Affairs* about six or seven years ago, or perhaps I should say I discovered, and that was the power of the

personal story. What I think you should be doing during this two-year period as a Citizens' Group going around the country is searching for that personal story that will move the dial.

I would just like to read here very briefly from the Editor's Note that I wrote when we opened a new section in *Health Affairs* called Narrative Matters. Basically, what it's all about is giving people who either were or are patients or family members of patients or physicians or nurses or other health care providers an opportunity to tell a personal story that has some kind of a policy hook to it.

This is what I said. This was back in 1999, when we created this section. It's brief. "In the 18 years that Project HOPE has published *Health Affairs*, America's medical care system and the making of health policy have become big business, but the voices of patients, their families, and their caregivers have often gotten lost in the relentless shuffle. *Health Affairs* is a policy journal and I never regarded publishing material that emphasizes the personal, the subjective, and the autobiographical, as its reason for being, but through a confluence of

factors, I have come to believe that we could enrich the journal by nurturing a form of health policy writing that affords greater opportunity for new voices to contribute to future debates."

We took this idea to the W.K. Kellogg Foundation in Battle Creek, Michigan which, more than any other philanthropy, has focused its resources on fostering community voices and recognizing the role of the patient and the caregivers.

Since then, we have had this section in the journal and I have brought with me and will leave with you copies of reprints of a few of these articles that will give you a real sense of how powerful, and I'm sure many of you, in your own lives as caregivers, as patients, as family members, probably have a personal story or two of your own to tell.

Nothing I can tell you in our 25 years at *Health Affairs* has had a more profound effect on our readers than these personal stories, far more than data sets and empirical findings on this issue or that issue. The personal story really resonates with not only policymakers, but with anybody who reads them.

I would say that I arrived at this nirvana not simply because really the architect of it,

Fitzhugh Mullen, persuaded me that it was the right thing to do, but we had our own family experience with serious illness some years ago, when our son was diagnosed with leukemia.

We went through a long period of time sitting at teaching hospitals and waiting for the word from the doctor or the nurse on the status of the patient on any given day.

I began to recognize that there is this chasm in our society, and I think it's probably in any industrialized society, between the elites that sit in Washington by and large making policy and people out in the land who are living their lives, going to work every day, paying their taxes, being good citizens.

I think the personal story may well be a link to close a bit anyway this chasm between elites in our society who make policy, whether it's private corporate policy or governmental policy, and people who are living their lives, well beyond the beltway.

I would encourage you, in closing, that you bring back to Washington, in your final report and in other midcourse reports that you have to make, the stories that you hear, the tales of the uninsured who forego care, the young women who have no access to

prenatal care, or the worker who loses her job, and thus, her health insurance.

It seems to me the Citizens' Health Care Working Group is very aptly named. You should do your level best, as I said, to bring back these stories that are poignant and often move policymakers to action. Thank you.

CHAIR JOHNSON: Well, thank you very much, John, for your comments and even your suggestions at the end. We'll open up our time for questions for you, John, if we may and I'll just go first, if I may.

Earlier, you talked about the uninsured and the potential cost increases that would go with trying to find coverage options.

What are the more effective options that are available today for a person who might have left their company in their 50s or early 60s, not eligible for Medicare? What are their options for picking up medical coverage to avoid going on uninsured?

MR. IGLEHART: Yes. Well, on a short-term basis, the provisions in the so-called COBRA legislation, which was one of the budget reconciliation acts of some years ago, that enables a worker to buy coverage for I think it's a period of 18

months after losing his or her job, for that continuation of health insurance during that period, able to buy that coverage, but it's often too expensive for people who have lost their jobs to afford.

Not a whole lot of folks take advantage of that. As you know, there have been attempts earlier, in the Clinton administration, if no other place, where the President recommended the idea that Medicare should be extended to people between 55 and 65. People could buy into it. It wasn't a free lunch, but people could buy into that program and get coverage that way.

There was not a great deal of support for that and thus, it's never come to pass. I'm of a mind that - I'm not by any stretch an ideologue and how we get to broader coverage of the population, those people that are uninsured, is almost incidental to me.

I think we're always - I can't imagine that our country, unless there's a revolution of sorts that I'm not envisioning anytime soon, will change our system in a fundamental way. I think it's always going to be pluralistic.

It's always going to be somewhat Rube

Goldbergish, where there was never a grand plan that laid it out at the beginning and we incrementally expand coverage in one way or another as groups come along that we deem worthy of coverage, most recently, the State Children's Health Insurance Program enacted in 1997.

I think we ought to, as a society, get on with the task of mustering the political will to gather around one approach or another and try to move incrementally to broader coverage.

I suspect if we put the right people in a room and said, you can't come out until you agree on a plan, that we might get somewhere, but we're nowhere near that and the subject is not even much on the minds of policymakers today.

If Congress is consumed by, whether it's terrorism or Social Security or a range of other issues, they're not focusing on health care and the committees that are responsible for the health care programs are not focusing on health care. At the moment, as I said, there's a real lull.

CHAIR JOHNSON: Other people who have - go ahead, Joe.

MR. HANSEN: Okay. Thank you. Before I

start my questions, there seems to be a theme, a number of different ways you addressed that the dynamic we're facing, I guess the poll kind of says it, but you also said somewhere along the line to not be our brother's - there's a growing sense in this country of not being our brother's keeper.

There's this dynamic, when you talk about getting to the personal stories, that we should be looking at the concerns and maybe with an eye of compassion and that's going to be diametrically opposed to the financial problem that is sitting out there in the health care - is that a fair thing to say, or do you --

MR. IGLEHART: Sure, it's a fair thing to say. As I said, there's no magic bullet that's going to get us anywhere closer to more universal coverage without paying for it. It has to be paid for.

Compassion is fine, but when it comes down to the writing legislation or whatever, it has to be financed, although when Congress enacted the Medicare drug benefit, they managed to do it in a way without financing it and added to the liability of our society.

MR. HANSEN: That gets me to a couple of

the other pieces that I was - I really appreciated your report. You had talked about, there's now more support for government subsides, and I wrote schemes or tax breaks, and I think that's the CHIP program and that, but could you expand on that a little bit, because it kind of goes against - if there is more support for these incremental programs, how is that coming about and why?

MR. IGLEHART: Well, for quite a few years, Republicans have been very strongly in favor of providing tax credits of one sort or another for people without insurance so they can take that tax credit and purchase health insurance coverage with it.

The credit - it's always been debated, well, how much of the cost of coverage should be covered by the credit? Should it be 100 percent, 75 percent, 50 percent, or whatever percent? Republicans have always been in favor of a smaller percentage than the Democrats, not surprisingly.

Over the last decade, as Democrats could see that the likelihood of expanding governmental programs, such as Medicare, where government is really the central player, simply wasn't in the cards, at least in the short term, and so they have really come

over in the last decades to - grudgingly, but now, I think more favorable, to the idea of providing tax credits as a way to expand coverage.

I mean, tax credits are not a free lunch. Obviously, they cost the Treasury money, but they do provide support for private sector programs, which obviously is a preference of Republicans.

MR. HANSEN: When you were talking about the different - you talked about Medicare, Medicaid, the employer-based system, and then you also mentioned the VA system. I don't have any sense of what percent of the whole health care system the VA system is.

As a follow-up to that, you said some positive things about the VA system, almost like you're telling us we should take a look at that and I would defer to Randy on that down the line, but was that your intent?

MR. IGLEHART: Well, it's a system that works for a lot of veterans who are poor, don't have other forms of coverage. In recent years, more and more veterans have taken advantage of their eligibility for the program, for the purchase of prescription drugs, if nothing else, as the cost of drugs has gone up.

I don't have in my head the percentage of the whole. I would guess it's probably ten percent or less would be my sense. Does anybody know those figures?

It has been certainly a growing percentage of VA's total budget and as that has happened, there has been more concern, particularly since Republicans have been in power over these last ten years, to try to tame the growth of the VA medical care system.

Without giving away the story here, we have a paper in-house at *Health Affairs* that we are considering for publication and the basic point it makes and gets back to the thing about, to some extent, the high administrative costs of private insurance versus the much lower administrative costs of Medicare is it's saying that well, if this unsustainable system that we have reaches a point where we simply have to take drastic action, one could look at the VA and say, it's certainly a form of socialism that's very uncharacteristic for the U.S., but it also delivers care at much less expense per head than any other system, whether it's Medicare or private insurance, and if we really get desperate as a nation, we could look at it.

I don't expect that to happen, but I mean, it's a scenario that one of our offices has drawn.

MR. HANSEN: My last is more of a comment and when you talked about the GM problem and Ford has the same agreement, that actually, it is a tremendous problem, but there's two parts of the health insurance.

I think what maybe is the killer for GM is the retiree piece more than the active piece. I think - as we study the health care system, I think we have to look at both active employees and the retirees, which are a growing number in our society. I would just add that onto your comments. Thank you very much.

MR. IGLEHART: Oh, you're welcome. You're absolutely right in the - economy-wide, the number of, say, Fortune 1000 companies that are differentiating their workforces in terms of those that start jobs now versus those that have been working or have retired is really quite dramatic.

You have to wonder as there's presumably many of these people are in this 55, 64 age group that Randy mentioned earlier, just what will become of them in terms of coverage I think is an open question.

Yes, sir?

CHAIR JOHNSON: Would you use your button, Frank? Thank you. That's a reminder to all of us. Again, we are transcribing our entire meeting and it would be helpful to have you push the button and we'll all forget, but we'll try to remind you.

DR. BAUMEISTER: The first thing, I guess, I would ask you, are your comments going to be in print? Because it's a wonderful essay on the current status of our morass in health care, I guess.

CHAIR JOHNSON: There will be a transcribing --

DR. BAUMEISTER: That will be fine.

CHAIR JOHNSON: Of our briefing so you'll be able to see that in writing, but maybe your question was, will it be in print in *Health Affairs* or some other piece?

MR. IGLEHART: No, not as such. I mean, if one did a content analysis of my writings in the *New England Journal of Medicine* over the last 25 years, you'd see a number of these ideas expressed there. But no, I didn't have any plans to --

DR. BAUMEISTER: Okay. Well, I read them in the *New England Journal* and I - but this

consolidation that we heard this morning, I'd like a leather-bound copy.

Since I've been involved in this group, it changes the way you think and it's a difficult way to think because for a long time, I have disengaged myself from the medical political scene and just been practicing daily medicine.

I went away for two weeks to Hawaii to clear my mind and soul and I came back and I worked one day in my office. I'm a senior partner of an eight-person gastroenterology group in Portland, Oregon. I attended our morning report. We have morning report every Monday morning, where the physician on call for the weekend presents what happened the weekend.

I'd really invite everybody here to attend one of those morning report sessions because the dissociation between the think tanks that you talk about and the policy wonks and the people that are flying the B-52s don't know what it's like to take call in a county hospital, city hospital, private hospital, for 72 hours and see the horrible things that come into emergency rooms that physicians have to deal with.

The list of uninsured, devastated people by physical illness, some of it, of course, brought on by themselves, alcoholism, smoking, but that's part of the poetry of life. It's going to be hard to take out.

The question is how - you talk about the personal stories, the narrative - that's all I deal with. I start out in the morning and I go home at night and all I've heard is personal stories, narratives of people who are just devastated by health care that comes out of the blue.

A man sitting at his desk suddenly vomits blood. A person suddenly has a stroke, falls over. Whether insured or not, they get care. The question is, how do we bring this - how do we narrow this dissociation?

Because I come here and I hear people say well, medical errors are accounting for 40 percent of the health care costs. Well, I don't see all those errors.

I may be biased, but I don't see that as an issue. I see incredible administrative costs. I see layers of administration that are just chewing up the health care dollar.

I face this task, on this working group, is - I said in our introductory remarks a few weeks ago, I said I see great futility here in bringing this message and overcoming this disparity here.

I don't know, I just feel compelled to make that statement, whether I may be blowing a horn in the forest, but it's very frustrating for me and I'm sure it is for many physicians. People think that physicians out there are just the Captains of the Ship anymore.

A lot of them are employed by hospital systems. They're working for peanuts. They are forced to see people in seven minutes. One organization in Portland took out chairs from the examining room so the physicians wouldn't sit down because it took them more time.

These are constraints under which physicians are working and it's very frustrating and I just throw that out for public consumption and I would like to have your comments.

MR. IGLEHART: Thank you. I feel your pain. I think my sense is that - well, several things. One, it is a challenge to bridge that chasm and will continue to be always.

But if you think of our elected officials, whether at the local, state, or national level, as the collective voices of our democracy that should be attentive to the interests and the concerns of citizens - if that is still a tenable formula in a country like ours, then that's certainly one place where you'd like to make your concerns felt.

I've thought increasingly, and I suppose I question influence by our own family experience, that the staff on Capitol Hill, for the most part, are young and healthy and whether they're Rs or Ds doesn't make a whole lot of difference. They're living policy in the abstract and somehow, individuals with concerns such as those you expressed have to try to break through that veneer.

You can do it certainly a lot better in your home backyard than you can in Washington. It is a challenge, no question about it, and I do think a group like this that has a national mandate to go out into the land and listen to a lot of people, you have an opportunity to make a difference, but it's not easy.

DR. SHIRLEY: Aaron Shirley. I think I heard on the news this morning that 100 senators voted

for military appropriation and made billions of dollars, probably without very little debate, and that happens, I think, because of a perceived threat.

What if, over the next two years, this committee could document the potential threat of the 45 - to the economy and to the nation of 45 million people being uninsured?

If we could show that over time, that could cause considerable amount of harm. Is that added to the strategy of what we should accomplish?

MR. IGLEHART: I think it could. A lot of work has been done in recent years, particularly by the Institute of Medicine. They put out a six-volume study on health insurance and what happens to people that lack it and so forth, so you have a base of information to work from on that.

It seems to me that your opportunity, as a working group, is to listen to a lot of testimony and personal witness out when you do your hearings around the country that can perhaps build a more personal or emotional dimension to the empirical work that was done by the Institute of Medicine.

Yes, I think, in my view, that's what this Citizens' Group is all about.

MS. MARYLAND: Building on what Aaron just shared, my thought would be what if we could really share the story of what's happening from an industry standpoint from our major employers and the impact that this is having in terms of crippling their effectiveness and, quite frankly, crippling the whole country's ability to be one of the major leaders, that that might resonate with an administration where they're seeing less of the, if you will, brotherhood supporting each other, if you will, may be an approach.

I know you mentioned, and I was startled by that number, $100 billion right now of premium - the costs of premiums by the major employers. All this is tax-deductible, but the impact we know is more on those individuals that have retired from their organizations and the costs associated with that has been just crippling a lot of our major employers.

Would that be an approach that could resonate, at least with Congress?

MR. IGLEHART: Absolutely. I'm certainly of the view that nothing much moves in America without the strong backing of Corporate America.

I think there really are, and there is a

case to be made, around things like absenteeism, worker productivity, and the like, which is certainly, I suppose in some respects, the flip side of the brother's keeper story, but definitely one of the arrows in your quiver, and a very powerful one.

I think with Randy serving as Chair and given his experience in Corporate America, he could certainly help a great deal in trying to build that case.

MS. CONLAN: I'd just like to say, as a chronically ill woman and a dual beneficiary of Medicare and Medicaid, I want to thank you and I'm very surprised at your recommendation, pleasantly surprised.

I think it's important for policymakers to hear that personal story. I think it's very therapeutic for the patient also and perhaps the doctor and industry to put a personal face on these issues.

I come from Florida. We've really been using that strategy for quite a while. Each year, when the state legislature comes into session, personally, I find it to become less and less effective. Every year, they give me a shorter and

shorter amount of time to tell my personal story.

The legislators always have pained looks on their faces, but the bottom line is, they're mandated by our Constitution to balance the budget and so each year, we seem to lose ground in terms of Medicaid.

The only thing I can think of, two possibilities, is for adoption of consumer-friendly reform, consumer-friendly cost-saving ideas, or taking Medicaid patients and sending them to managed care, which gives us kind of a dual system in a different way.

You may know that in Florida, this year, we now have a pilot program. Two of our counties, the Medicaid patients will be relegated to that other system in HMOs.

I was wondering, did you have any other possible scenarios? What do we do about policymakers becoming jaded by those personal stories?

MR. IGLEHART: I've seen those pained faces, I suppose, in Washington, and there is no easy answer for it. I think you simply have to keep on keeping on in trying to build constituencies around stories that should be told and try to make your case.

I do think that nationally, one of the things to watch in relation to Medicaid, and I was struck by this during the recession, when there were all kinds of calls from politicians of various stripes to reduce the growth of Medicaid spending, how little, once the recession ended and you look at the numbers, at least in the national aggregate - Medicaid survived pretty well and the lesson from that that I took was that the constituencies for Medicaid have become so vast and so far beyond people with limited means, whether it's the nursing home industry or a variety of others, that there's a lot of pushback potential among those stakeholders in relation to reducing the growth of Medicaid.

If you look at - I mean, the Bush administration proposed reductions in Medicaid spending of about $10 billion, I think, over - I forget the exact number of years, but multiple years, it might have been as many as ten, and you see what a really tiny sliver that is of the growth that's build into the system now.

You begin to have some appreciation for the difficulty that politicians will have, I think both at the state level and the national level, in

terms of efforts to gut Medicaid in one way or another.

I think it's a program that's a lot stronger politically today than it was in the past, but the point you make, I certainly understand and it resonates, it's not easy.

MS. CONLAN: Well, I guess I have one more question about Medicaid. You contrasted that with Medicare, and I like the idea of the social contract because when I was diagnosed with a chronic disease, I was always wondering, what about the social contract?

I have worked for years, paid taxes, voted, done all those things that I was supposed to do, thinking there was a safety net that would be there for me, but Medicaid now has become the ultimate safety net and it also provides catastrophic care for people that formerly worked and did pay taxes.

Is there a way to separate out, or - how can we let people know that Medicaid is also comprised of formerly working people that have just had catastrophic situations?

MR. IGLEHART: Well, I think your best chance is really at the local level, where you live, with the politicians you elect, certainly with the

media. It's a difficult time, though, to tell those stories, I think. It really, as much as I think that's the way forward for this Citizens' Group, it's not easy.

In my mind, the events around 9/11 were something of a demarcation for our society and that we've become - we have a harder edge than we did before then and we're less trusting and more oriented - or less oriented towards community than we were in previous times, in my view.

CHAIR JOHNSON: Richard.

MR. FRANK: I didn't realize that you wrote your first thing in the 70s. You must have been like 15 when you wrote it, right? Because you've been around for a while, I wanted to get your observations on the idea - you raised the managed care backlash as something that brought us to where we are.

I've been reading and hearing things about a risk-bearing backlash that's starting to form, that people are unhappy with having to bear more risk. I'm just wondering, given your perspectives, how are you seeing the pendulum going back and forth on that and then, specifically from the perspective of our work, whose backlash do you think it really was?

MR. IGLEHART: I think it was a backlash - first and foremost, in terms of a powerful voice, I think it was the employer, because the employer heard from his or her employees, who were complaining about not having access to specialists or a whole litany of complaints that are well-known.

It really was the employer, I think, where the main backlash was. I did an interview several weeks ago with the CEO of a corporation out in Indianapolis, Guidant Corporation, which is a large medical device manufacturer, who are in the process of being acquired by Johnson & Johnson for $25 billion.

This fellow - very articulate, very focused on a market-based system, very much wanting to embed in his company the managed competition model, basically where the employer would cover a generous, but basic level, of coverage, maybe an HMO level of coverage, and if the worker wanted a more generous package, then that worker would pay for that extra dollop of coverage.

I said, well, tell me how you're implementing that. He said, well, basically what he said was, we haven't, and the main reason overriding was, employees don't like that. That's the backlash

that I see.

In terms of risk, were you talking, Richard, about the risk that an individual is willing to bear? Your suggestion was that the individual is more risk adverse or less?

MR. FRANK: Well, there was a paper or a little article that the Paul Ginsberg Group put out, talking about some findings that they had showing that they were finding some hints that people were willing to give up choice in order to bear fewer costs. I was just - it sounded to me like a swing back the other way.

MR. IGLEHART: Yes, we published another survey that had a similar finding, that people were willing to think more about some approach to, call it managed care or whatever you want to call it, and were willing to make that trade-off.

Whether that's in the abstract or when people actually come down to having to face the reality, I suppose that's another question, but there are those findings.

VICE CHAIR McLAUGHLIN: To follow up on that, I think that one of the things about the managed care backlash, and I think about the special issue of

some of the journals of the backlash a few years ago and some of the people talking about it, if we look at a study done by David Mechanic years ago in a firm in which some of the employees went with fee-for-service and some went with an HMO, one of the things that I remember seeing and really it struck me as very informative was that the employees who had chosen the fee-for-service plan, when they were then interviewed, surveyed, said oh, yes, they were really happy, and one of the reasons they did it and one of the reasons they were so happy is freedom of choice.

Then when they asked them factual questions about well, what is your risk? How much is your out-of-pocket payment? They grossly underestimated what the cost to them would be under certain scenarios.

Similarly, for the people who chose a managed-care plan, they loved the $5.00 co-pay, they loved the fact that they really were not at risk for a lot of money, and when they were asked factual information about their ability to choose their provider, they really had no idea how closed panel that HMO was.

I thought that was really interesting

about people's perceptions of what they actually chose. The reason why I bring it up here is that I think part of the backlash was that people felt betrayed in some way, like, I didn't realize that's what I was getting.

We are part of - if you look at marketing and our market-based system that you referred to, people are - institutions are in the job of selling their product and so I think they sell their product and the details are in the fine print kind of story. I think people, therefore, thought they were buying something other than what they were buying.

I guess I want the same thing for us over the next two years. You talked about interacting with the public. We really are supposed to engage in a dialogue with the public and not just hear their personal stories, but also try to share with them other people's stories and also some information.

I think I - my message is that when Montye was saying about the personal stories and the legislators get jaded - John is right. Historically, we've been doing this for a long time. I remember in the 70s, Senator Kennedy bringing people to the Senate floor to tell their personal stories. We've been

doing that for a very long time.

I think what I'm hoping is different with this working group is that the personal stories are being heard by the public, not by the legislators, but by the public, because the public has to start to understand about shared gains and shared sacrifices, and they're the ones who have to hear the personal stories.

What you were saying is in *Health Affairs*, the Narrative Matters, your readers are reading those personal stories, but your readers, although you have a large readership, are still limited to an elite group of researchers and policymakers.

I think one of the things that we really want is a dialogue between different segments of the population, not a dialogue between citizens and legislators over the next two years.

As part of that, and this is where I want to get some feedback from you, is I worry that we may present things that promise more than they can give, and so there will be inevitably a backlash that when - just like with the managed care, that I think we have to be very honest with people.

That's why I liked your comment about

other determinants of health, it's not just medical care, it's not just giving health insurance to people, that there are other issues that have to be taken into account.

How do we remain very honest and not promise more than can be delivered, but the same time, garner public support?

MR. IGLEHART: Well, first off, Catherine, I'd say you need a marketing ace that when you go into these communities, will help you make certain that there's media coverage that can spread the testimony and the dialogue that you speak of to the broad community.

I think that kind of multiplier at the local level is just invaluable to what you would hope to achieve. I would say the stark reality of life is that most of the people are healthy most of the time.

I bet there's not a person around this table, including myself, who has ever read their health insurance benefit coverage book that tells you what you're covered for and what you're not.

It's only when some mishap or tragedy befalls an individual that the individual and the family begins to recognize, gee, I didn't realize that

wasn't covered or this wasn't covered and so forth. That's when you really get into the weeds. Short of that, as I said, most of us are healthy most of the time and we could almost care less.

It's a tough challenge, I think. I don't at all disagree with your assessment that trying to reach a public beyond the elected official is certainly one way to try to apply some pressure on the potential change agents.

CHAIR JOHNSON: Dottie and then Frank.

MS. BAZOS: I'm wondering, John, if you would say a little bit more about the social determinants of health? In New Hampshire, we're looking at the social determinants. We're lecturing about them in our universities. I'm working with communities that are thinking about them.

How do you keep the influence of those social determinants on an individual's health status in the forefront; when we think about health reform, we kind of always shift over to thinking about the medical system, period, but we never are able to look for a long period of time upstream or put monies there or make the case that monies there might be better spent than if they're spent in the medical system.

I think it's very hard to do and it's interpreted often as, well, what we're asking for or thinking about is more money. How do you ask for more money to be spent upstream when we're in a crisis downstream? If you could speak to that a little bit.

MR. IGLEHART: Well, there's no question it's tricky business that in a society that values individualism as much as we do, the idea that people should be required to wear helmets when they ride motorcycles, for instance, or smoke, or do a variety of other things, doesn't go down real well.

I was in Florida yesterday, in fact, and I was driving in from the airport in Jacksonville and a motorcyclist without a helmet went by us at 95 miles an hour or thereabouts, and I said, gee, don't they require helmets in Florida? No, they repealed that law. The motorcyclists got together, ganged up on the state legislature, and they repealed it.

I think one way you could make some progress or at least make a statement would be early on, as a Citizens' Group, to have a discussion among members to say, all right, do we want to look at this health care equation as the Johnson Foundation is looking at it today, more 50/50 than 95/5 as they did

for their first 25 years?

The group itself could make a statement that says we recognize that medical care represents only a tiny portion of the factors that influence the health status of an individual and we want to look at those things as carefully as we look at the financing and delivery of care.

I think another place where you might be able to have a voice that would make perhaps a modicum of difference is in the way the government itself approaches the subject of determinants of health.

I'll cite one example, for instance. The 2010 report of the Department of Health and Human Services, which basically focused on the subject of determinants, had I think 467 recommendations of things that could be done to improve the health of the American people.

Well, that's what you might call an unwieldy number. They also have, I think, ten key objectives that they had really tried to put in the forefront, but that's never - I mean, as a broad subject in the land, it just doesn't resonate at all.

You could ask the man on the street on this coast or that coast anywhere you like, the 2010

report, and so forth. It's a tough thing, but there are an increasing number of researchers in the academic community that are focusing on this.

Tommy Thompson put a lot of emphasis on prevention and he was dogged in the pursuit of things like reduced smoking, and so forth. He was a voice in terms of trying to make some headway on that. It's not easy, I agree with you, whether in New Hampshire or anywhere.

DR. BAUMEISTER: It just seems that there's a quantum leap between being a purchaser of health care and being a patient of health care. People make these decisions when they're feeling okay.

A young couple may choose a plan because they want obstetric benefits and a nice labor room in the hospital where they go, and then some tragedy befalls them and it's out of their control. That happens all the time.

In Oregon, we tried to do that. We tried to come up with a basic health plan, you know, with the Health Services Commission involving the public in deciding what constitutes a basic health plan. I would hope maybe that we can broaden that reach across the country through this group and that's one of the

reasons I'm here.

The other issue is these determinants of health care, one of the major determinants of health care that we run into as practicing physicians is aging. I think that the Medicare money that's spent in the last year or the last month of a patient's life.

The intensive care unit is full of people that are in advanced stages of heart disease, renal disease, end-stage organ disease where modern technology is exercised to its fullest and people who really did never smoke, did never drink, and never engaged in sex, protected or otherwise, and they're in the intensive care unit and you've got a team of the most modern physicians bringing all that modern medicine has to bear on these people.

I see that as a major issue in this expenditure of health care at the end of a patient's life, under the pressure of families who don't want you to give up. It's a real dilemma for medical practice and has nothing to do with risky behavior.

MR. IGLEHART: That's for sure, but we all age and we all value life and nobody knows when that six-month period or two-week period is going to be the

last of a person's life.

My mother is 95 and we're moving her next week from an independent apartment out in Gaithersburg to assisted living, and her main problem is her vision is shot, basically. Otherwise, she's healthy. You look at a situation like that and say well, she lived a good life for 95 years. Maybe we ought to turn off the machines. Well, she's not on a machine. Those kind of ethical questions, as you know, are exceedingly difficult to address.

MS. CONLAN: I guess in the conversation that we've had, I've been thinking a simple dichotomy, talking about a disease model and a wellness model. I had thought earlier if there was a way to empower people so that they didn't feel that this was something that was being imposed on them by the government. You must stop smoking, you must wear your helmet, and that thing.

