

CITIZENS' HEALTH CARE WORKING GROUP
WORKING GROUP PUBLIC MEETING

HEARING AND COMMITTEE MEETINGS

PUBLIC HEARING

City Hall
1221 SW 4th Avenue
Portland, Oregon

Friday, September 23, 2005

9:00 a.m.

PRESENT:

Catherine G. McLaughlin, Vice Chairperson
Frank J. Baumeister, Jr., M.D., Member
Dorothy A. Bazos, Member
Montye S. Conlan, Member
Therese A. Hughes, Member
Brent James, M.D., Member
Patricia A. Maryland, Member
Aaron Shirley, M.D., Member
Christine L. Wright, Member

HONORED GUEST:

Senator Ron Wyden

PRESENTERS:

Governor John Kitzhaber, M.D.
Dr. Michael Garland
Dr. Ralph Crawshaw
Ellen Lowe
Dr. Alison Little
Dr. Marian McDonagh
Diane Lovell
Dr. John Santa
Dr. Bruce Goldberg
Jean Thorne
Mark Ganz

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

2 9:00 a.m.

3 VICE CHAIRPERSON McLAUGHLIN: We've been
4 waiting for Senator Wyden, and we've just been told that
5 he on his way and will be here in a few minutes. So we
6 are hoping to be about to start by 10:00.

7 In the meantime, I would like to welcome all
8 of you for attending this listening session on behalf of
9 the Citizens' Health Care Working Group. We have just
10 finished field hearings in four citizens; in
11 Jacksonville, Mississippi and Salt Lake City and
12 Houston, Texas and Boston, Massachusetts. And at those
13 field hearings we heard a lot about local initiatives
14 and different things that are being attempted to try to
15 improve the system, as well as people coming and telling
16 us some of the problems that they as providers or as
17 administrators or as patients have been facing within
18 the system. We have used a lot of this information
19 along with a lot of data that are made available about
20 the health care system to produce a health report to the
21 American people. We plan to have that report ready next
22 month, and it will be distributed quite widely as well
23 as on our website.

24 The point of that report is to really try to

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1 explain to the American people this is where the dollars
2 comes from, this is where they go, what is the flow of
3 dollars and people in and out of the health care system.

4 We are hoping by doing this that that we will be able
5 to begin a dialogue with the American people in which we
6 can say, all right, now that we all have a better
7 understanding of where that \$1.7 trillion go and where
8 all of the millions of patients go, where the millions
9 of providers go, can we start talking about problems in
10 the system from your perspective as well as solutions
11 that you may have, desires that you may have for ways to
12 improve the system.

13 In order to do that we are not only going to
14 have surveys and we're going to have a website where
15 people can come on line and give us ideas, but we're
16 also going to hold community meetings all over the
17 country.

18 We plan to start these community meetings in
19 November or December. And we are certain that we will
20 have at least one in Oregon, particularly those of us
21 who love coming to Oregon, we're rooting let's come back
22 to Oregon. So we've had a wonderful, wonderful stay
23 while we've been here. Wonderful weather.

24 I know that Dr. Baumeister, who's planned

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1 this visit, organized to have the wonderful weather. We
2 give him total credit for that. And it really has been
3 wonderful.

4 At this point, though, we came here because
5 Oregon is the place to go in this country to find out
6 about listening to the American public about health
7 care, and giving us advice on what you learned when you
8 did this. And so, Dr. Baumeister and his staff have put
9 together a wonderful list of people who lived through
10 that experience to give us advice as we prepare to go
11 and listen to the American people.

12 So while today we're thrilled to see all of
13 you here listening, we won't be able to have an open
14 mike. We won't have an open community meeting. The
15 point of this really is for the working group to learn
16 from the people in Oregon who participated in that
17 process what they did right, what did they wrong so that
18 we do as good a job as we can going around the country
19 listening to people about their concerns and their
20 recommendations for the health care system.

21 So I'm sorry that we won't be able to hear
22 from all of you. I know that some of you would love to
23 be able to talk, and you will get a chance.
24 Unfortunately, it won't be today.

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1 We're waiting for Senator Wyden to get here.
2 He will be our first speaker. But in the meantime I
3 wanted to thank Dr. Baumeister, who is a member of the
4 working group, for getting this organized and for
5 bringing us into this beautiful city hall that we've all
6 been admiring and enjoying.

7 Thank you very much, Frank. And I think you
8 wanted to thank a few other people.

9 DR. BAUMEISTER: Yes. Good morning,
10 everybody.

11 I'm really influenced by the turnout here.

12 I have a lot of people to thank. You heard
13 said it's not what you know but who you know, and I
14 happen to know some people that really get things done.

15 I want to thank all the panelists for
16 participating. Most of them are with whom I've had a
17 personal or a professional relationship and I know their
18 qualities. And I'm very happy to have them here.

19 I'd like to thank Senator Wyden for
20 sponsoring this legislation along with Orrin Hatch. And
21 I would invite you all to read the bill, because it's a
22 rather remarkable bill that involves community, it
23 involves it nationwide. And then the final report by
24 law has to be heard by five congressional committees and

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1 the President.

2 What they do with it now, we can't hold a
3 gun to their head but we can put a fire in their feet.

4 I would like very much to thank John Santa.
5 John is just remarkable. John put this entire panel
6 together and all I did was say "John, would you?" And
7 he said "Sure." And our relationship goes back about 25
8 or 30 years. And it's just been wonderful what he has
9 done.

10 Jan Murdock, who works with the Foundation
11 for Medical Excellence and for Governor Kitzhaber is
12 also been instrumental in obtaining lodging for the
13 working group and making arrangements that otherwise
14 could just not have been made.

15 Lisa Rockhour who works with Senator Wyden's
16 staff has been just really critical to this event.

17 And I would thank Commissioner Sam Adams and
18 his assistant, David Gonzales who have opened City Hall
19 to us and showed my friends here on this working group
20 incredible Oregon hospitality.

21 And I'd also like to thank Legacy Health
22 System who provided transportation for their shuttle
23 buses for our group to and from my house last night for
24 a dinner party that we held.

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1 So with that, I'll turn it back over to
2 Catherine McLaughlin, who did not particularly introduce
3 herself, but she is an internationally known health care
4 economist who has studied the uninsured and knows more
5 about the uninsured than most people are afraid to ask.
6 And she is an economist with a heart.

7 So, Catherine?

8 VICE CHAIRPERSON McLAUGHLIN: Isn't that an
9 oxymoron?

10 Senator Wyden, we're glad to see you here.
11 All of last week, some of you may not know that every
12 time those of us who use MediaPlay hook onto it to
13 listen to our music, we saw a picture of you, Senator,
14 smiling on that computer screen. So you were in my heart
15 all last week every time I did that. So it's nice to
16 see you in person, and smiling. And we're looking
17 forward to hearing your remarks.

18 Everyone in the working group has heard from
19 Senator Wyden before, and I was very grateful to him as
20 Frank said, for getting this legislation through so that
21 we could go about doing this work. So we're eager to
22 hear your remarks, Senator Wyden.

23 SENATOR WYDEN: Well, thank you, Madam
24 Chair.

1 And welcome to all of you. You are really
2 at ground zero in the effort to improve health care in
3 Oregon and our country. We're a state of health care
4 firsts. We were the first to come up with real home
5 health care for older people. We were the first to
6 figure out how you had to determine whether drugs were
7 effective for people. We were the first to say that we
8 had to make some hard choices in American health care.
9 You couldn't be everything to everybody.

10 I want to start by just saying how thrilled
11 I am that you're here and that your work is going
12 forward. I know that you all have been working your
13 heads off, listening to people around the country. My
14 sense is you're firing off emails to each other at 2:00
15 in the morning. I hope folks understand that the
16 members of the Working Group have full time jobs.
17 They're not lobbyists or Washington insiders. They have
18 full time jobs - including being doctors who take care
19 of patients and advocates for people. I know that
20 you've been drafting, redrafting, and drafting some more
21 on the report that you're going to make public. And I
22 hope folks understand that in doing so you're making
23 history.

24 Never before have the American people been

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1 told where the health care dollars go today. Health
2 care reform in the past has been like telling people to
3 get dressed in the dark. How do you do that? How do
4 you find your clothes, let alone make the blue and the
5 red match? I can't even do that when the lights are on.

6 Nancy Bass is here somewhere. She's given
7 informed consent to marry me tomorrow night.

8 She was looking at some of your paperwork
9 the other day and she said "I'm just amazed. I'm amazed
10 at how hard this citizens' working group is going at
11 this." She said "They are working so hard, I get tired
12 looking at it. I'd like to sign everybody up for the
13 citizens' leisure group."

14 And I think that is where I want to start.
15 People are always asking me, "Well what are you up to?
16 What is this thing all about?" And I say. "Well
17 nobody's ever tried this before." And people almost
18 always say "Oh, Ron, come on. People have been at this
19 health care deal for years and years." But the fact is
20 nobody's ever tried anything like this, which is to
21 start it outside Washington, D.C.; get it out of the
22 place where the lobbyists and the insiders can hotwire
23 their deals that are favorable to them.

24 So nobody has ever done this, and it's to

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1 ensure that there's public involvement. Then there is
2 real political accountability with hearings and action
3 after citizens of the country weighed in.

4 So in a few weeks you're going to be
5 starting the effort to walk people through the tough
6 choices in health care. And suffice it to say this isn't
7 an exercise for the fainthearted. These are incredibly
8 difficult choices and there aren't enough dollars to go
9 around. And as you say in your draft, we're spending
10 more than anybody else in the neighborhood. There's no
11 one else in the world spending as much as we are on
12 health care. One of the questions that I know you're
13 looking at is how can it be that with wonderful doctors
14 and hospitals and providers that our country runs 29th
15 in terms of health expectancy, in terms of actual
16 quality of life that people have? And I think the fact
17 that you're going to try to help the country figure it
18 out is a tremendous service.

19 I think the questions really are ones that
20 you can't duck and get at the challenge that we started
21 in Oregon almost two decades. I mean, we know we've got
22 to do more in terms of health care prevention. We don't
23 really have health care at all in the United States.
24 What we have is sick care. We wait until somebody is

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1 flat on their back in a hospital somewhere and say let's
2 take care of them. And Medicare shows the craziness of
3 all of this.

4 As you know, Medicare Part A writes some
5 huge checks for some of these hospital bills. And the
6 Medicare Part B won't write hardly anything to keep
7 people well, keep them from getting sick in the first
8 place. I think that's pretty bizarre even by the
9 standards of Washington, D.C.

10 So, we got to do more for prevention, but
11 there aren't unlimited dollars. So one of the questions
12 I think is should we do more in the preventive area to
13 try to keep people well even if it means we've got to
14 take some of the dollars that now go for services for
15 folks that have various illnesses? It's pretty hard to
16 be Santa Claus there. That's the kind of tough question
17 that I know has to be wrestled with.

18 The same challenge exists with end of life
19 care. This was a tough issue before the Terry Schiavo
20 case, and it is a lot tougher today. But the issue
21 really is there when the best doctors and the best
22 hospitals in the country tell us that they can't do
23 anything to produce quality of life for the person and
24 that's medically effective, we ought to have a debate

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1 about what to do. Because we know that much of the
2 health care spending in those last few months of
3 somebody's life.

4 Another example is Medicare. You heard from
5 the experts. Medicare is the fastest growing program on
6 the planet: \$3 trillion in liability. One of the
7 questions I've been thinking about is why should Donald
8 Trump pay the same Medicare premium as an elderly woman
9 out here in southeast in one of the neighborhoods who's
10 got an income of \$20,000 a year, early onset of
11 Alzheimer's and a big prescription drug bill? Not a
12 very easy question.

13 That is a debate about transforming a huge
14 really important social insurance program, but again an
15 important kind of question.

16 What about the administrative part in
17 American health care? The physicians on this panel can
18 tell you. I heard Bill Clinton gave a speech two nights
19 ago and said 35 percent of the health care dollar goes
20 to administration. I don't know if he's right. I don't
21 know who is right. I know you're wrestling with it.
22 But I don't think that there's a provider around and
23 certainly scores of consumers who can't tell you the
24 system is choking on paperwork and forms and bureaucracy

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1 and red tape.

2 Tax policy -- We're spending more than \$100
3 billion because we've made the judgment back in World
4 War II that health care should be tax exempt for the
5 employer and tax exempt for the worker. We spend more
6 than \$110 billion on that. I think we ought to have a
7 debate about whether that's the best way to spend the
8 money.

9 I'd wrap up this section in terms of
10 questions by saying I do not pretend to have the answers
11 to the questions that I just posed. I wouldn't possibly
12 come before a group like this and say that I do. But I
13 do think that the public wants somebody with your
14 independence, your credibility and your expertise to ask
15 those questions so that they'll have a sense that people
16 like yourselves with your independence of judgment are
17 going to try to drive this debate rather than people in
18 Washington, D.C.

19 Usually when health care reform gets stuck
20 in the nation's Capitol, all the powerful lobbyists sit
21 where all of you are. They're the ones who almost always
22 find a way to get a seat at the table. What is unique
23 about this is this time they're locked out. The law was
24 written to do that. No members of Congress can serve.

14

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1 No lobbyist gets to serve. You were the ones who got to
2 fill out all the forms and make sure that you have
3 essentially what amounted to an ethical colonoscopy; the
4 Government threw the rope up here and said all of you
5 are independent and credible. And that's why we're
6 looking to your leadership.

7 I'd especially hope that the urgency of all
8 this can come through. We've had some discussions
9 about, and your Chair today, Catherine McLaughlin, makes
10 this point very eloquently, that people are told that
11 the sky is going to fall before, and we don't have
12 enough money and western civilization is going to come
13 to an end if you don't act. And people have heard that
14 before. But there are some forces at work today that
15 have never been present before. For example, we are
16 experiencing a demographic revolution.

17 On New Year's Day, January 1, 2007 we ramp
18 up to more than 15 million baby boomers retiring. We
19 have never had that before. They're going to need a lot
20 of health care. They're going to expect a lot of health
21 care. It's a driving force we've never seen before.

22 We've never had technology that pushed us to
23 the brink of immortality. We're not there yet. We're
24 kind of pushing our way up there, and the whole country

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1 is now wondering how to make the best use of these
2 wonderful devices and products.

3 My sense is we have never had a bigger gap
4 between the amount we spend and what we're getting in
5 return. We spent \$1.8 trillion last year; more than
6 \$6,000 for every man, woman and child; that is about
7 \$25,000 for a family of four.

8 You could go out and hire an internist,
9 who'd make over \$100,000 a year and would do nothing but
10 work for a handful of people, a family.

11 So all of those forces are different than
12 what we saw in the past 60 years as the country has
13 wrestled with this from Harry Truman in 1945 and the
14 81st Congress all the way through Bill Clinton, and
15 everybody else. Our citizens want you to show us how we
16 can right this wrong.

17 Now today I think you're going to get a
18 whole lot out of hearing from some Oregon pioneers. I
19 call them pioneers because they merely start the whole
20 effort to say "Look, in health care you can't do it
21 all." There's some difficult kinds of choices that have
22 to be made and no matter how much money you spend,
23 there's never really enough. They were led by the next
24 speaker, Dr. John Kitzhaber.

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1 And what Dr. Kitzhaber really taught us, and
2 I think when you write the history of American health
3 care it's going to be a big big deal, is the decisions
4 about health care are going to be made one way or
5 another. But what Dr. Kitzhaber told us is they're
6 going to either be made in the front door with the
7 public involved and a real debate about the choices or
8 they're going to be made in the backroom and they're
9 going to be made without the public involvement. The
10 fancy word in Washington is called "transparency."
11 That's the new big, you know, buzz word. Everything's
12 got to be transparent. But you and I know it's about
13 the grassroots; it's about whether the public is going
14 to be involved.

15 So essentially what Dr. Kitzhaber and our
16 Oregon pioneers started close to 20 years ago was
17 something that was really built around this public
18 involvement. They made the judgment that I know you're
19 looking at that health care is kind of like an
20 ecosystem. Everything is related to everything else.
21 And I think that's a critical concern as well.

22 And, frankly, as I look back on it, maybe
23 the pioneers will tell you other things, including
24 things we could have done differently. My sense is we

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1 didn't really ask for enough. Dr. Kitzhaber and I have
2 talked, and I have urged this with our state leaders.
3 I'd really like to see states go to the Federal
4 Government and say "Look, if you people aren't going to
5 get this health care thing right, let us take the
6 dollars home. Let us take the dollars home. Give us
7 waivers. Let us go out and do our own thing. Bring the
8 stakeholders to the table; the laborers, business and
9 seniors and disabled folks and minority and let us make
10 our own decisions."

11 There are a bunch of things that I think
12 that we probably would do over again if we have the
13 chance to do it. But I think the points that were made
14 then; got to make choices, got to do it in a public eye
15 and that health care is not just about dollars but it's
16 about values. It's about the things that are really
17 important to you. Those are inescapable truths. And
18 those pioneers, in my view, really got it right.

19 Now I mentioned in the beginning that Oregon
20 was a state of health care firsts. I just want to
21 mention what I think the firsts are about your work and
22 the Citizens' Health Care Working Group.

23 For the first time with your leadership, the
24 national government is trying to improve health care

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1 with a bottoms-up effort starting outside of Washington,
2 D.C. rather than going top down with people in
3 Washington trying to drive it.

4 Second, nobody's ever been told where the
5 health care dollar goes before. I know that sounds
6 astounding. I've mentioned it to people and people say
7 "You know, I just wish I could just to one place and
8 have somebody tell me where the money goes, where all
9 these programs are." So my understanding is, and Dottie
10 has mentioned this, you're talking about a definition
11 sheet where you just tell people in plain understandable
12 language, here's what Medicare is, here's why it's
13 different than Medicaid. Here's this thing called
14 SCHIP. You know, all of us who talk about health care
15 rattle off SCHIP. I don't think most people on the
16 planet know what it is, probably they think it's
17 something for their TV set or something. But, as we all
18 know, it's a plan for poor children, especially after
19 Katrina.