I had heard years ago about in the U.K., new mothers are given a little booklet and told, now, you're in charge of your baby's health. These are the things in the book that you need to ensure so that your baby will have good health. The mothers get very responsible in filling out that book and making sure

all those things are done.

Is there a way to empower the public so that they would willingly choose wellness and in that way, reduce disease?

MR. IGLEHART: Certainly, one line of thinking today is the value of empowering individuals and, as I mentioned in my remarks, the current label of consumer-directed health care or consumer-driven health care, where people essentially buy a health insurance benefit that covers things on the catastrophic end, has a tax-free personal account which you can draw from, and presumably build in some prudence or concern about how you spend that money, because you think it's your own.

I think that kind of an approach will resonate with certain kinds of people in our society, but in terms of having much impact, at least in my view, on overall expenditures, it's a big question mark to me because the people, as you hear, 20 percent of the people spend 80 percent of the money, they'll blow through their catastrophic cap early in their illnesses and that's where most of the money is spent.

No, I think part of the equation, going back to this social contract idea, is moving towards

greater individual responsibility and making the consumer feel like it's his or her money they're spending.

I think one thing employers could do more of and I've not heard, Randy, that there are many leaders going down this path, and that is pointing out, whether it's in the pay stub or other ways, that the cost of the coverage of that worker and his or her dependents is X and it comes right out of the hide of the wage.

Whether that would have much impact, I don't know, but I'm not aware that much has been done that way.

CHAIR JOHNSON: Mike, did you want to comment, and then I'll respond to John's comment?

MR. O'GRADY: Yes. A couple of thoughts, just in terms of, John, of thinking about this and back to the earlier thing about the managed care backlash, and one of the things of thinking about what that means and what that means for the system overall, not so much in that, as just an example.

When we think of the different submarkets that there are here of different people and what they need and what they look for, yes, there is this

pushback on managed care. At the same time, much of the West Coast, certainly Minnesota and Wisconsin, are still very heavy managed care markets.

What we see certainly in the Medicare program is different products fit different people's lives, like we find that the managed care plans are very popular among lower-income seniors who are not so low-income or have whatever disease to trigger Medicaid, that's kind of the near-poor or however you want to think about that, because it does reduce their out-of-pocket.

That sort of product is not attractive at all to other people under other circumstances, and how you think about how you offer to meet the needs of different consumers without triggering adverse selection is certainly one of the big challenges.

Back to Frank's point about kind of how do you figure out what people really need and we're not all technical experts in our own benefit design and things, I guess I'd point to what the Feds do, where, basically, a certain number of plans can compete for the Federal business.

Now, they go through a round through very skilled actuaries and kind of go over those plans and

what those offerings are and make sure that some of that stuff that people that either don't look at or don't want to look at - what happens at the end of life, what is your coverage on transplants, etc., etc. - you have, in effect, you've got your own group of consumer reports kind of guys working for you, those actuaries, and they go actuary to actuary in terms of what's in the benefit plan.

Once you clear that level of competition or consumer choice in terms of the government says it's okay, then different people get to choose between the multiple plans that offer to the Feds, and you see that distribution.

You see some people, given their circumstances or given the part of the country and what they're comfortable with, they move heavily to managed care, but that's maybe 25 percent total. But if that works for those folks, I don't know why you'd tell them no.

At the same time, then you see more traditional PPOs and fee-for-service - some of that other kind of mix and kind of how it goes back and forth. I kind of like it because it's not a one-size-fits-all and I think that when we experiment

with that, and I don't know what the CEO is going to find out, but to a certain degree, it takes an investment.

You, in effect, either have to have your own or you have to have those expertise. You have to have those actuaries that are looking out for your workers and they're in there to make sure that this is really done right.

MR. IGLEHART: Well, the Federal Employees Health Benefit Plan, Mike, is certainly one that has attracted a lot of interest and attention in terms of expanding it to other populations and I think that will go on in terms of the ongoing dialogue for some time.

CHAIR JOHNSON: I would like to just respond to your comment, are employers sharing the cost with their employees. A lot of them are, but oftentimes, that information, whether it's $6,000.00 or $8,000.00 or $10,000.00 per person or more, if it's family coverage, kind of gets lost and it's not really given much attention.

Where we're finding more and more attention is being given is when the person's facing the cost at the point of service, and it gets to some

of the consumerism focus that you had talked about.

I'd like to go back to a combination of comments that you and Frank and Pat had made. You've talked about the personal stories and Frank has talked about personal stories from a different perspective, and then Pat's talked about well, what's the impact in all of this on business?

Of course, as U.S. employers compete in a global economy, they have been more recently looking at the total health care costs, and they're making some decisions. What can I absorb and what can't I?

In some cases, they're saying we're going to share more and more of the percentage of the premium with employees, and you're seeing that having the effect of causing some employees to say, I'm not going to buy that because I don't need the coverage or I can't afford the coverage.

We're seeing more and more jobs of U.S. companies placed overseas because the competition, from a cost perspective, enables them to more effectively deliver to their customers that way.

One of the things we've been talking about a little bit is communicating the total cost and how that's impacting us as a society, $6,500.00 per person

and $11,000.00 in nine years. If you have a family of four, that's $44,000.00. Will you be able to pay that?

Of course, we really do have a challenge of communicating the stories that you've talked about and Frank has talked about, which are heart-wrenching stories, but then the other stories as well and what do we do about that?

We will be talking about how we try to use some marketing expertise that you've talked about earlier. Any further comments on how you combine all of that? You've spent quite a bit of time talking about that. Any further comments that you have?

Then, as you've reflected on all of our questions as we near the end of our time with you, John, are there any comments that you'd like to say that you haven't had a chance to say yet or maybe have been stimulated by some of the conversations?

MR. IGLEHART: I envy your mandate. I mean, as a curious journalist, I suppose, always like to hear different viewpoints, hear new things. I'm always struck when you go out beyond your home base, wherever that might be, and meet new people, what kinds of things you learn you hadn't thought about and

so forth.

That opportunity, I think, obviously will take a lot of your time and so forth, but I think it's well worth it in a country that's as diverse and dynamic as this one.

I do think - I would underscore what Pat said about the corporate community and the impact of costs on the products that the various companies manufacture and sell in the marketplace and really trying to - well, do two things, accentuate the impact of the rising costs, and whether that's a burden that can be sustained as part of the cost of doing business or whether, at some point, you want to abandon that role.

Perhaps even more importantly, then, is the impact on things like productivity and absenteeism and how much personal behavior of individual workers is a problem for the whole or whether it's a lesser problem today than it was yesterday.

I think these are questions that deserve more attention than they've had to date and I think a group like this can deliver answers or at least provide information that would be listened to.

I would urge you to go back - there's a

famous study that was done in the 1930s, Richard probably remembers the name of it, that was a government-wide study and I forget the name of it, but you can - the cost of --

VICE CHAIR McLAUGHLIN: I actually quoted from it at the meeting and I have a copy of the report from 1932 on medical care costs.

MR. IGLEHART: Yes, and you ought to look at that as a model that you might either follow or divert from, but it's interesting to me that it's still referred to now and again, quoted from.

I don't know enough about it in terms of the basis for whether it was authorized by government, whether it was a private commission, whether it was the time in our history that it was just propitious as a consequence of the timing. I'm not sure, but it's something I think would be worth taking a look at.

VICE CHAIR McLAUGHLIN: I just want to tell you, John, that Nathan Sinai was one of the primary people on that five-year commission.

It was all funded by foundations and private funding, but because of that, at the University of Michigan School of Public Health, in our rare books collection, we have the full set of

documents, so come out to Ann Arbor and it's interesting reading. You'll like it.

CHAIR JOHNSON: Go ahead, Chris.

MS. WRIGHT: I'd just like to finish up in the amount of time we have and just a couple of observations. Certainly, we say we want to tell those stories to the elected officials at the national level, when I see such a disjoint in our state legislative system.

Certainly, what Frank - what they tried to accomplish in Oregon. Even in South Dakota, there was no connection with trying to get smoke-free places in our local state because the state legislators said big government did not want to dictate those things to the citizen.

It's always amazing how 80 percent who don't smoke or the 20 percent who do smoke in our state dictate what the rest of the 80 percent are.

I think there's a huge gap there between national and our state governments and an educational process there to raise awareness - I know currently it's done with some of the funding that's handed out in the old - the carrot and stick so that we get a lot of that, but it is raising that bar and awareness.

MR. IGLEHART: I certainly don't disagree with you. I think part of the equation is that as a society, we can't decide what government's role is and so sometimes, policymakers will take that kind of stand that says, well, it's not our job to dictate whether people should smoke or not, on the one hand, but then on the other, whether it's the tragedy of Terri Schiavo or other kinds of cases that arise, sometimes politicians plunge in.

We've got a lot of mixed messages there.

MS. STEHR: I'm a person that doesn't have health insurance and I have a son who's a Medicaid recipient, so I know what it's like to share those personal stories and how effective they were ten, 12 years ago and how they're not so effective now.

It's interesting to see your data how the public perceives how we take care of health care. It seems to me, and I don't want to put any blame, that the right has done a wonderful job on the personal responsibility and the tax and all that.

I think we are going to have to learn how to talk about health care as being good for society in general, somehow or another changing the world view and I guess the challenge is, how do we do that so

that we get a message across about health care being good as opposed to - I don't know.

I don't know how to explain it. I need to do some more thinking on that, but we really need to learn how to get our message out and change how we're talking about health care.

MR. IGLEHART: I don't disagree with you. I think, to go back to something I've said before, that it's interesting, at this juncture, that Congress decided to create this body that they presumably genuinely wanted to hear what a broad swath of citizens are saying and hearing about the state of our health care system. I think you have a marvelous opportunity.

I would, given what this body is, basically charged by government to search for answers, I would suspect you could get a lot of pro bono advice from experts at messaging and at marketing and at how do you communicate, etc., without sacrificing your independence, but really trying to build some cache around this working group early on, so when you arrive in Des Moines or Denver or wherever, the city knows you're coming and greets you in a way that the messages you bring and the testimony you hear are

broadcast and reported within the confines of whatever the region or the community or city is.

I think you should really strive to build early on that kind of capacity because it could be the difference between having a really successful two years versus one where you're kind of struggling in oblivion and your voices are just not heard, so I think really thinking about that would be well worth an investment of time.

CHAIR JOHNSON: Well, John, thank you very much for your time this morning. We have benefited from your expertise and your investment of time and preparation and we appreciate that this morning. Thank you very much.

We'll take a break right now and reconvene at 10:45.

(Whereupon, the above-entitled matter went off the record at 10:18 a.m. and resumed at 10:47 a.m.).

CHAIR JOHNSON: Well, welcome back. We had a great first session this morning and Catherine and I were commenting on the participation by each of you as working group members, so thank you for that.

As we proceed now, we're going to ask Bill

Scanlon to talk about Medicare, Medicaid, and State Children's Health Insurance Programs. Again, we won't go through Bill's total bio. You will have a chance to review that right after the second tab.

He has, as you can see, been intimately involved with health care, and specifically Medicare, in a number of ways. He's worked in the GAO. He's been in other areas of the government.

We're glad that you're here. Catherine and I are just delighted to have another member or a colleague from the University of Wisconsin and we're not trying to force Wisconsin on anybody, but anybody from Wisconsin must be a good person, Bill. Just a little bit of humor aside, we'd like to welcome you.

We're going to ask you to share a presentation with us, if you would, and then, as we have mentioned in our comments outside the meeting, open the discussion up to questions and answers from our group and we'll be able to go until about 12:30, okay?

MR. SCANLON: Thank you very much and for those of you that don't know Wisconsin, having it forced on you is not necessarily a bad thing. I'm very happy to be here.

I approached this task with a bit of trepidation. As I was putting together the slides, the intricacies of these three programs struck me again and again.

Many times, there's a feeling that the programs are too complex, but there's another side of it which I think we need to keep in mind, that we're spending over $600 billion on these programs, which is more than twice the largest corporation in the world and if we went to that largest corporation in the world, we probably would find out that they have an incredible number of policies and specifications and records, etc.

In part, the challenge is, how do we spend that money in the most responsible way possible, make sure that there aren't barriers to needed care, there's not an excessive burden on providers?

It's something that we've struggled with and continue to struggle with and your input in these areas will undoubtedly be very important and hopefully very welcome.

What I want to do is start off with a bit of a comparison among these three programs in terms of eligibility, services, and financing and then talk in

more depth about the three programs separately.

In terms of eligibility, Medicare is, as you all know, for the elderly, for people with disabilities that are receiving either SSI or the disability insurance payments and who have been disabled for two years. That's a key that you need to wait two years before you can come onto Medicare.

It also is a program for people with kidney failure, end-stage renal disease. There is no income requirement for Medicare, but there is going to be an income screen in terms of the drug benefit with additional coverage for low-income people through the Medicare program.

Medicaid, categorical eligibility is important because one of the things that people don't realize is that you can be poor and not qualify for Medicaid. As you can see in this list, children, parents, the aged, and the disabled, we don't have adults, single adults without children.

There are nine million uninsured in this country who are below poverty in terms of their incomes. A very large number of them are people that would not be categorically eligible for the Medicaid program.

You've got to be low-income. How low depends upon the state that you live in. The same thing is true for the Children's Health Insurance Program, where again, you have to be low-income, but how low your income needs to be is determined by the state that you live in.

In terms of talking about the services these programs cover, I'd like to make a distinction that's not often done, and that is to divide services into three categories: acute care, chronic care, and long-term care.

The reason I do this is because very often, when you talk about long-term care, particularly among people with clinical training, they immediately think of the kind of ongoing care for a chronic condition, like diabetes, hypertension, etc. and they say yes, I provide long-term care.

The long-term care that we need to be concerned about in another context is very, very different. It's not a clinical or a medical service. What it is is a supportive service that supplements for your inability to do certain things because of your disability.

Those things are primarily activities of

daily living, bathing, dressing, toileting, transferring in and out of a chair, walking, or other tasks commonly known as instrumental activities of daily living that are involved in trying to maintain yourself and maintain your household.

I think these distinctions are important because the programs are very different in terms of what they cover. Medicare and the State Children's Health Insurance Program cover acute care and chronic care, as does Medicaid, but Medicaid is distinct in that it is the supporter or a financer of long-term care.

This is actually relevant to some of the current discussion that's going on about Medicaid between the governors and the Federal government. One of the positions or one of the perceptions on the part of the governors is that Medicare isn't doing its job with respect to long-term care.

We may make a social choice that Medicare should do more with respect to long-term care, but it wasn't set up that way in 1965. It's never been amended to finance long-term care since 1965.

We can have this discussion, but we should have it in the context that's accurate in terms of

what the program was intended to do and do we want to change that, not that it's failed in terms of what it was intended to do.

In terms of financing, Medicare and Medicaid are distinct from the State Children's Health Insurance Program in that both are open-ended entitlements. If you're eligible for these programs under either the Medicare rules or under the rules of the state Medicaid program, you will get the services of that program. There is an entitlement, you have to be enrolled in the program to be receiving the services.

The State Children's Health Insurance Program is different. Instead of being funded on an open-ended basis, there's a fixed Federal appropriation that requires matching. It's a matching grant to states, but it's a capped grant to the states.

The states, if those monies are completely exhausted, can close enrollment. Their options are with respect to whether or not they are going to put their own money in if the Federal monies have been exhausted.

There is a combination, as you can see

from this chart of funding that goes into each one of these programs and Medicare is the familiar deduction that you all have from your payroll each pay period.

Ultimately, it's used to finance some of your Medicare coverage after you've retired, as well as general revenue funds, income tax, and other revenue sources of the Federal government and beneficiary premiums.

In order to participate in a part of Medicare, you have to pay a monthly premium after you retire. With Medicaid, it's state and Federal general revenues which are financing that program. The Children's Health Insurance Program is again distinct in that premiums can be a source of funding for the Children's Health Insurance Program. For persons who are in families with incomes greater than 150 percent of poverty, they can be asked to pay a premium.

Let's talk now about these programs in some more detail. For Medicare, we've got 41 million beneficiaries and we're spending about 301 billion dollars this last year, a very significant share of the Federal budget, almost 12 percent.

You have probably come across or heard the terms Part A, Part B, and pretty soon, Part D, maybe,

in everyone's lexicon. Parts A and B are often referred to as original or traditional Medicare, sometimes as fee-for-service Medicare.

It's where the bulk of Medicare beneficiaries are getting their services. About 87 percent or so are receiving services through Parts A and B, in traditional or fee-for-service Medicare.

There is a Part C. It's now named the Medicare Advantage Program. That's a change that occurred in the Medicare Modernization Act of 2003. It used to be called the Medicare + Choice Program. It gives you the option of joining a private plan that is signed up with the Medicare program to offer Medicare beneficiaries essentially the Part A and the Part B set of benefits.

As I said, we're going to have a drug benefit, which is Part D of the Social Security statute, and that's going to be January 1st of 2006 when we'll have that.

Here are the sets of services that are covered by these different parts. The importance of which services are covered by the different parts ties back to the financing, as well as to the process whereby you sign up for the program.

The financing for Part A was the payroll tax that you paid while you were working and you're automatically eligible for Part A when you turn 65 or you become disabled for a two-year period.

Part B, you have to join. It's an action that you take and you have to pay a premium, a monthly premium, in order to be a member of Part B.

It's an automatic enrollment, though, when you go and apply for Medicare, you have to opt out, which is perhaps a part of the reason why virtually everybody signs up for Part B. The other part of the reason is that it's a very good deal. Your premium is only 25 percent of the Part B costs, so you can't beat that in terms of getting coverage.

Part D is going to be different in that you're going to have to sign up on your own. There's not going to be an automatic signup. It's going to be something where those 41 million beneficiaries are going to have to think about what is their choice in terms of getting drug coverage and taking action to sign up, so this may affect some participation, at least in the short term.

Medicare, I've said on different occasions, is not very good insurance in the sense of

being insurance against catastrophe. There is considerable cost-sharing that one faces in the Medicare program. This is the cost-sharing for the Part A services, hospital care and skilled nursing facility care.

As you can see, if you have an admission to a hospital, the first day, you pay a $912.00 deductible. If you stay for a long period of time, you're going to end up with a very significant per day coinsurance and if you stay for a very, very long time and you end up using your lifetime reserve days, you're going to get no coverage at all from Medicare in the hospital.

If you're transferred to a skilled nursing facility, you're also going to potentially pay significant amounts of money after staying there for a 20-day period.

On the Part B side, physicians and other ambulatory care services, you also can incur significant costs. You have $110.00 deductible, but more important, you have a 20 percent co-pay on all Medicare services.

There is no catastrophic limit to how much you pay on the Part B side. If you need extensive

care, such as very expensive surgery and ongoing medical management, you can end up having very significant costs.

The one very important protection for Medicare beneficiaries is that there is a cap on what physicians and other Part B providers can charge you over and above what Medicare sets as the fee on claims that are assigned and about in the 80 to 90 percent range of claims are assigned, so most beneficiaries benefit from this.

Though, as I said, Medicare is not great insurance. In terms of the liabilities that people have - these data are somewhat old and the numbers would only become more dramatic. Back in 1998, more than three million people ended up spending more than $2,000.00 out-of-pocket on Medicare coverage services.

We're not talking about drugs, which weren't covered then, and we're not talking about long-term care, which wasn't covered. We're talking about Medicare-covered services. As you can see as we move up, the $5,000.00 threshold into a $10,000.00 threshold, there are still significant numbers of people that are having to pay this for Medicare-covered services.

In contrast, if you think about most employer plans, most employer plans are going to have some type of a catastrophic limit. $2,000.00 may be a very common catastrophic limit. All of these people, in many respects, have less protection than you would expect from employer-based insurance.

It's then not a surprise that most Medicare beneficiaries end up having something besides Medicare to try and cover some of their health care costs. About 85 percent who are in the traditional program have supplemental coverage.

A large portion of this, about a third of these beneficiaries, get their coverage from employers and another 27 percent, or another quarter, they buy their coverage through medigap plans, individually sold medigap plans, which you probably have come across.

Those are expensive insurance plans. Because they're marketed individually and because there's significant administrative costs to them, you can end up paying $1.40 for the medigap plan to write you a check for $1.00 to pay your coinsurance. This is not necessarily a good deal for elderly Medicare beneficiaries.

Let's talk a little bit about Medicare Advantage right now, the Part C part of the program. This gives you another source of Medicare supplementary insurance in that you can join a private plan which is chosen to provide lower cost-sharing for individuals and also to have a catastrophic limit.

These plans, of which there are a variety of types - you can join an HMO, you can join a PPO, you can have a private fee-for-service plan which is operating in some parts of the country, you can have a high-deductible combination medical savings account plan.

Each of these plans has agreed, in exchange for a monthly fee from the Medicare program, to provide all of the Part B benefits and have generally suggested that they can do it at less cost than the Medicare fee.

One of the requirements of participating in the Medicare program for these plans is that they have to offer their savings back to beneficiaries in the form of additional benefits. Those additional benefits can be reduced cost-sharing; historically, they have often been also some type of drug coverage, other things that you might buy through a

supplementary policy.

We've had though a relatively varied history with respect to participation of private plans in Medicare. During the mid-90s in some respects, and I know you heard about it from John Iglehart this morning, a little bit about the heyday of managed care.

During the heyday of managed care, when managed care plans were doing quite well in terms of savings, there were a lot of additional benefits.

There was a lot of interest on the part of plans to participate. There was a lot of interest on the part of beneficiaries and, if you look at forecasts of the future in terms of enrollment, they would have been much higher than the graph you see.

In 1997, the Congress, realizing that we were paying more for people to join private plans than we were for people staying in fee-for-service Medicare, changed the rules in terms of payments and the participation on the part of plans changed dramatically, as you can see from the red line in this graph.

They still remain somewhat popular among enrollees, because the drop there is a whole lot less

than among the plans. Partly, though, some of that drop would be a reflection of the fact that some of the benefits that you wanted were no longer going to be available through plans because plans, in addition to dropping out, cut back on their benefits.

We've had some changes to the Part C portion of the program, as I've said, in the Medicare Modernization Act of 2003 to try and revitalize it. One of the things is that there was a significant increase in payments to plans.

We also changed the structure of how the plans were going to be paid so that we'd create, instead of an administered price to encourage competitive bidding among plans or competition among plans, with some of the savings from that competition coming back to the Treasury instead of all of it going in the form of additional benefits to Medicare beneficiaries.

In addition, there is an attempt to try and deal with one of the historical problems with this program which is that plans didn't often operate in sparsely-populated areas and so what was created were regional plans that would have to serve an entire region.

As you can see from this map, these are the regions and some of these are quite large. For example, from Montana to Iowa is going to be one region. If plans choose to participate in that area, there will be a private plan option for people in all of those states.

We'll know on June 6th whether or not we have plans in all of those areas because that's the date when plans have to submit their bids for 2006.

Quickly, on the drug benefit, it's starting again next year. As I mentioned, it's going to be a separate enrollment and a separate premium. That premium is expected to average some $37.00 per month nationwide, but there's going to be variation because these are going to be local drug plans and it's going to depend upon what the plans in a particular area feel that they can charge or what they feel they can offer the drug benefit for.

Partly, that's going to be a function of utilization of drugs and there is, as with all other health services, significant variation in the utilization of drugs as you move across the country.

Your drug plan could be offered by a private standalone plan that you purchase in addition

to your Part A or your Part B coverage. It can be offered by a Medicare Advantage plan. I think it's even conceivable you could be in a Medicare Advantage plan and for some reason, you could buy private standalone coverage, if you choose.

You probably have heard about the benefit. We're going to have a $250.00 deductible, then you're going to pay 25 percent coinsurance from $250.00 to $2,250.00.

Then, there's the infamous doughnut hole, which is that you're going to end up paying the entire cost between $2,250.00 and $5,100.00, though we shouldn't underestimate the value of being in a drug plan because they are going to pass on the discounts, the price that they get for drugs in that doughnut hole to you and issue, being a retail consumer, as opposed to a wholesale purchaser, which is essentially what you're doing when you're buying from the drug plan, is not insignificant.

Finally, there is catastrophic coverage, where you're only going to pay five percent above $5,100.00 and, as I said before, there are additional benefits for people with low incomes in terms of premium coverage and in terms of the cost-sharing.

Let's talk about Medicaid and SCHIP now. Medicaid is the much bigger of the two, covering about 52 million beneficiaries and over $300 billion. It's actually become bigger than Medicare.

It's also become the biggest share of state budgets. It just recently passed elementary and secondary education as the largest component of state budgets.

SCHIP, on the other hand, is this fixed appropriation from the Federal government. It's $39 billion over a ten-year period, has about six million beneficiaries. About $6 billion was spent in 2004. About 75 percent of that money is coming from the Federal government.

I think of Medicaid as having three distinct roles. One is primary health insurance and mostly the people that are getting primary health insurance out of Medicaid are going to be families.

I should also say that it's not insignificant when you don't have Medicare coverage if you have a disability to be getting Medicaid as your primary health insurer as well.

It also serves as a Medicare supplement, both for dual eligibles who are fully eligible for

Medicaid as well as for those who are only partially eligible for a Medicare supplement, which I'll explain in a minute.

Finally, from that earlier chart I showed you about types of services, it's a long-term care financer. In terms of where the money goes relative to the people that are being covered by Medicaid, it's a very disproportionate distribution.

About three-quarters of the people in Medicaid are in families, children or parents, yet they only comprise about a quarter of the total spending. It's elderly people and people with disabilities that comprise about two-thirds of total Medicaid spending.

Medicaid is not a single program. There's considerable flexibility given to the states, subject to certain Federal requirements, and the result is we have 56 Medicaid programs. That's the 50 states, the District of Columbia, and the territories, which are not often studied, but they do all have Medicaid programs.

There have been discussions of some of these requirements that have come up in recent years in terms of should we change the rules in terms of

what we require at the Federal level or how we finance what we require at the Federal level versus what the states are doing at their option.

There are rules with respect to eligibility and there are rules with respect to services, which are very important in determining the character of the Medicaid programs.

As you can see here, a slide with respect to eligibility, we have certain groups, such as children in poverty, young children up to 133 percent of poverty, pregnant women up to 133 percent of poverty, and then SSI cash recipients.

Those are people that are elderly or disabled who have low enough income to receive SSI through Federal qualification, which is about 75 percent of the poverty level.

States, at their option, can cover other people. They can cover children and pregnant women up to 185 percent of poverty, they can cover the elderly and disabled up to 100 percent, or they can create a medically needy program. I think about 40 states have done that.

With a medically needy program, even if your income is too high to normally qualify for

Medicaid, the State will allow you to become a Medicaid eligible if you subtract your medical expenses from your income and the result is below the Medicaid eligibility threshold.

Another mandatory aspect of Medicaid is that Medicaid has to serve as a supplementary insurance program for low-income, elderly, and disabled individuals on the Medicare program.

We have a series of different groups with different coverage, depending upon your income, and it will determine how much of your Medicare cost-sharing and premiums are being covered.

In terms of services being covered, and this is something where I think it's important to focus on the mandatory services because of the fact that they are the bulk of the services that you would think of in a normal benefit package, you're going to cover hospital care, physician care, the nursing facility, is a big component of the long-term care role of Medicare, and then a service that's a point of contention between the states and the Federal government, the EPSDT, or Early Periodic Screening, Diagnosis, and Treatment Program.

What this service involves is screening

children for problems, particularly developmental problems, and guaranteeing them the treatment for those problems. There's been a lot of tension between the states and the Federal government over whether or not this benefit is applied too generously.

Among the optional benefits, prescription drugs is obviously an incredibly important one. No one thinks of it as optional, though dental services and the extent of coverage in intermediate care facilities for people with mental retardation and the home and community-based long-term care services, have a lot of variation in terms of how well and to what extent they're covered within states.

In addition to Medicaid rules that states have to comply with, you can design your program to get an exemption from some of those rules. One of the Medicaid rules is freedom of choice of provider. In order to try and instill more managed care within the Medicaid program, there are provisions to allow what's called a 1915(b) waiver, which allows states to have people enroll in managed care plans to receive their care.

There has also been over the last say 15 years very great activity in terms of what's called

Section 1115 demonstration waivers, which were set up originally with the idea that these were going to be demonstrations which we would learn from and potentially incorporate within the program.

They have actually, in some respects, become the normal mode of operation for Medicaid programs. The State of Arizona was the last state to institute a Medicaid program, and it didn't do so until the early 80s. It did so only because it had an 1115 waiver to set up a different kind of a program involving mandatory managed care for all eligibles within the Medicaid program in Arizona and has been operating on a waiver now close to 25 years.

In the last three or four years, there has been interest in trying to be even more innovative in terms of waiver coverage to try and expand the coverage of Medicaid to reduce the numbers of uninsured to cover some of the people I mentioned before that wouldn't traditionally be covered, single adults and others.

Some of this innovation has involved trade-offs in terms of changing the benefit package, requiring premiums for people with different income levels, etc. There are at present, about 20 states

that have 1115 waivers to operate different types of Medicaid programs in their state.

Let's talk quickly about SCHIP. As I mentioned a number of times, it's capped appropriation. States have a lot of flexibility in terms of being able to try to control their expenditures.

During the past few years, when we've had a recession and there has been both strain on state revenues, as well as increased numbers of people that are seeking coverage from Medicaid and the SCHIP program, we've seen some of the states actually cap their enrollment and close the program down, either temporarily or create waiting lists, and we saw about seven of them between 2001 and 2004 and three of them still had a freeze in effect at the end of 2004.

We've also seen states change the eligibility. The State of Maryland, for example, went from having eligibility up to 300 percent of poverty reduced to 200 percent of poverty in response to their fiscal situation.

There is more flexibility in the SCHIP program in terms of the benefits that states offer. You can do a simple expansion of Medicaid, say, if

previously you were covering children up to 133 percent of poverty, you could say, I'm now going to cover children up to 200 percent of poverty and put them into the Medicaid program, in the way every other Medicaid eligible is.

Alternatively, you can create a separate program where the benefit package is designed to emulate either the Blue Cross Blue Shield plan in your state or the State Health Employees' Plan or the largest Medicaid HMO in your state or to something that's actuarially equivalent to one of those plans, or you can do a combination.

You could cover children up to 150 percent of poverty into Medicaid and then you could go beyond 150 percent of poverty in a free-standing program.

As I mentioned before, the SCHIP program is distinct in terms of cost-sharing, as well. You can actually have somewhat more cost-sharing below 150 percent of poverty, you can have a $5.00 co-pay, whereas in Medicaid, when you do have a co-pay, it can only be $3.00.

For people above 150 percent of poverty, you can even have more cost-sharing and you can charge premiums, but they can't exceed in total more than

five percent of individuals' incomes.

There has been a lot of focus recently on the costs of the Medicaid program. Right now, we're having discussions in the Congress about how do we bring those costs under control. Part of that discussion is generated by the recession over the last three or four years and the fact that Medicaid costs were going up quite significantly.

The reality is, part of that was Medicaid doing its job, being the safety net that picks up the slack when we are in a recession, when we lose a significant amount of employer-based coverage and people would otherwise be uninsured.

As you can see here, between the Children's Health Insurance Program and the Medicaid program, the rate of uninsurance was actually reduced in this period of 2000 to 2003. The vast majority of the growth in Medicaid in this period was a growth in the numbers of eligibles, not in the cost per eligible.

Medicaid has actually done about the same job as the private sector or Medicare over the last 20 years in terms of controlling costs, it's just that it has this cyclical pattern. It's particularly perverse

for states because their revenues are declining at exactly the point where there's the greatest demand for Medicaid.

Let me close out on Medicaid and talk to you a little bit about its role as a long-term care financer, because it's such an incredibly significant part of the long-term care system, but also because of its role in terms of its impact on Medicaid.

More than a third of Medicaid expenditures are going for long-term care. When you look at it from the long-term care side, it's paying for about half of all long-term care spending. Dollars spent on long-term care are coming from the Medicaid program.

It's 46 percent of nursing home revenues, which understates its role because two-thirds of nursing home residents are Medicaid recipients. The discrepancy is because of the fact that people who are Medicaid-eligible in nursing homes have significant cost-sharing. You give up your entire income, save a personal needs allowance, which can be $50.00 a month, in order to be a Medicaid-eligible in nursing homes.

We've also had over the last 20 years an incredible increase in terms of the amount of Medicaid funding of home and community-based services, where it

used to be that virtually every dollar of Medicaid long-term care money went to nursing homes.

We've had an increase where they're now coming close together in terms of the overall spending and we now have about 850,000 people that are receiving home care under Medicaid as opposed to about a million people that are receiving nursing home care.

My second to last slide, just to give you a sense of some of the things that worry some of us who work in Medicare and Medicaid over the longer term. You heard earlier this morning about the fact that aging is a reality and the aging Baby Boomers are on the horizon.

The next President of the United States is not going to be in the office very long before those Baby Boomers are signing up for Medicare. If you look out into the future, you can see that we're going to have a very, very large increase in the share of GDP going to Medicare and Medicaid.

The thing about this graph that's probably most telling is that it's a gross understatement in that it involves projections that imply that we are going to have better control over costs than we've ever had in the past and that somehow, we're going to

deal with, when you think about the Medicaid side, the long-term care problem, which we haven't really grappled with in the past and which is only going to get worse, not because of any type of technological change or anything of that sort, but just because of the demographics.

We are going to have so many fewer people available to provide long-term care informally, either family or friends, that we're going to have a very significant issue in terms of how that care is going to be provided.

Just a couple of weeks ago, CBO estimated that the value of that informal care currently is about $80 billion, which is about 40 percent of all that we spend on long-term care.

If this wasn't enough for you in terms of Medicare and Medicaid and SCHIP, let me refer you to this website. It's the National Health Policy Forum's website. In January, they did a two-day briefing on Medicare and Medicaid and SCHIP for Congressional staff and they passed out a booklet which was about four inches thick, double-sided, and all of those materials are on this website.

More than you probably will ever want to

know about these programs is there if you care to peruse it. I'm happy to answer any questions you have. Thank you.

CHAIR JOHNSON: Thank you, Bill. I appreciate your big drink of water in an overflowing glass, actually, of these three programs.

In the past and today, when corporations look at their health care program for the future, what they'll do typically is they'll take a look at the current design, recent trends in terms of quality, and recent trends in terms of cost, innovations, and then they contemplate, well, what changes are we going to make next year?

Of course, there is a limited treasury and if they're not going to make any changes, there's an additional cost that the corporation picks up, or the company might pass on some of the premium costs to its participants.

How does Medicaid work in terms of changing the program each year based on the cost? We've heard in newspapers, and you've touched on it a little bit, of the governors wanting to do something with Medicaid and we've heard about cost-cutting in Medicaid.

How does that whole process work? If I'm a Medicaid participant, am I likely to have a reduction in my benefits for next year because of the cost increases? Can you share a little bit more about that?

MR. SCANLON: Sure. At times, the changes will be very explicit and very obvious to the Medicaid beneficiaries in the sense that there have been times when states, because of exactly the kind of situation you described, were facing a budget increase for the following year and they may also be dealing with the reality that their revenues are declining because state revenues do go up and down at different points in time.

There have been times when states will make changes, such as, we are going to change the benefit package. We may eliminate something like dental services for adults or anything but emergency dental services for adults.

Or they will take maybe somewhat of a more intermediate step, which is to say, we'll put some kind of a limit on the amount of services that an individual can get. That you will only be eligible to receive so many physician visits in a month or you

will only be able to be in a hospital for a certain number of days that we're willing to pay for.

Some of those things are extremely obvious to beneficiaries and others only become obvious when they actually go to access services. Others may not be obvious to them at all because in the case of someone that's been admitted to a hospital and Medicaid says that we're going to pay for ten days, if that person needs 15 days of care, the hospital is not going to discharge them because they recognize their liability if that happens.

That, in some respects, becomes a hospital burden. Those kinds of changes are probably the most obvious to beneficiaries. A second one which is a little bit more subtle for beneficiaries is the fact that payment rates to providers are constantly being adjusted. These have an impact in terms of beneficiaries' ability to access services.

Medicaid payment rates are very often well below what Medicare pays for the same service, especially for physician care, and the proportion of physicians that are willing to take Medicaid patients is, I can't give you exact current numbers on it, but it's well below 100 percent or well below 90 percent

in contrast to Medicare, where more than 90 percent of physicians are willing to serve Medicare beneficiaries. That's a second area where there are restrictions.

Because of long-term care's very important role in Medicaid budgets, over the years, there has also been a lot of effort put into trying to control long-term care spending, less so on the amount paid per day, because there is a recognition that two-thirds of the residents in long-term care facilities are being supported by Medicaid, but more of an attempt to try and control the number of people that are in nursing homes.

That's done actually by limiting the number of nursing home beds that are available. In the one area, you may have touched on this or you will touch on it in the future, there have been, over the years, efforts to try and control the amount of health resources we have available in this country through certificate of need.

The one area that I would argue where certificate of need has been a binding constraint is in the area of nursing home care, because states recognize that they have the ultimate obligation to

pay for additional beds and they therefore take steps to limit those number of beds.

There are states that have had moratoriums on the construction of new nursing homes for five to ten years. What we've seen is that the number of beds relative to the number of elderly has been declining in those states. On top of that, we have a huge variation across the country in the number of beds that are available per elderly.

CHAIR JOHNSON: Can I build on my question?

MR. SCANLON: Sure.

CHAIR JOHNSON: What I'm hearing you say is that if we had - I'll just use a flat number - ten million people in a Medicaid program in a large state and because of aging, let's say a downturn in the economy, lowering of the employment rates, we have now an increased number of people to come under Medicaid.

There wouldn't be an automatic payment increase to Medicaid program because of the increased participants. There would be probably instead a reduction in the payment for the providers and a potential reduction of benefits.

MR. SCANLON: Now, there would be an

automatic increase in the sense that the program is an open-ended entitlement from the state perspective as well, so that essentially, every state's Medicaid expenditures are matched by the Federal government and the match rate varies between being 50 percent of the total Medicaid costs to, I think at this point, roughly 79 percent of the Medicaid costs coming from the Federal government.

When you have more eligibles sign up for the program and you incur more costs, the Federal government is going to automatically increase your payments. In the case of the state with the 79 percent match, you're going to get 79 cents for every additional dollar that you spend, so that happens.

What I was talking about is that states, even when half the money is coming from the Federal government or when 79 percent of the money is coming from the Federal government, still face budget crises over the Medicaid program and still take all of the actions that I was describing to you in terms of the Medicaid program.

To be also completely candid, we probably should talk about what are known as creative financing mechanisms, which states engage in. The way the

program works is that if the state records an expenditure for Medicaid, the Federal government is going to put up these matching dollars.

The creative financing schemes involve ways of recording Medicaid expenditures that in some respects are not true Medicaid expenditures. I like to think about it as the money always makes a round-trip.

It could be that, in some of the more recent schemes, money comes from a county. A hundred million dollars comes from a county in my state. I return that money to the county as a Medicaid expenditure because they happen to operate a hospital or a nursing home.

It's their $100 million plus if I'm a 50 percent state, it's another $100 million from the Federal government, so I return $200 million to the county, but the county immediately turns around and sends me back my $100 million that I added and they keep the $100 million that they sent you originally.

I now have $100 million of Federal money in my treasury to use as I wish. This is happening. It's been very significant.

There have been efforts on the part of the

Congress to try and change the rules so that these kinds of things happen less, but I think there's a reality that there's a lot of imagination in the world and so the states will think about these things when they are faced with this budget crisis that I talked about.

CHAIR JOHNSON: Last question related to both of those. In contracting for an employer plan, typically, I'll ask the question of my vendor, what are the discounts as a percentage of Medicare.

My question would be, what are the Medicaid discounts as a percentage of Medicare or what are the Medicaid payments as a percentage of Medicare in a range? You probably can't give me an exact number and maybe it varies based on service, but as a range?

MR. SCANLON: It will vary a lot by service and with some of them, it's hard to make a comparison. The area I think I'm most familiar with is physician care and I'll say that a rough range would probably be, say, 40 to 50 percent of Medicaid to paying the same as Medicare.

There's a relatively general requirement that Medicaid rates need to be adequate enough to

ensure access to services and there have been cases where rates have been challenged as getting too low. I mean, there was a point where a state was below 30 percent of Medicare and was challenged on that because providers wouldn't participate.

CHAIR JOHNSON: Okay. Thank you. Go ahead, Richard.

MR. FRANK: Thanks for that, Bill. I want to go to your set of - I think it was the second to last slide, the one with the GDP picture.

MR. SCANLON: Right.

MR. FRANK: What I'd like you to do is not so much talk about this in terms of GDP, but talk about it in terms of the Federal budget, because I think, as we think about solutions and these programs, I think it's important for us to understand the budgetary impact, not just the economy-wide impact.

MR. SCANLON: The budgetary impact is quite significant. I don't have with me another slide, which I've used at times, which would show you the components of the Federal budget.

Currently, the Federal budget is around 20 percent of GDP. If you move out to 2050, these three programs alone will be more than 20 percent of GDP, so

we then face a choice and that would be, how are we going to fund other discretionary services?

Discretionary services include things like all of defense, all of education, all of natural resources, roads, etc. The others are quite big.

Now, I also have to be candid and say, these projections in terms of the overall Federal budget are very sensitive to what happens to Federal debt, because the share of the Federal budget in 2050 or 2070 that is going to interest on the debt is going to be driven by how much debt we have.

There's a cumulative effect, both in terms of our decisions now in terms of trying to control health care costs, our decisions now in terms of what our fiscal policy is going to be with respect to how much we finance out of current revenues versus how much we finance out of issuing debt.

MR. FRANK: Just to follow up, as I understand it, and I don't know the numbers as well as you do, there's going to be a big jump because of the MMA next year and then over the next few years, it really accelerates, right, in terms of budgetary impact?

MR. SCANLON: Well, there definitely is

going to be an increase with respect to the MMA. I would say the bigger acceleration is going to occur when the Baby Boomers start to become actual heavy users of health care.

The reality is, when people are going to turn 65, if you have many more of them in the Medicare pool, it will actually reduce the average cost because people that are 65 tend to use fewer services than people that are 75.

It's when those Baby Boomers hit the age of 75, which is probably about 15 years out, we're going to really start to see this acceleration and that's the point when the demographics really do become more overwhelming.

MR. O'GRADY: Can I just make a - because this is part of the issues I work on. To a certain degree, what Richard is talking about has gotten a fair amount of media coverage. To a certain degree, that's just an artifact.

When Congress does a cost estimate or when CBO does a cost estimate, if you take something like this, like a new drug benefit, and of the various Republican, Democrat, House, Senate, all those proposals, as they move forward, had that making such

a big change, like adding a new prescription drug benefit, was going to at least take two years and I think one or two of them had three years before you'd actually get up and running.

You have to do the regulations, you have to take the bids that Bill talked about, some of these sorts of things. What you saw is the original CBO cost estimate of around $400 billion over ten years. What that meant was, you saw the first two years were zero or just a little bit of an admin cost to get started.

As we've moved out with now another year and then another year, you're seeing the most expensive years at the end of the ten years replacing those zero years.

All of the sudden, the shock of all of the sudden, what do you mean, it went from 400 to 700? Well, you drop a zero and you add a three, and you're at 700. That was understood. Certainly, those committees who were working on it, they understood how this was going to go on. Maybe some of the members that weren't directly - are surprised by it, but they knew what was going on here.

Then, Bill is absolutely right. It's this

demographic that you see that is really going to drive and it will have a differential effect here, because we know when people hit 65, Bill's right.

That's your cheapest year in Medicare, which is one of the things that, as we get into other discussions about eligibility age, part of that is there is very little bang for the buck of moving up to 66 because you're 65-year-olds are your absolutely cheapest people in Medicare.

How you get to that - but it will be, we'll see this mix of services. From 65 to 70 or so, you're mostly using outpatient physicians, things like that, and then when these guys move into heavy hospital care or when they start to hit those bypasses and whatnot, then you're going to see again this engine that will generate a lot of cost.

DR. SHIRLEY: Help me with this a little bit. My state just issued $100 million in bonds to attract industry that would employ 2,500 people. At the same time, it reduced the appropriation of Medicaid by more than $100 million that, if applied to Medicaid without match, it would attract another - we'd have a three to one match, $300 million.

The question is, when we cut Medicaid by

$100 million, what is the net economic impact in terms of jobs lost in the health care industry as opposed to the jobs that would be attracted by the $100 million investment in bonds?

MR. SCANLON: All right. That's a difficult question to answer. We have concerns about health care costs I think from two perspectives and there's a question of when we make a change that is going to reduce costs, are we doing it in a way that is at least in part positive?

One of the two perspectives I think that we have concern about health care costs is that our use of services is not always appropriate.

There has been a lot of work, and I don't know which state you're referring to and I wouldn't be able to tell you how well or how badly the service use in your state is, but there has been a lot of work that's shown that there's significant variation across the country in terms of service utilization and that in some of the high-use areas, things are just being done that don't need to be done and they may actually be being done to the peril of the people that are receiving those kinds of services.

If we can do something that is directed at

that problem in terms of reducing unnecessary and inappropriate service use, then I think we need to say that's fine and we should be doing it.

Simultaneously, there's an issue, and this is less true of Medicaid than it is for the other parts of the health care sector, of are we paying the right price for the services that we are purchasing or are we paying too much?

Again, I say that we need to think about that in terms of how do we control costs or how do we reduce costs? We should be wanting to make progress on both of those fronts, even if there's a job impact, because they're going to free up money to potentially allow job creation and things that are more beneficial to us as a society.

Now, that doesn't say that the cuts that happen in your state were that well-targeted. I can't comment on that, but I think we really need to dissect the situation before we reach a conclusion about these trade-offs. I'm not trying to defend the bond issue, but certainly the bond issue, as a concept, is that we're trying to promote jobs over time that are going to allow people to have higher incomes and allow them to be able to afford better medical care over time.

I'm not trying to avoid your question, but there's an incredible amount of trade-off involved in it that really needs to be sorted out before one can reach a conclusion.

DR. SHIRLEY: I was trying not to get into the appropriateness or non-appropriateness of the service. That's just from a business standpoint and a return on investment and that seems to be some inconsistency.

MR. SCANLON: Well, the reason I brought the service use up is because there have been discussions in the past about, should we actually be aggressive about cost containment in health care or should we be more concerned about the loss of jobs in the health care system that are potentially going to result?

I don't think of health care as a cyclical policy where what we're trying to do is encourage employment. I think what we need to be asking ourselves is, what's the right level of health care, how can we get it most efficiently, and then leave the rest of those resources that we might save be available for other needs and wants that people have.

One of the realities I think that is

occurring now with respect to health care is, we're starting to crowd out other consumption and other investment and we have to ask ourself, is that the thing that we want to do?

My sense is that we shouldn't be doing that crowd out because the trade-off is not beneficial to us in the long run. That's why I did bring up this issue, because there has been exactly this kind of discussion from a macroeconomic sense, should we go light on cost containment and I think the answer is no.

We should be careful about cost containment because we want to make sure that we have maintained access to services and we maintained the growth of science and knowledge and technology that's beneficial, but we don't want to go beyond that.

CHAIR JOHNSON: Deb, and then Frank.

MS. STEHR: I guess to address Aaron's question. Families USA a few years ago did do a Medicaid calculator report on it where it took - you could punch in the dollar amount and it would kind of tell the economic impact on a community. I think it's on their website yet.

I have another question and it more has to

deal with cost-shifting. For instance, the companies that are encouraging their employees to enroll their kids in Medicaid or CHIP, and I don't want to beat up on anybody, but like Wal-Mart for one, and then in Iowa recently, two large for-profit nursing home companies, there has been a study done on that.

What's the impact on our health care system when companies have shifted families into Medicaid or CHIP? I didn't read a lot of the data on it, I just saw headlines, so I'm just curious about it.

MR. SCANLON: Well, I have to say, it's not an issue that I have looked in and we never had, when I was at GAO, had a request to examine that.

There is an issue, in terms of designing both Medicaid and the State Children's Health Insurance Program, where there's concern about how much crowd-out there's going to be, how much the presence of this program or these programs is going to lead to people either not being encouraged by their employer, but deciding that they would rather be in this program, which may be free to them, as opposed to paying a relatively modest premium to be in their employer program.

I think one of the realties that we have to face is what our net change in coverage is going to be.

Are we going to regard the situation where we offer this coverage, we accept some crowd-out, we take some steps to try and limit that crowd-out, but the net result, in terms of the additional coverage that we have, is something that we value more than being absolute, putting greater restrictions on those programs, and totally preventing any crowd-out by not really offering the opportunity to be in these programs to people that are employed and families that are employed.

I have to tell you that in 1997, when Children's Health Insurance Program was enacted, it was incredibly popular. It was incredibly popular because the sense was that there were ten million children at the time who were uninsured and there was a feeling that the net social benefit was strong enough that even though there were discussions about crowd-out, people thought that they wanted to have better coverage for those children.

DR. BAUMEISTER: I just want to make a comment about - justice does not always prevail

here. In Oregon, where you talk about the variation in health care costs in the Medicaid programs and Medicare, in Oregon, our costs were very low. Expenditure per Medicare recipient was something like $3,700.00 a year, whereas East Coast, Florida, it was up to three times that much.

Yet, we had a very difficult time, number one, getting a waiver for the Oregon Health Plan for our experimentation, and of course, the ERISA got in the way of our employer mandate.

The Oregon Health Plan is now really floundering and this issue of the disparities in expenditures seems not always to be rewarded like perhaps it should. That was the feeling in Oregon that still prevails.

MR. SCANLON: Right. Well, I think that there are many aspects to the issues that you raise. Certainly, in the Medicare program, the question of disparities in terms of the spending that occurs in different areas has been raised because of the fact that in terms of the Medicare Advantage program, historically, it was how much a locality was spending determines how much Medicare was willing to pay.

That's been addressed over recent years by

creating floors so that the Medicare program is willing to pay a fixed amount above what really low-cost areas incur in order to try and encourage more private plan participation in areas, like Oregon or Minnesota.

We still have this issue of how do we deal with an area like Miami, where the cost of care is incredibly expensive, and how do we bring that down?

Some of the issues that you raise on the Medicaid side in terms of the Oregon Health Plan, I think you know, and we talked about it during the break a little bit. The Oregon Health Plan is incredibly innovative in terms of a new concept of trying to set a priority among the services and tie them to the treatments. It took more than one attempt before there was a comfort level with the setting of the priorities and before the waiver was granted to Oregon to do that.

But there's a second part of the Oregon program which is I think also an experience of some of the other states. There's this issue of whether or not, by having a more flexible Medicaid program, you're going to generate enough efficiencies that you're going to be able to expand coverage at close to

zero cost or very low-cost.

I think that's where Oregon and Tennessee and some other states have discovered that you might be able to generate some efficiencies, but you're not going to be able to cover huge numbers of additional people over the longer term.

Over the longer term, as costs have grown, states have looked at their own budgets and said, we need to cut back. That's where Oregon is today. That's where Tennessee is today.

It's not that the innovations were not valuable, it's just that the expectations for them were maybe too high.

MR. O'GRADY: Yes, I just wanted to go back in terms of what Deb said about the woodwork effect and the idea of employers and Medicaid and SCHIP.

I think that one of the things that we saw when SCHIP came in was one of the bigger increases in enrollment and cost were on the Medicaid program, that you had lots of people who were eligible for Medicaid, they didn't know, they thought they might be eligible for SCHIP, so they went in and then when they got there, whoever was enrolling them, they said, well,

I'm glad you're interested in SCHIP. You're actually Medicaid-eligible. It's a more generous set of benefits.

The Medicaid program saw this big push and as Bill pointed out, there's always this dilemma in Medicaid, because an awful lot of states have gone with a notion of balanced budget amendments and things like that, so you have this situation of when times are hard in the economy is when states are seeing less money come in, it's the same time they're seeing this spike in their Medicaid rolls, because more people are becoming eligible.

In terms of thinking about this in terms of how you do this and to your specific question about how you keep the employer's money in the game, that's part of what goes on in these waivers.

Bill talked about a HIFA waiver and part of that is to think about, do you have people where - and you could have things in families where one kid's eligible for Medicaid and another kid's Medicaid - is SCHIP.

Some of this notion of how you use waivers, which Bill also mentioned, is this a demonstration or is this to allow state variation,

allow states to try and figure and answer to their particular set of circumstances? Is that idea? That's one of the more challenging aspects.

Can you think of different ways that if you have an employer who might be willing to make a contribution for at least the worker - because we do see these where you'll have a family where some members are uninsured, some members aren't, and you keep thinking, couldn't somebody get a family policy in there someplace?

You'd like to be able to think about how you handle these flows of funds and how you handle the flexibility, so if that family wants to go with the employer, how do they do that?

If they want to go through something more like - we don't have kind of a family policy, in SCHIP, eligibility is individual, as it is with I think every program we've talked about. It's not quite the family.

It is - that's the challenge. If you have an employer, whatever the employer happens to be, whether they're more or less generous on it, can you pool that money with maybe SCHIP money, with maybe Medicaid money, and get something that looks like more

comprehensive coverage so you're not having one card for this kid and one card for that kid and then mom uninsured.

How do you think about that? I'd say it's one of the challenges that we're coming across, but it's only made harder with the idea of Medicaid being under such tight financial and trying to push on the Feds because the Feds don't have the balanced budget constraints that many of the states do.

VICE CHAIR McLAUGHLIN: Bill, you just turned off the slide that my question relates to, so if you could go back to that - plus it's much more colorful than this slide, you know, it's a better backdrop for those of us.

I have a clarification question from you that I'd like an answer from you and then I have a follow-up. You gave us earlier a slide that had eligibility, the different categories, and so for Medicare, had aged, disabled, ESRD, and then for Medicaid, children, parents, aged, disabled, and SCHIP.

When we translate to this, how do we translate to that? I'm just saying at our earlier meeting, when you weren't here, there were some

members of the group saying, I don't want to sound really dumb asking what may be an obvious question and so I'm volunteering to sound really dumb. How does SMI and HI translate to the earlier table you gave us?

MR. SCANLON: I should have said this. SMI and HI are the Medicare program. SMI is actually the Part B portion of the program. It's known as Supplementary Medical Insurance. HI is the Part A part of the program, known as Hospital Insurance. Thank you for making me clarify.

VICE CHAIR McLAUGHLIN: Then my question is, I want you to parse this out even more because you did make an interesting comment about the distinguish between disabled versus ESRD versus elderly, etc. and with Medicaid, that's also not clearly only people who are - women and children who are below the poverty line, etc.

When I look at this, how do we think about the current division and the change? I'm looking at the change. How much of it is due to countercyclical assumptions?

How much of it is due to aging of a population? How much of it is due to employers dropping retiree benefits? It's really hard for me to

look at this and understand what's driving these predictions.

MR. SCANLON: Well, what's driving these predictions, because of the fact that they are so long-term, you can appreciate being a researcher, are simplistic assumptions.

The reality here is that if you move out beyond 25 years, the assumptions that underlie this are that health care costs are going to grow at GDP plus one percentage point.

When I said before that that was optimistic, it's because the reality has been that health care costs have grown at GDP plus about two percentage points, if you say certain things are not going to occur in the future that have been occurring in the past, such as expansions of coverage.

We may not achieve something as optimistic as GDP plus one percentage point for the future. That's the only thing that's built in here beyond 25 years.

For the shorter term, it's also not a very sophisticated forecast in that what we're talking about is looking at trends and extrapolating from simple trends, not taking into account cyclical

changes. Think about what happened, and you may have talked about it in the prior session and maybe before, with health care over the last 15 years.

I know you talked about managed care with John and the fact that during the mid-90s, we, in some respects, were euphoric about our ability to control costs. We actually sometimes saw declines in health insurance premiums and we actually had a very significant dip in costs.

Simultaneously, Medicare was having a very difficult time with a couple of its benefits that were growing at more than 25 percent a year, but that all went away, right?

We had the potential issue of backlash. I think I would add to what John was saying about it coming from the employer and the consumer side.

We also had providers who had accepted unrealistic contracts during the managed care heyday out of fear that they were going to be excluded and they suddenly said, we're not going to do this anymore. If we form various types of coalitions, then we can get much better deals.