20 So in telling people where the money goes,
21 we should be treating health care like an ecosystem.
22 Certainly after the debacle of '93 and '94 people
23 stopped treating health care like an ecosystem. We kind
24 of got it piecemeal; a little piece here and a little

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1 piece there. Boy, does that cause you problems.
2 Congress passed a prescription drug bill this year. I
3 voted for it. I still have the welts on my back to show
4 for that. But towards the end of the debate, out of
5 nowhere, people said well if we had this government
6 program for seniors and prescription drug coverage,
7 maybe the employers are going to drop their coverage.
8 Nobody wanted to do that. Certainly don't want to
9 discourage employers. So Congress without any debate,
10 without any hearings, without any discussion, said let's
11 spend \$60 billion -- \$60 billion -- on helping employers
12 keep their coverage. Nobody ever asked once, "Was that
13 the best use of \$60 billion dollars?" Boy, you can buy a
14 lot of health care in this country for \$60 billion,
15 serve a lot of people. And nobody ever had that
16 discussion because health care isn't treated like an
17 ecosystem anymore.

18 So the first time our national government is
19 going to make it convenient for people to participate,
20 what you're talking about going online and offline where
21 somebody can show up in their office or a senior citizen
22 center, type into the computer and get a sense of what
23 some of the choices are. That's a real service to
24 people.

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1 For the first time our government has said
2 that after the public involvement there's got to be
3 political accountability. And I wanted to come and tell
4 you that in particular Senator Hatch and I have got your
5 back on this. We sit on the Senate Finance Committee.
6 The law has been written so that this isn't about
7 another public opinion poll. This isn't about people
8 just jabbing about health care a little bit and then
9 going home.

10 When you're done, when the citizens have
11 been heard, the law states that Congress and the
12 President must act. They've got to quickly move not to
13 talking about what they're interested in, but what you
14 come up with. There have got to be hearings in the
15 Congress quickly while it's fresh in people's minds
16 about what the citizens want in America on health care.

17 So that's a lot of firsts. I'd wrap this up
18 simply by way of saying that together I think we can
19 figure this out. I think that the American people want
20 to think through health care for themselves.

21 And I am tremendously honored to represent
22 our state. I never thought when I came to Oregon to
23 start law school that someone like myself, a first
24 generation Jewish guy with a face for radio would have

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1 these opportunities for public service, or the
2 opportunity in particular to serve on the Senate Finance
3 Committee where could I make the extraordinarily
4 important work that you're doing really count.

5 I think the country is ready for this,
6 folks. If you walk people through the choices, if you
7 arm them with the facts, if you ask tough but important
8 questions in language resembling English so that it is
9 not health-speak, I think people are there. I think
10 this time we can do it right. I think this time together
11 in a partnership we can do something that we should have
12 done a long, long time ago, and that's to get health
13 care that works for all Americans.

14 (Applause).

15 VICE CHAIRPERSON McLAUGHLIN: Thank you very
16 much, Senator Wyden.

17 We can take a few minutes for questions
18 before we move on.

19 I just wanted to thank you very much for
20 that talk. Everyone on the working group appreciates
21 your enthusiasm about not only this group, but health
22 care in general. And in the spring when you came to
23 talk to us at our first meeting you warned us that this
24 was like a trek through the Himalayas. And certainly

1 after these last few days of hard work here in Portland,
2 we needed this energy boost that you just gave us. So
3 we're very grateful to you for coming here because it
4 has been hard work. And we really appreciate your
5 enthusiasm and your reminding us of what you and Senator
6 Hatch put into that legislation which, hopefully, a year
7 from now will make a big difference. So thank you very
8 much.

9 Did anybody want to ask Senator Wyden some
10 questions? I guess not.

11 SENATOR WYDEN: I've never heard this group
12 so quiet.

13 VICE CHAIRPERSON McLAUGHLIN: I haven't
14 either. I don't know. I'm not sure.

15 PARTICIPANT: It's not a question.

16 I'd just like to thank you for bringing out
17 the disabled community. I feel very welcomed here in
18 Portland. I think this is the most disabled people that
19 I've seen participate so far. I think this is an
20 important contribution and effort.

21 SENATOR WYDEN: I think you've made your
22 point.

23 I don't know where he is. Where is
24 Commissioner Sam Adams?

1 VICE CHAIRPERSON McLAUGHLIN: He had to step
2 out, but he was here earlier.

3 SENATOR WYDEN: This is really the people's
4 happening. I mean, it's not really freedom unless
5 everybody's free to have a chance to participate. And
6 just as we thought that the law that we wrote would
7 liberate health care, what we want to do is liberate
8 public involvement, not just for people who can spend a
9 lot of money and make long trips as you said, Montye.
10 But people who can see that government is more
11 accessible and convenient to them.

12 We're glad you're here.

13 VICE CHAIRPERSON McLAUGHLIN: Thank you
14 again, Senator Wyden.

15 SENATOR WYDEN: Well, thank you.

16 VICE CHAIRPERSON McLAUGHLIN: We also want
17 to wish you and Nancy the best tomorrow. We've been
18 told tomorrow's weather is supposed to be picture
19 perfect, so you're starting off on a very good note.

20 SENATOR WYDEN: Was that part of your --

21 VICE CHAIRPERSON McLAUGHLIN: Probably.
22 Thank you very much.

23 Next we're going to hear from Governor
24 Kitzhaber. The Governor is a former emergency

1 physician, a legislator and two term Governor of the
2 State of Oregon. All of you know this, but this is
3 being part of the formal record.

4 He is the past President of the Oregon State
5 Senate where he authored and implemented the ground
6 breaking, as we will hear more about, Oregon Health
7 Plan, now in its tenth year.

8 His legislative career, which began in 1979,
9 was marked by active leadership in the areas of public
10 education, community development, environmental
11 stewardship and a wide variety of health care.

12 In January of 2003 Dr. Kitzhaber began
13 serving as President of the Estes Park Institute, which
14 conducts six annual educational conferences for
15 community hospital.

16 And I must say I heard Governor Kitzhaber
17 give a talk about the Oregon Health Plan at a conference
18 this spring in Princeton, to which he got a standing
19 ovation. It was wonderful, wonderful information, and
20 I'm looking forward to hearing you share that with the
21 full working group here today.

22 Thank you for coming.

23 GOVERNOR KITZHABER: Thank you very much.

24 For the record, I'm John Kitzhaber.

1 First let me say what an honor first of all
2 it is to have been asked to participate and to
3 contribute to this tremendous work that you're doing
4 here today. And I want thank Senator Wyden, and
5 certainly Dr. Baumeister for helping to put this
6 together, and all of you for the fine commitment that
7 you've made to what is a very very significant
8 undertaking.

9 I also want to extend my personal thanks to
10 Commissioner Sam Adams who, along with his staff, worked
11 day and night to arrange meeting rooms, to take care of
12 logistics to make this work. So I'm very grateful to Sam
13 and his staff.

14 I noticed from the screen up there that my
15 battery isn't fully charged. It ought to be Health Care
16 That Works for All Americans Group. I think you might
17 consider calling it the Health That Works for All
18 Americans Group, a point I'm going to come back to in a
19 minute here. I think we shouldn't confuse health with
20 health care.

21 Before I start I just want to add to the
22 urgency, the sense of urgency that Senator Wyden
23 indicated in his remarks today. I don't think we have
24 time in this country for incremental change. We need

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1 change of truly revolutionary scope if we want to get
2 ahead of this problem. And to illustrate that I want to
3 use the words of Denis Hayes, who is the Executive
4 Director of the Bullitt Foundation in Seattle, who puts
5 it this way. "Zeros matter. A million seconds ago was
6 last week. A billion seconds ago Richard Nixon was
7 resigning from the White House. A trillion seconds ago
8 was 30,000 B.C. and humans were just beginning to use
9 stone tools."

10 Our national debt is \$7 and a half trillion
11 and it is escalating as the population ages. And while
12 Congress is preoccupied with the solvency of Social
13 Security, the real problem is Medicare. The Social
14 Security gap is around \$5 trillion; big but with
15 retirement -- actually not even the retirement. You
16 don't even have to retire. When my generation turns 65
17 the unfunded liability in Medicare exceeds \$60 trillion.
18 That's the magnitude of the problem that is rapidly
19 overtaking us. And it means that we've got to act
20 definitively and very boldly.

21 I was asked to provide an overview of the
22 Oregon story, if you will, one state's effort to try to
23 develop a more rational and accountable framework of the
24 allocation of health care resources. And I'd like to do

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1 that by trying to offer a personal perspective on the
2 Oregon Health Plan, about why it came about, some
3 thoughts on the larger context in which it was
4 developed, and also some lessons that can be learned
5 both from its successes and from its failures.

6 So for me the story began in May of 1986
7 when I was serving my first term as Senate President.
8 And during the interim, after the legislature had
9 adjourned, we had a budget deficit. And about half of
10 it was due to increased case loads and utilization costs
11 in the Medicaid program. So in order to comply with our
12 constitutional requirement to balance our budget, the
13 State Emergency Board took a number of actions to bring
14 the budget back into balance, one of which was to change
15 the eligibility standards of the Medical Needy Program
16 and to disenfranchise 4300 people from state health
17 insurance coverage.

18 And I remember being astonished at how easy
19 it was. We were in a hearing room and spring was
20 happening outside. And we looked at some numbers on a
21 piece of paper and took a couple of votes and the budget
22 was balanced. But also with the stroke of the pen we
23 dropped 4300 people from financial assess to the health
24 care system.

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1 And, of course, at the time none of us
2 appreciated the fact that we were in, in fact, rationing
3 people. It was just a sterile budgetary exercise. But
4 it was disquieting. And unlike the other members of the
5 Emergency Board I was a physician. And I went back to
6 my emergency department and five months later I began to
7 see a few individuals in the ER who had lost coverage
8 because of that sterile budgetary exercise five months
9 earlier. And in most cases they were people who had
10 delayed seeking treatment for minor problems because
11 they were concerned about how they were going to pay for
12 it. And in one case it was a middle aged man who had
13 suffered a massive stroke because he had been unable to
14 access his blood pressure medications over the preceding
15 five months.

16 And that had a profound effect on me and
17 what happened subsequently. And that sustained that
18 disquiet I had felt when the Emergency Board had
19 disenfranchised these 4300 nameless, faceless people.
20 And I realized that they weren't nameless, faceless
21 people. They had names and faces and hopes and dreams of
22 their own. And this wasn't just a sterile budgetary
23 exercise. What we were doing by balancing the budget in
24 that way was to disenfranchise other people from access

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1 to the health care system, with very real human
2 consequences. We simply didn't have to be accountable
3 for them.

4 Now the next year in 1987, the Oregon
5 legislature voted to discontinue Medicaid funding for
6 major organ transplants, at the time, an optional
7 service. And there were some rational reasons that they
8 did that, which we can discuss later if you like. The
9 point is it was an explicit social rationing decision,
10 and it was totally uncontroversial and almost unreported
11 by the press. Probably because there was no one who
12 needed a transplant there at the time the decision was
13 made, something that was soon to change.

14 So the legislature adjourned in June. They
15 used to actually adjourn in June. And in November a 7
16 year old boy named Coby Howard showed up who had acute
17 lymphoblastic leukemia and needed a transplant. His
18 family was covered by Medicaid and the program no longer
19 covered that service, so his family turned to the
20 public.

21 Throughout the media now this problem was
22 played out on the nightly news and on the front page of
23 newspapers and the media fanned the public emotion to a
24 fever pitch while completely ignoring, in my view, the

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1 larger policy issues that surrounded this tragic
2 situation.

3 I remembered watching a very premature
4 infant die very quietly before my eyes of respiratory
5 distressed syndrome while I was an intern. And the
6 cause of his death, which essentially was lack of
7 prenatal care, was not as dramatic and apparently not as
8 newsworthy as dying for lack of an organ transplant.
9 But I can tell you from personal experience that it was
10 no less tragic because it was simply not reported.

11 So on Wednesday December 2nd Coby died at
12 Emanuel Hospital in Portland. This was indeed a very
13 real human tragedy. But it was also a sensational human
14 interest story and local and national media descended
15 upon Oregon, although they had totally ignored the
16 decision to cut the program a year earlier. And in the
17 wake of that publicity there was an effort mounted to
18 partially refund the transplant program, for it was
19 eight or nine people; the people who had applications
20 into the program at the time. And I opposed that motion.

21 The media saw this as a debate about
22 transplants; I saw it as a debate about how we allocate
23 limited public health care resources. So to me the
24 question wasn't whether transplants had merits, clearly

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1 they often do. The question wasn't whether the state
2 could afford eight or nine more transplants; it could.
3 The question to me was simply this: If we're going to
4 spend more money on the public health care budget, where
5 should that next dollar go? What was the policy that
6 would lead us to fund transplants as opposed to further
7 expanding access to prenatal care? Is one more
8 important than the other? What was the policy that
9 would lead us to offer transplants to eight people as
10 opposed to 18 or 80? Where was the equity in taking a
11 group of poor individuals who had access to a fairly
12 good Medicaid benefit package and adding transplant
13 coverage for a few of them while ignoring 20,000 or
14 30,000 people, also deeply impoverished, who had access
15 to nothing?

16 And what became clear is that there was no
17 policy. There was no policy whatsoever.

18 And while we could easily have funded
19 another eight or nine transplants, we had no way of
20 knowing or being accountable for the consequences of not
21 spending those resources on other individuals in Oregon
22 who were deeply in need and excluded from the system
23 altogether. And it was precisely this lack of
24 accountability in the way in which we allocate our

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1 public resources for health care, which we were trying
2 to address with the enactment of the Oregon Health Plan.

3 Now to understand the nature of the Oregon
4 Health Plan and also the lessons I think it has to offer
5 to this working group, I think it's necessary to review
6 the underlying structure of the U.S. health care system
7 in which all state reform efforts must necessarily take
8 place. And I think this is important because you're not
9 about changing the health care system in Oregon here.
10 Your charge is to make a recommendation about how to
11 change that larger U.S. health care system which
12 influences everything we do at the state level.

13 I think that the single major structural
14 flaw in the U.S. health care system is that it was built
15 around the concept of categorical eligibility rather
16 than around a commitment to universal coverage which
17 means that in order to be eligible for publicly
18 subsidized health care in America, unlike public
19 education in which everybody's eligible; in order to be
20 eligible for publicly subsidized health care you have to
21 fit into a category, and those categories were
22 established with the enactment of Medicare and Medicaid
23 four decades ago.

24 Now the enactment of those two programs with

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1 the existence of employment private-based coverage left
2 the U.S. with a public/private health care financing
3 system with two major arms. A private arm, primarily
4 employment-based coverage, as you know. And then the
5 public arm, which is essentially Medicare and Medicaid.

6 But because the system was developed around a concept
7 of categorical eligibility rather than commitment to
8 universal coverage, a growing gap began to develop
9 between the public and private arms of that system. And
10 in that gap were people who don't fit into a category,
11 if you want to look at it that way.

12 They're not 65, so they're not eligible for
13 Medicare. And they don't meet the income or categorical
14 eligibility requirements for Medicaid. They don't have
15 work-based coverage and no one will insure them in the
16 private individual insurance market.

17 Today, as you know, there are over 45
18 million people in that coverage gap, including 600,000
19 people in this state alone. And a gap exists because
20 we've organized our system around categorical
21 eligibility rather than around universal coverage. And
22 we have therefore avoided explicitly answering as a
23 society a very fundamental question, which every other
24 industrialized nation in the world has answered in some

1 form or another. And that question is simply this:
2 "Who has the responsibility to pay for the health care
3 needs of citizens who can't afford to pay for it
4 themselves?" And because we've never answered it, we
5 have to allow the economic market to make the decision
6 for us. But economic markets are designed to make a
7 profit, not to foster social responsibility. So it
8 shouldn't come as a big surprise that no one goes out
9 and competes to take care of people who can't pay for
10 it.

11 Why is that so surprising? In fact, in our
12 market oriented terminology people who have a payment
13 source are referred to as market share. And we compete
14 for them. And people who don't have a payment source
15 are referred to as liabilities. And we avoid seeing them
16 through adverse selection and through cost shifting.

17 Now if you think about it, the ability to
18 cost shift serves as a pressure valve in our system and
19 it also reduces the accountability and thus the
20 political pressure needed for needing full reform. And
21 you know how it works.

22 People who don't have coverage, who find
23 themselves in that coverage gap, eventually many of them
24 get sick enough and go to the emergency room where

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1 federal laws require that they be seen and treated. And
2 then the uncompensated costs are simply shifted back to
3 both the public and private third party payers through
4 incremental increases in their insurance premiums and
5 their bills.

6 Now those third party payers then seek to
7 shift the cost back on the individual. States do it by
8 manipulating income eligibility to reduce the number of
9 people who are on Medicaid; it's what we did in 1986.
10 Employers either drop coverage altogether, which is a
11 steady trend, or they increase co-payments and
12 deductibles that shift costs on to individuals who at
13 some point can no longer afford to pay for their health
14 care services. So they've actually simply increased the
15 number of people in the coverage gap, they go back to ER
16 and the cycle is repeated.

17 It was this cycle, this vicious cycle, and
18 the implicit rationing that goes along with it that we
19 were trying to address with the enactment of the Oregon
20 Health Plan.

21 Now, as I mentioned earlier during that two
22 day debate over the transplant program, I kept asking
23 myself if we're going to spend more money in the public
24 health care budget in Oregon, where should the next

1 dollar go? And, of course, the answer to the question
2 depends on what you're trying to accomplish with the
3 allocation. So is it the objective to ensure that all
4 citizens have access to the health care system, or is
5 our objective to ensure that all our citizens are
6 healthy? It's not the same thing at all.