There's just an incredible amount of variation in any short period. None of that's built

in here. This is driven by demographics and the relatively simple assumptions.

VICE CHAIR McLAUGHLIN: One of the reasons I asked this is because one of this working group's charge is to prepare a report to the American people to try to start a national dialogue on where does the money come from, where does it go, and looking at some of these issues.

I think you were here, perhaps, when John and I were talking about, we really - we talked about this within the group before.

We really want to be honest with the American people and we want to give them information that not only is understandable to them and helping them to think through what the issues are, but to the best of our knowledge, is reliable and based on sound research.

I guess I look at this and I think, I don't think we should show this to the American people because it is so dependent on what employers do. It is dependent on technology. It's dependent on the countercyclical issues.

What's the economy going to look like in 2040? You and Richard and I, as economists, if we

could predict that, we wouldn't be here. We'd be with George Soros and we'd be quite wealthy.

I guess I know CBO, GAO, CEA, part of your jobs are doing these kind of predictions, but just within the confines of these four walls, would you really stake anything on this and say to the American people, look at this, 20 percent by 2080?

MR. SCANLON: Not if you were going to penalize me if it was only 19 or if it was more than 21, but I think that this is important because it's the issue in some respects of are we in the right ballpark?

We really need to start thinking about that concept in terms of what we're doing now because if you go back over trends over a 40-year period, historical trends, and then extrapolate them forward, taking into account known demographics.

Yes, everything that you said is true about that 40-year period, that there's the whole variety of different experiences within that 40 years, but this is what the trend has been.

The question is going to be, can we afford to be in this ballpark? I don't mean afford just in a financial sense, but from a social sense. Is this

where we want to be? Do we want this much of our economy, this much of our activity, devoted to health care in 2050 or 2070?

I think those are the kinds of questions the American people should be asking themselves, because if we don't take something that's this graphic seriously, then it becomes a tomorrow problem.

VICE CHAIR McLAUGHLIN: You think the margin of error really is like one percentage point in either way?

MR. SCANLON: No, no. I think this is grossly underestimated, and one of the things that Medicare has struggled with, and I didn't go into some of the details, over the last four years is how to pay for physicians.

What's been happening with respect to physician services is that the volume has been going up eight percent. This last year it went up close to 14 percent over a single year.

If we were to say that was the trend, and I'm very skeptical about taking two data points and making a trend out of them, if anything close to eight percent or ten percent is a trend, these numbers are incredibly conservative.

Even as grim as this is, it's an understatement and it's a reality we need to start to think about. We need to start to think about health care costs, because this goes back to the discussion that I heard you have with John. The issue about a backlash and the concern about not getting access to services. Access to services is incredibly important, but costs are incredibly important, were incredibly important, and have become even more important.

I think we need to try to approach them in the way I said before. Think about what is the utilization that I want to change. Think about what is the price that I want to change and how do I accomplish those two goals?

Don't think about how do I slash costs in a way. That has a whole series of negative consequences on the principle that we can't afford it. I think you will do a great service if you can elevate the debate to think about how do we operate with precision in terms of trying to affect costs.

Whether we're going to be able to be successful here in terms of changing this, I don't know, because again, as I say, these are conservative.

I'm really worried about the long-term

care side. As you know, I spent a lot of time working on long-term care issues before going to GAO, and it has been that informal family supports have been an incredible part of long-term care in this country, but the reality is, there aren't going to be that many children, adult children, available to serve that large Baby Boom population.

It's not clear we want to have our economy and our society further compromised by having all kinds of people leave the workforce, leave other activities, in order to provide long-term care. How are we going to do that? I don't know. Over recent years, we've heard a lot about nursing shortages and other health care shortages. They pale in comparison to when you look out at 2020 and you look at who might be available to provide long-term care.

I would discount this from a precision perspective. I wouldn't discount it from an importance perspective.

MS. MARYLAND: I want to follow up with Catherine's comment because actually, you asked one of the questions I wanted to ask. The follow-up is, we really need to see, and we talked about this, I think,

at our first initial meeting, that matrix of the breakdown of the total dollars consumed by each of the components of Medicaid and Medicare.

You have pieces and parts here, but it would really be nice to be able to see the details, because to me, it's startling to hear, with the Medicaid program, how much is really being consumed by just the long-term care component of that.

I think that that would help us as a group to understand before we can formulate any strategies of how do you address this issue? I would agree with you that - that is just an observation and comment that I wanted to make.

We have had a lot of experience with managed care and a number of states have been able to create these managed care plans that have been extremely effective and there are other areas where that's not the case.

You talk about service utilization. What can we draw from our knowledge base and experience with managed care that might help us with Medicaid and the Medicaid plan in particular? I know that some states, for example, have implemented managed care Medicaid plans versus straight Medicaid plans.

What knowledge do we have of how effective the managed care plans have been over the straight Medicaid plans in terms of service utilization and clinical outcomes?

MR. SCANLON: I'm not sure we know a whole lot about the impact in terms of utilization or the clinical outcomes.

I think we can look to the states in many instances, for effective management of managed care, so to speak, in that states have really devoted effort to trying to make sure that managed care plans that they contract with actively engage in the management of services and are held accountable for it.

One of the things that I would say we were impressed with when we did studies at GAO about different aspects of managed care was particular states devoting considerable resources to try to oversee their managed care plans.

Now, I think that's an important first step. The question that should be asked now is how effective were they to be able to provide the information, to answer your question. That's a lot more difficult because one of the key things is to actually know about the experiences of people within

managed care.

That was where states were trying to get data, but at the point when we were studying them, they hadn't gotten them yet.

MS. MARYLAND: I have one final follow-up question. It's regarding creative financing, particularly at the state level, the provider taxes that a number of states are moving towards, where they're asking the hospital providers to put in their fair share, if you will, and then to receive matching dollars from the Federal government.

What are your thoughts about the provider tax approach and is it really helping the states to subsidize and pay for the uninsured, uncompensated population?

MR. SCANLON: Well, it can. The issue is, how the monies are going to be used. Provider taxes were a big part of the creative financing schemes of the early 90s.

We saw a huge increase in Medicaid in the early 90s and the reality was, most of it was creative financing. At that point, provider taxes were very narrowly focused on Medicaid, and providers basically said, we're going to tax you, but then we're going to

return the tax plus the Federal match to you, so this is the way you're going to get your payment increase.

Those kinds of taxes were outlawed in the early 90s by the Congress and now, what we're seeing are these broader based taxes, which can include a broader purpose in terms of expanding coverage.

The history is that fiscal crises can change how monies are being used. There were other creative financing schemes that were targeted in terms of the money was going to be used for a specific purpose, but when the revenues of states were restricted by the recession, then the monies ended up being used for different things.

The reality always is that funds are fungible and it's not a guarantee that they're going to be used that way. Now, having this money available, states have operated to expand coverage in various ways and have been effective at it.

At one point, Tennessee had about a quarter of its citizens covered within their expanded Medicaid program and you almost had universal coverage in Tennessee. Fiscal realties, as well as potentially being too ambitious in terms of what they were trying to get plans to do for what they were willing to pay,

have forced them to cut back and reduce the coverage that's available.

MR. O'GRADY: I guess back to the graph for a second, a couple of things to point out there. I certainly support, and I think it's a very important set of information, the two top - the SMI and the HI. Those are coming right out from the Office of the Actuary, who we will meet the Chief Actuary in another day or so.

One of the things that is going on here is it really is, when we - back to Pat's point about, geez, I didn't know about these pressures, the long-term care pressures, on Medicaid.

Part of the problem here is that we don't have enough trustees - we don't have a trustees report for Medicaid, so there's not something that is easily understood, penetrable, like this program will run out of money in the year 20 - fill in the blank.

But we do face that and that's one of the real value added. I think of what GAO did there by adding a Medicaid number, because when we think about some of the issues we talked about the last time we met, how do you make this money make sure it really does go to the target populations you're interested

in?

Part of this in the Medicaid is a long-term care financing which moves well into moderate-income, if not upper-income people, through their ability to hide assets and therefore, get the state to pay when I don't think anybody, when they put together the Medicaid program, was thinking that they were going to help people to be able to pass on $100,000.00 in assets to their children and therefore, we'll shelter it.

Some of these things - I think that that knowing what's coming - and Bill's absolutely right - if anything, it's an underestimate of what we probably will face, but I think you've got to sound that warning.

Otherwise, people will just chunk along thinking things are a short-term problem or whatnot and really, they're not. We can't keep growing at this rate and have the demographics we do have without some serious rethinking about the system.

CHAIR JOHNSON: Joe?

MR. HANSEN: To follow up a little bit about what both Mike and Patricia said, as you look at those numbers, and Patricia was asking about the

different components, I'm assuming that different things - you've got straight lines there, but there will be different elements as you go up that will have different percentages and that would be information that might be useful.

I don't know if that would be the function of the actuary or Bill, if you could maybe take a shot at that right now, in the broadest sense.

Then the other question is, and I don't know if it is a problem or how big a problem, but in the Medicaid, how big - if it is a problem - is providers' refusing or dropping out of the program?

I read headlines about that, but I don't get a sense of if it's big or little or growing or whatever it is.

MR. SCANLON: In terms of trying to be even more heroic with the projections, I think I'm going to pass and I think when you meet the actuary, I think he will be prudent enough to pass, too.

Our reality is that, and Catherine hit on it, in terms of trying to make projections over a longer term there are so many factors changing. Think about hospital care and what used to be inpatient versus what used to be outpatient.

How long ago was it that people, for cataract surgery, were in hospitals for ten days with sandbags around their head? No more. This kind of a thing is an aggregate and it's only valuable to stay as an aggregate. If we started to try and predict the components, we're probably going to end up really seriously misleading you.

I think that it probably wouldn't be safe for you to try and design something based on the components.

The issue of long-term care versus acute and medical care may be something that you should think about because they are so different in terms of how they're currently financed in this country.

Acute and chronic care are largely insured, particularly for elderly people and people with disabilities.

With long-term care, the only option for most people is to have Medicaid because they haven't bought insurance, and even though long-term care insurance has been around and actively discussed for probably more than 20 years, inroads in terms of people with policies is very, very small.

We're not going to get a big change there.

I'm sorry, there was another part of your question which I'm blocking out now, the --

MR. HANSEN: You talked about how the Medicaid --

MR. SCANLON: Oh, the participation rate. Yes. It's definitely a problem and depends very much on the state in terms of how the state has set rates and when they're very low, you will hear problems that are real about individuals having great difficulty finding a physician, in particular.

Hospitals are different. They're going to serve you. The question will be, though, to what extent they will provide you all the services they might provide to someone else knowing the rate.

Nursing homes, they obviously are very dependent upon Medicaid, so virtually all nursing homes will participate in Medicaid, but they have a clear preference for serving private residents first, where they get a higher fee, and it's the beds that are left over that will be Medicaid beds. The access is a real issue.

MS. WRIGHT: I think, extending onto this a little bit further, we're talking about physician access and how that is diminishing. Can you explain

to me or discuss portability for some of the people with Medicare, specifically looking at your disabled or your ESRD patients - I mean, portability from state to state. Are there differences? Is it a reaccess problem, a reapplication situation, or it travels with them, because I've seen - states are getting different funding, so --

MR. SCANLON: This is one of the intricacies where I'm probably going to have to plead some ignorance. Now, we're talking about Medicaid. Definitely, if you move from one state to another, you're going to have to become Medicaid enrolled within your new state. Medicare, that card, your Medicare enrollment goes with you around the country.

If you've joined a health insurance plan, that's an issue of whether or not you have some out-of-plan benefits that you can get if you are temporarily in another state or whether you may have to leave your plan if you completely move to a different service area and then face the choice of joining a new plan.

What I'm also worried about in terms of answering your question is states many times administer their Medicaid program at the county level

and I don't know what kind of complication that can create for an individual who changes counties within a state as opposed to leaving the state.

They still should be Medicaid-eligible, but they may have to go through some process to either recertify, either initially or when their periodic Medicaid review is up, they may have to go through more of a process because they've moved.

MS. BAZOS: I was wondering if you would talk, Bill, a little bit about the Federally Qualified Health Centers and the opportunities there to increase provider participation because of the way the costs are reimbursed for Medicaid, and at the same time, talk about whether there are going to be future opportunities to expand those, because as I understand, nobody is quite sure what will happen with that.

MR. SCANLON: Well, I know that there's been interest in them in part, because they are providers that are very interested in targeting too-poor individuals and part of it is the issue of the money that's coming from HHS independent of Medicaid, intending to expand services to the poor.

I guess I'm not in a position to make a

political prediction in terms of how much support there's going to be. There has been interest over the years in terms of expanding support for these services, but how much the Congress is willing to put into them, I don't know. I can't make a prediction on that.

MS. CONLAN: I'm trying to reconcile some of the things I already know about Medicaid with things I thought I knew and things that you've told me anew. I know the Governor Association came to Washington with rising Medicaid costs on their mind. They went home not resolving that issue.

Meanwhile, the Governor of my great state of Florida, Governor Bush, has been desperately seeking a Medicaid waiver. Those of us who are Medicaid beneficiaries, we fear that.

The flexibility that you're talking about, and you put a positive spin on it, we fear that that means in terms of our state, there will be drastic cuts that - temporarily, yes. There will be more money in the short term.

In the long term, there will be a capping of the number of beneficiaries and long waiting lists after that, and in fact, it will no longer be an

entitlement program. I'm wondering - and then you told me that there are already a number of states that have already applied for and received these waivers.

Are you saying that they did that to increase benefits or have they already done what Florida's contemplating, which is, I think, to decrease benefits?

MR. SCANLON: No, I think - what's happened in terms of the waiver --

CHAIR JOHNSON: Bill, may I ask you to just build a little bit on her question and describe what the waivers do and just a few more words on what waivers are and what they mean?

MR. SCANLON: Sure. Well, within Medicaid, there's a variety of waivers that a state can receive. Essentially, what's being waived are the Federal requirements for the Medicaid program.

The ones that are perhaps most important today are what are called Section 1115 waivers, which were originally demonstration waivers that allowed new ideas to be tested to see if they were something that you would want to incorporate into the program on a more permanent or usual basis.

There has been a whole range of these

types of waivers and I would say, perhaps the most frequent use of the waivers is to get people or to have people enroll in managed care plans.

The second aspect that's been most frequent in terms of these waivers has been to try and use private plans and the savings that the states have achieved, or feel that they have achieved by using private plans, to try and expand coverage.

There's a big difference between a state's proposal and what might be in it and what might get approved as a waiver. There's the question of, well, what will happen with the Florida proposal?

There's always been a negotiation that's gone on between the Department of Health and Human Services and the states in terms of what they find acceptable to waive.

There have been states where things, in some respects, are relatively straightforward. I would say that as big as it was, the Tennessee waiver, which goes back to 1994 or 1995, was relatively straightforward in that they moved from having people in Medicaid in fee-for-service, getting services individually from providers, to having managed care plans or private insurers enroll people.

The key thing from the waiver perspective was would the savings that they "generated" there be enough to pay for expansions and they ended up, as I said, covering about a quarter of the state in terms of Medicaid eligibles, making those people Medicaid eligible.

That's relatively straightforward. An example of something that's not as straightforward and potentially much more controversial is the waiver in Utah, where in order to expand coverage to a group of people, the waiver allows for a different benefit package to go to that group of people, a benefit package that emphasizes more primary care, to the exclusion of covering hospital care.

Now, we can have disagreements about whether or not that's a good thing or the right thing to do.

On one level, it probably makes the hospitals more vulnerable because these individuals, when they do need those kinds of services, are going to end up in hospitals and hospitals, because of the nature of being a hospital, are going to have a difficult time saying no, we're not going to treat you at all.

They may restrict their treatment, but they're not going to be able to say we won't treat you at all.

The issue of changing the entitlement in terms of if you're eligible, we're going to be able to say no at this point in time, that's another very basic question and I'm not trying to say pro or con on it. It's a question of what group did you do this for? Did you do it for all the traditional Medicaid eligible, or did you do it for people that wouldn't have been covered at all?

It might be that if a state says, we are going to cover a new group that we wouldn't have covered otherwise, but we want a limit, we want a cap on our liability, then it may be perceived positively.

When I talked about long-term care and the fact that we cover home and community-based services in long-term care in Medicaid, now we didn't used to cover them until states were given the ability to say, we've reached our limit. There's a cap. You're going to have to wait for services.

I think the trade-off there is, are we better off giving the states that certainty and having them expand coverage with some certainty, versus

having them say, we're not going to expand coverage at all because we don't want to take the risk for the future?

I think we would need to talk about the Florida waiver proposal detail by detail and ask, what is it accomplishing? Is there any benefit from it? What are the risks from it? And I don't know the Florida proposal well enough to be able to do that for you.

MS. CONLAN: I guess if we could take the example with the developmentally disabled in Florida. Again, we got more money, temporarily, but there are huge waiting lists of people who are now not probably ever going to get services. Some people have received services, but that's the end, and then there are all of the rest.

I guess that's what we're looking to as the pattern, thinking that they're not expanding services for anyone. The intention is to cut costs and services.

MR. SCANLON: Right. You bring up an important point which is, to go back to something that Mike said, we need to look at the Medicaid program in a broader perspective.

One of the realities is that the availability of services, particularly for people with disabilities, is hugely variant across the country and that in some states, it could be an issue of that you're on a waiting list and it's going to be a long time, if ever, that you're going to get services in other states.

You're not on a waiting list because there isn't a program or there aren't services, and so in other places, you may be much better served. I think one of our problems, and this is particularly in the area of long-term care, is the consequences of that are invisible to most people.

If you could raise the consciousness about what it means not to have services available, that would be a very positive contribution from a long-term care perspective.

It might change people's perceptions about their own sense of responsibility or their own need to prepare for their long-term care future, because long-term care, at this point, is very invisible to most of us and we don't do anything in the way of preparation.

It's too late when you're 20 years away from doing it, and it's obviously much worse when you

have the immediate need. There hasn't been the movement to make this a much greater priority in terms of both thinking about it from an individual perspective, as well as from a social perspective.

MR. HANSEN: This is a question more on the financing and it's difficult for me to even try to figure out what I'm trying to say here, but on the financing of the Medicare and soon to come the financing of the prescription drug program, part of that is from premiums and there should be significant premiums on the prescription drugs, at least in my point of view.

It's a lot of dollars for people on fixed incomes. I know there's no data on that, but do you have any sense of with the premiums on the Medicare, of when that becomes a point of no return, where more people drop out because they can't afford the premiums or it gets too burdensome, or is there any thoughts along those lines at all?

MR. SCANLON: Well, I think there is obviously concern about the increasing premium, and this goes back to the idea of the need to get some control over costs, but the reality is that regarding both the drug benefit, as well as the Part B premium,

what we're talking about is a premium that's 25 percent.

In the drug case, it's 26 percent of the cost of the program. Compared to what you could get in going out and buying a private plan, this is an incredible to good deal.

I think that's going to, for a long time, influence people's choices of whether or not to stay in the program. With the drug benefit, there is a question of whether or not people decide that maybe it's worth the risk of not signing up when I'm 65, but there's a penalty for signing up later. Is it worth waiting to see when I actually have significant drug spending and sign up at that point in time and pay the penalty?

That's something that's been talked about. We have no experience yet to know whether or not it's going to be a real phenomenon or not.

CHAIR JOHNSON: Bill, I think we've kind of run out of time, but if you would take just a brief time to respond to the following question, it would be appreciated.

As we have offered long-term care to employees who are actively employed, a good percentage

of sign-ups will be about three to six percent, and more often, it's lower, rather than higher than that.

There have been one or two companies that I've heard of that have had up to ten percent, but that's been a huge number. Here in Washington, D.C., I frequently hear the term long-term care and it's almost discussed as a companion to health care in terms of need and so forth.

In terms of your observations based on our discussion earlier, can you give us a little more sense of the level of importance and priority in terms of preparing a health care system for the future in terms of where do we focus on in terms of long-term care or health care or more traditional health care and wellness, health prevention issues.

Do you have any comments on that? It's a value question, I know.

MR. SCANLON: No, I know, and it's also one in which it's very hard to set priorities because of the fact that the need in each dimension is very pressing. I know you discussed this with John, the issue of wellness programs versus health care sickness programs, and I think that we should be pushing forward on the wellness side to the greatest extent

possible and that we shouldn't be discouraged.

Coming over here, I was walking down the street and there was a group of people outside the building smoking and you think to yourself, would you have seen that ten years ago or so?

I think we're changing behaviors in some ways, but at the same time, I think you shouldn't regard that as a substitute for dealing with the health care side and in dealing with the health care side, it's really tough to make a choice between the long-term care versus the acute care side.

The reality is that our acute care system is absorbing probably about $1.3 trillion. Our long-term care system is maybe absorbing about $150 billion. In some respects, we might say, well, let's focus on acute care.

The reality though is that long-term care part is very, very concentrated. It's a very small number of people needing an incredible amount of care, and I think if we really understood the consequences, we wouldn't want them to go without.

I think one of the most important things that you can do is to make sure that there isn't confusion about what you're working on and what any

recommendations you may have are going to deal with.

A lot of times, and this goes back to when you talk about the take-up rate for long-term care insurance offerings, there continues to be incredible confusion about whether Medicare covers long-term care.

We do surveys and the best we've ever gotten is I think around 40 percent of people saying, Medicare covers long-term care. In other surveys, it's been as high as 70 percent who said that Medicare covers long-term care.

Long-term care, as a distinct type of service, is not understood. If we make inroads on the acute care side in terms of expanding coverage, making coverage more affordable, we need to make sure that society knows and the American people know that we haven't dealt with the long-term care component and that somebody should be thinking about dealing with that.

I'm afraid I can't set your priorities. But I would say, just make sure where the lines are around what you actually do decide to work on.

CHAIR JOHNSON: And maybe a closing note is for us to at least consider providing some

education to the American public on this subject.

MR. SCANLON: Right.

CHAIR JOHNSON: Well, thank you very much for your time.

MR. SCANLON: Thank you.

CHAIR JOHNSON: Appreciate - excellent help to us and we appreciate your investment of time and energy and expertise on our behalf.

MR. SCANLON: Thank you. It was a pleasure to be here.

CHAIR JOHNSON: We'll have until 1:15 for lunch and I'm wondering if we can get some directions for lunch? Anybody help us?

VICE CHAIR McLAUGHLIN: Lunch is open, but I guess I would like some people who are from around here to tell us where our options are. Do we turn left? Do we turn right? Go across the street?

Is it a five-minute walk, a ten-minute walk?

(Whereupon, the above-entitled matter went off the record at 12:36 p.m.).

CHAIR JOHNSON: Welcome back. To give you a little preview, we're contemplating getting together for dinner, and we were asked what time would be good.

The initial response was 6:00. Let me test that with you, however, see if that's an okay time from your perspective as a working group. Is there anybody -- we know there will be one or two that will not be joining us. Can I see a raise of hands of how many of us will be here for dinner. Okay. Thank you.

Okay. Welcome back. We're delighted to have Peter Cunningham, who is a Senior Health Researcher at the Center for Studying Health System Change with us this afternoon to talk about the issues and opportunities with the uninsured.

Actually, Peter, as you might have sensed, and I'm sure you've been told, our intent is to do a foundation briefing to give the working group an understanding of what is happening in the uninsured market. And you all, as a working group, have had a chance to take a look at his bio. We actually talked with another person about presenting the uninsured topic, and that person, who is widely known and highly respected said, I'm not the right person. Peter Cunningham is the right person, so that's why we've invited you, and we're glad that you're here, and we'll look forward to hearing you.

What we've been doing is taking 20-30

minutes for a presentation, and then questions and answers. And since we're starting about a half hour late, we'll go about a half hour longer than according to our agenda, and then we'll take a break, if that's okay. Okay.

MR. CUNNINGHAM: Well, thank you. Thank you for giving me the opportunity to come and present. It's been an issue that I've been involved with for pretty much most of my research career, so I am glad to see the committee taking it up. And again, I appreciate the opportunity to come here.

What I'd like to do is basically pull together a lot of information from a variety of data sources that basically summarizes what we know about the uninsured, and to some extent what we don't know, as well; what are some of the gaps in the knowledge. And I'm going to cover several issues. How many uninsured are they? How is it changing, what are the trends? Who are they? Gives us some insight on why they're uninsured, and then also the consequences of being uninsured.

So to start in terms of how many uninsured are there, just to kind of give you the take away points, there's a number of surveys that attempt to

measure this, and the estimates vary because of differences in the methodologies, as well as the definitions.

Another important point is that health insurance coverage is a lot more fluid than the estimates that are usually published, actually conveyed. And many are uninsured for relatively brief periods. So at the risk of thoroughly confusing everybody at the outset, I'd like to just present some of the estimates from the major national surveys that quantify the number of uninsured. The surveys that are listed here are the Current Population Survey that's conducted by the Census, the Medical Expenditure Panel Survey conducted by AHRQ, the National Health Interview Survey that's conducted by CDC, the National Center for Health Statistics, and then to throw in an example of a non-government survey, the Community Tracking Study, which my organization conducts periodically.

So as you can see, the estimates vary depending on the survey, and I could do a whole presentation on the differences in the survey methodology and the way the questions are asked, also taking into account the confidence intervals as to why

numbers vary across surveys. You'll also note that the estimates vary even more substantially depending on the length of time uninsured you're trying to measure. So, for example, the point in time estimates which either ask are you uninsured on the day of the interview or over a relatively brief time period - those tend to be substantially larger than when you're measuring whether you're uninsured over a full calendar year. And then the highest estimates are were you uninsured at any time during the calendar year. So you get quite different estimates depending on which time period you're measuring.

Now the most widely cited estimate that you usually see in the media and a lot of published information in the CPS estimate of 44.7 million. The reason it's most widely cited, I think is because they've been doing that survey just about every year for a long time, and so they're one of the few surveys that have the capability of tracking these numbers over a fairly long period of time. But I think another reason is that's what everybody else cites, so if everybody else is citing that number, we should be citing it too.

Now the estimate supposedly reflects an

entire calendar year, but if you look at the estimate, it's substantially higher than the full year estimates from the other surveys. And it's actually closer to the point in time estimates, and so what a lot of the researchers think is that because of the way the question was asked, basically it's asking people to recall whether they were uninsured the previous calendar year. People think that that estimate more closely reflects a point in time. However, there was a report that just came out by ASPE that actually found that there's a substantial under-reporting of Medicaid in the CPS, and that that might also account for the higher number.

So I guess the sum of this is that that's the most widely reported number. I think a lot of the researchers are pretty squeamish about that because it's not exactly the best way of asking the question. And I guess I would say that I have more confidence in surveys like the MEPS and the Health Interview Survey, because I think they - especially the MEPS, they do a much more thorough job of trying to actually count it.

Now part of the reason why the estimates vary so much based on the different time periods is

that health insurance coverage is much more fluid than just the kind of static estimates would suggest. There's a considerable amount of churning on and off coverage by a substantial part of the population. So, for example, 45 percent of the uninsured are uninsured for four months or less, and then 70 percent are uninsured for a year or less, so there's really only a fairly small percentage, although it still translates into millions of people, but only a small percentage that are actually uninsured for a prolonged period of time of say two years or more.

And I think one of the things we don't know is, if you look over a longer time period like ten years, what does the picture look, for how long are people uninsured over that period of time. And I guess even more importantly, does it matter if you go through brief periods of being uninsured for one or two months? And I think those are important questions for policy in terms of how to address the issue.

So how have the number of uninsured been changing? The take-away points are uninsurance generally has been increasing for adults of late. They've been decreasing for children. And I think even more striking is there's been a pretty

substantial shift from private to public coverage for low income persons.

Now the good news in terms of the different estimates that you get from the surveys is that they tend to be more -- the trends tend to be more similar regardless of the survey that you're looking at. This slide shows estimates from the Current Population Survey. Again, they go back on an annual basis a lot further than all of the other surveys. And the top line shows the percent uninsured for adults. And as you can see, that's been increasing gradually since at least 1988. And actually, I think the increase has been going on for longer than that.

There was a bigger jump between 2000 and 2003, which I think everybody thinks reflects both the economic recession, as well as rising healthcare costs. However, if you go to the bottom line for children, you'll see starting about 1997, the percent of children who are uninsured started to decline. In fact, there is a fairly sharp decline between `97 and 2000. And even during this period after that when uninsurance rates were increasing for adults, they continued to decrease for children. And that reflects

the effects of the State Children's Health Insurance Program, as well as Medicaid expansions that went along with that, which substantially increased the number of children, especially low-income children who became eligible for public coverage.

Now one of the main things that is responsible for the long-term increase in uninsurance rate is an erosion of private insurance coverage. And this is due primarily to the increasing costs of private health insurance. The research I've seen indicates that it's really consistently high healthcare costs that are responsible for the long-term decline of private health insurance. There are some other factors that you hear about from time to time, including the shift of jobs from manufacturing sector to service sector, more temporary workers, more part-time workers. That has some impact, but it's really the long-term increase of health insurance costs that have been primarily responsible.

And this just shows the increases that have taken place since 1999. The top line shows the annual percent change in health insurance premiums, and you can see that they've been rising much faster than either general inflation or worker's earnings.

And what this has done, the long-term decline in private health insurance, is that it's also led to some shifts between private and public. This slide takes some findings from the Community Tracking Study Household Survey. It's for low-income adults, and it shows the percent of low-income adults, the change in the percent of low-income adults enrolled in private coverage between 1997 and 2003. And you can see that in that time period there is a big decline in private insurance coverage, from about 45 percent to a little under 37 percent.

Public coverage increased off-set some of that decrease in private coverage, but still you see there was an increase in the percent uninsured during that period, from 33 to 36.6 percent.

If you look at low-income children, and again remembering that 1997, or after 1997 you saw the big expansions in SCHIP and Medicaid. You see an even bigger drop in private insurance from 47 percent to 34.5 percent. However, the increase in public coverage not only offset the decrease in private coverage, but it also led to a pretty substantial decrease in the percent of low income children who were uninsured, from 19.4 to 11.4 percent.

And this slide just shows the trend from `97 to 2003. But if you go back even to the late 70's and you look at that long-term, you can see that this trend from private to public, public meaning both Medicaid and SCHIP, has actually been going on for quite some time.

I guess the other point to make is that researchers have been concerned, and policymakers, as well, have been concerned about how much of this increase in public coverage is the result of people substituting public coverage for private insurance. The more colloquial expression has been crowd-out; that is, that people who have private insurance or who have access to private insurance, once they realize that they now have a subsidized product that they're eligible for, they drop their private coverage and get on the public coverage.

There's been a lot of research on that. The estimates vary, again, pretty substantially, but I think the consensus, at least from what I've seen, is that there is a fair amount of crowd-out that goes on. I guess the question is well, how do you interpret that; again, realizing that these are low-income people. Health insurance premiums are increasing at

double digit rates. It's kind of a political and policy question - do you say well, private insurance is just not affordable any more, so it's a good thing that people switch over to public coverage. And then the other side says well, we should never use public dollars to subsidize what people could get through the private market, so it's an ongoing issue. For years, there was a debate about whether it even existed. To me, I think the research has been pretty consistent that it exists; how much is still a source of debate.

Now turning to the question of who are the uninsured? And again, the take-away points, most are in working families. They're in situations and jobs where employment-sponsored insurance isn't available to them. And particular groups, such as low-income, young adults, and Hispanics are at particularly high risk for being uninsured.

I think one of the things that's often overlooked in the discussion is that most of the uninsured are either employed or they're members of working families. Sixty percent are in a family where there is a full-time worker, full year worker, and another 22 percent are in families where maybe there's a part-time worker, so fully 80 percent of the

uninsured are employed or are in families with a worker.

If you're not working, or if you're not in a family that has an employed member, your likelihood of being uninsured is much higher, but still they comprise a relatively small minority of the uninsured.

So why are there uninsured workers? Well, the main reason is that these workers and their families, they don't have employment-sponsored coverage available to them. Two-thirds, 67 percent, are not offered coverage at all by their employer. Their employer does not have health benefits. And then for another 20 percent of these workers, benefits are offered by the employer, but these particular workers aren't eligible for them. And in only 13 percent of the cases are workers offered and eligible for benefits, but they turn them down, and so they're a fairly small group. If you look across all family members, they comprise about one-fifth of the uninsured. But in general, take-up rates of the SI coverage are pretty high. They've been declining over the years because of the cost issue, but over all they're still very high, about 85-90 percent. And I guess the question is in a voluntary system you're

always going to have some people who opt out, and how high should we expect take-up rates to actually get?

MR. FRANK: If 13 percent of all the uninsured were eligible, and presumably didn't take-up, how can 85 percent of those who are offered be taking-up?

MR. CUNNINGHAM: Well, this is uninsured workers, so I said of all workers --

MR. FRANK: Oh, I see.

MR. CUNNINGHAM: -- about take-up rates. All workers who have coverage offered to them, take-up rates are -- the estimates vary, but they're between 80-90 percent.

CHAIR JOHNSON: So are you saying that 67 percent of the prior slide's 60 percent?

MR. CUNNINGHAM: I'm sorry. I guess I didn't hear you.

CHAIR JOHNSON: Are you indicating that 67 percent of the prior slide's 60 percent?

MR. CUNNINGHAM: No. The next slide refers to --

CHAIR JOHNSON: This is --

MR. CUNNINGHAM: This reflects -- they don't translate exactly. This reflects workers, as

well as family members, so it's really just getting a handle on how many uninsured people are working or in families that are working. But of uninsured workers, which is this slide, 67 percent do not have health benefits offered at their employer, and then another 20 percent aren't eligible. And the 13 percent, what I said is if you take that out and also include family members, it comes out to between 15 and 20 percent of all uninsured people have access to employer-sponsored coverage, either through their own job, or through a family member's job. But this just reflects the workers themselves.

MR. O'GRADY: Peter, just quickly in terms of just expanding a little bit of what I took as your interpretation. Some of these people we worry about because it may be affordability, even if they're subsidized by their employer. Others of those people due to whatever, over 300 percent of poverty or whatever, there's something else going on there. We do not have an individual mandate in this country.

MR. CUNNINGHAM: Right.

MR. O'GRADY: And if somebody walks away from their insurance, there's nothing we do about that.

MR. CUNNINGHAM: Actually, that's my next slide, because of this 13 percent that don't take up coverage, two-thirds of them cite cost as the reason why they didn't take it up. They can't afford it. Only 6 percent said well, they don't need insurance, but then there's this whole other group of don't knows, so when you ask these kinds of questions, it's kind of squishy as to what you're getting, because even people who maybe sort of opt out of the health system or they're healthy and they don't really think they need it, they might say well, cost is an issue because I don't really want to pay anything for it. So it's not clear exactly what this means, but we know that at least among the low income that affordability of premiums is a major issue.

And then of those workers, it was the 20 percent slice who said that it's offered by my employer, but I'm not eligible for it. The reason for that is 51 percent are contractor temporary workers, so they're not regular members of the workforce there. And then the next biggest chunk, 33 percent, they either work too few hours, they're part-time who are often excluded from benefits, or they haven't worked at the firm long enough in order to qualify.

So those are some of the major reasons as to why a lot of employed workers and their family members don't have coverage. And this lack of availability is related to characteristics of employers. Most uninsured work in small firms, so this graph shows workers, the red bar shows all workers, the gray bar shows uninsured workers. And you can see that uninsured workers are much more likely to be working in small firms that have less than 25 workers, compared to all workers.

And the reason why it's so high among small employers is that the cost of providing insurance is higher in smaller firms. There's a smaller risk pool, and the potential for fluctuations in risk to be greater, and there's also higher administrative costs because of the smaller number of workers.

Small employers are also more likely to hire low wage workers who are less able to afford coverage, even when it's offered. So again, this shows the percent of workers who are earning less than $10 per hour, and 58 percent of uninsured workers are in jobs that pay less than $10 per hour compared to about 28 percent of all workers. So small firms, low

wage workers. There are also particular industries, a lot of the service sector industries, are less likely to be offering coverage.

It's not true universally. A lot of the service sector, the professionally oriented service sector industries have much higher levels of employer-sponsored coverage offer rates, but certainly it varies a great deal by industry. And it's also no surprise that most uninsured tend to be in low-income families, so 60 percent of the uninsured are in families with less than 200 percent of the federal poverty level, which I think is about $36,000 right now for a family of three or four, somewhere in that area.

And I think while the changes that we see in terms of the erosion of private coverage tend to be more concentrated among the low-income, there's increasing concern that with the increase in health insurance premiums that this is going to affect people with incomes above 200 percent of poverty, so say maybe 300 percent of poverty, so there's a concern. It's not really showing up clear in the data yet, but I think in the next few years with costs in the last five years having gone up so much, there's a concern

that we could start to see more moderate income or even middle income people joining the ranks of the uninsured.

MR. O'GRADY: Peter, can I ask a quick clarifying question on that?

MR. CUNNINGHAM: Sure.

MR. O'GRADY: In terms of when we think about this, and the picture you've painted here of this is more of a small firm problem. It's clearly if you're part-time or part-year it's more of a problem. Do we think that much of what we've seen as the change in the problem is because -- are there more people working for small firms, or are small firms less likely to offer coverage than they were 10 years ago? Is this less people in manufacturing, more in service, so the rates of those sort of -- is this a movement around the economy, or is this something else going on there?

MR. CUNNINGHAM: In the last three years, it's a little bit of both. We have seen decreases in small firms offering coverage. I think during a recession there's often not only higher unemployment but more people being self-employed, as well as working for small firms, so I think that accounts for

some of the more recent decreases in private insurance.

I think long-term, I'm not sure what the trends are in terms of small firm employment, but offer rates across all employers actually remain pretty stable. I think at least through much of the 1990s, that that decreasing private coverage was not the result of fewer employers offering coverage, it was the result of fewer employees taking up coverage. That's what some of the trends from MEPS and other surveys have shown. So that's where we're seeing the impact of higher cost, that they get passed on to workers in the form of higher premiums, and sometimes in the form of higher co-pays, and deductibles. And employers will still offer coverage but increasingly it's becoming less affordable for many employees, as well as low-income employees to take up the coverage.

MS. PEREZ: So in relation with the small firms, isn't there a mechanism for those small firms to kind of form some kind of coalition to be able to go after lower premiums, lower cost?

MR. CUNNINGHAM: That's the subject of a lot of legislation, to try to increase the ability of small firms to pool their risk, and offer -- I mean,

there's restrictions, state regulations often, that prevent them from doing so, and that's been the subject of some federal, as well as a lot of state legislation.

The research I've seen, which is limited, doesn't look like that it has much of an impact, but it's certainly something that has received a lot of attention by legislators.

CHAIR JOHNSON: Peter and Rosie, tomorrow afternoon we'll hear from an organization that has tried to form some purchasing pools that might help answer some of your questions. And may I assume that retirees, even though they may or may not be covered by retiree medical coverage, would be considered unemployed in your numbers?

MR. CUNNINGHAM: Yes. Right. If they're out of the work force. And that's actually one group. I don't have it in my presentation, but that's actually one group where we've seen some pretty substantial increases in uninsurance rates in recent years, because a lot of firms are cutting back, of course, on their retiree coverage. But as a group, they don't necessarily make up a large percentage of the uninsured.

MR. HANSEN: I agree with Michael's point about the small companies, but I think the numbers might be skewed by the largest employer of people, and that's Wal-Mart, especially when you get to the situation where they put the premiums where the people are not able to afford the cost. And that's starting another trend in the bigger companies. Has that been taken into consideration, or have you done any studies along those lines?

MR. CUNNINGHAM: Well, it's hard to look at it on a company-by-company basis, but historically the largest firms have had the most generous benefits. Again, take up rates again across all industries have been pretty high. Of course, there are exceptions, but I think normally when we think of the large industries, we're thinking of the GMs, the Boeings, Ford, the traditionally large manufacturers.

Now I think your question makes a good point to the extent that here's a large service sector industry employer, and over time if there's a decline in manufacturing, an increase in service sector, then we could see that picture start to change. But the estimates I've seen - again, we're talking nationally across hundreds, if not more industries. Those kinds

of trends are hard to tease out, I mean, how to distinguish Wal-Mart. That's where if you look by service sector in industry, that's where you see some big differences in terms of employers offering coverage. But generally, the large firms have been the most generous, historically.

MS. CONLAN: Can I just jump in with something that I thought - when I was reading over the materials that were furnished to us, I thought there was a glaring omission, and again and again I was seeing the service jobs or the under-class, and things like that as being factors for the uninsured. What about the role of government?

Increasingly, I'm seeing both state and the federal government going to temporary employees who don't have the offer of any benefits. And I wonder if that skews the results, and if you did a survey inside the beltway, if that wouldn't have significantly different results from doing a survey outside the beltway.

MR. CUNNINGHAM: Yes. Again, the question is looking over a large number. That certainly has been a trend, more out-sourcing of jobs, not only in government, but other industries, as well. What I

don't know or what I don't think we've seen yet is that trend become so prominent that it's made a serious dent in the uninsured estimates, but it's certainly something that's there. And if you look within particular industries, kind of the same as the Wal-Mart question; if you look in particular industries where you know that kind of thing is going on more, I'm sure that you would see a big increase, you might see a bigger increase. But again, aggregating over all the millions of jobs out there, it's really been cost, the cost issues that's affected, that's really had an overriding effect on all other factors.

And it's been studied during the 1990s. I don't think there's been any studies recently that have looked at say the past two or three years, in part because the data tends to lag behind, but it's certainly something that could change.

MS. CONLAN: I guess I was thinking of young people fresh out of college, and where do they go? They go to these temporary jobs to try to get experience, and as a society we forget about them, and that they have healthcare needs, as well.

MR. CUNNINGHAM: Right.

MS. CONLAN: We need to protect their health, as well. We can't just exploit them as new workers so that they then sacrifice themselves in the effort of gaining experience so they can further their careers.

MR. CUNNINGHAM: Right. Actually, that's my very next slide.

MR. BAUMEISTER: It's just of interest in Oregon when they were trying to get an employer mandate, that the figure that was quoted over and over again was that 78 percent of businesses in Oregon employed less than 10 people, 78 percent, very dramatic.

MR. CUNNINGHAM: Yes. And I think in other places -- I think that was one of the instigators of the Dirigo Health Plan in Maine, because they also have a very large workforce in small firms, and this is a plan that provided subsidies for low-income workers. I mean, the one thing that you always have to remember when looking at these national estimates is that the variation across the country is pretty substantial, and it's something that we found in our work at the center, so you definitely see in certain sectors, in certain geographic areas that

there's a confluence of factors that come into play, that can result in a very high rate of uninsured.

CHAIR JOHNSON: Peter, you can see your subject matter has a lot of interest in our working group. Maybe what we can do is let you finish your presentation, and come back to the questions that a lot of us have. Okay?

MR. CUNNINGHAM: Okay. Well, there is the question of young adults, and it's certainly the case that a disproportionately high share of the uninsured are young adults; that of the uninsured, 42.7 percent are between the ages of 18 and 34, which is considerably higher than the representation in the general population. And if you contrast that with children, for example, the percent of uninsured who are children less than 18 years of age is 15 percent, which is a lot lower than the overall percentage of children.

So, obviously, as we made all of these efforts to expand children's coverage, which I think have succeeded to a great measure, there tends to be a big drop-off once you no longer have that privileged status of being a child, and it's due to a number of factors. Obviously, they lose eligibility for a lot

of these public programs, Medicaid and SCHIP. They're no longer eligible to be covered by their parent's policy, and young adults tend to be in the entry level jobs, many of which are often going to be the temporary types of jobs or positions that don't offer employer-sponsored coverage.

There's also some sense that because young adults maybe have this notion that they're going to live forever and they're never going to get sick, they're more likely to want to trade-off higher wages for less benefits, because there does seem to be some tendency that firms that don't offer coverage tend to pay somewhat higher benefit, tend to pay somewhat higher wages compared to firms that do offer coverage.

So I guess the question is, probably over time a lot of these young adults will eventually get onto coverage as they progress in their careers and start families, and the idea of being insured becomes important to them. To what extent are they at high risk now? Well, they tend to be a much healthier group than older adults, but it is something that is increasing. This is one of the groups where we're seeing increases in uninsurance rates over time, which I think makes sense, given the fact that they tend,

being at the start of their earning careers, they tend to have less money available to afford the increasingly high health insurance costs.

I think another fact that often gets overlooked is that if we talk about uninsured being a national problem, I think it's a major problem in the Hispanic community. Right now, the percent of the population that is Hispanic is about 15 percent, but the percent of uninsured who are Hispanic are about a third, so about a third of all uninsured are Hispanic, and it also works the other way around. Of all Hispanics, about a third of them are uninsured, which is twice the rate as all of the other major racial and ethnic groups.

And we understand some of this. They tend to have the types of job characteristics working in the small firm, low wage types of jobs - agricultural types of jobs, and service sector jobs come to mind, where coverage just simply isn't offered. There's also immigration issues where they're often excluded from eligibility for Medicaid and some of the other public coverage programs.

In fact, if you look at non-citizens, fully more than one-fifth of the uninsured, almost 22

percent, are non-citizens, and that includes not just Hispanics, but other non-citizens, as well.

I think the other interesting thing is that there's a very strong correlation between the percent of the population that's Hispanic and uninsurance rates, so the areas of the country that tend to have the highest uninsurance rates, places like Southern California, the Southwest, Miami-Dade County, they also have the highest rate of Hispanics. And I think we have to consider this more because Hispanics are increasingly making up a larger part of the U.S. population. And I think we need to understand more are there particular circumstances of their situation that needs to be addressed, or is it just simply the economics, or are there other things. Are they less likely to take-up coverage? Are they more reluctant to be involved in the healthcare system, are there cultural issues? Those are the things that I think are important to look at to address the problem nationally, as well.

MR. O'GRADY: Peter, was there enough sample size to be able to say Hispanic citizens, and to see whether there's still the differential in terms of what's going on?

MR. CUNNINGHAM: Yes. The non-citizens, obviously, they're much higher, but even among Hispanic citizens, I don't have the numbers with me, but Hispanic citizens still have higher uninsurance rates than say Whites or African Americans. And there's actually parody between Whites and African Americans. There really isn't much differential any more. And a lot of that has to do with the expansion of public programs.

There's a fairly high percentage of the African American population enrolled in Medicaid and SCHIP, and that has eliminated a lot of the disparities that used to exist in coverage between blacks and whites.

VICE CHAIR McLAUGHLIN: I was just going to add, Mike; at ERU, the website, I'll send you the -- we did something on citizen/non-citizen for Asian, Hispanic, actually country of origin, so you can see the comparisons. The disparity is greatest actually for Asians in terms of whether or not they're citizens. It's greater than it is for Hispanics.

MR. CUNNINGHAM: Yes. And I think there have been studies that have shown that uninsurance rates tend to decline the longer people have been in

the country, so there's sort of an economic and maybe even social integration kind of issue that goes on. So there's some expectation that maybe over time the uninsurance rate among Hispanics will go down, again, as they become more integrated. But then again, on the other hand, that's also one of the largest sources of immigration, so I think that's probably going to continue for some time.

And finally, I'd like to talk about some of the consequences of being uninsured. Again, just to summarize - the result of being uninsured means reduced access, more unmet medical needs, higher use of emergency departments, greater financial problems in paying for medical care, and worse health outcomes.

Surveys have been pretty consistent over the past 20 or 30 years when we measure the percent of people who report that they have unmet medical needs. And this graph compares the uninsured to the insured in terms of their levels of unmet medical need for both general medical care, as well as prescription drugs. And in general, uninsured people tend to have two and a half to three times more problems than the insured do, and that's pretty consistent regardless of the kind of measure.

There's also newer measures that attempt to do these kinds of estimates based on specific kinds of symptoms and health conditions, for which there is more of known need for medical care. And again, the findings are pretty consistent.

There's also much greater reliance on hospital emergency rooms for the uninsured, so what this graph shows is that of all ambulatory care visits that the uninsured made, that fully a quarter of those visits are in hospital emergency departments. And that compares to just about 9 percent for insured persons.

MR. FRANK: Does the insured box include both Medicaid and private?

MR. CUNNINGHAM: Yes.

MR. FRANK: How about if you just cut it by Medicaid, how does --

MR. CUNNINGHAM: Medicaid tends to be higher. I think it's about 14 or 15 percent for Medicaid. Medicaid also tends to be higher users of emergency departments, as well.

MR. FRANK: So part of that is just an income.

MR. CUNNINGHAM: Yes, and health status.

I mean, Medicaid tends to be higher users of all kinds of healthcare, but yes, part of it's income too, as to why they go to the emergency department.

I think the other notable thing is, I looked at this a few years ago in terms of how it's changed over time, and this is estimates for 2001. I also looked at it for 1996, and found that at the time 17 percent of all visits were at emergency departments for uninsured people, so it's gone up quite a bit. And I think this reflects, based on some other trends that I've seen, that uninsured people simply have fewer options. There's fewer physicians that are willing to take uninsured patients into their practice. There's a lot of financial pressures that have been going on that have limited provider's ability to cross-subsidize the care that they provide to the uninsured. And so, obviously, EDs have to take uninsured patients to the extent that they're required by law to at least provide a screening, but I think it's an indicator that there's increasingly fewer options for the uninsured to go.

MR. BAUMEISTER: This is 25.2 and 8.9 percent of what?

MR. CUNNINGHAM: This is all visits -- the

percent of all ambulatory care visits at ED.

DR. BAUMEISTER: So one out of four visits are to emergency rooms?

MR. CUNNINGHAM: Right. Right. Out-patient ambulatory visits.

VICE CHAIR McLAUGHLIN: But, Frank, part of the question is that all depends on what the denominator is. And I was confused too, at first, but that's because the denominator in this case is all ambulatory care visits.

DR. BAUMEISTER: I knew you were, but since you weren't bold enough --

VICE CHAIR McLAUGHLIN: Well, I need you to be the leader. It is reflecting partly what Peter said, that they don't have many other options if they have an ambulatory care problem. This is different than saying what percent of all emergency department visits are people who are uninsured, which I think is another way that people have looked at this problem. And what several of us have shown is, it's about proportional. In other words, if an area has 15 percent of the population uninsured, about 15 percent emergency room visits are by people who are uninsured. And I think this is partly what Richard was getting

at; the really big kicker are people who are duly eligible, people who are disabled, and Medicaid recipients. Those are the ones who are disproportionately using the emergency room, when you use that as your base. So it really depends on how you're looking at it, because the other way, the insured actually have a higher level if they are insured through disability or through Medicaid.

MR. CUNNINGHAM: Right. No, I think that's a good point, that if you're looking at who uses the ED the most, it's the insured people, particularly Medicaid certainly use -- they use all forms of healthcare much more than the uninsured. But what I was trying to get at here is sort of where do uninsured people go when they use healthcare? And when they use healthcare, they have restricted access no matter where they go, but when they use healthcare, they go to the ED a lot more often, or they're much more dependent than the insured are. But that's a good point.

And the uninsured also have more financial problems related to medical care. And this is despite the fact that they use much less healthcare overall, regardless of whether you're looking at EDs, or

hospital in-patient visits, or physician office visits.

This is a measure of the percent of out-of-pocket costs that exceed 10 percent of their family income, and you can see that the uninsured are, again, about three times more likely to have large out-of-pocket costs relative to insured people. And then in our 2003 survey, we also asked some questions regarding the extent to which people were having problems paying their medical bills. And again, the uninsured, almost a quarter of the uninsured reported that they were having problems paying medical bills, which is twice that of insureds. So again, the fact that they use much less healthcare, they have lower overall access, and despite that, they still have greater financial problems, which also reflects their lower incomes to a large extent. It kind of presents a double-whammy for them.

And then in terms of their effects on health, do we know that lacking insurance in and of itself leads to worse health outcomes? There's been much less research on that. It's a lot more difficult to get at. It's something that survey data really can't get at, I think, with any degree of

satisfaction. There was an Institute of Medicine report in 2002 that documented a number of studies, which showed health insurance to be important. Health insurance was important in determining outcomes associated with some chronic conditions, including diabetes, HIV, hypertension.

There was one study I think pretty notable where cancer patients who are uninsured are more likely to be diagnosed at a later stage of the disease, and they're more likely to die sooner than being insured. From a research perspective, the question is, is it health insurance itself that leads to worse health outcomes, or is it because of the reduced access and fear of generating high medical bills that leads to untimely use and greater health problems.

And to conclude, I think we also have to consider the consequences to the healthcare system, and society as a whole. Again, the uninsured, they use healthcare at a lower rate, but they do use healthcare. They go to emergency rooms, they go to community health centers. Sometimes they go to private physician offices. And providers who serve the uninsured often have to absorb these expenses as

uncompensated care.

There was an estimate that came out a couple of years ago. It's notoriously difficult to estimate, but a couple of researchers estimated uncompensated care costs to be about $34 billion annually, I think, for the year 2002, maybe. And so something we observe on our site visits as part of the Community Tracking Study, is that too many uninsured, or high numbers of uninsured can create financial pressure and threaten the viability of a lot of healthcare providers, especially the types of safety-net providers that tend to see a high number of the uninsured.

And even community health centers, which receive federal subsidies to operate and serve the uninsured, they're still dependent on sources of revenue, such as Medicaid. They can't operate on the federal subsidy alone, so I think there are some costs to the healthcare system. Researchers have also tried to measure the impact of uninsurance on things like lost productivity because of untreated illness, but this is something that hasn't been studied too much, and the findings haven't been very conclusive. So I'll stop there, and entertain other questions.

CHAIR JOHNSON: If I might, I'd just like to start, and I'm sure we'll have a whole series of questions. Peter, let me test something with you. From what I'm hearing you say, I'm hearing the problem is going to get worse before it gets better. And the reasons are, what I'm hearing you say, at least, is that we have high cost, and costs are increasing, forcing some employers to get out of providing medical coverage, forcing some companies that provide retiree medical coverage to get away from that. So employees, retirees, are asked to be picking up their own coverage.

Employers are also saying because of the high cost, we're going to have to shift some of the premium cost to you. And because that cost is going up, employees never knew what their employers were paying, now they're having to pay more, and they're saying I'm going to forego coverage. The data shows that 30 percent of those who enter ninth grade do not graduate - 70 percent approximately graduate from high school. And in today's society, for them to keep up or have an income level that's going to allow them to pay for a portion of healthcare coverage, it's going to be very, very difficult.

What we're hearing you say, at least I'm hearing you say, at least, to some degree is that the uninsured is somewhat of a function of low-income. And so if we have graduation rates like that, low-income, high cost. Am I understanding your comments correctly, and do you see it differently?

MR. CUNNINGHAM: I think for the most part, I think that's correct. Again, I think the issue with the low-income is, it used to be maybe 25 years ago, they had higher rates of being uninsured than others, but a lot of them were still able to get some insurance. And I think increasingly that's not the case. You really see the shift in private/public coverage. And then the other concern that I think goes along with that is, and you may have heard this in your previous presentation, are the problems that states have been having in affording their Medicaid programs, and the soaring healthcare costs that they're seeing there, and they're increasingly having to deal with cost containment.

States are doing a lot of different things. Some are even still trying to expand, but others are putting forth some pretty radical plans that are going to cut a substantial number of people

off; mostly people who benefited from the expansions. I think children tend to be pretty protected right now, but I think a lot of the expansions that were targeted at low-income adults who didn't meet the very strict poverty definitions, I think a lot of them are potentially going to be at risk. And I think the troubling thing is nobody really sees a solution to this.

Ten years ago, actually when the Center was first starting, managed care was seen as the solution to a lot of these same problems, because it was a way that the costs were going to be controlled, while being able to provide quality care, and services to more people. And for a while, managed care did manage to help contribute to lowering healthcare costs. But that movement has pretty much run its course. There was a consumer backlash against a lot of the restrictions. Managed care has retreated, and the only thing that's really been going on is passing the higher costs onto employees.

Plans are experimenting with trying to design plans that encourage more efficient utilization and that, but I think they're trying to get a handle on their cost, but right now they're not necessarily

seen as things that are going to turn the corner. And I think costs and access are inherently related. You're not going to be able to deal with the access, the uninsured problem, without the cost issue, because it's just become inherently expensive, and there needs to be some way to get a handle to manage the costs, I think, before access can be expanded.