7 And I think that our objective is or
8 certainly should be health rather than simply the
9 financing and delivery of health care. My point being
10 this: Health care is a means to an end; it is not an
11 end in itself. It has no intrinsic value outside its
12 relationship to health except as an economic commodity,
13 which is pretty much how the current system treats it.
14 And, of course, that's a large part of the problem.

15 So clearly, access to some level of health
16 care is necessary for individuals to remain healthy.
17 Yet the fact remains that not everyone has the financial
18 access to pay for their health care, which gets us back
19 to the question of who has that responsibility.

20 So what we tried to do first and foremost in
21 the Oregon Health Plan besides clarifying our objective
22 was health not just financing and delivery health care,
23 was to try to answer that question of responsibility by
24 establishing that the state would assume responsibility

1 for financing health care to the poor, which we defined
2 as anyone with an income at or below the federal poverty
3 level.

4 Now, in retrospect, particularly given the
5 rise in health care costs, you could argue that that was
6 way too low. You should have established it at 150
7 percent or 200 percent of the federal poverty level. But
8 the important aspect of this decision is that it
9 represented a clear rejection of the principle or
10 concept of categorical eligibility.

11 We believed that the sole criteria to access
12 publicly financed health care, at least for the Medicaid
13 program, should be financial need, not merely a set of
14 categories that were created four decades ago and that
15 excluded poor men and poor women without kids who were
16 pregnant, no matter how impoverished they might be.
17 That made no sense to us. We couldn't find any way to
18 justify it.

19 And of equal importance was the fact that we
20 proposed to establish that eligibility criteria in
21 statute to make it hard to change, thus removing one of
22 the major tools of the implicit rationing by the
23 legislature, who was simply manipulating eligibility.

24 Now, by clearly defining the public sector

1 responsibility, and that's why I think if the nation
2 were to say we're going to have universal coverage,
3 we're going to assume that responsibility, you
4 significantly shift the focus of the debate of
5 eligibility to benefit -- from who is covered to what is
6 covered.

7 I mean, my God, in Medicaid there are 28
8 different statutory eligibility categories. Do you know
9 how much money we spend trying to discern which are
10 deserving and which are undeserving? It's a nightmare.
11 It makes no sense. It defies common sense. It defies
12 logic.

13 So if you can shift the focus of the debate
14 from the eligibility to benefit, then instead of
15 debating which individuals should receive funding for
16 which services, and by implication which individuals
17 should be denied those services, we would instead ensure
18 that everyone had access to the health care system and
19 then we would debate the funding priority established in
20 each specific service available.

21 So as a consequence, establishing priorities
22 to an open and explicit and accountable process became
23 the centerpiece of the Oregon Health Plan, and it's
24 based on a clear eyed recognition that we were dealing

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1 with public resources, and that public resources are
2 ultimately finite.

3 States, unlike the federal government, can't
4 push their hard fiscal choices into the deficit to allow
5 our children to deal with. Most states have a
6 constitutional requirement to balance the budget, which
7 means that since we can't spend all of our resources on
8 health care at the expense of education and public
9 safety and infrastructure, the amount of money available
10 for health care in public budgets is ultimately finite.

11 And what does that mean? It means that
12 health care rationing in some form is inevitable. If
13 the amount of money the public sector can spend on
14 health care is limited, then people who depend solely on
15 that source of revenue to finance their health care
16 needs will face some limitations on what will be
17 financed. And it's our job to embrace that reality and
18 to make the process explicit so that we can ensure that
19 that level, that that floor is adequate and meets the
20 health care needs, and thus the health of all of our
21 citizens.

22 And there's two ways that health care can be
23 rationed, as we've discussed earlier. You can ration it
24 implicitly or you can ration it explicitly. And today

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1 because we have no explicit policy of universal coverage
2 in this country, most of our rationing is done
3 implicitly by dropping people from third party insurance
4 coverage. That is the most insidious, impersonal kind
5 of rationing. It's based on no policy whatsoever, and
6 it is utterly devoid of any type of accountability. It's
7 very much like high level bombing: For the people who
8 are responsible for the decisions, never have to see the
9 faces who suffer and sometimes die because of their
10 choices. And let me give you a tragic case in point.

11 In February of 2003 the Oregon legislature,
12 to balance the budget because of the recession,
13 discontinued prescription drug coverage for the
14 medically needy program, an implicit rationing decision
15 very similar to the one that I participated in during
16 1986, and the result was every bit as tragic. As a
17 consequence a man, I guess he was in his mid 30s, named
18 Douglas Schmidt, who suffered from a seizure disorder
19 was no longer able to access the medications that
20 managed his seizures. So he was still eligible for state
21 coverage, but the program no longer covered prescription
22 drugs.

23 After about ten days he went into a
24 sustained *grand mal* seizure, suffered serious brain

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1 damage and ended up on a ventilator in a Portland
2 hospital, where he remained in the intensive care unit
3 for a number of months. He was eventually transferred
4 to a long term care facility where he died in November
5 of 2003 when life support was eventually withdrawn.

6 Now the cost of this anti-seizure medication
7 was \$14 a day. The cost of his intensive care unit visit
8 exceeded \$7,500 a day. A total cost of over \$1.1
9 million, all of which was simply billed back to the
10 state. So the legislature didn't save any money through
11 this implicit rationing decision. In fact, it increased
12 its fiscal liability, and in order to deal with it, had
13 to drop more people from coverage perpetuating this kind
14 of human tragedy and fiscal disaster.

15 So my point is simply this: In this country
16 of ours, we're going to pay these costs one way or
17 another, unless we're willing to let people die on the
18 ambulance ramp if they don't have health insurance
19 coverage. And I haven't heard anyone propose that we do
20 that. So we're going to pay the costs either explicitly
21 or implicitly. And by refusing to do it explicitly on
22 the front end, the cost is much, much higher both in
23 human and in fiscal terms.

24 Think about it for just a minute. Douglas

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1 Schmidt died of budgetary and political expediency based
2 on a policy that says, in effect, we won't pay a few
3 dollars a day to manage a seizure disorder in the
4 community, but we'll be happy to fork out over a million
5 dollars to sustain you on life support once your seizure
6 condition had destroyed your brain. It's a policy that
7 says we won't pay pennies to manage blood pressure in
8 the community, but we'll pay for the cost of your stroke
9 in the hospital when you have it. It's a policy that
10 says we won't ensure that all women in our country have
11 access to good prenatal care, but we'll be happy to pay
12 the costs of resuscitating your 500 gram infant in a
13 neonatal intensive care unit. And that should not be
14 acceptable to any of us. Any of us.

15 The Oregon Health Plan was based then on the
16 premise that if publicly subsidized health care has to
17 be rationed, then it has to be done explicitly, it has
18 to be done accountably, and it needs to focus not on
19 people, but on benefit levels based on their relative
20 value and effectiveness in producing health. And that in
21 turn required that we be able to establish priorities
22 through the creation of a framework for evaluating the
23 effectiveness and the appropriateness of the health
24 services being purchased.

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1 So to carry out that responsibility we
2 created the Oregon Health Services Commission. It
3 consisted of five primary care physicians, a public
4 health nurse, a social worker and four consumers, one of
5 whom served as the chairperson. And through an open and
6 transparent process, specific services and treatments
7 were prioritized according to their clinical
8 effectiveness and based on our determination for value.

9 So there were things like, just to oversimplify it,
10 appendectomy for acute appendicitis or penicillin for
11 bacterial pneumonia; conditional treatment.

12 Physicians were used to provide the
13 necessary clinical information as well as the literature
14 search. And thousands of volunteer hours for Oregon
15 physicians have gone into the development of this
16 priority list. And then the determination of social
17 values was through an extensive public outreach process.

18 And you'll be hearing more later this morning both
19 about the Commission and its work and about our public
20 outreach process to help integrate social values into
21 the privatization process.

22 The first priority list was completed in
23 February of 1991 and it consisted of 709 of these
24 condition treatment areas that were originally in the 17

1 categories. So the categories, the 17 categories, were
2 prioritized on the basis of our interpretation of the
3 social values and within each category, the condition
4 treatment pairs were prioritized on the basis of the
5 expected outcome and benefit and duration of that
6 benefit.

7 So to give you an example, services in the
8 highest category were treating an acute fatal condition
9 where treatment saved your life and returned you to your
10 previous health state. Everyone agreed that those
11 definitely needed to be treated.

12 Because of the high value placed on
13 prevention by the participating members of the
14 community, the category maternity care, including
15 prenatal care, natal care and postpartum care, ranked
16 very high, as did preventive care for children.

17 Because of the value of compassion, hospice
18 care was also ranked very high.

19 And at the bottom of the list were
20 categories for services of self-limiting conditions,
21 services that had little or no effect on health status,
22 and what we defined as futile care, which was less than
23 a five percent five year survival rate.

24 And that final priority list was given to an

1 independent actuarial firm that determined the cost of
2 providing each element on the list into a managed
3 capitated reimbursement system. And that list, along
4 with its accompanying actuarial data, was given to the
5 Oregon legislature.

6 Now the legislature was statutorily
7 prohibited from altering the priorities as established
8 by the Health Services Commission. Reimbursement had
9 already been determined by the independent actuary and
10 physicians and hospitals had input into the actual list.
11 So the two major tools of legislative rationing
12 implicitly had been taken away; cutting provider
13 reimbursement rates arbitrarily and changing
14 eligibility. So they simply had to make the resource
15 allocation decision, which by its very nature is
16 political.

17 So they looked at the existing Medicaid
18 budget and saw what kind of benefit that you could gain
19 with that, and then the debate was on how much more
20 money you want to pump into the system and to get a
21 benefit level that we felt was adequate and defensible.

22 So in that way the definition of basic care or what is
23 covered was directly linked to the reality of the fiscal
24 source, which hopefully it is if you remove all of our

1 implicit ways of avoiding the confrontation with that
2 reality.

3 Now before I conclude and comment very
4 briefly on the lessons that we learned from the Oregon
5 Health Plan and on its ultimate fate, I want to just say
6 at this point that the same principles around which the
7 Oregon Health Plan was built are also reflected in the
8 Health Resources Commission and its work that you're
9 going to be hearing about here later this morning. So
10 equity, transparency, explicit decision making,
11 accountability, value, the use of evidence continue to
12 be the guiding principles for the Health Resources
13 Commission and also for the Center For Evidence-Based
14 Policy at the Oregon Health & Sciences University in its
15 continuing work of evaluating through a systematic
16 review of the evidence of various classes of
17 prescription drugs that was first started by the Health
18 Resources Commission under the leadership of Dr. Frank
19 Baumeister, who was at the time the chairperson.

20 Now let me simply conclude my comments this
21 morning on the Oregon Health Plan. If you recall, to
22 implement the program required waivers from the federal
23 government, because the plan violated Medicaid law on a
24 number of levels. And we can come back to that if you

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1 have any questions, because I think that is a key
2 element in leveraging future change in the larger health
3 care system.

4 First, we wanted to be establishing our
5 covered benefits through the use of a priority list
6 rather than through the existing mandated Medicaid
7 services. And it's astounding, if you think about it,
8 why we should have to get a waiver to actually build a
9 way based on what works and what doesn't work in health.

10 Nonetheless, that was one of the areas that we had to
11 get waived.

12 The second one was we wanted to cover all
13 Oregonians below the federal poverty level, not just
14 those that fit into categories. So there were some 90
15 or 100,000 new eligibles; there were the poor men, the
16 poor woman, kids who were pregnant that we wanted to
17 cover and still keep our federal matching dollars.

18 So we were first denied our waiver request in
19 August of 1992 by the first Bush Administration. We were
20 finally granted our waivers under President Clinton in
21 March of 1993. And the Oregon Health Plan was
22 implemented on February 1, 1994.

23 After a ten year run, during which time over
24 a million Oregonians benefited from this program, the

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1 Oregon Health Plan was largely dismantled in 2004 after
2 the legislature in effect eliminated coverage for the
3 new eligibles who came into the program under the
4 waiver. Since then, over 60,000 Oregonians have lost
5 coverage. Since that time I'm sure more will follow,
6 and unfortunately it is moving back to the old system of
7 categorical eligibility and implicit rationing and huge
8 cost shifting that the plan was originally designed to
9 address in the first place.

10 Although you'll be hearing more from other
11 speakers about the history of the Oregon Health Plan
12 over the last decade, I want to take just a moment here
13 at the end to touch on three major lessons that I think
14 it has taught us. Hopefully, they'll be relevant to the
15 work that you folks are about.

16 These are lessons I think that we learned
17 both from the halcyon days of the plan but also from its
18 ultimate demise.

19 The first lesson is that it has taught us
20 that it is possible to develop a clinically and
21 politically defensible priority list and to use that
22 list to establish a covered benefit based on that list.

23 The second lesson is that it is possible to
24 confront the reality of fiscal limits and to assume

1 accountability for the difficult choices which those
2 limits made inevitable. You can do that and actually get
3 reelected. But perhaps the most important lesson, and I
4 think this is the one I hope you really take home, is
5 that meaningful reform cannot take place in my view
6 unless the basic structure of the U.S. health care
7 system is revised. Unless we are willing to openly
8 challenge the underlying premises and assumptions on the
9 way it should be built.

10 The demise of the Oregon Health Plan was not
11 simply due to the recession and the budget deficit. It
12 was also due to the larger system in which that health
13 plan existed. So the fact is that we were trying to
14 bring about meaningful reform in the constraints and
15 contradictions of a fatally flawed federal structure.
16 This is not a state problem. This is not a Medicaid
17 problem. This is a national problem and it is a system
18 problem, and it cannot be fixed at the state level
19 without fundamentally changing the structure in which
20 all state reform efforts have to exist.

21 How long do you suppose Microsoft would last
22 if Bill Gates held on to a ten year old operating system
23 or a five year old operating system, or one that's two
24 years old?

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1 We're clinging tenaciously to a 40 year old
2 health care operating system and we wonder why we can't
3 solve the health care challenges of the 21st century.
4 What we have been doing up to this point is nibbling
5 around the edges of a very serious social and financial
6 problem. Modernizing Medicaid is not the same as
7 challenging the basic structural assumptions on which
8 those programs have been built.

9 Certainly there are many poor elderly
10 citizens in this country and in this state who need and
11 deserve publicly financed health care. But there are
12 millions of poor children and working adults who need
13 and deserve exactly the same thing and today who are
14 entitled to absolutely nothing.

15 (Applause).

16 My hope is this working group will provide
17 the leadership necessary for the United States Congress
18 to realize that it is time to stop defending programs at
19 the expense of solving problems. And that we cannot
20 successfully meet the challenge that this crisis poses
21 by continuing to allow our thinking and our reformed
22 efforts to be constrained by a 40 year old eligibility
23 and financing structure that reflects the realities of
24 the middle of the last century.

1 Thank you very much.

2 VICE CHAIRPERSON McLAUGHLIN: Thank you.

3 (Applause).

4 VICE CHAIRPERSON McLAUGHLIN: We have some
5 people standing to applaud. Thank you very much for
6 that information.

7 When you say that it's important to ask what
8 works and what doesn't work in producing health, as
9 Frank announced, I'm an economist, so this is language
10 that I deal with all the time. And it's a way of
11 thinking, a conceptual framework that is very familiar
12 to me.

13 I'd like to point out, however, that the
14 statute has charged this group not with coming up with a
15 list such as that, but going out and talking to the
16 American public and saying, what's one of the four
17 questions we've been asked to address is, what services
18 do you want provided. So my question to you and then
19 we'll have some time to have other members of the group
20 ask you some questions, how do you think that tension
21 should be balanced between what the American public say
22 these are the services that we want provided in the U.S.
23 health care system, this is what we want to be part of
24 the system versus what experts would tell them these are

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1 the services that at the margin issue, as you said, are
2 worth the extra dollars; that you get something for what
3 you pay? How would you recommend that for us to go
4 about our charge in the next six months to balance that
5 potential tension?

6 GOVERNOR KITZHABER: I don't think you can
7 balance that tension unless you put cost in the equation
8 and also answer the question who has paid that cost.
9 And I'll give you just a real quick example, and you
10 heard a little bit of it.

11 I think what's really in contention in this
12 health care debate is the allocation of public resources
13 -- who benefits from that allocation. I don't think
14 we're really arguing about private resources. The
15 people who can pay for their own health care aren't the
16 system problem. It may be too high, they may not like
17 it, but they're not the system problem. What we're
18 really concerned about is how you allocate those public
19 resources.

20 And right now, you know, we basically
21 believe in this country that death is optional, right.
22 It's not a part of the life process. It's optional and
23 we're encouraged in that belief by modern medicine.

24 Dick Lamm, former Governor of Colorado,

1 tells about the study on death rates he did all over the
2 world, in the U.S., in Uganda, in Argentina, in Bolivia,
3 and he found an interesting thing; it's all the same,
4 one per person.

5 So we've basically built a system of health
6 care that maximizes benefit one individual at a time,
7 but we increasingly rely on public resources to pay the
8 cost of that care. And there's nothing wrong with that
9 if people are paying the cost of their own care. But
10 we've created something that can be Gerhardt who is
11 tracking the comet, where basically we're requiring to
12 finance health care for individuals at the expense of
13 common resources. And a lot of people aren't in that.

14 It's simple. You have to be able to ask.
15 You have to have a framework of which you can ask, is
16 that marginal benefit that we're paying for one person
17 coming at the expense of thousands of other people who
18 can't even get into the system. That's exactly what we
19 were debating with Coby Howard.

20 So I think if you asked people what they
21 want in a health care system, they'll pretty much tell
22 you everything. And that doesn't get us down the pike.
23 The pike is to ask yourselves how are we going to
24 finance it, how are we going to assure that there's

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1 social justice, but that there's equity in the way we
2 allocate those public sources.

3 You know, people with more money will always
4 be able to buy more health care, more cars, more
5 everything. There's nothing wrong with that. The real
6 problem is that we're subsidizing those extra
7 expenditures with resources paid by people who don't
8 have access to the system.

9 It's a two-sided entry. You can talk about
10 what you want, you also have to talk about how much it
11 costs and who is going to pay that cost. I don't think
12 you can avoid that.

13 VICE CHAIRPERSON McLAUGHLIN: Brent?

14 DR. JAMES: I have a relatively complex
15 question about this. While I've been interested for a
16 very long time as I followed your work, I spent a lot of
17 time in other countries, particularly Sweden, Australia
18 and Canada looking at the way that they ration care.
19 It's done through government policy. It's done largely
20 out of the public view. I want you to tell me about the
21 politics of this in a particular way, because I think
22 that's one of the key issues.

23 First, in the idea when you say explicit
24 rationing, you've implied that so let's make explicit,

1 again explicit multi-tiered systems. Minimum two tiers
2 where some people have one level of services and others
3 have the private funds to buy something buy that. In
4 that context the medical industrial complex is only
5 appropriate where people who want access to the public
6 funds because it so greatly expands their market and
7 they stand to make an awful lot of money from it, who
8 often times work in conjunction with people who aren't
9 making a lot of money but have very strong personal
10 beliefs, strong social justice. So you have kind of the
11 moral push of the social justice and the money push of
12 the medical industrial complex.

13 So I just wanted you to comment some on the
14 practical politics, can we do this explicitly and what
15 are the politics of making it happen explicitly in the
16 world? Can we face that issue as a people and how would
17 we go about doing that?

18 GOVERNOR KITZHABER: Well, the first part of
19 it, I believe you can do that. I believe that's
20 essentially what we did in Oregon.

21 I recall Dr. Jackson on the front page of
22 the *San Francisco Chronicle* and *Newsweek* and it was a
23 very unpleasant two years after this business, but I
24 went on to get reelected to the Senate by 60 percent and

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1 Governor.

2 I think people are willing to hear the truth
3 if we tell them. People know there's a problem here,
4 but you've got to create a framework. You keep creating
5 a real framework, people have great choices. When you
6 lose your job, you don't tell one of your kids they
7 can't eat. You allocate your resources differently. So
8 people I think are capable of doing it. The challenge
9 is to have political leadership that talks -- that tells
10 us what the choices are and creates a framework where
11 they can engage. And I think that's really what we did
12 through the Oregon Health Plan.

13 We have the prioritization process where the
14 Health Services Commission didn't terminate the benefit.
15 They simply said based on the framework you gave us,
16 here's what the priorities can look like. The
17 legislature had to make the allocation decision. It was
18 political. It was explicit. They were ultimately
19 accountable to the voters. And you can see exactly what
20 you covered and what you didn't cover. So I think it's
21 possible to do that.

22 Someone once said there's no survival value
23 of pessimism. You know, if we're unable to come to
24 terms with that, we are going to allow our future to

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1 become a matter of chance rather than a matter of
2 choice. Because the cost of this animal is going to
3 overwhelm us all. And in fact, the stability; it's a
4 huge issue.

5 Could I just add one more. Maybe -- I hope
6 I've tried to answer your question. And if you want to
7 talk about specifics, I do have an idea how to go about
8 this.

9 But I just want to say one thing about
10 rationing. And I'll give you a personal story. My son
11 injured his spleen a while back, and ended up in the
12 emergency department of one of the local hospitals. And
13 I was sitting there thinking two things, while I watched
14 them with the IVs and the wonderful cardiac monitors and
15 the things that literally saved this little boy's life.

16 To get to that hospital I drove through a
17 section of our city that's very, very poor. And I
18 couldn't help but ask myself how can they have so much
19 health care concentrated here and so little health four
20 blocks away. Where women can't get prenatal care, where
21 kids don't get immunizations, where young people get
22 shot or where we're losing people because of the neglect
23 and substance abuse. That's a huge contradiction that
24 we need to think about when we talk about rationing. We

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1 need to talk about what the system is currently doing.

2 The second thing that occurred to me is my
3 mother is 88, very frail and was in to see her physician
4 and she had a high sed [??] rate with a nonspecific
5 indication for inflammation, one of the indications of a
6 neoplasm tumor. The workout in her case would have
7 involved an endoscopy and colonoscopy and a whole lot of
8 things that she had no desire to have done. We would
9 have paid for all that, by the way.

10 The doctor said let's check her blood work
11 in a few weeks and see how she's doing. I said why? I
12 said if you're going to continue to check the blood work
13 on an 88 year old woman who has decided she doesn't want
14 a bunch of treatment -- you know, why do it because
15 you're going to continue to find abnormalities and
16 you're not going to change the outcome.

17 What my parents want is to stay in their
18 home. \$18 an hour it costs about for in-home care to
19 allow them to stay in their home. Medicare doesn't pay
20 for that. But it will pay for an MRI, CTscan, a cardiac
21 bypass, a transplant and it makes no sense.

22 So when we talk about rationing what we need
23 to ask ourselves is what we're rationing compassionate?
24 Is there a health associated with it? And I think the

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1 answer is clearly no. And I think the way you deal with
2 it politically, is you've got to somehow tease that out.

3 It doesn't have to be the way we did in Oregon, but you
4 have to tease it out so it's not just hospital services
5 and doctor services. You have to be issuing treatment
6 or something where you can actually see what you're
7 buying. And I think there's a perfect opportunity then
8 to take the next step, which would be to, let's say,
9 take those conditions that are core rate or chronic
10 conditions and do a real evidence based review to see if
11 there's any evidence to support how we're managing those
12 things and to move best practice schemes. And I think
13 there's a way to do this that will save money -- I think
14 there's more than enough money in the system so we don't
15 deny any American the treatment of services for
16 effective and appropriate care. I believe that further,
17 and it's a matter of how you reallocate them. And I
18 think the explicit nature of that will help survive the
19 political process.

20 VICE CHAIRPERSON McLAUGHLIN: Well, I have
21 to be the person of bad news, but I'm afraid we have to
22 end at this to try to stay on schedule.

23 You've been wanting to drink that water for
24 a long time. Thank you very much.

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1 (Applause).

2 VICE CHAIRPERSON McLAUGHLIN: Next we're
3 going to be hearing from Dr. Garland. Dr. Garland is
4 professor emeritus of the Department of Public Health
5 and Preventive Medicine, the Oregon Health and Science
6 University. He is also a senior scholar at the Center
7 for Ethics and Health Care where he has served on the
8 faculty since 1978.

9 He received a bachelor's degree in
10 philosophy and letters from St. Louis University and a
11 master's degree in theology from the University of Notre
12 Dame (at the University of Michigan, we don't like to
13 talk about them too much, they just beat us again in
14 football).

15 He earned a doctorate in religious studies
16 from the University of Strasbourg in France where he
17 focused on the theory of responsibility and ethnics,
18 obviously something very important to this working group
19 as we're starting.

20 Dr. Garland has been active in the field of
21 biomedical ethics since 1973. He's published widely in
22 the field of biomedical ethics. And he co-founded the
23 Oregon Health Decisions in 1983 to foster public
24 participation in development of state health policy.

1 DR. GARLAND: I think we should stop there.
2 I want to introduce Dr. Ralph Crawshaw who is the co-
3 founder of Oregon Health Decisions and who is a --

4 VICE CHAIRPERSON McLAUGHLIN: Two for the
5 price of one.

6 DR. GARLAND: Yes. Since that time we've
7 been somewhat joined at the hip. And so we thought it
8 would be best to try to put these thoughts together
9 hearing from both of us as we walk through them.

10 VICE CHAIRPERSON McLAUGHLIN: That's fine.
11 We also do in fact welcome Dr. Crawshaw, who is
12 psychiatry [?] of public health and, as you said, you've
13 been joined at the hip which must not be very
14 comfortable but seems to be productive.

15 So we welcome your comments and looking
16 forward to hearing from you as we face our difficult
17 journey along ethical issues.

18 DR. GARLAND: Dr. Crawshaw has been a mover
19 and shaker in Oregon health policy for many years and
20 that's how we first came together with Oregon Health
21 Decisions was thinking about the role of the public in
22 that health planning system, at which time he was the
23 Chair of the Oregon Coordinating Council. And shortly
24 after we began working together, we were interviewed by

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1 a reporter from the *Wall Street Journal*, who after
2 hearing about many of the interests that Dr. Crawshaw
3 had and the things that he had done to try to improve
4 health care in Oregon, said "Ah, now I recognize you.
5 You are a natural born buttinsky." He won't leave
6 things alone that need to be fixed because of the
7 suffering going on.

8 I gave you a kind of outline that I will
9 briefly talk from, it's some slides. I want to go
10 quickly through those so that you have a chance to have
11 some interchange, especially around what can b done in
12 terms of public participation.

13 Oregon Health Decisions was founded in '82.
14 Its whole point was to foster public participation and
15 access to discourse around the health care system of
16 what it could be doing and should be doing.

17 There were a couple of projects prior to
18 1989 that showed support for the underlying ideas of the
19 Oregon Health Plan, which was not a success for
20 everybody. And a sense of difficult decisions needing to
21 be made. And the public ought to be involved in those
22 hard decisions.

23 In relation to the Oregon Health Plan we
24 worked prior to that with then Senate President Dr.

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1 Kitzhaber who chaired one of our project's steering
2 committees on access issues in health care looking
3 forward to the 1990s. And as the Oregon Health Plan
4 took shape both in his mind and the political arena, we
5 met with him and I see the former Executive Director of
6 Oregon Health Decisions at that time, he and Tim sitting
7 up there. We had a chance to meet with Dr. Kitzhaber
8 and talk about making sure that the public input had
9 community meetings, not just hearings. That there's an
10 opportunity for discourse that's horizontal as well as
11 vertical up and down the power lines.

12 And since the Oregon Health Plan was formed
13 and launched we have sat in follow up public engagement
14 programs to look at issues and fallout from the Oregon
15 Health Plan, and that includes three random sample
16 telephone surveys in 1996, 2000 and 2004 all of which
17 have reasserted in particular a strong widespread and
18 persistent commitment to Dr. Kitzhaber's theme,
19 universal access being a fundamental fixture or value
20 that has to be fulfilled. And a notion that we should
21 be rationing the services that available, not the people
22 who get access to it. That's the core thing that has
23 really gotten through Oregon. And that cost awareness
24 and personal responsibility were an important part of

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1 this.

2 In relation to the Oregon Health Plan, we
3 have 47 communities statewide. The idea was to be
4 geographically and demographically comprehensive. Over
5 a 1,000 people participated. There were 12 statewide
6 public hearings, the traditional public hearing with
7 people testifying. And 1500 people participated in
8 those.

9 And there was a telephone survey using the
10 quality of well being scale to try to get at
11 quantitative judgments of the values that people would
12 give to certain states of well being. Ultimately that
13 one got set aside in the wave of process. So as Paul
14 Starr in his wonderful book on *Transformation of*
15 *American Medicine* reminds us that when we start down the
16 path of a dream of reason, something rational, we have
17 to take power into account. So power will always be
18 there.

19 The structure of the Oregon Health
20 Decision's community meetings was to establish some
21 focus. And we always felt we could get people out for
22 maybe a couple of hours in the evening, but not for all
23 day meetings and the like. That if you really want to
24 get participation, you have to put it into the lives of

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1 people. SO we would have a brief focus on the issue.
2 We used a 20 minute slide show. We had an exercise in
3 which everybody there was divided into small groups
4 where they made individual judgments about some
5 scenarios in health care. Then they discussed the
6 values that were embedded in those individual judgments.

7 And then the values that emerged from that discussion
8 were accumulated for the whole group to see. And then
9 from all of those 47 meetings there was further
10 accumulation of those values into a standard list that
11 was forwarded to the Health Services Commission.

12 Several kinds of values were identified.
13 And I really want to stress this as you think about your
14 community meetings.

15 There were some health values; prevention,
16 quality of life, keeping people alive, making sure
17 mental health and chemical dependency are provided for,
18 and having the ability to function. That those were all
19 health outcomes that were very important people.

20 There were economic values that folks
21 thought of when they thought of what makes health care
22 important to them. And that was that the treatment be
23 effective. We won't to buy things that were -- and that
24 it be cost effective. That if two things both work, we

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1 should get the most cost effective of them.

2 There were a number of social values that
3 emerged. As soon as you talked about what's important in
4 health care, you can see that we used the health care
5 system to achieve some social values like equity, like
6 the fact that it might benefit many people. So the
7 benefit spread around. The personal choices and
8 important social value impact on society. The exercise
9 of personal responsibility for one's health and
10 community compassion.

11 Prevention and community compassion actually
12 provided the Health Services Commission with a couple of
13 highs because they weren't on the list of diagnoses and
14 procedures that they were using. Prevention wasn't
15 really there. And the people all talked about
16 prevention being very important to them. And so the
17 Prevention Services Task Force, U.S. Finance Task Force
18 lists were used.

19 Community compassion focused on the fact
20 that we can't always cure, but it's very important to
21 stand by somebody who is suffering and dying, a lot like
22 Dr. Kitzhaber's reference experience. They want to live
23 in their life comfortable -- live in their home
24 comfortably and not just be out chasing another health

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1 care treatment.

2 I note on here that there are lots of
3 methods of participation and you want to fit the methods
4 to the goals of the outreach. And those goals are to
5 gather information, which I think you're charged to do.
6 But also to build a constituency, a political
7 constituency and to educate the people. And I think all
8 three of those goals are working in your projected
9 activity. And you want to shape the methods of those
10 community meetings to achieve those goals. And it is a
11 real design problem.

12 We have found in our work over the years of
13 20 years now that a focus on values is really important.

14 And so if you think about what health care services
15 people want, answering that first question, I would urge
16 you to try to frame it so that it moves into valued
17 outcomes rather lists of specific services. And we
18 learned that people are much more aware of valued
19 outcomes and describe those and talk intelligently about
20 those, but will be quite confused about specific
21 services because they need more paths than their
22 priority disposal.

23 The data from the input is going to be both
24 qualitative and quantitative. And I think you want to

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1 have both. And I was delighted to hear you say earlier
2 that you're going to be using some surveys as well as
3 community meetings. And I think that's important since
4 surveys allow you to gauge the distribution and the
5 intensity with which opinions are held.

6 A couple of things on decision phases from a
7 good colleague of ours, Dr. Gary Anderson who is a
8 cognitive psychologist. That at the front end of problem
9 structuring, I think that's what you're charge is is to
10 help structure the problem for Congress and the
11 President to deal with this, you want to distinguish
12 facts and values so that it's very clear who you're
13 going to ask for the right information and get values
14 from the public, approach experts about facts and
15 probabilities. And the policymakers have to weigh the
16 alternatives. So there's work that just can't be taken
17 from the policymakers and the public outreach can't
18 substitute for that kind of work either; yours or later
19 on Congress and the President.

20 Just a final note about something we have
21 learned about public participation over the years is
22 that there are real constraints. In fact, it always has
23 to fit some political process. And so you'll be
24 designing this around the political process that you can

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1 hope for.

2 Timing has got to be right.

3 There's a level of concern. So we have a
4 level of concern, but I think it's important to be able
5 to play into that level of concern in America, the 46
6 million uninsured Americans who are worried about where
7 they're going to get their next health care.

8 And then the understanding of the issues.
9 And it appears that you aimed at that, but you want to
10 glean out some better understanding of the issues and a
11 framework that you think will lead to intelligent
12 discussion.

13 And bear in mind and be patient, and
14 persistent with the barriers. That we have a kind of a
15 weak sense of community. Our intense individualism
16 leaves our sense of community rather weak. I think in
17 health care we operate on some illusions about health
18 care being a private individual commodity rather than a
19 mutually provided service.

20 Alienation from politics is extreme and
21 cynicism is rampant. And all three of in part increase
22 dragging on the effort that you're going to be working
23 on.

24 And my final slide is just a summary of what

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1 we've learned. In public participation you really want
2 to bring together two things: Messages from the public
3 that say this is what's important to us and messages
4 from experts saying this is how we get the most of
5 what's important to us. And that final point of pulling
6 together is that work of policymakers.

7 Thank you for your time.

8 I want to get Ralph to comment on some of
9 his ideas around this, and also that he can field any of
10 your questions.

11 VICE CHAIRPERSON McLAUGHLIN: Great. Thank
12 you very much.

13 Dr. Crawshaw?

14 DR. CRAWSHAW: We're a real team, the two of
15 us. And I thank you for the privilege of speaking to
16 you.

17 I'm reluctant to be here. I'm reluctant in
18 speaking to you for two reasons. One is it -- the
19 Governor of going to give you the technical part of
20 what's happening. The other reason is how much I envy
21 you. I personally envy you.

22 If your experience is anything like the
23 experience I had sitting in those seats at the state
24 level instead of a federal level, I can tell you it

1 changes you. You will be a different person. Now why is
2 this? Because you are in a position to uniquely see the
3 vision of America's future. You people are going to
4 listen, not to radios, not to TVs. You're going to
5 listen to real people. And once someone comes and
6 testifies before you and says I didn't have the money to
7 get the medicine for my child and my child is deaf,
8 you're going to be a changed person because you're
9 responsible to see that.

10 Let me give you an example of how shocking
11 this can be, your position. We had a Oregon Health
12 Decision meeting in a county which we were going to
13 review what the reactions were to some of our findings.

14
15 Incidentally, Frank looks worried there. I
16 should make sure that you understand this is not a
17 patient/doctor relationship where he may get sued by me.
18 Because he's my doctor and I'm his patient.