CHAIR JOHNSON: And one last statement and a related question. Our experience has been that when trying to hire employees, many of them would prefer to be contractor workers because they prefer the cash instead of the benefits, so they're saying to us I don't even want to be an employee of your company - and it's not only our company, it's not anything against our company, but that's what they're saying. I don't want to be an employee of the company. I'd prefer to be a contract worker because I know I get more money that way. Have you done any studies on that?

MR. CUNNINGHAM: I'm not aware of anything particular on worker's preferences, but I think maybe what goes along with that is increasingly with many households being dual earners, where both spouses are employed, they often can get coverage through their

spouse. And I think that probably has softened the impact of a lot of the change, or greater out-sourcing of jobs, is that there are more families now where they have two earners, and at least one of them are in a job where health insurance is offered. And being two earners, they can afford that.

In fact, looking at long-term trends, the erosion in private insurance coverage is greatest in families where there is only one earner. If you've got two earners, the chances are very high that at least one of them are going to be offered employer-sponsored coverage. So that kind of social trend has offset some of the erosion to some extent, but not completely.

MS. WRIGHT: Randy, I just want to mention in the healthcare industry, hospitals in particular in the early to mid-80s; now, Pat, I don't know if you saw it or not, but we had whole trends of nurses who went to per diem pay because they discovered they could get more wages, like you said - did not need the benefits because they were the dual income, their husband had all the benefits. We literally had intensive care units and coronary care units staffed with all per diem nurses, because of that money.

MR. HANSEN: Just a couple of technical questions on your graphs, on the percent of the uninsured, I was a little confused. You made a reference to those people that are on Medicaid. Do they consider themselves insured or uninsured, and how did you count them?

MR. CUNNINGHAM: They're counted as insured.

MR. HANSEN: But some of them didn't understand that they were; was that your reference?

MR. CUNNINGHAM: Well, it's a survey issue where -- yes, Mike has actually --

MR. O'GRADY: Yes. It's a study done by my staff and by some of our contractors. And part of what we found is that we had, especially when we were talking to states - state administrative records have gotten much, much better through IT and other reasons like that, so you hit a state that would say -- the national survey, the 45 million one that you pointed to, would say there's 2.2 million people on Medicaid in my state. And the state would come back and say we've got 3.4, those sort of discrepancies. So we started to wonder.

What we also saw was in `95-96, you had

welfare reform. The Census Bureau used to be able to know that if somebody had standard welfare, age of families with dependent children, they automatically had Medicaid. Welfare reform changed all that, so it's much harder for Census through a traditional survey to track who does and doesn't have Medicaid. So what we did is we had a team of actuaries, and a team of health economists both look at that problem. And one came back; what do you think is the under-count of Medicaid people, and then does that lead -- and it doesn't automatically lead to an over-count of the uninsured, because some of those people - they were being counted as having employment-based or some other form of insurance, so it wasn't that it was a one-to-one. But it did come back with this idea - the actuary thought it was about 9 million people less, which would put it kind of in the ball park of the other three surveys you saw. And the health economists at the Urban Institute found it around 3.6, so the way I view it as sort of the office that funds all this research is, that's sort of step one. We didn't narrow that. There's always these kind of things, but it's a terribly, I would say, untenable policy situation to go forward to any decision maker

and say well, chief, there might be 45 million uninsured, or there might be 32 million uninsured, or there might be 28 million uninsured.

For the research, and certainly that part of the survey community to not be able to nail this down better of exactly who we're talking about, is always going to undercut the ability to move forward on a well-informed policy. So nobody is trying to say that this -- this problem is big, I mean, whether it's 28 or 32, or 45. But you have to be able to figure out, just for the sort of stuff Peter's talking about, who are these guys? What part of it is small firm, what part of it is part-year/part-time, what part of it is immigrant, to drill down and find out who these key sub-populations are, so you can design programs that will give them insurance. You've got to kind of know who you're dealing with.

MR. HANSEN: All the inference in these is that this is a growing number, and you just showed us statistics for 2003. Is that fair to say that these numbers are getting larger, no matter what the survey is?

MR. CUNNINGHAM: Yes, I think most -- of course, some of them don't go back that far, but I

think for adults, in particular low-income adults, the uninsurance rates have increased. I think for kids, it's a different story. I think kids benefited from public coverage expansions, regardless of how much crowd-out there is. It's apparent that the expansions starting in the late 1980s and on through CHIP have helped to reduce the number of children who are uninsured.

MR. HANSEN: On your next graph, you refer to premiums, and I'm assuming, but I'm going to ask, the premiums - do they track the cost, or is there a variance there?

MR. CUNNINGHAM: The cost of healthcare?

MR. HANSEN: Yes. Premiums are rising faster than earnings, and you show it over 1999 to 2003. And I think it was your sixth graph.

MR. CUNNINGHAM: Right. Yes. This is from the survey of employer-sponsored benefits. It reflects actual reported premiums. I'm not sure if they're exactly equivalent to cost, but I think they generally track in the same direction.

MR. HANSEN: That would be my assumption. My third question, and you answered part of it - I was confused on the emergency use in the uninsured and

all that, but there's a lot of uninsured that get healthcare someplace, and either a public program, I understand, where there is costs are, but if they go to a provider like a hospital and get coverage, and then don't pay, somehow those costs are absorbed. Is there any figures on anything like that?

MR. CUNNINGHAM: I mentioned that there was an estimate of $32 billion, I think from a few years ago. The AHA does keep track of hospital uncompensated care costs. Those numbers can be a little funny, because it's hard to dis-entangle the uninsured from unpaid expenses by the insured, but I think -- it's difficult to get a handle on, but there were a couple of researchers who took probably the best stab at this than anybody has, and over the whole healthcare system, they came up with an estimate of 32 billion.

Now you have to realize that the uninsured use much less healthcare, and so if you gave them coverage, then these expenses would go up, not as uncompensated care, but as total healthcare expenses.

MR. HANSEN: Well, maybe the popular belief, maybe not correct, is that any time that I would use the hospital or my wife or anybody else,

that those costs are added onto my bill one way or the other.

MR. CUNNINGHAM: Yes. Traditionally, that's been the way it's been done. Hospitals have less ability to do it now, because they negotiate payment rates with health plans for the most part. Hospitals just can't bill whatever they feel like any more, which is basically the way it was done, and Medicare has their system. So I think there's still some cross-subsidization through Medicaid, especially the disproportionate share hospital payments which hospitals who treat a high number of low-income, they still provide a lot of subsidies. A few states like Massachusetts, actually have uncompensated care funds which I think go a long way to providing relief for hospitals. But it's still the case that a lot of hospitals have to eat the cost.

MS. MARYLAND: I'm Pat, and I actually represent the hospital side of the business. I've been in the operations side for about 26 years, and I will say that the burden from the uninsured has definitely shifted to the hospitals, and to many of our providers, our physicians. And yes, the disproportionate share dollars do support and help to

cover and offset some of those costs, but it's not sufficient. And I think you can just look to, and I'll use the example in Detroit, with the Detroit Medical Center, St. John's and Henry Ford all coming together with this hue and cry about how difficult it has been for them without a public county-subsidized facility within the City of Detroit, to manage this increasing number of uninsured patients, so it's extremely been a very difficult problem I think for major cities like Detroit.

I think that the statement was made earlier that the uninsured may not use the system, or they may not be adding cost to the system, if you will, because they tend not to use the system until they have a major catastrophic situation, and then they come to the emergency departments. And I think that's the problem, is that if we can look at the use of community healthcare centers, and federally qualified healthcare plans in a way that will help to get them in early enough in a preventive mode, to be able to prevent the catastrophes that we do see when they walk into a hospital emergency department, I think is key. And being able to find ways of paying for more community initiatives like that I think is

going to be key long-term to be able to offset the cost.

MR. CUNNINGHAM: Right.

MS. MARYLAND: And then the last statement I wanted to make was the shifting of costs, if you will, to major employers, and the increasing rate of premiums for the major employers; yes, some of that was done beforehand, but I think as you indicated, Peter, it is becoming much more difficult for hospitals to have any opportunity to increase their charges with other pairs to offset the costs associated with the uncompensated population. And I think that everyone is finding that if we don't work together and figure this out together, particularly for our providers, our physicians who are saying I'm no longer going to take this type of population. I can no longer afford to manage it with my increasing malpractice costs, has become a major challenge for all of us. And we are literally finding ourselves begging our physicians to please accept these patients, particularly the sub-specialists, or pay for that from the hospital's portion to subsidize the physicians in order to support this population. And it's been a huge challenge for us.

MR. FRANK: I just have some questions. Do you know what's been happening to both the level and the trend in take-up for Medicaid and SCHIP?

MR. CUNNINGHAM: Not off the top of my head. I know of a study that looks at it. I think the take-up is actually lower than ESI coverage. I'm thinking two-thirds, maybe 70 percent, although I don't want to be held to that number. But the estimates I've seen are that it's lower than ESI coverage. And I think it's -- my sense is that it's probably -- if I had to guess, my guess is that I think it's increased, at least up until the last few years, because there was a lot of money by both the federal government and the states put into outreach, and again, as part of our site visits, where we at least get anecdotal reports, a lot of those have been very successful.

There's also private efforts, foundations that have been involved. So I would guess that at least since SCHIP, it probably increased, but I don't know by how much. And then more recently, some states have decreased their outreach efforts because now with their state budget problems, all of a sudden they don't want any more on the rolls, so maybe the last

few years, if anything, it's decreased a little bit. But I think some folks at the Urban Institute have looked at that. I know of a study at least a few years ago that looked at it.

MR. FRANK: Yes, well let me ask a corollary. Are there simulation studies out there that show sort of the realistic potential to cut into the problem based on just sort of improving take-up rates?

MR. O'GRADY: The Urban model he's talking about is the TRIM model, and the last things I saw were 3-3.5 million people who were eligible from all that. You sort of look at their income, and we pay Urban every year, and they kind of go through and do the Medicaid eligibility, and the SCHIP eligibility per state; and, therefore, whatever you hope you've got as quality income data coming off the current population survey, so you're talking somewhere in the ball park -- and what denominator are you using here? But, you know, if you can reduce the number of uninsured by three million, I'd call it a good day, so there's that kind of stuff.

There's always the old kind of well, if they showed up at the emergency room, the social

worker would sign them up, but that kind of flies in the face of all our prevention work and everything else we'd like to do. I think California went to like a $50 bounty, bring in an SCHIP kid, and we'll give you fifty bucks, and still we know that we don't have everybody in that's eligible.

VICE CHAIR McLAUGHLIN: Mike, I just want to say, also in California and some other places they found one of the most successful ways to get kids enrolled in Medicaid and SCHIP was by having parental expansions. So that was more successful than any of the other outreach to the families, was in California and a few other states during the late 90s as part of Medicaid expansions, they allowed parents of Medicaid eligible kids to enroll in the same HMO or plan, and that had the biggest pay-off of any outreach effort. And, of course, those have all been rolled back, which is consistent with what your comment was earlier. Not all, but most of them have been rolled back.

MR. O'GRADY: But that's what -- the HIFA waivers that Bill Scanlon was talking about this morning, that's where you can sort of start to get to that idea, of how do you get the whole family enrolled.

MR. CUNNINGHAM: Right. And I think -- I don't know of studies that have documented this, but just my sense is that there's a lot of people who enroll in these public programs, almost at the time of service that they need, and hospitals and other healthcare providers have -- they screen people for eligibility, and it's often the case that a lot of people haven't thought about it or haven't bothered until they actually need service, and then they land up in the hospital, and they find out that they're eligible. And I think that's what a lot of these outreach programs have tried to address, but I think it's a good question that Richard was asking; is realistically in a voluntary system, how high can we go? And again, I look at take-up rates of employment sponsored coverage, and they're very high. They've decreased somewhat, but they're still above 80 percent. And there's always going to be some people who, for whatever reason, are just not going to sign up, and so how much of that population can we expect to cover? How much will a subsidy make a difference, and how much in a voluntary system, you're always going to have some who just opt out. And I think that's a good question.

CHAIR JOHNSON: Mike, did you have another comment?

MR. O'GRADY: Yes, I do. I think that in terms of - and it's something having to do with what Pat brought up just a minute ago, because part of our overall charge was sort of looking at money and where is it coming from, and where is it going to, and whatnot.

One of the ways that we've dealt with this, at least they dealt with it in the past, is the program that Pat was talking about, with disproportionate share payments going. And that was a notion of using federal funds through both Medicare and Medicaid, but not necessarily to subsidize coverage in the way an employer would, or when we think about these others sorts of programs like SCHIP; it was to identify hospitals that looked like they were having a disproportionate burden from the uncompensated care, and giving them a direct payment. And that certainly has been successful at making sure that hospitals that really are taking the major hit don't go under, or trying to help them offset.

At the same time, as an investment of funds to deal with the uninsured, it doesn't address

their physician visits, and their other sorts of things like that. So when we think about kind of where this money is, I think that that's an important thing just to keep in the back of our mind, that there's this money that's been obligated and dedicated, to use a particular strategy to deal with this problem. But I certainly have heard people say could that money be, in effect, reprogrammed into offering a subsidized health insurance policy to the uninsured?

Now the hospitals would not be happy with that, other than the idea that the percentage of people walking in without health insurance would decrease proportionately.

MS. CONLAN: I just wanted to bring to the discussion a response to what Joe asked earlier about are Medicaid patients considered uninsured? There is a group called the medically needy group, and actually, I keep saying I'm a Medicaid beneficiary, but I'm not a full-fledged Medicaid beneficiary. I'm a medically needy beneficiary. So, in fact, at the end of every month, I'm uninsured, and I have to re-certify. I'm also a chronically ill medically needy beneficiary, so when I pick up my -- medically needy

is also called share of cost program by some. When I pick up my injectable drug, which costs $1,200 a month, I meet my share of cost. But I am often refused care because it takes about 10-15 days legally in the State of Florida - my case worker has 10 days to process my claim, and then there's communication problems between the computers for the Department of Children and Families and AHCA, the Agency for Health Care Administration, so it can be up to 15 days before I come onto the system as a Medicaid beneficiary.

Oftentimes, hospitals and doctors in an effort to protect themselves, don't want to believe me when I say oh, but it's going to be retroactive when they finally process it. They don't want to believe that, or too often I guess they've been fooled by that. So for me, it's a sure bet that each and every month I will become certified as a Medicaid beneficiary, but there are many people who are not chronically ill, or who have lower medical expenses every month, that may not meet their share of cost, so there's the spotty pattern, sometimes they are Medicaid patients, sometimes they aren't, sometimes they are uninsured. It could be for a month, it could be for six months - sometimes those people give up

because their worker requires them to keep running in bills and it gets to be a very cumbersome process. Oh, here's another one for $20 I forgot to give to you, until they finally meet their share of cost. So I think that's something that the group needs to understand about the medically needy program, and one component we need to understand in terms of your presentation that affects this uninsured figure.

MR. CUNNINGHAM: Yes. Well, I think that's one thing that makes it very difficult to count in surveys, and even compare it to administrative data, because I think in most states, they do need to re-certify or the eligibility needs to be redetermined periodically, and so at the time that the interview is conducted, sometimes it may not be clear exactly -- I mean, the individual themselves may be confused as to whether or not they're actually enrolled at the time, so it makes it very difficult. It's also something that can create barriers, because again, when we were in this expansion mode in the late `90s, a lot of states were removing those kinds of things, because they were a barrier. People were losing coverage, having difficulty getting services. But again, with the state budget problems, a lot of states have re-

introduced them as a way to try to keep a hold on enrollment, and it does have an effect. So it's a tool that they can use to limit enrollment without actually reducing eligibility.

MS. CONLAN: Right. And the other thing I wanted to point out is, technically -- when I first heard of this system, I thought it was Medicaid fraud. In the State of Florida, they're more generous than many states, because they allow my pharmacy to submit a bogus bill as if I had paid that bill for the $1,200, and then on the basis of that I meet my share of cost. Then the state says okay, now she's Medicaid eligible, and then the pharmacy resubmits another bill for $1,200 that is then paid, but many states are not that generous. You actually have to pay that share of cost before you are certified as Medicaid eligible.

MR. CUNNINGHAM: Okay.

CHAIR JOHNSON: Okay. Rosie.

MS. PEREZ: A couple of things. I think the federal government just released some funds to be able to pay for healthcare for undocumented immigrants. Obviously, some states will receive more funding than others. I think Texas is due for about $46 million, and then we've all got to fight it out

within Texas as to who's going to get that share of the money.

But I think my question, and it's pretty big, and forgive how stupid it's going to sound, but how much does it cost to get healthcare? I mean, throughout the entire day, I've heard about Medicaid paying certain percentage, Medicare, negotiated insurance contracts, and then there's no one negotiating on behalf of the uninsured, so what is the real dollar, what is the real amount, as far as costs for healthcare? Because I heard through your presentation that we need to contain cost; what are the costs? We're looking at all these different reports, and it's just kind of all over the place. And is there anywhere, or does anyone really have an idea of how much it costs to provide healthcare?

MR. CUNNINGHAM: I don't have the number off the top of my head.

MS. PEREZ: But it's out there?

MR. CUNNINGHAM: Well, I think it depends on what assumptions you make. We certainly know CMS, we certainly know how much we spend on healthcare per person in the country, and we can do that based on various risk categories through surveys, and that. I

think the question that makes it difficult is if you cover somebody that's uninsured, how much additional healthcare are they going to use? And you can make estimates, and people have made estimates. I mean, I can point you to some documents where that's done, but there's always some uncertainty about the precision of those estimates.

I don't have the number off the top off the top of my head, but I know it's a lot. And it's a lot more than we're currently spending on uncompensated care, because when you cover somebody, when you give them coverage, in general the utilization will increase.

CHAIR JOHNSON: Andy. And then we're getting to the end of our time.

DR. SHIRLEY: Mine is very brief and related to the uninsured or the Medicaid is counted as insured or uninsured, and Montye's comments is one of the reasons we often frequently refer to the Medicaid population as under-insured.

MS. BAZOS: I was just curious again about the numbers. When you talk about a percentage of the population that don't take up insurance when they have the opportunity, I'm assuming there are some

studies that looked at what level of cost would people be willing to take it up, based on -- you gave in one of your slides, you said that if someone made $10 an hour, so if you made that, that's what - $36,000 a year or something like that. And if they were offered a premium, at what level would they -- if costs were the issue, are there any studies that suggest that at what proportion of salary would someone be willing to pay?

MR. CUNNINGHAM: I think there have been some surveys that have gotten at that, have tried to ask similar questions.

MS. BAZOS: Does SCHIP ask that, because isn't there a buy-in from families for SCHIP?

MR. O'GRADY: There is a certain --

MR. CUNNINGHAM: Well, yes. I mean, I think there are surveys, I'd have to look. But I think the only danger in that is I think there's a difference between what people might report on a survey in response to a hypothetical question, and then what they might actually do given the opportunity. I mean, there's been surveys about how willing small firms would be willing to offer coverage given if they could get certain prices on that, and

how much that that corresponds to reality is not clear. So I think there are surveys, but you have to be a little bit careful as to how much to infer that would actually happen. Because, again, if you're looking at low-income, you're looking at people who lots of competing needs on very limited income, and they have to make choices, even $50 a month which would make me very happy if that's all I had to pay for health insurance. They have to consider what they're trading off, so it's difficult to get at, and it depends on their need, as well.

CHAIR JOHNSON: I apologize for indicating that we're running short on time. I looked at my watch and it was upside down, that's not a very good facilitator's practice. Mike, and then we'll keep on going.

MR. O'GRADY: Yes. Just a couple of things on a couple of the things that have been said so far. There is this - kind of harkening back to a second about the idea of the surveys - there is this discussion that goes on among the people who try to ask these questions and get good solid answers of what do you mean by insurance? And what's clear is that there is a category, and I hesitate even to put a name

to it; quasi-insurance. But Joe was asking before about the idea of who's counted, who isn't.

Like the Indian Health Service guys, now that's certainly clinics and a number -- but they're counted as uninsured, if you're an Indian Health Service covered member of a tribe. There's other people, some of the VA stuff. Clearly, people are going to get it, but they would be counted as uninsured here, so it breaks -- what do you do with the people who are getting a fairly high percentage of their care through the community health center, especially in those communities that sort of do this link-up to some of the faith-based hospital going with the community health center. And so you're getting a little bit of both primary and secondary care, so it's not only is there sort of a certain mushiness here in terms of what the right number, but even how you sort of define insurance is something that's being debated back and forth.

The guy to ask about how much this costs per person, that's Rick Foster. He's coming in tomorrow, Friday. The last number I saw was around 55-56 hundred dollars per American, but Foster would know the right number.

MS. PEREZ: I think that's doable.

MR. O'GRADY: Yes. And then the question is to Dottie's about take-up; we see all kinds of different -- I mean, some of this stuff that when we talk about the kids, the sort of I don't need health insurance, as long as I don't fall off my motorcycle - I'm immortal kind of stuff. Boy, you can drop it close to zero, and they still don't take it up. Other people you can see clearly, in some of the MediGap and some of the things we've seen with their -- they're offering a supplemental coverage. You're asking for $3,000 to just your coverage that comes after Medicare, and people pay it.

Now we do assume that most people are rational, and so the danger there is if they're willing to pay $3,000, they're estimating that they're probably going to have five, or six, or ten thousand dollars in spending.

MS. BAZOS: That's a different population from Medicaid.

MR. O'GRADY: Oh, yes. But all I'm saying is that when you're sort of saying what would it take to trigger this behavior, you're seeing such variation there in terms of what different people perceive that

they need. And the thing that was brought up earlier today about the Medicare drug benefit, one of the real kind of education problems is, is to talk to seniors today about that this is insurance - that they sort of look at a premium amount and say well, last year I didn't spend that much. And then sort of say whoa, this isn't to just budget your average spending; this is to really make sure if you hit a 20 or a 50 thousand dollar year on your prescription drugs, that you're covered. I mean, most of us hopefully don't get a return on our investment back on our homeowner's. Our house doesn't burn down, you know, congratulations, you've hit the jackpot on your homeowner's insurance. It's insurance, and that's very hard in terms of especially with low-income populations, that this is insurance, not budgeting or however else you want.

VICE CHAIR McLAUGHLIN: I'd like to add a couple of things. One, as Dottie was pointing out, that with the Medicare - and, Mike, you acknowledged this - you're really dealing with elderly people, so the MediGap coverage is not considered very -- the estimates of that are not considered very indicative of what would happen if we subsidize premiums in the

working population. And most of the studies that have been done looking at workers between 21 and 64 have found out, and Peter alluded to this, that you have to subsidize quite a bit. And if you look at some demonstrations that were done in the early `90s, and projects funded by the Robert Johnson Foundation, they had demonstration programs where the premium was subsidized by up to a third, and still the take-up rate was very, very low.

Similarly, an economist named Jon Gruber did an actual experiment with postal workers and found that you almost have to give it away for there to be a large take-up. And part of it, when you start to think about it, makes sense. Given what Peter said, the overwhelming majority of workers eligible for health insurance take it up, or have insurance through their spouse. So what is left if you look at people who don't take up employer-sponsored insurance, and are uninsured, that's out there at the tail. And as Mike alluded to, they've already expressed a strong preference not to have insurance, and so most economists who have studied this in a careful way, not through surveys but through either natural experiments or demonstrations, or simulations have found that you

have to almost give it away to really get huge changes in take-up rates, so it's not very sensitive for that group.

Then the other thing about the cost of covering, a difference between just the average cost per person, but the cost of covering the uninsured, one of the dilemmas, and Pat could certainly talk about this much better than I can, and maybe we'll talk about it when we talk about cost, is the difference between costs and charges. So to use data now for the cost of uncompensated care, we're never really sure how much of that is charges, and how much of it is actual cost. And economists often talk about -- they try to point out that what we really need to think about is the marginal cost, the additional cost. If we provided health insurance coverage to the currently uninsured, what you want to know is what's the additional cost to society of providing that coverage, and so then you have to take out the costs we're already incurring.

As Pat pointed out, hospitals and other providers are already incurring the cost of providing the care. And Joe was saying how much do the insured people pay for it. It goes a lot of different places,

so those costs are already in the system. We're already paying for those costs, so then you're left with what would be the change in behavior and, therefore, the change in cost, the additional cost? And as Peter was saying, economists and others assume that if you provide them coverage, they're going to change their behavior. But what I want to throw out to the table is think about what is the behavior they're going to change?

Pat and some others articulated that they hope the behavior they're going to change is to go to a doctor sooner, to take more preventive measures, if they're a diabetic, to have constant source of good care. Some people talked about cardiac, and Asthma is often one, and Diabetes, the cost of being uninsured. If you gave them constant care, we actually might see a decrease in the cost to society of them being uninsured.

Okay, so take that out. But then what other change in behavior? Well, maybe you'd see them going to a doctor's office if they have a bad sore throat, where now they wouldn't because they don't have insurance, and they don't want to pay for it. Okay. So that would be an additional cost that we,

the insured, maybe already do. The question is, what is the additional cost to society of that behavior, and that's when you have to think about what's the additional cost to physicians of a throat swab? What's the additional cost to physicians of somebody coming in and complaining about low back pain? And we're going to learn more about this, I think, with the cost stuff if you think about the really high cost things; they're the two-pound babies, they're the quadruple bypass surgery, they're the kidney transplants, they're the end-of-life stuff. That's not -- even surgeries, emergency surgeries from car accidents, that's not what's going to change if we provide insurance coverage.

What's going to increase are the utilization of these, what could be seen as discretionary services, which by definition are lower cost. So I just think we have to keep -- I don't have a dollar figure, but I just want us to keep in mind logically, conceptually that what we're thinking about is what would change, and then you have to think about how would these people who currently don't have insurance, how would they change their behavior? And in some ways, it may end up saving us money - Pat's

issue. And in areas where it's not saving us money; in other words, it's not medical care that's going to really make your health status much better, but people want it. They're going to be pretty much low-ticket items most likely, so we need to think about it within that framework, and think about changes in what we witness, if you changed the provision of healthcare coverage.

CHAIR JOHNSON: May I ask a follow-up question, Catherine, first to you and then anybody else?

VICE CHAIR McLAUGHLIN: Do I have to answer it?

CHAIR JOHNSON: And then anybody else. You talked in your first point about the fact that you almost have to give the coverage away for some to pick it up, and yet one of our primary areas of trying to cover the uninsured is with tax credits. Have any studies been done that you have seen or you have done that have dealt with the potential impact of tax credits to deal with the uninsured?

VICE CHAIR McLAUGHLIN: That's a good question. Actually, a lot of people use this study by Gruber. And the reason I'm so familiar with it is

that the Research Initiative on the Uninsured that I direct funded that research project, so I know it better than I wanted to. But it's used a lot by CBO. A lot of people are grasping onto it because what Jon did was he looked at the postal workers, where access to insurance coverage was changed basically because of federal law, and so he had a pre/post look at what changed, and it was equivalent to a tax credit. It wasn't a tax credit, but it was equivalent to a tax credit in terms of the way the union/non-union subsidies came through. And what he found was that it would end up costing a lot of money, I forget - something like it ended being about $100,000 per newly covered person to have this tax credit, because the tax credit would go to everybody at a particular level, whether or not they have health insurance, and so you would be providing a tax credit to people who already have exercised the choice to purchase health insurance, and you wouldn't change very many people who've already decided not to have it unless the tax credit was quite large.

So the bottom line of his study, and it's one of the few that aren't just based on simulation, but actually on observed behavior. The bottom line

is that it's a very inefficient way to get coverage for that small percent of the population, because it costs a lot of money in government outlays, and you don't get much payback.

Mike, I wanted to put up one more thing about the Medicaid, and this whole issue of are you insured or aren't you insured? Part of what this relies on, and Peter talked about this a little bit, of do we think that uninsured people behave differently? And if we do think uninsured people behave differently, which is part of the assumption that oh, my gosh, if we give them insurance, they're going to start going to the doctor every time they cough and sneeze, like some of us do, then it makes a difference whether or not they think they are covered for Medicaid. And Mike's comment about Aspian Urban Institute came up with some estimates of 3 million, 9 million. People actually are eligible for Medicaid but they don't know it. If they don't know it, then I think behaving like they're uninsured --

MR. O'GRADY: He said three to three and a half million are eligible, but not --

VICE CHAIR McLAUGHLIN: Okay. So the three and a half million, if they are eligible but

they don't know it, then are they behaving like uninsured people?