19 We had a meeting at the county and the word
20 got out that the AARP was going to show up and critique
21 what we were doing. And I sat in a seat similar to the
22 seat you're sitting in. And the representative from the
23 AARP got up and he said "We, the senior people in
24 Oregon, do not wish any improvement in our health care

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1 that comes at the expense of children." Let me tell
2 you, that was unexpected. And that was a view of
3 America's vision.

4 So, in talking in this way I want you to
5 know that my life has changed. It was changed in terms
6 of my capacity for compassion. When you hear that
7 person suffering in front of you and you're not allowed
8 to say "I feel your pain." What you're going to have to
9 do is say "I live your pain."

10 And when it comes to the whole business of
11 judgment, you're going to be up late at night wondering
12 just where should I come down on these issues. It's a
13 personal decision and I have to make that decision. And
14 that's very difficult to do.

15 And lastly, the thing that you are not
16 prepared possibly to know is that you have to use
17 willpower. You have to use conviction. You have to make
18 it in words and in print, and in your behavior that you
19 believe that you are right in speaking for all the
20 people who spoke to you.

21 Now I'd like to close with an ancient
22 parting from the Greeks. And they had a way when they
23 left each other to say be strong, grow stronger, be ever
24 so much stronger.

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1 VICE CHAIRPERSON McLAUGHLIN: Thank you.
2 What better than Oregon to comment here about what we're
3 facing? Thank you very much for that.

4 I'm going to let other people ask some
5 question. I know some of us are responsible for the
6 community meetings, and I suspect they want to get some
7 wisdom from you, some response.

8 We'll start with Aaron who is Chairing our
9 Community Meeting committee.

10 MR. SHIRLEY: If you briefly describe how
11 you organized and carried out a typical community
12 meeting.

13 DR. GARLAND: Yes. It's one of the slides.
14 But we always start with a need to focus the attention
15 of the people who have come to a meeting. I mean, I'll
16 get into the meeting but most of the work goes on before
17 the meeting starts. That's recruiting. So we used
18 everybody we could to get into the local networks: The
19 county health departments, chambers of commerce. One of
20 our major partners in all of this was the Oregon Health
21 Action Campaign with Alan Kenny as the leadership who
22 has a wide network. So there's an effort really to get
23 people into the room with enough demographic mix that
24 you can have a fruitful conversation.

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1 And then assuming that we have 30 or 40
2 people in the room, we would have four tables with no
3 more than 10 chairs around it because we want to build
4 small group discussion into this horizontal
5 conversation.

6 So we have a focus. We have the room laid
7 out so that that small group discussion can occur. And
8 we have an exercise that causes people to make a
9 judgment about the health care system, the services that
10 they want. And then we -- actually we tell them, and we
11 lead those judgments on the floor because what we want
12 to really get at is the conversation that occurs when it
13 says well why do you want newborn intensive care covered
14 as an extremely important thing and why do you think if
15 it's okay if we can get that, and get at the values that
16 underlie those judgment.

17 And then after a period in which, say if
18 it's an hour and a half meeting, after a period of a
19 half hour to 45 minutes of small group discussion, we
20 will take reports from each of the tables so that we
21 begin to accumulate the core values that have been
22 discussed at the table.

23 We have put at every table a training
24 facilitator who will keep the discussion moving and who

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1 will make that report.

2 That effort we used to call a graffiti wall,
3 but what it does it allows everybody in the room to take
4 ownership of the ideas and to see whether their table
5 was like other tables and whether they're inspired or
6 given a fresh idea about what came up at one of their
7 tables.

8 The end of the meeting all of those things
9 on the graffiti wall are reviewed publicly by everybody.

10 They get a chance to say well that's really not what we
11 not meant or that reminds me, here's another thing I
12 want to get into this discussion.

13 That is accumulated and sent to a central
14 office that's pulling all of these values together from
15 all of the millions and refined into a manageable list,
16 which was the 13 values that I showed you on the slides.

17 DR. CRAWSHAW: There's another element to
18 all of this, and that is it costs money. And what we
19 did I went to -- I'm a member of the IOM. And I know,
20 who was at the time the head of the Robert Lee Johnson
21 Foundation. And I had discussed what we were doing. And
22 he felt about it about favorably, and he said he could
23 give a presidential grant of \$100,000 to help us, but he
24 wasn't going to do. Instead what he did was he called

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1 two local foundations and told them they'd better give
2 us each \$100,000 or he wouldn't give us any. And that
3 gave us \$300,000 to be able to take care of some of the
4 important things.

5 MS. MARYLAND: Patricia Maryland from
6 Indianapolis, Indiana.

7 Dr. Garland, after you synthesized the
8 information, the data, how were you able to take that
9 information and work with the policymakers to be able to
10 create the Oregon Health Plan and the components that
11 made up that plan? And the second part of the question
12 is and how were you assured that those individuals who
13 participated in those community meetings felt as though
14 their voice was heard?

15 DR. GARLAND: Well, we always had a
16 feedback. I'll answer your second question first. So
17 that everybody who participated in the meetings got the
18 report that went to the policymakers so that they saw
19 what was happening.

20 The question about how do you make sure that
21 the policymakers are paying attention, that's all front
22 end stuff. We've developed a kind of biological lingo of
23 talking about the receptor site, which is the
24 policymaker. And we want to make sure that the receptor

1 site wants to receive this hormonal input of public
2 information and is able to do it, and is planning to do
3 something with it.

4 So a lot of I think the continuing work of
5 this working group is getting a sense of how to express
6 what comes out of your labors in such a way that the
7 policymakers are ready to hear about it. So that I
8 think you need front end conversations.

9 We always have those with Dr. Kitzhaber
10 starting with and the staff, but also as the Health
11 Services Commission was created, we worked hand-in-glove
12 with them. And the Health Services Commission, which
13 was the receptor site for our input, provided the
14 chairperson of the steering committee of this public
15 outreach. So that there's an intertwining from the
16 beginning. And that I think is a crucial way of making
17 it important.

18 To encourage you, we -- but even though we
19 struggled to get people to come, it's hard to get people
20 to come out. And somebody pointed out to me years ago
21 that the problem is health care is everyone's third most
22 important issue and that there are other things and
23 displace it. So it isn't always the first thing on the
24 mind of everybody on the street.

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1 But those who came invariably stayed
2 afterwards. We almost had to shoo them out of the room.

3 And expressed great gratitude to be asked and involved
4 in these kind of meetings. And it gave a weight to our
5 calling of the meetings to be able to say authentically
6 and truthfully at the front end the reason you're here
7 for this conversation is that somebody who has their
8 hands on a health policy lever is listening and is
9 committed to hear what you have to say.

10 VICE CHAIRPERSON McLAUGHLIN: Okay. Montye.

11 MS. CONLAN: I just wanted to talk about
12 values. I'm interested in the community meetings and it
13 sounds like you were able to accomplish getting both
14 qualitative and quantitative data with one session. Do
15 you feel that the quality of that data on both sides is
16 equal? And that also the policymakers, did they review
17 both the qualitative and quantitative with equal
18 interest?

19 DR. GARLAND: Actually, we didn't get
20 qualitative and quantitative at each of the meetings. We
21 got qualitative at the meetings. They ran sample
22 surveys, telephone surveys done independently. So I
23 think you have to go after those separately. And what
24 you want to do is try to coordinate the focus of them

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1 enough so that they eliminate each other. And that the
2 qualitative information will give you insights into the
3 problems, help you stretch the problems. The
4 quantitative always allows you to say we heard this at
5 the community meetings. I wonder how widely distributed
6 that is. So I think you get them by separate paths.

7 How do you express them so that policymakers
8 pay attention, that they're important to them? Or
9 actually which one did they listen to most?

10 MS. CONLAN: Well, were they receiving them?

11 DR. GARLAND: I think that they -- actually
12 what happened was that the qualitative data was allowed
13 in the federal waiver process. The quantitative data was
14 disallowed. So that the Commissions knew of the
15 quantitative results, but had to look at those
16 qualitative results. So they said this set of insights
17 is what we will use to structure the logic of our
18 debates as they moved through some other process.

19 So the qualitative data turned out to be
20 very important and very useful.

21 DR. CRAWSHAW: One of the outgrowths of the
22 Oregon Health Decision's movement was American
23 Decisions. This was 17 different states that came along
24 and did this. And in the course of that the Kellogg

1 Foundation had me go around the country to help start
2 these things. And I can tell you, it is the qualitative
3 information that starts the meeting. Quantitative may
4 end it. But in North Carolina, there was one woman
5 there who was just afire with wanting to get health
6 decisions for North Carolina. I asked her what's your
7 motive. She said "My father died in such a terrible way
8 that at his death bed I swore I would never -- never
9 cease to prevent it from every happening to anyone else
10 again." That's qualitative data.

11 VICE CHAIRPERSON McLAUGHLIN: We have time
12 for one more question from Dottie and then we will take
13 only a ten minute break instead of a 15 break because
14 we're trying to get sort of back on time.

15 MS. BAZOS: Well, thank you very much for
16 coming. I think I have what I think is a very big
17 question. We need to let the whole of the United States
18 know that we exist, that we're here to listen. And we
19 have a long period of time in which we're going to be
20 going to little pockets of the United States. We
21 obviously can't go to every community.

22 We will be asking for public input on the
23 web. We will be using whatever types of tools we can
24 develop to get that input. But my questions to you are

1 how on a national scale are we really going to get
2 ourselves in the newspapers so that people know who we
3 are and really in a very genuine way. I don't think any
4 of us want to sell anything. What we really want is
5 input. We want the public to know that we're serious
6 about this. But I think what I'm having trouble
7 grappling with is how we are going to then help the
8 public know that we've taken their input seriously,
9 because they may need us.

10 We may have a website that says tells us
11 what you think, tell us your story. How do we get back
12 to them? How we will keep them engaged through the long
13 term? Because this is just the beginning. You know, we
14 have a long term engagement. We need to keep them
15 involved. Can you help me with that?

16 DR. GARLAND: It is a constant problem. I
17 think getting ready you really need to invest in a
18 communications campaign and you recognize the reality of
19 a communication campaign, that people will pay attention
20 that you're going to go into their neighbors.

21 MS. BAZOS: Right.

22 DR. GARLAND: And so you've got to focus
23 that and you're not going to be in every little town in
24 American and so you know what neighborhoods and states

1 you're going to be in. And I think you really have as
2 one of your tasks is to create this communications
3 outreach so that you have reason to believe that the
4 word is out; newspapers, both the television and radio
5 and the like.

6 How you stay in touch with them and
7 afterwards I think is trying to get sufficient reports
8 of a meeting when it has occurred and then making sure
9 that everybody who comes to those meetings are is
10 willing to give their name, address and/or email gets
11 feedback from you at the various stages in which you
12 produce a report. So if you're going to have an interim
13 report and then a final report, that they get that
14 delivered with them and with it a note saying "Thank
15 you. You helped create this."

16 MS. BAZOS: Did you build some of the
17 reports as you went along so that people saw what was
18 happening?

19 DR. GARLAND: From every meeting we sent
20 notes in email and I think a hard copy back to people
21 who had been at that meeting saying this is the report
22 from your meeting.

23 MS. BAZOS: But did you accumulate those
24 reports so that when you went to fifth report, did you

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1 say now we've been four and this is what is coming up.

2 DR. GARLAND: No. There was that meeting and
3 then the final report.

4 DR. CRAWSHAW: The other point that I'd make
5 is very important. And Senator Wyden made this one.
6 You should identify yourself with the political leader
7 of people. When we worked at Bend to talk to the people
8 in Bend, we had the mayor of Bend introduce us.

9 When you go to X, Y and Z, find out what the
10 political network has as the star performer. And if
11 you've got that endorsement, they know that speaking to
12 you is going to echo to where something's going to make
13 a difference.

14 So it's that validating your position to the
15 Congress is so important.

16 DR. GARLAND: Just one last thing. I think
17 that the statement that was made earlier today by
18 Senator Wyden saying that he and Senator Hatch intend to
19 keep legislators and the congressional feet to the fire
20 is a promise that you ought hold him to and that you
21 ought to be able to promise the people that you have
22 meetings with. Because otherwise you'll run into the
23 cynicism of saying, you know, what good does it do to
24 hold this, this is just more gum flapping and nothing

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1 ever happens. So the drive to say this is intended to
2 be an action item and that you and the Senator and
3 others are intending to make that happen. And I think
4 that's an important message to be able to get out. It
5 keeps their interest.

6 But things are going to happen. You know,
7 hurricanes will come along and other things will
8 displace and focus on the 46 million uninsured.

9 Thank you very much for your time.

10 VICE CHAIRPERSON McLAUGHLIN: Thank you very
11 much.

12 We'll reconvene in ten minutes for the next
13 session. Thank you very much.

14 (Whereupon, the meeting recessed for a
15 break.)

16 VICE CHAIRPERSON McLAUGHLIN: We need to
17 start our next session. It's always wonderful to see
18 everyone so stimulated that they want to keep talking
19 and want to interact. And I wish we were able to take a
20 longer break, but we really can't or we'll run into a
21 crunch at lunch and we won't be able to continue to
22 afternoon.

23 We now are going to continue hearing about
24 this issue of prioritizing benefits and how the Health

1 Services Commission can make these kinds of decisions.
2 And first we're going to hear from Dr. Little. Is she
3 in the room? Oh, great. Wonderful. Gee, I thought we
4 were going to start.

5 Dr. Little is a family physician from Lake
6 Oswego. After initially practicing in a small town in
7 central Oregon, she shifted her interests to public
8 health and administration receiving her MPH degree from
9 the University of Washington in 1998. She spent seven
10 years as Medical Director of a fully capitated health
11 plan in central Oregon and served as Commissioner on the
12 Oregon Health Services Commission from 1996 to 2002.

13 She's here to, as I said, address even
14 further how we go about prioritizing benefits as we go
15 along in our community meetings and make some of our
16 suggestions. And we welcome your advice and from your
17 experience in doing that.

18 Thank you very much.

19 DR. LITTLE: Thank you.

20 The Health Services Commission was created
21 by legislation passed in 1989 with the following
22 directive: Report to the Governor a list of health
23 services ranked by priority from the most important to
24 the least important representing the comparative status

1 of each service to the entire population to be served.

2 Prioritization was initially based on the
3 ability of the treatment to prevent death, the lifetime
4 cost of treatment in equivalent cases, and set of values
5 derived from public meetings across the state that you
6 just heard about. These values included such things as
7 a higher priority for maternity and preventative care
8 and a lower priority for limited conditions and those
9 without effective treatment.

10 Today the prioritized list is a ranking of
11 710 condition treatment pairings. I have a sample set
12 of lines in your hand out for the record. Each line
13 includes one or more related ICD9 codes as well as CPT
14 treatment codes that define the appropriate treatment.

15 In addition to the codes, many lines also
16 have guidelines attached which serve to further specify
17 under what conditions a diagnosis or treatment is
18 covered.

19 The Commission, as you heard previously,
20 consists of five physicians, a public health nurse, a
21 social services worker and four consumer advocates.

22 The work of the physician commissioners, who
23 comprise the health outcomes subcommittee, includes both
24 the mundane and the controversial. Every year both ICD9

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1 and CPT codes are added and deleted and modified. And
2 these changes must be reviewed and recommendations made
3 for incorporation into the list.

4 In addition, the subcommittee reviews action
5 on new technology and considers changes to the list
6 suggested by providers, enrollees and advocates who
7 believe that a service should be prioritized
8 differently.

9 In 2003 the Commission responded to requests
10 for a more evidence-based approach by creating an
11 algorithm for evaluation of new technology. I've
12 included that in your handouts as well.

13 Some of the changes the Commission has to
14 consider are quite minor such as adding more specific
15 diagnoses codes or a procedure that was inadvertently
16 left off. Others are quite controversial. Sometimes
17 that controversy is external and the Commission has
18 remained remarkably united. In other cases there was a
19 little spotlight but the Commission itself was divided.

20 And I'd like to give you an example of each of those.

21 The first situation was exemplified by the
22 need to incorporate the Oregon Death With Dignity Act
23 which was passed into law in 1997. Although the Act was
24 completely unrelated to the Oregon Health Plan, it still

1 represented a health service available to the population
2 and making it necessary for the Commission to consider
3 it. They were charged with deciding whether and where
4 physician assisted suicide should be placed on the
5 prioritized list.

6 After hearing hours of public testimony and
7 in front of an audience of over 100 people the
8 Commission voted ten to one to add this service to the
9 comfort care line of the prioritized list. They were
10 unanimous in their belief that services available to the
11 general population of Oregon should also be available
12 for those on the Oregon Health Plan. The lone
13 dissenting vote was from a consumer advocate who was
14 concerned with the law that the law was discriminatory
15 against someone who was so disabled they could not self-
16 administer the medication and be unable to take
17 advantage of it.

18 In the end, I believe this public debate
19 provided reassurance that many voices were heard and
20 helped everyone involved to understand the issues
21 better.

22 I do need to make clear that this service is
23 funded strictly with state dollars and no federal
24 monies.

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1 Now let me give you an example of when the
2 Commission experienced some discord. This occurred when
3 they considered the addition of a stem cell transplant
4 to the breast cancer line also in 1997. Preliminary
5 clinical trial results showed improved outcome for women
6 with advanced breast cancer, but all the randomized
7 control trials were still in progress.

8 Several lawsuits had been filed across the
9 state to force private insurers to cover this treatment,
10 and the Commission sought legal advice regarding state
11 liability in the event of such a suit as well as the
12 implications of covering experimental treatment which
13 was prohibited by rule.

14 Ultimately stem cell transplant was added to
15 the breast cancer line by a five to four vote but with
16 very strong dissension from the opponents.

17 During the time that I served as
18 Commissioner I was a medical director of a fully
19 capitated health plan in central Oregon. In my role
20 there I had intimate knowledge of how the list worked
21 and daily contact with providers about it. Often times
22 we would identify oversights which I would then forward
23 on to the Commission for their review and action.

24 Occasionally they disagreed with the

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1 placement of a particular condition. But in my role as
2 Commissioner it was always helpful to be able to explain
3 the rationale and the limits of the plan.

4 Perhaps most illuminating in my seven years
5 as medical director despite being the bearer of bad news
6 regarding the coverage of a condition on many, many
7 occasions I never once heard a physician say that they
8 thought that the concept of the prioritized list was a
9 bad one. And I believe that it is this strong support
10 both from the public and from providers that made the
11 plan as successful as it is.

12 And I think Ellen would like to speak next
13 and then I'll take questions.

14 VICE CHAIRPERSON McLAUGHLIN: Thanks. That's
15 wonderful. Thank you.

16 Next will be Ellen Lowe, who is a consumer
17 advocate. She's a seasoned participant in the processes
18 of government including the legislative process. She
19 has served on many decision making groups related to
20 health care, and retired in 1999 as the part time
21 Director of Public Policy for Economical Ministries of
22 Oregon and continues to serve as the legislative
23 advocate representing the Oregon Food Bank, the Oregon
24 Law Center and United Way.

1 So thank you for joining us, and we look
2 forward to hearing your comments.

3 MS. LOWE: Thank you. It's my pleasure to
4 be able to participate today.

5 The Health Services Commission had actually
6 been in existence for nine months when 15 years ago, and
7 I'm now the veteran on the Commission, our Governor
8 asked me to join it. I was very aware of the
9 difficulties in expanding health care access for poor
10 Oregonians, for I along with many other stakeholders was
11 the server as that first computer run emerged. And I'd
12 like to say that the stakeholders that were there with
13 me during those first nine months, it's amazing how they
14 continued through the whole process and still are
15 watching us. But there are folks in this room today who
16 were there 16 years ago and they maintain their interest
17 from consumer groups, from providers and some -- those
18 that I sometimes refer to as "The suits."

19 Now I had also been an observer, though, of
20 the legislative session during the previous three
21 sessions. And I began to be aware of the real
22 shortcomings of the traditional Medicaid program as I
23 heard some very tragic human stories. The system was
24 broken. And in my work stories of the human and

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1 monetary costs of the lack of access to timely,
2 appropriate health services was also frequently shared.

3 Now, some individuals and groups feared that
4 this new approach would endanger the category for the
5 eligible. They weren't very confident that two birds in
6 the bush wouldn't fly away. And so they came to our
7 meetings, they came those listening sessions that Mike
8 Garland describe. They asked questions, we responded.
9 They educated us. And I truly believe that the openness,
10 the responsiveness and the leadership of the process
11 built trust. And so, in fact, those local health
12 advocates for people with special needs became the
13 activists with the national group, their counterpart.

14 I appreciated often being able to be part of
15 those conference calls.

16 Now my life gave me access to many
17 individuals with poor health status, but I also spent
18 some time reaching out to folks I thought wouldn't come
19 to an official hearing where it would come the attention
20 of a helping agency. And I do not believe I was unique
21 among the Commissioners in this informal fact and value
22 finding.

23 For example, I went to several laundromats
24 on Saturday where I tried to engage young families in

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1 conversation about health services, what their needs
2 were as they were waiting for their clothes to dry.
3 Now, granted, this wasn't a very scientific approach,
4 but it really broadened my understanding of the time
5 pressures on young low wage families. These were the
6 ones least likely to go to some of these other groups.

7 And I found out that for them it just wasn't
8 what the benefits are but when and where they are
9 available.

10 I'd like to highlight several services that
11 I do not believe would have their current placement
12 without citizen requests. And this was particularly true
13 of general care. It had not been part of the adult
14 Medicaid program, so we really heard from them.

15 We also heard from the working poor. And
16 when asked why dental was not considered a medical
17 service, I was always hard pressed to come up with an
18 answer that satisfied me, let alone them. Our
19 Commission really would have ignored the public if
20 dental care had been bypassed.

21 Another area was mental health. Tradition
22 in both the private and public system called for a
23 continued separation. The public didn't, nor did many
24 primary care physicians. Their belief in the efficacy

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1 of the integration of mental and physical health
2 services advanced the practice. But institutional
3 barriers, in my judgment, still keep it from full
4 integration. And in Oregon the documented community
5 costs when the Oregon Health Plan standard population,
6 those are the new eligibles, lost mental health
7 services, serve as a reminder that anything less than
8 integration is penny wise and pound foolish.

9 Now our comfort care line in the very
10 beginning evoked discussion about the meaning of
11 healing. In my age group I've long heard criticism of
12 futile, expensive and sometimes painful care in the last
13 months of a terminal illness. And families at our
14 meetings, both at the Commission and those that Dr.
15 Kitzhaber and Dr. Garland talked about, they questioned
16 why there was financial support for aggressive care but
17 there was no assistance for palliative.

18 Palliative care does not come, though,
19 without some additional costs. And they were seeking
20 just modest help for patient choice.

21 With the current acceptance of hospice, it
22 seems so strange that just a few years ago this choice
23 rarely received any governmental assistance and often no
24 health insurance support. Our definition of healing had

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1 to be expanded, and as it was we began to see changes in
2 private insurance plans as well.

3 Now, I used to go to the outcomes meetings,
4 the ones where the physicians worked on those condition
5 treatment pairs in order to more fully understand health
6 conditions and treatments. And as the physicians shared
7 their findings and the views of the physician panel, I
8 was impressed with the depth of their knowledge. But I
9 also heard them acknowledge the need to seek more
10 information.

11 Now the lack of data couldn't become an
12 excuse for closing down our project. But rather it
13 became the impetus for periodic review of the condition
14 treatment pairs and for stimulating more research such
15 as is taking place at OHSU.

16 Now I do not recall using the term evidence-
17 based medicine 15 years ago. But that really was what
18 we were about, and it is what we are still plan. The
19 Oregon Health Plan by its very nature is a work in
20 progress.

21 I believe the strength of our project is the
22 success of using community based coordinated plans,
23 managed care if you will, for the delivery of clinical
24 and ancillary health services. For the unorganized I

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1 have come to know so well and for the time constraint
2 working for it, these plans work with neighborhood
3 clinics so that there can be extended hours, a
4 simplified access and participation and specialists. And
5 to me very importantly they've worked with other
6 community based groups to coordinate access to other
7 vital support services, the kind of activities and
8 services that create a healthy community. They are a
9 community resource, and I truly believe that the Oregon
10 Health Plan is a national resources as well.

11 And I thank you.

12 VICE CHAIRPERSON McLAUGHLIN: Thank you very
13 much.

14 (Applause).

15 VICE CHAIRPERSON McLAUGHLIN: As I said, it
16 was actually our recognition of the leadership shown by
17 what Oregon has done that led us here to this meeting.
18 And I already can tell you that the members of the
19 working group have expressed to me how grateful they are
20 for all of you today coming to talk to us. We've learned
21 an enormous amount.

22 We have time for one or maybe two questions
23 from the working group. I think everybody's seeing lunch
24 in the future.

1 MS. HUGHES: Hi. I'm Therese Hughes, and I'm
2 from the Family Clinic in Los Angeles, California.

3 One of the things I wanted to ask you about
4 was in terms of provision of specialty services under
5 the plan, if patients need specialty services do you
6 have a problem with -- I guess in LA one of our many
7 health care problems is that we have a network of
8 clinics that work very closely together to serve as a
9 medical home for all of our patients. But specialty
10 services is something that is severely lacking. And I
11 wondered if there was a way that, you know, you came
12 upon something that through this process that allowed
13 entrance of specialty services into the arena of care
14 for these underserved populations?

15 DR. LITTLE: I think we achieved that mostly
16 through the heavy use of managed care. About 80 percent
17 of Oregon Health Plan members are enrolled in a managed
18 care organization and they are required to ensure access
19 to specialty care.

20 MS. HUGHES: And I just follow up with that?
21 What about the wait time? Is there --

22 DR. LITTLE: Well, I haven't been in that
23 position for a few years, but my perception is that it
24 has gotten more difficult in the last few years. And I

1 know Oregon has limited to some degree the decisions
2 that they are making.

3 As far as accurately, of course it depends
4 on the specialty.

5 MS. HUGHES: Right. Right.

6 DR. LITTLE: It is somewhat of an issue, but
7 I think perhaps less so than in other -- managed care.

8 MS. HUGHES: Okay. Thank you so much.

9 MS. LOWE: And could I just interject, that
10 I think one of the things we did well is that the panel
11 of specialists who assisted us with information in
12 putting together the list, we involved the specialists.

13 And so I think many of them sort of accepted that they
14 were partners.

15 VICE CHAIRPERSON McLAUGHLIN: One more
16 question from Montye?

17 MS. CONLAN: I was interested, actually
18 intrigued in your creative method of going to the
19 laundromat to contact respondents. And you mentioned
20 that it helped you to learn. I was interested again when
21 you tried to pass that information on, was that accepted
22 for weight to the more scientific studies and the other
23 more formal qualitative studies?

24 MS. LOWE: I think it was a balancing act.

1 But I think we listened to one another. And I think the
2 public, every meeting we had was open. And so they
3 could respond if indeed they wanted to challenge some of
4 our anecdotal findings. But I think that other members
5 of the Commission also went to special places to seek
6 information. And some trends call it elevator talk. And
7 I won't tell you the places that I went to get the best
8 information.

9 VICE CHAIRPERSON McLAUGHLIN: Thank you
10 very much. Thank you.

11 Now we're going to be hearing from Diane
12 Lovell and Dr. McDonagh. And I understand they've
13 reversed order, and we're going to start with Ms. Lovell
14 who began her career as a union advocate at the age of
15 21. It doesn't give the year for that, so we're safe.

16 She has represented a variety of employees
17 including health care workers, correction staff, public
18 defenders and general government employees. Diane
19 is currently a member of the Oregon Public Employees
20 Benefit Board and the Oregon Health and Sciences
21 University Employees Benefits Council.

22 So we're looking forward to hearing what you
23 have to share with us.

24 MS. LOVELL: Thank you, Madam Chair, members

1 of the Commission.

2 It is my pleasure to be here today and talk
3 about the Health Resources Commission work, but I think
4 more we have not had absolutely the smoothest commission
5 in the history of Oregon. And I'd like to speak to some
6 of those challenges and how we worked through those
7 challenges.

8 When the Health Resources Commission was
9 initially established it focused on further review of
10 medical technology, medical procedures. And there was a
11 lot of pushback. It was a new commission. There was a
12 lot of resistance from drug manufacturers, but also
13 manufacturers of medical products.

14 We spent a lot of time developing a very,
15 very public process which worked very, very well. We
16 had a technical advisory panel which consisted of
17 physicians, of other experts and they reviewed all of
18 the medical evidence that a staff to the Resource
19 Commission pulled together. It was a very public
20 process.

21 And at that juncture the Commission then
22 really added public policy to the scientific evidence.
23 So we would get a report from the staff, we would think
24 about how it would impact on Oregonians and the state

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1 and we would make recommendations. But there was really
2 not a forum for those recommendations.

3 After a couple of years in the next
4 legislative session there was really an attempt to
5 undermine the Commission's work and they created
6 legislation that would really cancel it. And we
7 languished after that for a couple of years. We weren't
8 abolished, but it was just a very uneasy relationship
9 amongst the state legislature and other policymakers in
10 Oregon.

11 Former Governor Kitzhaber gave us actually a
12 challenge, which sort of brought us out of semi-
13 retirement. We put together a project looking at mental
14 health drugs and making some recommendations. And we
15 then reinvented our technical advisory panels, brought a
16 nucleus into play. But at that juncture it was even a
17 more open process. And I do want to talk about the sort
18 of the way we incorporated the public. But we made a
19 very significant effort at that point to involve some of
20 the advocate groups, real people because it was beyond
21 public policy. We really needed to hear about how all
22 drugs were -- and how they impacted their lives.

23 There was a reference made earlier to suits.
24 I swear that within 24 hours of the charge, people from

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1 all over the United States and outside the United States
2 got on planes and headed to Oregon. You were seeing for
3 the first time representatives of the drug
4 manufacturers. And it was a very, very intense process.

5 And still at this point our staff was gathering --
6 evidence for the review for the Commission's review. It
7 was a great process. We had wonderful public testimony.

8 Wonderful testimony of these groups. And people had
9 been getting all scared that, you know, we were about
10 making sure that new drugs weren't utilized in Oregon,
11 that they were too expensive. And we were able to show
12 through that public process, a very transparent process,
13 that that was not what we were about. It really was
14 about the science that offered compassion and
15 understanding that we need to look at what's going to be
16 people productive in Oregon, what is going to improve
17 their quality of life, it's all those factors which are
18 in consideration.

19 After that we were sort of again a
20 Commission and took a more serious look at drugs and
21 drug family. And at that point in time we started
22 working with the Oregon Evidence-Based Practice Center,
23 you'll hear a lot more about. And that was a really
24 fluid process.

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1 Again, the process of the Health Resources
2 Commission change. The Commission, again, was tasked,
3 the technical advisory committee. And in these
4 recommendations, but we really did not apply public
5 policy to any degree. It was really about in the first
6 phase the eligible key questions and then we were
7 tasking that to make sure that they had answered those
8 key questions.

9 The other thing that we were charged with,
10 and this was again a big political issue, was to provide
11 this information to the Oregon Medical Assistance
12 Program. Not to advise them on what drugs people should
13 have access to, but to provide the scientific evidence
14 within drug families which drugs would be fully
15 effective. We gave them pricing information, but what
16 then they made available to patients was up to them.
17 But that was a very gray area. And then people, the
18 Health Resources Commission was making those
19 recommendations, I think sometimes people were led to
20 believe that. And again, just very frankly,
21 representatives of different pharmaceutical companies
22 really made great efforts to muddy that process. And it
23 was very difficult, but at the same time because our
24 process was so bare to the public, whenever

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1 misrepresentations happened, we were always able to go
2 out to this public meeting, this public technical
3 advisory committee, this public motion; there was
4 nothing that didn't happen in the public and there was
5 nothing that didn't happen where there was a very
6 significant electorate. So it was really very valuable.

7 We, and largely would have a doctor -- his
8 credibility, we've handled hundreds of volunteers and
9 thousands of hours of volunteer time. A very busy time.

10 Physicians, pharmacists, nurse practitioners, a variety
11 of people. And it has been really amazing.

12 I think that the OMA really understanding
13 that this is a scientifically based that physicians
14 really were providing the technical information was
15 very, very important. But the other thing, the public
16 process. The fact that there are four non-physicians on
17 the Health Resources Commission, too, specifically
18 consumer representatives have been very, very valuable.

19 Because it extends -- this information is very, very
20 technical. Lay people can't understand it. Lay people
21 can explain it. Lay people can advocate for its
22 acceptance. And I think that is very, very unique in our
23 progress. And I would just really urge -- as you look
24 at different models, I would just really urge to really

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1 champion those types of models because they are so very
2 valuable.

3 I think that as the Commission moves
4 forward, they're now again looking at the medical
5 technologies, which is where they started, in addition
6 to continuing to do the work of reviewing different
7 families. I think that we'll see a lot more positive
8 changes and more recommendations.

9 Again, I think the Oregon Health Policy with
10 the Health Services Commissions is looking at
11 technology, each of us is beginning to do so. We are
12 sharing information and sharing it with other public
13 bodies such as the Public -- Board. So in Oregon we
14 really are, it's very organic. There is a lot of
15 sharing information and a lot of synergy to handle the
16 different groups. And I think that it's been really a
17 positive experience.

18 And a positive experience from the
19 perspective of organized labor having a unique
20 opportunity, I guess I would say, to sort of speak into
21 a collective bargaining process, which as you know is
22 very contentious around health care, to sort of speak
23 into -- it makes sense to use evidence in making medical
24 decisions and really having an opportunity to teach

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1 collective bargaining around that philosophy it's been a
2 unique experience for me. And I really appreciated that
3 opportunity.

4 VICE CHAIRPERSON McLAUGHLIN: Thank you very
5 much.

6 The fact that you're keeping recommission
7 suggests that you're doing something right. So we
8 appreciate your input.

9 You suggested that we were going to hear
10 more from the evidence-based, and that is in fact what
11 Dr. McDonagh is going to add. Perhaps we should hear
12 from her, and then if you would be willing to stay, we
13 can ask questions of both of you.

14 Dr. McDonagh is an Assistant Professor of
15 Medical Informatics and Clinical Epidemiology, a core
16 investigator with the Oregon Evidence-Based Practice
17 Center and a principal investigator of the Drug
18 Effectiveness Review Project.

19 She has been a Clinical Assistant Professor
20 at the University of Washington School of Pharmacy and
21 Geriatric Medicine Team Clinical Pharmacists and
22 Director of Investigational Drug Services at Harborview
23 Medical Center in Seattle. And so I'm eager to hear
24 more about the evidence-based research and how this

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1 blended in together, and we look forward to your
2 comments.

3 DR. McDONAGH: Thanks very much for
4 listening to me this morning.

5 I want to tell you about our link with the
6 Health Resources Commission here in Oregon, because I
7 think it was unique.

8 I want to go through the methods that we
9 used in our reviews, but what I want to highlight in
10 that is the part that is unique in the Oregon process,
11 the part where it incorporates public comments.

12 When we were asked to work with the Health
13 Resources Commission we were given some challenges.
14 First we were asked to apply our systematic review
15 methods to comparative questions and in this case
16 comparative drug questions, but with public input which
17 was somewhat unique.