MR. O'GRADY: Oh, absolutely.

VICE CHAIR McLAUGHLIN: And so then how you want to count the numbers depends on what you're trying to analyze.

DR. BAUMEISTER: This new utilization, the expectation of more utilization after new coverage of the uninsured, isn't that referred to in some quarters as moral hazard?

VICE CHAIR McLAUGHLIN: Yes, that's one of those unfortunate terms that economists use. And Mark Pauley first talked about it in the 1960s, and very readily says please don't confuse it with moral turpitude. It's not moral turpitude, it's moral hazard. It actually comes from centuries ago with Lloyds of London shipping industry, when all the -- back then there were a lot of accidents out in the high seas, and ships would get lost in the Bermuda Triangle, or they'd be subject to piracy, or they wouldn't do very well, and so the ship owners in London, in any given year they didn't know whether they were going to make a lot of money or nothing, and lose money. And so after going through this for a

while, they actually designed Lloyds of London as a cooperative where they said let's pool the risk so that no matter whose ship gets pirated, or whose ship gets lost in a storm or whatever, that we share that loss, because we never know whether it's going to be our ship this year, my ship next year, and so let's pool it together. And so that was actually the first kind of insurance pooling of unequal risks, and what happened was that the ship owners started sending their ships out in seasons where they knew there was a high risk of a storm. They started asking them to go places where they knew there were a lot of pirates. They started not having the ships being so well-built. They didn't spend as much time and money and getting a good tar, having a skilled crew. And so that was where the term "moral hazard" came about, which really was moral turpitude, because they were putting at risk these sailors' lives, but saying what do I care, because if something happens to the ship, I'm covered. And unfortunately that term was adopted, Frank, and it's still used now for anything - fire insurance, everything where because you are reducing your risk of the full burden, financial burden, you change your behavior.

DR. BAUMEISTER: Well, it's a nasty thing to be applied to the uninsured, and I think that part of the mission of this group should be to somewhat soften that, because we just heard this morning about the change in attitudes about paying for somebody else's benefit, and it's kind of disheartening.

VICE CHAIR McLAUGHLIN: I agree.

CHAIR JOHNSON: Mike, and then Aaron.

MR. O'GRADY: Yes. I just wanted to touch briefly on the tax credit notion. The tax credit notion does two things. It sort of does two policy goals at the same time, and we do see uninsured as one. And Catherine is right in terms of that there's normally at least half the people, two-thirds of the people, however you want to structure it, they already have coverage. But the second policy goal is this affordability goal, so if you're talking about most tax credits, they'll be eligible for people below poverty, below 110, 120, however you want to draw that, so it's not -- if all you're trying to do is take people who used to not have insurance and give them insurance, there is that inefficiency question. But if you're also trying to take people like below the poverty line and make insurance more affordable

for them, it has that dual edge to it, where it does two things. So I just want to say in terms of for those of us who play with those kind of designs, that there's two things going on simultaneously in terms of both affordability and increasing the number of people who are insured.

MS. BAZOS: But there's nothing tied to that tax credit that mandates taking up the insurance that is offered.

MR. O'GRADY: Well, you can't get the credit if you don't take the insurance, so you can't just take the money.

MR. FRANK: No, but there's no individual mandate is what --

MR. O'GRADY: Oh, no. Yes, the only time I've ever heard individual mandates even sort of brought and discussed at all was what I think of as sort of the Louisiana Plan. Senator Breaux raised it two or three years ago at the same time that Congressman -- I'm blanking on it. But again, two Louisiana members of Congress sort of -- and we never saw like a bill language or anything else come out, but it was that idea of when they were -- and I think it was just discussions they must have had maybe on

the plane home, or whatever, on the idea of all these other forms of insurance that we have, like auto, and homeowner, and whatnot, and it's not mandating your employer, or mandating the -- it's basically the responsibility is to the individual.

And it's clear that in terms of our discussion of per capita spending, if you could take fairly young, fairly low-cost people and have them pay premiums that they probably would not use the services very much, I think most actuaries would tell you that would be a good population to reduce your premium cost because you're spreading it across these people. But that's also back to their individual calculation that they don't need it, and probably the actuaries would say that unless they fall of their motorcycle or whatever, they don't, so it's complicated.

DR. SHIRLEY: I'm fascinated by your original comments related to cost, and how do we get that discussion going outside of this room?

VICE CHAIR McLAUGHLIN: In the report that this committee develops to then put up on our website and to go out and do community meetings. That's part of our charge, Aaron. That's part of the reason I'm interested in even doing this.

CHAIR JOHNSON: Peter, we have moved away from comments from you, but I think it would be appropriate to just come back and say are there any other thoughts you'd like to share that we haven't been asking you about, but have come to your mind in the last several minutes?

MR. CUNNINGHAM: Maybe just sort of a technical kind of getting back to sort of the original question of how many are there? I mean, survey research/social sciences is just inherently -- there's just inherently error in it, because you're making estimates, and you're basically relying on what people tell you.

I think there is widespread skepticism among the research community about the numbers from the CPS, but I don't think that because different surveys get different numbers, doesn't necessarily mean that well, we really don't know. I would say that a survey like the Medical Expenditure Panel Survey, the MEPS, they probably do the best job, just based on their methodology, because they actually go to people's houses and interview. They have extensive prompts, a lot of follow-up questions asking details, and I think they probably do a little bit better job,

or they do a better job on this whole issue of the Medicaid under-count.

It doesn't mean it's perfect, but I think some surveys are better than others. And I would say that I would have more confidence in that, so I think it's just -- I'm not trying to plug - even though I used to work there, I'm not trying to plug them or anything. But I just think being familiar with the methodology they use, and the extent to which they go in to collect the information, I would say they're a lot more credible and trustworthy. But there's always error around the number that anybody puts out, whether it has to do with sampling error, the confidence interval, just recall error, people being confused and not knowing exactly what they have.

CHAIR JOHNSON: Well, on this subject, thank you very much.

MR. CUNNINGHAM: Thank you.

CHAIR JOHNSON: Whoever recommended you had a favorable response from our group, as you can tell, so we appreciate your coming.

MR. CUNNINGHAM: Okay. Thank you.

CHAIR JOHNSON: Just before we take a break, we're scheduled -- we'll take 15 minutes, and

then we're going to go through a number of working group matter subjects. First what we'd like to do is introduce George Grob to you. Secondly, AmericaSpeaks is scheduled to be here at 4:00 for about 15 minutes or so, just to update you on some of their work and so forth, so we'll plan to do that. We'll share with you some thoughts on hearings, and then we'll see how much time we have left to get into some things like a report and some new thoughts on subcommittees and so forth, so those are the subjects that we're contemplating. Thank you again. We'll take 15 minutes, and then reconvene.

(Whereupon, the proceedings in the above-entitled matter went off the record at 3:31:58 p.m. and went back on the record at 3:49:03 p.m.)

CHAIR JOHNSON: Okay. I think we're about ready to reconvene. One last cup of coffee here, and we're ready to roll.

VICE CHAIR McLAUGHLIN: Mike and I are in competition, and Rosie.

CHAIR JOHNSON: When we broke we said we would come back and talk about one subject, and then we were going to have AmericaSpeaks with us, but AmericaSpeaks is ready to speak ahead of time. So

Carolyn Lukensmeyer is with us this afternoon and, Carolyn, we'd like to welcome you.

Right after the public relations event or the press conference in which we were announced as a working group, I received this thick packet of stuff from AmericaSpeaks, and shortly thereafter I received some more word about AmericaSpeaks. And the good work that you have done has been coming to us on more than one occasion.

Carolyn, this is not intended to be an RFP today, or this isn't intended to be a full-blown thing of what you're doing. It's merely intended to allow you to share some of the things that your organization does so that we might have that in mind as we contemplate our future direction. But we'll likely be forming a town hall subcommittee, and a communications subcommittee, and be looking more in-depth at how your organization and/or others might work with us in the future. But your willingness to come and share on a very short notice, what you're doing would be very helpful, so we welcome you, and we'll turn it over to you.

MS. LUKENSMEYER: Thank you very much. We're delighted to be here today. I think the

existence of the Citizens Healthcare Working Group and this legislation is a pretty hopeful sign to a lot of Americans who have been paying attention to the healthcare issue for a long time. And what I'd hoped to do with you in my time, as Randy suggested, frame just a little bit of context about citizen engagement practice in the country today, give you just a quick look at how our particular model works, and extend an invitation to you, and then, frankly, open it up to whatever kind of Q&A people would want to engage in.

So our mission statement is to engage citizens in the most important decisions that impact their lives, and we've done this in the arena of national public policy issues, state-level public policy issues, long-term regional planning issues, and in several instances around the country, resource allocation where citizens actually come in and do trade-off processes around budget decisions in communities.

Again, just a bit of context. Looking all the way back to Jefferson, Franklin, et cetera, and the foundation philosophy of American democracy, clearly one of the hallmarks of our Constitution and Bill of Rights was the strongest statement of

aspiration for human being's capability for self-governance that had previously existed globally. And part of the view of many people who track these kinds of issues today would say there's a deficit in America's democracy in terms of our capability to make real the authentic link between citizens and public policy processes.

And I think in most schools of public administration you'd find theoretically the stance is that the very highest quality public policy comes from the right link between expert knowledge and the collective wisdom of ordinary people. And that's the gap we're trying to fill, it is how you make that link between expert knowledge and a large body of ordinary people.

A lot of conventional wisdom exists in this country about citizen engagement, and many, many practitioners of this work beyond myself, if they were sitting in front of you, would you say there's about 10 years of practice in the U.S. to blow that conventional wisdom out of the water; that it is largely myth at this point, but it still resonates because of the way these topics are talked about publicly. But just quickly, our experience is that it

is definitely a myth that people will not participate. The general stance is people don't have time.

Well, very often the public hearings that we invite them to in no way respect the time constraints of their own life or, frankly, are so visibly and transparently not particularly effective, that people do not want to take their time.

In our work, we ask people at a minimum to be in the same location for eight hours, and we have no trouble. Now we've learned a whole lot of ways we do outreach, but we have no trouble getting poor people there, we have no trouble getting wealthy people there, we have no trouble getting minority groups there. It is your level of seriousness about it, and their judgment that it is a credible forum.

Second issue – it is conventional wisdom, that people are not competent to deal with complex public policy issues. Healthcare is certainly a wonderful example of that. And yes, it's true that a whole of the issues that need to be looked at, you wouldn't put in front of citizens in the way you would put them in front of experts.

We did a national process on Social Security in 1998 and 1999, it is much easier than

healthcare because there's agreed upon framework; you raise revenues, you cut benefits, or you change the structure, so there's a context within which the options are out there. But I will never forget as long as I live, when I met with Charles Grassley and then Daniel Moynihan as Chairman of the Finance Committee, and the big issue around complexity was the trust fund. And fundamentally, Daniel Moynihan looked at me and said, "Carolyn, this Congress will pass legislation on Social Security reform with most members not understanding the trust fund. Why should the public be required to understand the trust fund?" So again, we put up some barriers that are essentially false barriers.

We discovered in our work that one of the dilemmas is, most of us who are experts receive no training or incentive to make our expertise transparent to the public, so in most of our work, we hire writers who, by their profession, that's their job, is to make it assimilable at the third-grade level.

Third myth - people will not be able to rise above self-interest on behalf of the common good. Again, it depends on how you frame the questions, and

what's the context. This is very critical. I'll give you an example in city work. We do work on Washington, D.C.'s budget just across the river. If we gather people in their neighborhoods and ask them about the budget questions; of course, they would lobby for what they need in their neighborhood. But when we bring them all downtown to the Convention Center, and we pose the dilemma about what are the safety issues for the whole city, one of the wonderful things that is inspirational about this work in the United States is, most ordinary people still actually feel responsibility for the common good, if the process is designed that way.

The last, and maybe the toughest myth to crack or conventional wisdom, is that decision makers will not listen. Lots of them will not. I served as Chief of Staff to Dick Celeste in the State of Ohio, and was the recipient of many efforts where people had done dialogue, and then brought us the results. In that Chair in that way, I had no choice but to deal with it as special interest, because we had no idea who had organized it, how it had been organized, or what, in fact, was the context in which it had been done. Critical thing - if you involve decision makers

in the beginning, most of them are quite interested in listening.

In the extraordinary challenge that you're facing, to me there are three streams of this kind of work, all of which are equally important, some of which need to be done in sequence, some of which need to be done in parallel, but actually require that you use different kinds of expertise.

From a leadership perspective, you must have buy-in and commitment to the outcomes. And multi-stakeholder dialogues are exactly the best approach to getting an agreement. What are the areas we can, in fact, assume we could come to agreement on, and what are our specific areas that are serious conflicts that have to be worked out? And that is best done in much smaller groups, and best done with institutional stakeholders who have a lot to win or lose based on the change in public policy.

Broad citizen engagement is all about how do you develop, I started to say political constituency, but I definitely mean small "P". It's a political will to, in fact, to follow the reform. And this is why you can't only do polling. Polling is important, and I assume you will be doing it at

several points in the process, but polling creates no commitment of any citizen to any particular version of the reform. It is the actual deliberation process that moves people to a place of, this is my commitment on the issue, and I will follow good leadership to reform in that direction.

Public awareness and education - in recent history most dollars have gone into the awareness and education process, and have skipped both the multi-stakeholder and citizen engagement. You definitely need some kind of media partnerships that will, in fact, bring millions of people some steps further to understanding the tough choices we're going to have to make in healthcare, but that is a different way to link with people, and will not produce the kind of commitment that the actual engagement will produce, and will not come to agreement with the stakeholders. So what I would say, it's three strategic approaches and you eventually will want to figure out how to combine them.

Okay. Our particular unique contribution in this arena is, in fact, large scale citizen engagement processes in the thousands of people, over months of time ten thousands of people; and, in fact,

the capability to do hundreds of thousands of people. What you see on the screen is actually the Jacob Javits Center in New York City on July 20th, 2002. There are approximately 5,000 people in the room. There are 500 roundtables, 10 people at each table, totally selected against a demographic matrix that started with the Census categories; age, income, ethnicity, and gender.

Then in any one of these situations, there are certain populations that by definition have been more marginalized and their voice is less heard, so you may want to over-sample for those populations. In the case of New York City, despite what an extraordinarily large tragedy that was, almost 3,000 people died, looking at the perspective of family members of victims, if you stayed strictly with the Census data, given the intensity of population in New York, there would have been less than one body in the room. We knew that voice needed to be at every table, so the agreement we made was to recruit 500 family members.

You also know the principles of good group dialogue. You never put one young person at a table with all other adults and expect them to hold their

own. You never put one person who's holding most of the tragedy from an emotional point of view, and expect them to deal with very rational architects, developers, et cetera, et cetera. So in New York we also over-sampled for groups like emergency workers, people who owned apartments, small businesses, other people whose lives have been unalterably changed, and ended up with a mix at the tables.

In your case, in our case, in America on Healthcare, clearly you would have to do a demographic sample of the entire population in this kind of process. And you might choose - at this stage I think it depends on the framework and the politics - you might choose to over-sample certain categories of people.

In Social Security, we distinctly chose not to over-sample in the beginning, and then when we discovered, for example, that there was a sixty two to three percent support for raising the payroll tax, and think back in `98-99, that was truly a radical perspective. It's a little better understood today. The immediate response on the Hill was, but what about self-employed people who, in fact, pay both halves of the payroll taxes? So we immediately went to the

Census bureau and the Labor Department, the Demographic Bureau and said where is the highest concentration of self-employed people in the United States? It turns out that they are geographically located in terms of per capita, by state, in the Plains and Mountain states, the combination of independent farmers and ranchers. So we went specifically to those five states, added Nebraska, so there was one major population center, and did a five-state teleconference targeted only to people who owned their own businesses. And much to the shock of the Senate Finance Committee, the Ways and Means, and certainly conventional wisdom in this country, that population supported a raise in payroll tax at exactly the same percentage that the general population did. I tell that much of a story only to say given what the policy issue is, there may be times when you need to do in-depth outreach to a specific demographic.

Okay. Quickly, a couple of other slides. From this large scale where you're getting the input collected, how does it work? I mentioned already, we want diversity at each table. I think you can probably see on the screen - you can't see all the diversity of New York City at one table, but you can

make sure that no one at the table is talking to anyone at the table that has the same life experience.

Daniel Yankelovich is the epitome of the breakthrough work on this in this country in his book called *Coming to Public Judgment*. There are two criteria this kind of deliberation has to meet to be legitimate. First and foremost, it has to be an informed public, the material has to be neutral, fair, and balanced, it can't be weighted toward one solution rather than another. And the second is, that the people who are deliberating about it must be in a safe public environment in which they articulate their own views on the issue.

Think about this yourself in some policy issues you care about. Sometimes people say things about an issue they don't even realize they know. I'm sure you've had that experience sometimes. So number one, each person needs to articulate their own position, and then they need to be up against people who think differently than they think. And at that point, you can have some confidence that you have a stable public opinion.

Critical to this is keeping the process democratic at each small table, so each group of ten

or eleven actually has at the table a volunteer professionally trained process facilitator. In our nation, whether it's in corporate, education, or government, we now have literally millions of people with these skills. It has been a wonderful discovery in our work. The people who are paid to do this as a living, love to be asked to do it as a community service. So for example, in New York, we had 500 table facilitators, all of whom did it for nothing, all of whom paid their own transportation, and came to New York to support what was going on. And in that case, there was a reason to do this. There were actually people from every single other state in the United States there to help with that. In the case that you're working on, if you were doing a meeting in Seattle, we'd just call together facilitators in Seattle.

I want to show you about a three-minute video, because it gives you a dip into the table conversation. And that way, I think you can make your own judgment about the quality of the conversation and the depth of the deliberation.

(Video shown.)

MS. LUKENSMEYER: So you sort of saw how

the process works in that film, but I just want to walk you through a couple of other features -- how do you go from the table discussion that you saw to actually getting to the convergence of the 5,000 people in the room, or 1,000 people, or 500, or whatever the number is; how does this system work? So I want to spend just a couple of minutes telling you that, and then I'll open it up for questions.

So again, I've said enough about diverse participants. Each table has at the table, as you see in the upper left-hand picture, a laptop computer that's wireless. That laptop computer is connected to a central computing system, so each table, as they have their conversation, whether it was about the height of the towers, whether it was about the transportation choices, there were six categories of issues that the Lower Manhattan Development Corporation and the Port Authority needed to learn the public's response to. So in each one of those categories, the table discusses the options, comes to convergence. We never push it to be consensus, because that's unrealistic in the time frames.

And anyway, you're also wanting to be sensitive to strong minority voices that should be on

the record. So when the table has finished its conversation, let's say they had a 45-minute conversation about the transportation options, each table types in its ideas that they want to be part of the outcomes. Those are simultaneously going to the theme team that you saw in the video. Margaret was saying, "Let's take Item 52. I think that expresses it well."

The theme team members are highly trained policy analysts who are capable of being neutral on the issue. The skills they utilize are synthesizing intelligence, quick reading, really understanding how to summarize data, so it's like any other content analysis that a good researcher does.

They read it real-time, and come up with a summary of the themes. Those themes are then projected up on the large audio/video screen so they're equally visible to anyone no matter where they're sitting.

Because of the technology, this can be made very immediate and very transparent. Tables might feel like the theme team had missed something. If they do you just give them another five-minutes of discussion, and add the outcomes of that discussion to

the themes.

Now a critical stage at this point, and again, remember we're in a context that the public highly distrusts most leaders, but particularly media and government leaders in these kinds of public policy processes. If we had just given the outcomes of the themes, it was eleven different options. And remember, we're talking about billions of dollars of investment from the federal government as to the new transportation investments. And they were going to be divided up between subways, central joining stations - I don't know if there are any New Yorkers in the room, but when the subway system in Lower Manhattan was created, they were done intentionally by independent companies that were competitive, so they are separate lines that you can't link across like you can in Midtown and Uptown.

Well, Port Authority has wanted for decades to have the opportunity to fix that problem. In all tragedies, there are some opportunities, so they were strongly biased in the direction of exchange stations going east to west in Lower Manhattan. Citizens were also interested in the trains and in ferries. About 800,000 people come across from New

Jersey every single day. They want a better ferry system. So if we had just handed the officials the eleven options, it would have left a hole big enough to drive a semi-trailer truck through in terms of just doing whatever they wanted to do. So it was critical that we narrowed down the options, not a false zero sum choice, but one that will be able to tell the decision makers what the public's priorities are when they make the trade-offs.

That's where the second technology becomes critical. The lovely Asian woman in the lower left-hand corner has in her hand an electronic keypad. If any of you have ever been in a David Walker meeting at GAO, he loves to use these in terms of testing the conversation at a certain stage.

In the particular way we use them, a critical function they play is to move from the collective shared view. We're confident those eleven themes represent the majority of thinking in this 5,000 people, but then how do you rank order them? How do you know one, compared to seven, compared to eleven? It is very important then that you go back to an anonymous process, because let's say we sat at a table where the majority of you thought that Westside

Highway should be underground, but I happen to have children, and I want them to be able to go back and forth between Battery City Park and the grass on the other side without having to be in a tunnel. I really want it above ground. So at the stage we make these votes, it's important that I vote myself, and that there's no peer pressure. You don't have any idea how I'm voting for those choices, even though I was in the discussion with you.

The other critical factor about the keypads is in the morning when we start, we use the keypads the first time to actually show live the demographics in the room. So we literally take the time to say if you're male - press one, if you're female - press two, and all the way through the demographics, so right then real-time in front of the media, in front of the public we're saying 51.2 percent of the people in this forum are women, and 49.8 are men, and in this actual region the real number is 50 point whatever it is, so you can show the exact statistical difference that you have in all of the demographic categories.

But from a group like your's point of view, the more important reason for you to do that, is

to key in the keypads. This keypad is now keyed to an Asian woman who is 72 years old, who earns X amount of money, and every vote she takes that day can be tracked to that demographic category. So from a policy perspective, you after-the-fact can look at it whatever way you want to slice the data. How did young people feel about this access option compared to older people? How did middle-aged people favor the rationing of this service compared to that, you can do whatever you want to do.

In terms of the public report that day, you're only interested in reporting the convergence, because your goal was to get to the collective wisdom of everyone who was involved. But for the policy makers longer run purposes, you want to be able to slice and dice that data any way you want to.

Okay. One last thing in a summary comment. You saw the live theme team in the first project we did in New York. It depends on the size, how many people we use, but you can see here we usually have pairs of people at a screen. They work as a pair to come up with it, and then there is a summary process that brings all the data together.

We're very careful when we put it back up

on the large screens to both use the generic policy language and, in fact, to also use real quotes that came out of the discussion, because that makes a very strong link in terms of the people's sense of the credibility, and sense of empowerment. And, frankly, it very often becomes the headlines in the next morning's paper.

I don't think anyone who was at the Javits Center will ever forget what the public was presented there with were the six conceptual designs that the Port Authority had done against the old program. And you'll probably remember this; there was an astonishing consensus of people in New York that rejected all of them. And one of the phrases was, "It looks just like Albany", and I think about 75 percent of the papers that covered the event used that quote some place in the paper. So you end up getting also a media outcome that is a stronger single message that shows credibility, and actually uses citizen's real voices.

Another very critical part of this, and we're almost embarrassed now, it took us several years to even think of this; you've got all this technology on-hand on-site, so all you have to do is bring

industrial sized copy machines also to the site, and you virtually can produce preliminary reports that give you the outcomes on everything but about the last 45 minutes of the day. It gives a kind of new meaning to "hot off the presses." And then you literally give that to every citizen, every media outlet, and every decision maker, and every stakeholder, so they walk out with access to exactly the same summary level data.

The uniqueness and value of this particular model, and again, I just want to remind you that the way we look at this is, there's a role for multi-stakeholder dialogues, and in healthcare there are lots of good ones that have happened in the last years, and some going on now; the Wye River Group's work, the work that Andy Stern and SEIU did at White Mountain, Search for Common Ground literally as we speak has brought another group together. It has some of the participants from Wye River, some from White Mountain, and some new ones. Their report will be finished in about November. That has one role.

Another role is this large scale citizen engagement. What's unique about this, and what does it give you that's different? First of all, you're

after the common ordinary people. You're not after sophisticated stakeholder groups. They can participate; in fact, you want them to, but they don't dominate. It doesn't become a stakeholder dialogue. The first critical criteria is every voice is in the room. The second critical one is decision makers involved every step of the way, so that you can make an alteration. Like the example I gave you in Social Security, where Grassley, and Moynihan, and Archer, and Rangel said, "We've got to understand self-employed people." That wasn't part of the original plan. Given the data they saw, you quickly make an adjustment and do it.

Scale creates a public constituency for reform. If you just do small groups all over the country over a long period of time, it never accumulates a sense in the public's mind of something happening here that's different.

When we did Social Security, we did a very compressed schedule of 500 to 750 person groups, literally 11 weekends in a row. States were carefully chosen to match the politics of the committees that control those decisions. That allowed the media to track the story in a different way, that allowed

members of Congress and Hill staffers to track the story in a different way, and it allowed people in Arizona to know that people in Detroit, and people in Boston, and people in Albuquerque were all on the same wavelength.

We actually, also, often do this with multiple sites hooked by satellite television or teleconferencing, so that literally people in different geographies are actually dialoguing with each other.

The last point is the transparency and immediacy of concrete results. In D.C., a lot of citizens if you talk to them on the street would tell you that citizens influence the budget to get $70 million extra put in education at a time the mayor didn't even control education. Now, of course, there are other citizens on the street that wouldn't have a clue that this even happened, but you would find a critical mass of people that actually know - year one it was education, year two it was affordable housing, and year three it was a very sophisticated link between community policing, criminal justice services, and mental health services of youth in schools, along with public health.

So I want to stop. I hope I stayed to my 15 minutes, but I want to stop and give people a chance to react, and ask any kinds of questions that you'd like to ask.

CHAIR JOHNSON: Well, let me just comment first for you as a working group. If we were to employ Carolyn and her team, we would actually bring them back again, and share more comprehensive proposal and be available for more time for questions. But having said that, if there are questions that you'd like to ask this afternoon, feel free to do so. Yes, Aaron.

DR. SHIRLEY: How distracting was the media, if any?

MS. LUKENSMEYER: That's a great question. You really want to work with the media as partners as much as possible, so there is a whole media strategy that accompanies this. The only place the media becomes distracting is if, in fact, they have a theme that they want to follow; in New York, the theme they chose to follow - there was a very sophisticated small special interest group that right from day one suggested the only way to get back American pride and dignity, and show that democracy is the most powerful

system on the earth is to build the tower higher and taller. And even though that's not where the majority of the public was; in fact, many of you may know that there's a pretty sophisticated process having gone on for about 20 years trying to get regulation out of Congress about not occupying buildings above a certain level because of disaster conditions, but the media continued to follow that as a distracting note.

So one of the interesting things to us was after the forum was over, because of this preliminary report we give, citizens themselves started writing letters to the editor, because they actually had the data. So the *New York Times*, I give them credit; the *New York Post*, also - *Daily News* did not, but some of them actually then published the citizen's response to that, so it got more obvious that it was a special interest that was lobbying for higher and taller.

MS. BAZOS: I was just wondering if there was any educational component of this pre the conference, so to bring all of the citizens sort of up to speed about what the issues were?

MS. LUKENSMEYER: I appreciate you asking me that question, because I forgot to mention it. It's different in different cases. I think Social

Security is the one that's most analogous to your situation, so in each community prior to the actual deliberation process, we partnered with some set of community organizations. And in Phoenix we were extremely fortunate that the newspaper also partnered with us, so the Phoenix newspaper actually ran six two-page feature stories on each of the critical decision options about Social Security. It started six weeks before we did our meeting, and then about 10-days before the meeting, we went to geographically comfortable places, because for the education it doesn't matter if you're in a diverse group. And we did it in schools, we did it in churches, and League of Women Voters was a good partner with us, Business and Professional Women was a good partner with us. In some communities it was Rotary Club. In Phoenix, it was some retirement organizations where we would say we'll be at this school from 8 in the morning until 1:00. You need to be there for a 45-minute session, bring your materials with you, because they had already been sent it in the mail, and we'll just have an open dialogue that's about education on the issues.