18 Additionally, in producing these reports we
19 were asked to make sure that our methodology was
20 consistent, across all reviews. Make sure that our
21 methodology was transparent. It was very clear what we
22 had done, why we had done it and how we had done it. To
23 make these reports very readable. We wanted to make
24 sure that the committee members who were using them

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1 would be able to locate information easily, get to the
2 bottom line, what are the conclusions from this body of
3 evidence.

4 And also we wanted to be able to ensure that
5 our researchers had the least potential for bias
6 possible. So like you, we also required the highest bar
7 for conflict of interest, which was absolutely none, in
8 order to be a part of the research process.

9 So, we started the review. Whenever we
10 start a review the very first step is to identify the
11 questions. What is it that you would really like to
12 know from this review. We did this process through
13 multiple meetings with the subcommittees that were
14 developed by the Health Resources Commission. An
15 individual committee for each report was put together
16 with experts from various fields. And so we met with
17 them multiple times to talk about what it is they wanted
18 to know.

19 In general, our reviews always had three
20 questions. The first question was about comparative
21 effectiveness, looking at the different drugs in that
22 same class, looking at efficacy or effectiveness.

23 The second question was about tolerance and
24 tolerability. Both the short term adverse events that

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1 lead to tolerability differences and also long term
2 harms. In looking at comparative evidence between drugs
3 over many months and years, to see if there are any
4 differences.

5 And the third question is a very important
6 question, looking at both of those first two questions
7 in subpopulations. So other differences between these
8 drugs in effectiveness or harms when you're looking at
9 subgroups based on age, gender, race or ethnicity, co-
10 morbidities or other medications.

11 Those were the key questions that we started
12 with. And those were developed in a public process. So
13 we did have input on those key questions from the public
14 at that time. Also they were posted to a public website
15 for additional input.

16 The next step in the systematic review is to
17 try to find all the literature on this topic, both
18 published and unpublished. And we start with multiple
19 electronic databases such as MEDLINE. We also send out
20 requests to the pharmaceutical companies manufacturing
21 the drugs that are included in this particular review
22 requesting information on any study on their drug,
23 whether that has been published or not. We also then
24 search the references, first of all, of any studies that

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1 we uncovered. And we go back to our committee and ask
2 them as experts if we missed anything. And we also
3 search the FDA documents that are available on the FDA
4 website, which turns out to provide quite a lot of
5 valuable information particularly for the newer drugs.

6 Now that we have this group of studies
7 identified from searching, we then apply our inclusion
8 criteria. The inclusion criteria come directly from the
9 key questions and they cover four main areas.

10 The first is the population, including the
11 groups of patients in the review who have an interest in
12 the evidence pertaining to it.

13 Second is the intervention. In this case we
14 have a specific list of drugs that you want to have
15 included in this review. We would always review
16 different formulations that were available, for example
17 extended release compared to immediate release as
18 different drugs.

19 We also have included the criteria around outcome
20 measures. For these reviews we always preferred health
21 outcome measures, things that are important to patients,
22 so mortality certainly, morbidity outcomes such as heart
23 attack or hospitalization. But we generally did not
24 include intermediate outcomes such as lab values and

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1 blood pressure changes, for instance, without those
2 other health outcomes.

3 And the last area where we have our
4 inclusion criteria is the study design. For
5 effectiveness we generally include randomized control
6 trials. But when we went to look at harms, we also
7 added observational designs to try to evaluate the
8 longer time harms in a broader population.

9 So once we have identified the final list of
10 studies that were going to be included, we then quality
11 assess each individual study. And we give it a rating
12 of good, fair or poor. And the first quality study
13 because we believe that they have a significant risk of
14 bias, were not included in our trial since it was
15 reflect in the evidence.

16 We have also designed a quality assessment
17 of over all body that is for each individual key
18 question at the end of the report.

19 The next step is to take all of these
20 studies that we've identified and extract data from
21 them, put them into tables so that readers can look
22 across the study and evaluate the same data from each
23 study and try to get a comparison in a head-to-head
24 fashion.

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1 We also then go about doing our analysis.
2 Generally that involves a narrative synthesis and where
3 possible we will do quantitative analysis doing meta
4 analysis or other techniques.

5 We have found that when you're dealing with
6 within-class reviews, it turns out that meta-analysis is
7 not possible as often as it is with cross-class
8 comparisons. And so our reviews have some meta analysis
9 but it is not appropriate for all of the reviews.

10 Finally, we produce the report. Anyway,
11 this is the most important part, again, trying to focus
12 the report - have them be transparent, direct. And
13 every report has a summary table that is a summary of
14 the evidence by key question. And these reports undergo
15 peer review. The Oregon Health Resources Commissions
16 subcommittees review them and then they also go out for
17 national peer review.

18 Importantly, they are posted for public
19 comment. And in addition they are presented in person
20 at a subcommittee meeting were it's also public. And we
21 have had quite a lot of public comment on our reports
22 through the 3 years that we've been doing them. And we
23 really find that approximately 80 percent of the
24 comments that we receive do come from within the

1 pharmaceutical industry. We do get some comments from
2 advocacy groups and very few from individual private
3 citizens.

4 Looking back over all the comments we've had
5 we would guess that approximately a third of the
6 comments are substantive. Many are really about other
7 issues or taking a stand on the decision-making process,
8 which is not part of the evidence, but really are about
9 issues we didn't review. In approximately a third of
10 those we have actually changed the reviews because of
11 them. So we have found that the public process has been
12 quite useful in improving the quality of the reviews.
13 But that's been very important.

14 We also send our reviews to the Agency for
15 Health Care Research and Quality whom we ask to review
16 them for methodologic quality so they give us their
17 stamp of approval for methodology.

18 Each review then undergoes an update either
19 every six months or every year. And the timing on that
20 is determined by the Subcommittee. We give input to the
21 subcommittee based on what we see happening in the
22 literature, but it is really up to the committee to
23 determine how often they want to have it updated.

24 When an update begins the process is that

1 the key questions are revisited because things change in
2 medicine. And it may be that in using the review in
3 their decision-making processes that your key question
4 was off target or maybe that something new has happened
5 in the year that you did the review, and -- the optimum
6 measure of -- in the last year. A great example of this
7 is in the statins review where new evidence has come to
8 light and HDL has become more important and so that
9 outcome measure would be added to the review.

10 In addition, new drugs are continually being
11 added to some of these classes so that is another reason
12 for reviewing the key questions. After that the process
13 continues as usual and we end up with our update review.

14 And again, the final reports are posted on a
15 public website. The key questions and draft reports are
16 posted for public comment. And then the final reports
17 are posted for use by anyone.

18 That basically summarizes our methods. I'd
19 be happy to take any questions.

20 VICE CHAIRPERSON McLAUGHLIN: Thank you. I
21 had one question. And that is with drugs in particular
22 there are different side effects for different drugs.
23 And you talk about outcomes. Do you incorporate that?
24 And I ask because consumer preferences, of course, vary

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1 according to their tolerance for different side effects
2 and what they're willing to give and take. Do you
3 incorporate that in what you do or is that in a
4 different part of the process?

5 DR. McDONAGH: I think that it's both. I
6 would say that from our point of view is how we produced
7 the review we try to present balance of benefits to
8 harms for each question, although a lot of times we find
9 that for long term harms there's evidence about
10 individual drugs but it is not comparative. So we feel
11 that sometimes giving -- really has a lot of doubts but
12 we give them what we have -- is actually more a
13 committee decision.

14 MS. LOVELL: And I would say that we have a
15 very strong interest publicly on what is effective but
16 always the key question is -- what are potential harms.

17 And I think that is one of the benefits of the program
18 as new drugs come on the market so very rapidly, very
19 often we don't know what the negative side effects can
20 be -- should be mindful of that.

21 VICE CHAIRPERSON McLAUGHLIN: We're going to
22 take one question from Chris and then --

23 PARTICIPANT: I have a question, too.

24 VICE CHAIRPERSON McLAUGHLIN: Are you going

1 to go get us lunch.

2 Go ahead, Chris.

3 MR. WRIGHT: I have a question in regard to
4 new drugs coming on the market, particularly as it
5 relates to research and the pharmaceutical or drug
6 research that we have. And did that play into your
7 program or they were not looked at? That was outside of
8 your scope?

9 DR. McDONAGH: We thought that if a new drug
10 come out that was within a class that was reviewed, then
11 it certainly did have a big impact. We would review
12 that. If it was completed, it would be done in the next
13 update.

14 But typically if a new drug is coming out
15 the committee would decide to have the update sooner.
16 So we would pretty much finish the report and start the
17 next one.

18 MR. WRIGHT: So you were just looking at FDA
19 approved drugs. You were not looking at protocols at
20 all?

21 DR. McDONAGH: That's right. We would be
22 keeping an eye on what we knew was coming in order to
23 inform the committee, but we did not review the
24 evidence.

1 MS. LOVELL: I think maybe both of us
2 neglected to mention is we only utilized public study.
3 So if the public couldn't look at the study, that they
4 were not considered. And so that really forced us to
5 look --

6 VICE CHAIRPERSON McLAUGHLIN: Did you have a
7 question?

8 MS. MARYLAND: My question is the relevance
9 in terms of how you took that information and create a
10 formulary I'm assuming for the health care plan?
11 Because I'm trying to get the link in terms of the
12 relevance, in terms of how you used that information to
13 be able to reduce costs possibly for pharmaceuticals.

14 MS. LOVELL: And that gets back to that gray
15 area. Because there really is a handoff. The Health
16 Resources Commission could use the finance and the
17 recommendation in terms of within this -- these five are
18 all basically equally effective. And then the health
19 plan determined which of those drugs that they're going
20 to pay for.

21 VICE CHAIRPERSON McLAUGHLIN: Frank will
22 have the last word.

23 DR. BAUMEISTER: Well, this is my playground
24 for a decade, and I know a little bit about it. And I

1 don't think I see any drug salesmen here today and
2 that's unlike our meetings when we hardly can find
3 seating for the public because the drug salesmen were
4 there and they flew there from all points from all over
5 the land to really assail and assault this program.
6 Because this program is really expensive.

7 And I think it should be pointed out to my
8 working group here who are sort of awestruck by hearing
9 all this stuff, and that's why they're quiet. They're
10 not that hung over.

11 The costs for pharmaceuticals for the Oregon
12 Health Plan exceeded the cost of physician hospital
13 costs altogether. We're talking about big money. You
14 know, a million dollars here, a million dollars there.
15 So we're talking about big money.

16 And, for example, when they reviewed the
17 literature on the proton pump inhibitors they reviewed,
18 I think, 3,000 articles and found that approximately 100
19 were worth the paper they were printed out. The rest
20 were not signouts. It was advertisements, propaganda and
21 physicians read that trash and the public reads that
22 trash. They see the purple pill on television. And you
23 need objectivity somewhere in there to make some sense
24 of this business.

1 The Medicare drug plan that Senator Wyden
2 says he has the welts on his back from was in some ways
3 a give away probably to the insurance companies and to
4 the drug companies. And I think that this program here,
5 which is unique as you said the way it was put together,
6 the way it was constructed it had to be good because it
7 aroused so much ire in the pharmaceutical business. We
8 never had such -- the airports were busy here bringing -
9 - we had 25 lobbyists in the Capitol at one day and I
10 think I was the only defendant of the program. And it's
11 where then Governor Kitzhaber drew the line in the sand
12 for Senate Bill 819 that created the Practitioner
13 Management Drug Program over create opposition from all
14 those lobbyists.

15 And the question I have is I know that Dr.
16 Kitzhaber, in addition to Estes Park obligations is
17 still involved with this evidenced-based pharmaceutical
18 program that they've taken out into the nation, and I
19 think there's something like 15 states or organizations
20 that have signed onto this program, which would
21 perfectly align itself with our program.

22 Somewhat pessimistically, the fact that
23 there aren't drug salesmen and representatives from the
24 Health Industry Manufacturing Association in this room

1 points out that there are people out there that don't
2 take this working group seriously. Because if they did,
3 they'd be lined up right outside right now.

4 VICE CHAIRPERSON McLAUGHLIN: Thank you very
5 much for your contribution.

6 We're here in the last stretch before lunch.
7 That's always an interesting position to be in to be the
8 speaker between the group getting to lunch.

9 We're going to reverse this order, too, I'm
10 told and start with Dr. Goldberg who is administrator of
11 the Office of Oregon Health Policy and Research. Dr.
12 Goldberg is a family physician and has devoted his
13 entire professional career to public health policy and
14 to improving the organization and delivery of health
15 services to vulnerable populations.

16 He received his MD from the Mount Sinai
17 School of Medicine, New York City. Did his residency at
18 Duke University. You went then to New Mexico and then
19 finally, I guess, as one of these pioneers immigrated to
20 Oregon.

21 DR. GOLDBERG: And you know I'm from New
22 York.

23 VICE CHAIRPERSON McLAUGHLIN: I know.

24 DR. GOLDBERG: And worse than that, I

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1 thought I was in a bad position because I was standing
2 between you and lunch. But now I also am following
3 Frank. And so following Frank and you getting to lunch
4 puts me in a tough spot.

5 So I will forsake eloquence for brevity.
6 John Santa, I am competent and I know can be both brief
7 and eloquent, but I'm not quite as talented.

8 You've been here today and you've heard a
9 lot all morning long. And the purpose was for you to
10 hear one chapter of the Oregon story. You know, this is
11 a process in evolution, but the rest and hopefully the
12 best is yet to be written.

13 And John's and my job this morning is to sum
14 it up for you. And I'm going to try to sum it up for you
15 with seven lessons learned, many of which you've heard
16 today, which will allow me to brief. And John is going
17 to follow with some principles upon which we can move
18 forward. Because as we've done this and as we've
19 innovated, we've evaluated what we've done. And that
20 learning has really helped us continue, and it really
21 fuels us towards our goal of continuing to improve
22 health care for people in our state.

23 So lesson number one, and since I am a New
24 Yorker and it is baseball season and the Yankees are now

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1 in first place, you've got to believe. You really have
2 to believe that you can make a difference and that your
3 work is important.

4 You know what we learned here that the
5 ingredients of: (1) valiant; (2) public process; (3)
6 hard work; (4) leadership, and; (5) political muscle can
7 really be harnessed to help improve the health of the
8 state. Our attempt at doing that was what you've heard
9 today, the Oregon Health Plan. And, indeed, it was
10 successful. You know, we improved the health of
11 individuals in our state, we've seen uninsurance
12 decrease dramatically at the height of the Oregon Health
13 Plan. We saw uninsurance in kids go from 21 percent
14 down to 8 percent. In our hospitals drop by 50
15 percents. The numbers of emergency room visit dropped,
16 the numbers of low birth weight children dropped. Low
17 income individuals in our state had dramatic increases
18 in preventive care to keep them healthy. And, you know,
19 this increased accessed to health care for our citizens
20 decreased cost share to our business, it helped us
21 create healthier communities, healthier health care
22 systems and better live for the people in our state.

23 Lessons number two, and one of the ways we
24 got there and you heard this morning was explicit

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1 allocation of resources is not only necessary, but I
2 think we showed that it works. That the reality of
3 fiscal limits makes choices about resource allocation
4 inevitable. And through our use of the prioritized
5 list, which you heard this morning, we were able to
6 allocate resources in the way that made the most sense
7 for people in our state.

8 That brings us to the next point, which is
9 the next lesson, probably the most germane to you which
10 is that public process is essential to that, and it was
11 essential for our success and you've committed
12 yourselves to that process. And I'm not going to repeat
13 more that was said, because I thought that Mike Garland
14 and Ralph Crawshaw said it most eloquently. But what
15 I'd like to do is give you an example of how you can
16 sort of harness that. And that's this: You know, if you
17 believe that you can sort of ask people what they want,
18 so go out, have a problem process and ask them what they
19 want and then operationalize it, we prioritized it and
20 we then operationalized that, it can work. But I'm
21 going to just for a moment take our experience here in
22 Oregon , what we've done and I'll leave you with a five
23 page analyses.

24 We've taken our prioritized list and where

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1 are line of services is now drawn and we have very
2 successful in delivery and whole package of health care
3 services to individuals. Take that line and extrapolate
4 that to the entire nation. And what you'll find is that
5 you'll save about \$5 billion a year in health care
6 costs. \$50 billion in ten years and then go one step
7 further. The objective isn't just to save money, it's
8 to help make people healthier. And that's what we do.

9 So take that money and rather than cutting
10 Medicaid for a nation, you could add over 2 million
11 people to the Medicaid rolls in our country, 2 million
12 adults, you could cover over 5 million children for that
13 money. So you can make this work. Public process is
14 essential.

15 Also, as you heard from Frank and from
16 others, and it's the fourth lesson: Evidence is
17 essential. Regardless of what we do, regardless of
18 whatever health care system we choose to adopt, we're
19 going to continue to face an unsustainable system unless
20 we can reduce the rate of natural inflation and unless
21 we can do what we all need to do, which is pay for
22 things that work and that improve people's lives and
23 don't pay for that people that don't. Evidence is the
24 key to that.

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1 Lesson number five, somewhat of a political
2 lesson. Community delivery systems work. Tip O'Neill
3 said "All politics is local." In many ways all health
4 care is local, and as you heard this morning when you
5 go into the communities you'll hear that communities
6 have very different issues. But there is a common theme
7 that we've learned. And what we've learned is that
8 communities have been most successful when there's an
9 environment in which community-based clinicians,
10 hospitals, ancillary service providers and community
11 members come together to help meet their local needs.
12 Communities that share equitably among the providers the
13 responsibility of creating healthy communities have
14 really been the most successful. And you've heard this
15 morning about some of the community-based health plans
16 that we've created in this state which really have been
17 very successful in operationalizing this vision and in
18 taking it to communities and making it work at the local
19 level.

20 Our sixth lesson, essentially our most
21 recent lesson is that cost sharing or cost shifting to
22 the poorest individuals limits their access to their
23 care.