We've sometimes been successful where you get a good partnership with the media, of where the

actual participant discussion guide - I brought along a few samples from Social Security. Oh, you gave the Maine example. Okay. Where the newspaper actually published the participant guide. *Washington Post* does this here with the budget, so not only people who are coming see it, the budget choices, but literally everybody who subscribes to the paper and buys it from a paper box does too.

Now the web is good, and that obviously gives a lot of people access for education ahead of time. But you're, I'm sure, extremely sensitive to - it's still true in our society that many of the most vulnerable groups really do not have meaningful web access. And this worries me about a lot of government agencies, because they think well, peopla can go to the library to access the internet. Well, we decided to do that in D.C. I live in northwest, which is the more affluent area - Cleveland Park Library - the line to get access to use the computer in the Cleveland Park Library is two to three hours, and that's in an affluent neighborhood in Washington, D.C. So I think from a fairness, equity point of view in this culture, to assume a strategy that all your education is on the web is not fair play.

MR. HANSEN: I see how this works in the larger cities, but as a citizen's group, how does this work in a place like say, Denison, Iowa, or in Mississippi someplace, or something like that?

MS. LUKENSMEYER: I grew up in Hampton, Iowa. We did a large forum in Des Moines, because Charles Grassley was the Co-Chairman of the Finance Committee, and we chose the region, the county that is Des Moines. If you know Iowa a little bit, even Des Moines has quite rural areas, some of which are being absorbed into the exurbs, and we took the -- in those days we didn't yet make the differentiation between suburb and exurbia, now you would, and demographic data does, so you'd recruit specifically for four categories; city center, suburb, exurbia, and rural.

When we were in the even tougher states than Iowa, like the Plains States, we had cooperative agreements, sometimes with the U.S. Department of Agriculture Extension Service, where we used their telecasting system to do it in several locations at the same time. In fact, I want to extend an invitation to anybody here - Maine two years ago developed something called the Dirigo Health Plan, and they're at the tough choices stage of implementation.

Maine has, again as an example of a very exaggerated split between highly populated coastal areas, and minute little villages in the north, so we're going to be in two locations; one south of Portland, and one north of Bangor. And people from the northern part and way down east are being bussed to the Orono site. So you do it through a combination of transportation and remote locations.

MR. HANSEN: Is this all by invitation then?

MS. LUKENSMEYER: We do it two different styles, depending on the choices made by the sponsors. You can do it with random samples, so that you are absolutely ensured of a spot on demographic, and then it is invitation only. Or, frankly, and this has now been researched, our work has been evaluated by several different universities, some people at Harvard, some people at Columbia, and some people at Northwestern, where we don't do it by invitation only. We do a four-tiered outreach, and these are probably some of the questions Randy would want us to go into more depth later. But a four-tiered outreach strategy that makes it pretty clear that everybody had an opportunity to come, and then we use a matrix in

registration by demographic cell. So if we've got too many white men above 62, which was who filled out first in Social Security, then we can just say you're on a waiting list. And then we know --

CHAIR JOHNSON: Sorry, Joe.

MS. LUKENSMEYER: And then we know we have to go out and recruit more African Americans below 34, or whatever. So that's the way you make sure you're -- both systems work, and it depends on -- in Maine, because of the politics, we've done a random sampling process, because the partisan politics are definitely going to have an impact on the reaction to the outcome, so we wanted no chance of the attack being only the governor's friends were invited, or in some way Democrats had more access to this forum than Republicans. Independents are a very important category in Maine, so thanks.

MS. MARYLAND: I was reading the *Washington Post*. It was one of the inserts here, and it talked about Mayor Anthony Williams' bringing together the members of the city to basically hear their concerns and priorities, if you will, to help him set priorities. This was the statement that really caught my mind, because I'm thinking about the

responsibility we have as a citizen's working group here, and how this might play out from our end.

The last statement says, "I think this is a mayor who has made a commitment to something. The question is what he does with the information. He's got the burden of proof to show that he produces something", and I think that's key for us, too; that as we go around the country with these town hall meetings, the burden of proof will be placed on us in terms of what do we do with that information, how do we use it in a way that people will feel that they've not wasted their time.

MS. LUKENSMEYER: Very well said, Patricia. Montye, I think you had a question.

MS. CONLAN: Yes. I come from Florida, and one could make the case that we're a little weary of the public process. We've had some controversial elections. We recently voted on our ballot, and put through some constitutional amendments, which then either the governor or the state legislature thought that we hadn't thought it through properly, and so they were going to turn it back to us to reconsider, and nothing would be done in the meantime. Or locally in my county, we recently had a judge overturn a

growth management ballot issue. So I'm wondering, would this provide an incentive for people to participate, or would people figure what's the use, or would it have no effect?

MS. LUKENSMEYER: That's a great question, Montye, and I think Florida and California, and Ohio are probably the most dramatic examples of weariness. California because of the tremendous number of initiatives they have on the ballot on a continuous basis. We've been surprised - I want to give a couple of answers. We've been surprised at how sophisticated citizens are of the distinction between going to the public on strictly electoral, the mechanics of voting and putting people in office, compared to deliberation on resource issues, planning issues, policy issues. And our experience is there's more immediate buy-in, more expectation of possibility of positive things coming out on the policy side than on the electoral side.

But having said that, I also want to say there is no community that we've worked in that there's not some kind of fatigue about - and it's right on your point also, Patricia - of where the public was asked, and nothing happened. So in each

case, you are building a credibility case, and again, I think in one way, you are well-positioned to start that credibility case. I think that the sponsors, the legislation that created you, did some extremely astute thinking about how to position this as truly non-partisan, different for people who really watch Congressional process. This is a differently constituted commission than typically comes out of either the White House, so there's a story there to be told for the public that watches that critically.

And then, frankly, what makes the difference is that you can show how this is going to go back into the process. And there, again, the authorizing legislation has given you one platform for that in terms of it's written right into the statute, that the outcomes of the public discussion will, in fact, become part of the floor conversation. It can't be stopped at the committee level. That is radical in American politics, so you've got a story to tell.

Do I think you have to really work at it, and really tell it, and get with opinion leaders so that that starts to be the conversation in the community? Yes. And then I'll go the whole other way - why do I think you'll get response to this? Look at

any of the poll data in the United States of America - what is the single issue that more people are worried about than any other, and have been consistently for some period of time? It's fear about what's happening to their health benefits.

And once again, it's become a middle-class issue as the restructuring corporations have shifted the burden of family benefits, so this is no longer -- we're out of the cycle where it's just the uninsured, so I don't think you'll have any trouble getting people there.

MS. BAZOS: Could I ask you to say a little bit about your online deliberations and your proxy dialogues, and how they interface and interconnect with the forums that you have?

MS. LUKENSMEYER: Yes. Because you want to reach as many people as possible, it is important to do online work. And we take the position -- there's been a lot more promise of the Internet for creating deliberation than actual effective practice yet. The Internet is phenomenal for mobilization, phenomenal for broadcasting. I mean, I can type, and I can send my opinion to 2 million people instantaneously, or whatever. But there are many less

examples of real deliberation, so the document that you're looking at, we actually convened, we actually brought together the lead practitioners from this country, and frankly some people from Europe, who had done real experimentation in online deliberation; not chat rooms, not bulletin boards, but where it's facilitated in the same way we're facilitating if you do this face-to-face.

We've done it many different ways. In Listening to the City, we actually took exactly the same agenda that we did with those 5,000 people in Javits Center, and we put exactly the same data and background up on the website, and then ran a two-week process where people didn't have to be in the same place, same time, but they could come in and have the same discussion on transportation, the same discussion on values about the memorial. And we actually did a scientific research piece on that one on the web, how important is it to have a facilitator of the dialogue on the web compared to how important it is, so we did half the groups facilitated, and half the groups not facilitated.

Because it was the World Trade Center, we could have just opened it up to everyone, and this is

a choice you folks will have to make someplace down the road. We had millions of participants, people all over the world wanted to weigh-in. But the decision makers, the Port Authority and the Lower Manhattan Development Corporation, they wanted to meld the online data into the face-to-face data, so we used exactly the same demographic criteria to select the groups online that we did, so nobody outside the United States could participate. So those are decisions you have to make.

Some cases for what you're doing, I would say for that public awareness education piece, you want to use a lot of interactive website, deliberation like in Social Security. This is now done commonly, but in 1998 this was breakthrough work on the web. We actually had an interactive game right up on the web that we worked with the Social Security Administration where you could type in the information of your salary and what was coming, and you could type out your benefit statement. Well, Social Security now does that for you on a semi-annual basis, but that didn't happen then. That started later.

Proxy dialogue, Daniel Yankelovitch was the pioneer of that. It was a discovery that if I

watch a dialogue on television, and I identify with someone on the television set, i.e., I see another Hispanic woman in her late 20s, early 30s, I'm likely possibly to go through the same shift in my thinking that I watch her go through, so that it does have a change element, where most television work doesn't have that impact on people.

MS. CONLAN: I guess I have two questions. One, are elected officials involved in the live event?

MS. LUKENSMEYER: Yes. Again, you folks have a lot of talking to do about that. What we found successful in anything that had national implications; for example, in Social Security, every site we went to, whether it was linked by satellite or whether it was in the room, the members of Congress and the Senators were invited to that site. Now the kind of work that has to be done with their staffs; and, frankly, in most cases I think I'm speaking to people who know this, but their staffs are more difficult to work with than they are, because none of them give speeches.

Why is Seattle in my mind today? Jennifer Dunn and Jim McDermott were the co-hosts in Seattle. They each had two and a half minutes to open the forum

and welcome people. And then what they did for the rest of the day, and that's what they took, two and a half minutes. In more than 55 events that involved almost 50,000 people, we only had one Senator who cheated, and you know what happened? I mean, talk about the public. It went on for a little while. I was the moderator in that case. I was doing all the diplomatic things I could think of to get this Senator to stop and remove himself, and there was a certain point I was not going to embarrass myself. And finally, a citizen stood up and said, "Senator, you have abused your privilege. We came here to talk." It was great.

MS. CONLAN: The other question I have - we talked this morning about the value of, for instance, patients being able to tell their own story, or doctors to tell their own story, or providers.

MS. LUKENSMEYER: Yes.

MS. CONLAN: Is there room for that in this process?

MS. LUKENSMEYER: I'm really glad you asked that question. Storytelling is a very powerful way to get at the heart of how I carry my views of this policy issue as a result of my life experience.

And it's also a very compelling way to influence other people who have had no access to that experience.

Certain kinds of storytelling that you might want to do, you could do with this. But, frankly, again it's a principle of good public deliberation if any of you looked at this in your university settings. You always want to get people to start any discussion with values, a meta level the social scientists would call it - values, vision, storytelling.

Social Security, the way we started every forum across the country was tell a story of how your family or someone you know has been impacted from Social Security. Second question - what values do you want members of Congress and the President to keep in mind as they consider reforming Social Security?

We spent about 45-minutes on the combination of those two questions. The answers to those questions were part of the record. And then if you look at taped dialogue later in the day, when people got into conflict about privatization, people literally would say to each other - but wait a second, this morning when you told that story about your disabled sister, what are you -- so there is a link,

people make a link between that. And it's a way in which people stay open-minded and open-hearted longer when they get into difference.

One of the things we've thought about when we were asked to develop the strategy that's in this Millions of Voices document, was actually to have a space on the website for people to share their stories, and there are many examples of this. I didn't think about bringing in some that you could go look at today, and most of them are spontaneously created by people. They're not by organizations or associations, but we thought literally of a nice parallel to this would be having a place on the web that people could go to and tell their stories about health, and could go to and tell their stories about discoveries of alternative processes for health, et cetera. Because when you start to do this publicly, that need is going to be evoked in lots and lots of people. And I think having strategies to create a safe place to do that, but leave enough room for policy discussion in the places that you're really investing engagement is probably the right way to go.

MS. CONLAN: I guess what I was thinking is some of those stories can be quite lengthy, and

also, one person can dominate in that way.

MS. LUKENSMEYER: Yes. That's why you have the facilitator.

MS. CONLAN: That's what I was wondering; are they skilled at diplomatic --

MS. LUKENSMEYER: Absolutely.

MS. CONLAN: Cutting those people off.

MS. LUKENSMEYER: We actually do training in it. Because these are so open, I can think of only two categories of people that have ever gone past the capacity of a facilitator to influence. And frankly, in the one case we just asked them to leave. A special interest group did organization, and this probably would be a question in your case, to send a small number of representatives to the Social Security forum in Phoenix to plug only for privatization; that no matter what anybody said, they were just going to plug, plug, plug. And there were about eight of these people that were just dispersed around the room. And, frankly, most of them quit and engaged in the discussion. There was one young guy who was about 34 - I mean, he was obnoxious about it. And the facilitator was just about - and we have a system with support for facilitators so they don't have to do it

themselves, and we were just about to ask him to leave the table when he literally got up and said, "I can see I'm not going to be able to do anything here. I'm going home."

The other example is, we have had, because we do it as such an open process, a few cases where you describe someone with enough of a disability, maybe developmentally slow, maybe an attention issue, that it's very difficult to keep them in the conversation. And again, handling it very sensitively, we have a small number of people on-site who can literally become a buddy for that person, so we don't ask them to leave the table, but the table facilitator doesn't have to deal with them anymore. There's someone who literally helps them get to say something once in a while, but also basically not have the whole group go to their level. Is that helpful?

CHAIR JOHNSON: Well, Carolyn, thank you very much for your time this afternoon. One more?

MS. CONLAN: You're just triggering so many questions on my part, I guess I'm real taken by the process. If you're choosing people that have differences, do you ever have outright confrontations that become kind of --

MS. LUKENSMEYER: Here's the real art and science of this -- it is creating a safe public structure. And here's what most people don't see -- because it's not how we interact with others most. Most Americans do still feel responsible for common good solutions. That's a fact. That's one of the researcher's things that Northwestern University did - the most common response people gave to our work was how appreciative they were to discover that to be in a public setting that was so well designed, that they actually discovered - I knew I still cared about the common good, but I had no idea all of you do. So the energy isn't like that.

However, if we had started our discussions, and it would be worse today than it was then, if the first question we'd asked at 9:00 in the morning is, are you for or against privatization - we would have had those conflicts. So it is a wisely designed set of questions that takes you into each of those issues, so by the time we got to privatization, people are looking -- all of us together are looking at the pros and cons on privatization. We're not pitting me against you on privatization.

CHAIR JOHNSON: Thank you.

MS. LUKENSMEYER: Randy, I brought a couple of the actual letters about this process happening in - I don't know if I finished the sentence. Maine is actually doing it on healthcare. The staff gave you the discussion guide. We're doing this on May 21st, and always - this is not special in your case - always we do a little program we call "Behind the Scenes", where we have any observers that want to come join us on Friday night. They get a briefing on exactly what's going to happen. Then on Saturday they get to sit at a table for part of the time, they get to sit with the theme team for part of the time, they get to sit with the experts for part of the time. The facts in Maine, it'll be about someplace between 700-800 people, 500 of them will be in Bidiford, which is south of Portland about 45 minutes, and that's the place we would suggest you come. So you fly into Portland and drive about 30-45 minutes. So dinner together on Friday night, participate and observe all day Saturday, and then our experience has been, it's been a great thing for people who commend us to do a little debriefing session on Sunday morning before you go home. So I just brought a couple of these, if any of you actually

would like to do that, we should talk to you fairly quickly. This was supposed to happen in March in three sites, and we got snowed out.

CHAIR JOHNSON: Thank you, Carolyn, for your time this afternoon, and we'll come back to you.

MS. LUKENSMEYER: Thanks, Randy. Really appreciate the great questions.

CHAIR JOHNSON: Okay. Well, I think looking at the time, we'll go to one other agenda item today, and target 5:00 as an adjournment time.

George, why don't you come up at this microphone here, and by now at least some of you have had a chance to meet George Grob. We have offered him the opportunity to serve us as Executive Director, and we think it's an opportunity. He says it is, too. And we'd like to welcome you, George. You all have seen his resume, and we've had some discussion on that, and just thought it would be helpful to introduce him at this time. Do you want to say anything? Catherine is speechless.

VICE CHAIR McLAUGHLIN: Except turn on your mic.

CHAIR JOHNSON: Yes. We're pleased that you're here, George. And even though you are not on

our rolls yet, just thought maybe you could share a few of your comments regarding your thoughts regarding the working group and so forth, so feel free.

MR. GROB: First, I really have to tell you that I am both proud and humbled, but particularly excited to join this group and the enterprise that it's doing. I hope to join you very soon. I hope that it will be a matter of days. Until then, I'm not part of your group, and I do need to say something sort of a semi-legal point of view here, which may explain some of my behavior to you; which is that, since I am not on your group now, I am still in the Office of Inspector General, and so I was asked to not participate in the business of the meeting, which is why you see me sitting back here until I am. But it is a good opportunity for me to get to know all of you, and I really would like to do that, so I've button-holed a few of you around longer than allowed cups of coffee and too many cookies. I hope to find a way to talk to each and every one of you during these three days at least for more than a few moments. Plus, of course, just watching you participate here really helps a lot.

Now it may be that you would like to get a

chance to know me, too. And I'd be grateful for that because we conduct most of our business by conference calls in my office. And when we studies, which we do a lot of, we usually link up to three cities at a time, people working on the study, our headquarters statisticians and others, and then our policy people, and we found this works really good, as long as you really know the people on the other end of the line. If you know the personality and you know who you're talking to, you can be pretty efficient in doing that. And we'll probably have to do a lot of that, so the more I can get to know you, and you can get to know me, it'll make the communications a lot better. So I'll just tell you a little bit about myself, not much.

I've been with federal government 36 years, and 32 of those have been in the Department of Health and Human Services, half of them have been in the Policy Development Office, which is the real name, the real function of the Office of the Assistant Secretary for Planning and Evaluation, which Michael now heads. It's mis-named, it really is the Office of Policy Development, and should be. And I really enjoyed that part of my life very much.

I moved to the Office of Inspector General, which you probably think in terms of its auditors and investigators, and crime fighters, and lawyers; actually, we have a unique office in our Inspector General's office. It is the largest such unit in all of the Inspector General's, which is an Office of Evaluation and Inspections, which I've headed up for the last 15 years. We have about 130 people do this, and I've personally been involved in over 1,000 studies, and my involvement has been expansive and deep in every one of them over that period of years.

The term "inspections" doesn't mean to inspect, to see if someone is obeying the law. It came from an idea that actually originated in ASPE, all those many years ago, which is they wanted to send people out to find out what was really going on out there, and not what was being said just in studies alone. They wanted to know, as we said, what's happening on the pavement, and so we initially began doing a lot of that kind of work. Now we're spread out doing much other work, but there's our roots and something we've always enjoyed.

The technology is going a lot faster than

my youth is slipping away from me, but over the course of our years, we were actually very much on the cutting edge of the technology. We've conducted the first surveys of Social Security beneficiaries. We would call them up or send them letters and say how did they treat you the last time you went to the office? How many times did you have to call before they answered your phone? Did they treat you with respect, did they answer your question, did you feel like it was worthwhile?

Then we conducted the first one for Medicare beneficiaries, and then we conducted I think the very first one of people in health maintenance organizations, the Medicare HMOs, but they weren't being done at all. And one that's currently done is modeled after our original design for that, so we're very proud of all that. And at that time, no one was doing that kind of work, so it was cutting edge, and we've done some of the original Internet surveys, as well, and we're working with people doing that, so it's been an exciting field to work with us.

Just in terms of my attitude toward the group - after all these years, I got this phone call, and asked if I would be interested in doing this after

having announced that I was going to retire at the end of the year. And I thought about it for about a day, and I said I really am, but I knew I would be interviewed, and I knew there would come a time when they would say well, George, do you have any questions? And I had already rehearsed the one question that I wanted to ask Randy and Catherine, and anyone else I interviewed. In fact, I interviewed with Randy and Catherine, Senator Wyden, and with Patricia DeLoach from Senator Hatch's staff, and I had rehearsed the idea that I was going to ask them one question; which is, are you serious about this?

I did not have to ask that question because they beat me to the punch, and they asked me that question without exception, which was one of the things that convinced me that I really ought to join up. So that will tell you a little bit about my attitude, and a little bit about my background. Perhaps we have a few minutes, if there's some questions you'd like to ask me, I'm more than happy to answer them. Or if you want to button-hole me and really drill me, whatever you'd like to do, I'd like to tell you anything you want to know about myself. Well, then I look forward to the company and the food,

and the rest of the discussion. Thank you very much.

CHAIR JOHNSON: Okay. Well, thank you, George. We're glad you're here. And with George coming on, that probably reflects a little bit different working style than what we've had in the past. I'm expecting personally to be less involved in day-to-day operations, and George to lead those. And, whereas, both Catherine and I have had connections with the staff, we'll continue to have connections with the staff, but George will be leading the staff and consultants, and handling the day-to-day operations. So we're pleased that you all are here, and again, we wouldn't have been able to have this day as effectively, and tomorrow and the next day if people like Caroline Taplin hadn't done an awful lot of work, so we thank you, and Andy, and Ken, and the guy in the blue shirt back here, as well, Larry Patton.

I think that tomorrow we'll talk about some other matters, but is there anything that you would like to talk about right now. It's five to five. We're going to have dinner at six, and we may we just see again hands who will be at dinner. Okay.

VICE CHAIR McLAUGHLIN: Where is dinner?

CHAIR JOHNSON: Right next door. Okay?

VICE CHAIR McLAUGHLIN: Well, then I'm not there. I'm kidding. I'm kidding.

CHAIR JOHNSON: Okay. Just wanted to make sure that you all know you're welcome. And let me just check with you, staff, to see if there are any logistical comments or announcements. The dinner tonight cost would be part of our per diem.

MR. PATTON: That's right. The per diem is $51 a day, so any expenses for dinner or meals during the daytime since we don't have lunch scheduled will be coming out of your per diem, so you won't have to submit the bills for lunch or dinner. That simply will be paid to you, and I think that's it. The only thing I would say logistically we're going to try - I've had discussion with the contractor about this - is that in terms of when we contact you about the airline reservations for future meetings, if either staff at the agency while we're still handling travel, and that will eventually turn over to the working group staff, or the contractor's staff do not mention to you, would you please make your hotel reservation - make sure you ask, and don't get off the phone without asking what's the number to call, because this is the

second time we've run up against a deadline without people having hotel reservations. So if they don't mention it to you, make sure you ask because we'd like to get that resolved.

One last thing, Randy, do you want to deal with the Minutes?

CHAIR JOHNSON: I would be a good time to do that. Do you have some to hand-out? And while Larry is passing it out, there are two series of Minutes or sets of Minutes; one is a transcription, which will be available on the website of our last meeting. Staff has also put together a 12-page summary, and what we'd like you to do is take a look at the summary, and if you -- tomorrow we're going to ask you for your comments and/or blessing of the notes. So if there are corrections that you think should be made, if you'll come back tomorrow and let us know that; otherwise, we will formally adopt those as a summary of the last meeting's Minutes.

MR. PATTON: If I could just ask that you keep two things in mind; one is that because we're doing the transcript, these do not cover every single aspect of the dialogue, and they're not intended to. You'll see the very last paragraph - two paragraphs of

the Minutes refer to the fact that the Minutes will be posted on the website and available at the working group headquarters in hard copy for people to review if they want to go into great detail, so this is a broader overview.

And the second question I had for you is because we used a writer from the contractor last time, we did not give any specific instruction about how people are referred to. In some cases, folks are referred to by their institutional affiliation, and my reaction was that as a citizen's working group in general, you're representing yourselves, and I'd like you to consider whether you want to have that retained, or just have individuals referred to only by their name. It seems to me you're not here representing the institutions you're affiliated with, but that's a matter for your choice.

CHAIR JOHNSON: Aaron, go ahead.

DR. SHIRLEY: Related to the hotel reservations for this meeting, there was an 800 number and a direct hotel number. When we called the 800 number, maybe five days before, they said they all have been sold out, so that was a little confusing.

MR. PATTON: That's part of the reason why

I think -- I think it's a time issue, to some extent. There may, in fact, be a disconnect, which the contractor needs to work out with the hotel system. But the closer we get to the deadline date, the more inclined they are to tell you that the block is full. And so, as a result, if we can try to get in sync that whenever you're contacted about airline reservations - I know, Joe, we said - this doesn't pose an issue for you, but for everyone else, or when we're outside of Washington, we just need to make sure that we link your airline reservation time with the time that you make the hotel reservation.

The other thing that came up, and I know it applies to a few people because carrying the cost from meeting to meeting may be an issue. When they contact you about making the airline reservation, if you would like an advance, the federal government can do an advance of 80 percent of the cost. Just make sure that you raise the question that you would like them to do that. There's no shame, no issue involved. A lot of federal employees ask for advances, so it's just a straightforward thing, but they will not always -- they tend not to remember to ask, no matter how often I tell them they should, so please ask if you

think that would help you, and we'll be happy to do that for you.

CHAIR JOHNSON: And may we assume that all expenses and per diems for the last meeting have been taken care of, and been paid?

MR. PATTON: I was told everything has gone into the system, and that most people -- again, it depends when you sent your information in. We will give you, again, the address before you leave on Friday where to send all of the information. The only bill you really need to send in is your hotel bill, and then just simply give us any transportation amounts.

MS. STEHR: Did you ever figure out what the mileage rate was per mile? Because I just sent mine in with a set amount of miles, so I'm hoping they --

MR. PATTON: Oh, they just plug that in. I don't know, Mike, do you know?

CHAIR JOHNSON: It's around 40, 41, 42 cents.

MR. PATTON: For mileage, particularly if you're driving to an airport at a distance and leaving your car, just put the round-trip mileage and they'll

just calculate it in. The other reason not to put a specific number is in actually that it changes every nine months or twelve months, so you don't want to undercut yourself, in fact, if the rate moves up, so just it's easier to leave it blank and just put the miles.

MS. STEHR: In my case, I'm having someone take me to the airport, so it's a round-trip going in, and a round-trip going back, because I don't drive. So I just want to be clear on that.

MR. PATTON: Other questions just in case -- Randy.

CHAIR JOHNSON: Yes, a couple for the working group. Today we went to lunch and we took a half hour longer than the 45 minutes allocated, and my question is, should we already now plan to have an hour and 15 minutes for lunch tomorrow, or would your preference be to try to have the 45 minutes, and keep to it? What would you like to do?

VICE CHAIR McLAUGHLIN: I know today people didn't realize I think how far away it was, and how long it was going to take to walk it and come back. And so I know a lot of people stood around schmoozing for 15 minutes before we even left the

hotel. I think an hour would be plenty. I don't think we need to go an hour and 15 minutes, because tomorrow we'll know to hit the boards running and go get our lunch. That's my reaction.

MR. HANSEN: I agree with Catherine. If the lunch is here, well, let's eat it and keep working. But when we have to go out, we need an hour.

CHAIR JOHNSON: Okay. Tomorrow night, by the way, we have not planned for a get-together group dinner. The thought process by the hearing's subcommittee was that you might want to get away on your own, a opposed to with a larger group. Maybe some of you would like to go with smaller groups, but that's how we've kind of planned for tomorrow night. Yes, Mike.

MR. O'GRADY: Well, that's the question. We've gone into sort of executive session now. We kept the transcript running. He's not been controversial, there was nothing today, but I can see in future meetings we may want to have -- just the idea of at some point we may want to talk more candidly amongst ourselves. I don't know that is something you would want on the website at the end of the process, and with different ones. Sometimes

there's sort of a public meeting, and then there's the executive session, and I didn't know what the thinking was.

CHAIR JOHNSON: Well, maybe as we're planning the agendas, as we contemplate topics to discuss, we can review with Larry and or others those subjects that might be -- what are the legal requirements regarding those kinds of sessions. But your point is well taken. Thank you.

Okay. Well, thank you very much. We'll reconvene tomorrow morning at 8:30, and we appreciate your participation today.

(Whereupon, the proceedings in the above-entitled matter went off the record at 5:05 p.m.)

Submitted by Cygnus Corporation, Inc., for the Agency for Healthcare Research and Quality under Contract No. 290-01001.