24 You know, we founded the Oregon Health Plan

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1 on a principle of eliminating cost share. And we
2 believe and continue to believe that shifting,
3 concealing, minimizing the true cost of care, you know,
4 really undermines effective public policy. And with
5 that said a few years ago we increased premiums and
6 copays in the Oregon Health Plan for our Medicaid
7 population for our most vulnerable citizens. It was a
8 noble goal, the idea was to increase the premiums and
9 copays and using those savings to actually cover more
10 people. In essence, what we tried to do with our
11 prioritized list. And our experience now really well
12 documented and well evaluated shows that, you know,
13 these policies have had a number of unintended
14 consequences and they've led to many of our most
15 vulnerable citizens losing coverage and going without
16 necessary health care. So that was an important lesson
17 for us.

18 And let me leave you with the seventh and
19 last lesson, it really is perhaps the lesson that
20 Governor Kitzhaber left you with. It's that no plan is
21 an island and that the Oregon Health Plan is part of a
22 larger delivery system.

23 Many of the challenges that the Oregon
24 Health Plan faces are not unique to it as a public

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1 health program. And I think that it's critical to note
2 that the Oregon Health Plan exists as part of a larger
3 health care system. And as you all know all too well,
4 it's complex, fragmented, costly. Health care costs
5 nationally are soaring. Individuals can't afford health
6 care, business can't afford health care. Our rates of
7 uninsurance are increasing. But you know, in fact, the
8 increasing number of uninsured Oregonians since 2001 is
9 largely attributable to the decreasing enrollment in
10 employer sponsored health care and not to the cutbacks,
11 although we've made cutbacks, in the Oregon health plan.
12 That's because of the economic circumstances that
13 existed.

14 And you know exacerbating the economic
15 challenge is the private and public sector face is the
16 fact that our health care system lacks incentives for
17 promoting access to effective medical care and cost
18 containment or quality.

19 And so in short because the public and
20 private sector both utilize the same delivery system,
21 they're inextricably linked. And in the long run both
22 sectors ability to maximize the value of what they do to
23 the value of their being able to improve health is
24 really the key.

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1 You know, on its own the Medicaid program
2 you know is neither a problem or a solution. It's part
3 of a larger health care system. And that's indeed how
4 the Oregon Health Plan was originally envisioned. And
5 with that said, and in the efforts of brevity, let me
6 turn things over to John Santa.

7 VICE CHAIRPERSON McLAUGHLIN: Thank you very
8 much.

9 Next we're going to hear from Dr. Santa, who
10 is the Assistant Director for Health Projects of the
11 Center for Evidence-Based Policy at Oregon Health and
12 Science University. He was previously the Administrator
13 of the Office of Oregon Health Policy and Research. He
14 has been involved with issues related to the uninsured,
15 Medicaid, prescription drugs and evidence based
16 medicine. And we're counting on you to sort of wrap
17 this all up.

18 DR. SANTA: And I'm going to do that, and
19 really briefly.

20 You all have actually my written comments in
21 your packets. There are copies over there for the
22 public. And I'm going to be very brief.

23 First of all, I want to say thanks for doing
24 this. I just really love people who are willing to do

1 this, like the folks who have come before you today.

2 Thanks for coming to Oregon. We really
3 appreciate you coming and listening to what we have to
4 say.

5 I know you must be looking at your task and
6 wondering if we are developing a health care approach
7 similar to Woody Allen's world view here. Woody said
8 "More than any other time in history mankind faces a
9 crossroads. One path leads to despair and utter
10 hopelessness, the other to total extinction. Let us pray
11 we have the wisdom to choose correctly." We don't feel
12 like that. We're not at that crossroads, and I hope you
13 come away feeling there's a lot of optimism that this is
14 tough stuff, but we can get it done.

15 I'd remind you of the goal. When I went to
16 work for the state of Oregon, John Kitzhaber brought me
17 into his office. In the room, he looked me right in the
18 eye and said "The goal is health. It is not health
19 services. I don't care about health care. I care about
20 health."

21 And here are the rules. You have got to
22 improve equity. You have got to figure out value,
23 that's what we learned in our prescription drug project.

24 This has got to be transparent. You've got an advantage

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1 when you make it public because the other folks are not
2 used to working on that playing field. You have got to
3 be explicit. Don't be afraid to tell people exactly
4 what you're doing. And we have all got to feel like we
5 are in charge, so you've got to give away some local
6 control. It's the middle of our health care system that
7 we don't have any about-- we don't have those hospital
8 boards, those care groups. You know, this is an
9 industry.

10 I'll end, really, with what I think is a
11 very sweet paper and a comment from this paper by --
12 I've probably breached some copyright rules by putting
13 it in your packet.

14 Marthe Gold went to England to study
15 priorities. And the English are at the same point we
16 are -- looking at their health care system. And she
17 basically listened into public sessions including,
18 including teas that she would go to where really, as
19 you'll see if you have chance to read the paper, they
20 talk about these same kind of issues. She closes with
21 this statement: "Our next great wave of empowerment
22 will come when we begin to think at the population level
23 by asking the public for its views on the health care
24 system: What should our country provide and how should

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1 it be paid for? These are no less life and death
2 decisions than those made at the bedside." Interesting,
3 she's got the population and individuals included.
4 "Listening to public voices could help us move our
5 stalled efforts of health care reform forward in a
6 publicly responsive and responsible way. Maybe we'll
7 even adopt the tradition of afternoon tea. Worse things
8 could happen."

9 Thanks.

10 VICE CHAIRPERSON McLAUGHLIN: Thank you very
11 much.

12 (Applause).

13 VICE CHAIRPERSON McLAUGHLIN: I don't know
14 whether anybody had any questions for Dr. Goldberg or
15 Santa or whether you would be around for us to talk to
16 over lunch maybe.

17 We were supposed to reconvene at 1:00.

18 (Whereupon, the working group was recessed
19 to reconvene at 1:00 p.m.)

20

21 [transcription resumed with hearing in process]

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A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

1:30 p.m.

Dr. GANZ: . . . in 1992 I worked for them.

And the basic idea was that people as a community would pool their resources and that it wasn't about themselves, it was about pooling their resources to help someone in the community in a time of need. And only secondarily was there a notion that maybe they get sick or they might get injured and that community would be there for them. That was the principle upon which this was founded. And I would submit that this is still a fundamental principle that is at work and can be at work today.

I hope to believe, however, that we have gotten far away from that principle. In the public discourse, in the way that we view the system and, frankly, the way that the system functions it does not function out of that fundamental good place; people being there for one another. Instead, it's been replaced with a system that looks more like an entitlement system in which everything happens behind the platform and the focus is amongst the players in the system, if you will, institution to institution. And

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1 the individual patient is kind of a icon in the entire
2 affair. Think of it as when health insurers are
3 negotiating with hospitals and hospitals are talking
4 with physicians and insurers are talking with physicians
5 and people are talking to pharmaceutical companies.
6 It's like titans, you know, stomping around the meadow
7 looking at each other and the individual consumers are
8 the ground. That's my sense of much of what we have in
9 the system today from the perspective of a consumer.

10 I come by this somewhat honestly, I guess,
11 in the sense that my dad was a physician in Spokane. He
12 was a family doctor. And he was a Marcus Welby
13 physician, if you will, if you remember that show. He
14 delivered babies, he did minor surgeries, he did house
15 calls and gave away a lot of care free to various
16 religious communities. He was Catholic and so many of
17 the religious communities in Spokane got free care from
18 my dad.

19 And he always -- well, he did many things
20 and he took great pleasure. The thing that he took the
21 greatest pleasure in was the ability to diagnose that
22 very difficult disease. And he credited his own success
23 in that was because he took the time to get to know his
24 patients. And he did that at considerable cost to

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1 himself because that was not the way that the third
2 party payment system was structured to work. But he
3 thought it was important.

4 However, about three years ago, maybe it was
5 actually about four years ago, we started noticing some
6 changes in our dad. He had retired. And we just started
7 noticed as his kids that he wasn't quite the same person
8 we had seen before physically.

9 It started with a very bad backache that he
10 had. And he went in to see his doctor, and the doctor
11 spent about five minutes with him. Looked him over and
12 said I think you've got early -- I think you've just
13 strained your back. Sent him away with some medication.

14 Three months later it wasn't getting better.
15 We came in, did some tests. I think he did an x-ray or
16 an echo or CT, determined that they found that he had
17 early osteoporosis. Sent him away.

18 A few months later he started having issues
19 with his eyes. He wasn't seeing very clearly and that
20 this was coming up very soon. He was sent in -- or he
21 went in, went to the doctor, he was referred to an eye
22 doctor. They did a bunch of tests looking at his eyes,
23 determined that -- I forgot what the condition was, and
24 they started treating it with some new medication.

1 A few months later he came back into the
2 hospital because -- or came back to the doctor because
3 his mind wasn't working very well. We were noticing he
4 was getting very foggy. And so they looked at that and
5 decided it was an early Alzheimer's.

6 Then he had a compression fracture of his
7 back. And he went and they looked at it and said, no,
8 this looks like osteoporosis getting worse. Treating of
9 this either adjusted his dose of medicine and sent him
10 away again.

11 Eventually he was so weak he could hardly
12 stand. And it was only then that his doctor actually
13 took time to weave together the various strands and the
14 insight came that maybe this wasn't just a bunch of
15 individual symptoms, but it was something there. And
16 they diagnosed that it was multiple myeloma. And at
17 that point they had him by the throat. And while he
18 did, you know, go to the hospital and get stabilized for
19 a time, it was a little bit late.

20 I told you that story not because accusing
21 anybody of doing anything bad. But it's a little
22 indication the way that health care works. I think you
23 probably have stories in your own family that are not
24 dissimilar. The system that creates incentives to move

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1 people through the system, to not necessarily spend
2 time, to not create relationship but to treat particular
3 conditions in an episodic way and throw technology at
4 it.

5 The other experience he had was when he was
6 in the hospital, what was particularly interesting for
7 all of us as a family was, watching how he was treated
8 in the hospital. He was treated in the hospital that he
9 had done most of his work, and he was well liked at that
10 hospital. And yet when he was there the most basic
11 human needs were hard to come by in the hospital.

12 When he was in intensive care he got all the
13 technology that he needed just to keep him alive. But
14 when he was on the medical floor he was made to wait on
15 average 45, sometimes even 60 minutes to just get help
16 to go to the bathroom.

17 And we kind of looked at that, and because
18 he could afford it, he was able to -- my parents were
19 able to get a 24 hour duty nurse to privately come and
20 sit in the hospital room so that when he needed to go to
21 the bathroom or needed basic needs, he had that.

22 Now, what is the lesson there? What is it
23 saying to us? I don't think it's saying that they were
24 bad people. I don't think that they were saying that

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1 there was an evil intent. I think what we were seeing
2 was a system that's been set up to operate in a
3 particular manner with business processes that operate
4 in a particular manner. And the investment follows the
5 money. So from a hospital perspective, they make
6 investments related to the many referring physicians who
7 want a particular type of technology to be able to serve
8 their patients. And the hospitals want to keep
9 physicians within their hospital not going to work to
10 somebody else's hospital. So investments are made to
11 try to make sure that there is the right technology. But
12 the attention is not necessarily on the patient. It's
13 on the referring physician, to use that exactly.

14 But I think it's repeated throughout that
15 when you have a system there there is not an economic
16 relationship between the patient and their physician or
17 the hospital. That you shouldn't expect that
18 necessarily the hospital or the physician, or whatever
19 is going to give it the same attention as if there were
20 an economic relationship.

21 It's made worse by the fact that prices are
22 hard to come by. If you want to take control of your own
23 health care and you want to go to a hospital and you
24 want to find out things cost, it's very difficult to be

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1 able to find out.

2 When we are second day here in Portland, we
3 went to the hospital for a tour. And we saw this
4 beautiful maternity ward. Very impressive. And they
5 talked about all the low lights and the stereos and the
6 nice TV and that. So I asked what this would cost for a
7 noncomplicated maternity. And I asked five different
8 people, including people in the billing department who
9 could not help.

10 Now how am I going to be a shopper? How am
11 I going to know when I can't get that kind of basic
12 information?

13 So I believe that we have an opportunity
14 here now to reset. We have to opportunity because there
15 is such a sense of crises in health care that often when
16 there is that sense of crises like we're seeing in the
17 Gulf region in a different context, that we also have a
18 tremendous opportunity for creativity to create a better
19 world. And our company is focused on that.

20 So here's, I guess, what I would say is that
21 we have a problem with access and we need to address
22 that. But if all we do is change the payment
23 relationship or come up with a novel way to address
24 access to get more people under the tent and we don't

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1 create a better tent, the tent will still collapse.
2 That merely, and frankly, by trying to put more people
3 underneath it, it will collapse faster than it already
4 is now. And that the challenge that you have, the
5 challenge that we all have is to get at the economic
6 rules that drive this system and change those at the
7 same time we're trying to address access. That is where
8 I think the long term win is, the long term gain is.
9 And let me talk a little bit about that.

10 First off, I think we have to stop the blame
11 game. Right now I think very much of the system is
12 people are so upset that they're looking at who is at
13 fault. Well, I'm here to say on the record today that
14 we're at fault, our company. We've been part of the
15 problem.

16 And about two years ago when I came into
17 this role, we took ourselves through a very difficult
18 and introspective process of looking at how we operated
19 within the system and how we helped perpetuate
20 brokenness, tyranny and fear in the system. And what was
21 interesting was is it wasn't the people. You know,
22 we've had a few people within our company that, frankly,
23 enjoyed power and exercised it at the expense of others.
24 But really what we found and where the evil lay within

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1 the company, if you will, was in our processes. The
2 fact that we had clearly focused for many years as a
3 wholesale institution; we sold to businesses. And so we
4 built our infrastructure and our business processes to
5 serve brokers and to serve businesses. And we did not
6 focus so much on the individual member.

7 We had good transactional capability;
8 payment of the claims, you know answering the phone.
9 And we measured. But what we measured was more in the
10 nature of how fast, how many and not necessarily was
11 there a customer satisfied at the other end. The
12 reason? That was because we were serving a business and
13 what the business wanted to see was how fast and how
14 many and how efficient in that respect.

15 You can look at that across hospitals,
16 across doctor's clinics, across pharmaceutical
17 companies, you name it in health care, this system is
18 built today on an institutional wholesale proposition
19 because that's the way the money flows. And what we're
20 working on as a company, and what I firmly believe, is
21 that the answer is to move back to a very clear focus on
22 the consumer, the patient and build our processes around
23 that.

24 I know in an earlier hearing you talk about

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1 electronic health records and you had some information
2 on informatics and clients. I think it would be a
3 terrible mistake if we embraced that technology and use
4 it as an institutional proposition only so that we can
5 continue to play big brother with regard to that
6 information as opposed to building and using the
7 information to give consumer better tools and better
8 information to open up what is now an opaque system to
9 bring light there for individual consumers.

10 One of our key initiatives for next year is
11 to work to build out a personalized health care record,
12 one that the patient owns, not one that is owned by the
13 hospital or governed by a physician. But one that
14 becomes portable and can be highly accessible so that if
15 a patient is in Florida and is in a car accident there,
16 who lives here in Oregon, they can have access or their
17 doctor there can have access to the basic information
18 that will hopefully make sure that they're only treating
19 the conditions that were caused in the accidents and not
20 create a new problem, for instance giving a drug that
21 they're allergic to or something else because they
22 simply don't have access to that information. That
23 there's opportunity, and that's just a little example.
24 But the idea being that we build it around the consumer.

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1 I this year moved to a HSA product because I
2 wanted to see for myself what it was like to operate
3 without insurance, if you will. Because for the first
4 \$3,000 of any payment that our family needs this year,
5 that's coming right out of our pocket now. And it's
6 been a fascinating proposition and I've learned a lot.
7 It has confirmed a lot of what I believe.

8 When I have gone to the doctor I have found
9 that it is very difficult to find out when things cost.

10 And when a doctor wants to order a test, I've
11 challenged them. Well, why do I need the test? Is
12 there anything in my history that really suggests I need
13 this test.

14 And in my recent encounter the doctor, after
15 some back and forth, he said "You know what? I don't
16 think this is really necessary." But had I not had the
17 incentive to ask those questions.

18 Oh, by the way, when I asked him how much
19 the test would cost, he didn't know. And when he asked
20 his front office person, she didn't know. So we just
21 made an assumption of how much it would cost and then
22 talked about whether or not there was value in having
23 the test. And we decided that there wasn't.

24 I think the opportunity is to have those

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1 kinds of conversations, to accept those kinds of
2 conversations where in fact the patient and the
3 physician, the patient and the hospital are in direct
4 economic relationship. And through that will come the
5 economic discipline that you see in other areas of
6 health care that aren't subject to a third party payment
7 system.

8 For example, lasik eye surgery. Compare
9 lasik eye surgery, if you will, with cataract surgery
10 over the last ten years. There's not a whole lot of new
11 exciting stuff going on in cataract surgery. One thing
12 that is true is that because techniques are better,
13 they're able to do more units in the same period of time
14 than they used to.

15 If you look at the cost to the system of
16 cataract eye surgery over the last ten years, you will
17 see a marked rise that is not that dissimilar to the
18 general inflation rate in health care, which
19 unsustainable, we all agree.

20 Compare that with lasiks. Over the past ten
21 years what's happened in lasik. There are more people
22 doing it. The technology has gotten better. The
23 results, outcomes are generally better. And prices are
24 falling pretty significantly over the last ten years.

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1 The difference? One is exposed to a market and has the
2 economic disciplines where patients are shoppers and
3 have tools and can get information on pricing and get
4 information on different providers and the other is not.

5 That's just one of many. If you look to alternative
6 health care provider and see the same thing. That
7 prices tend to maintain reasonable levels, efficiency
8 get better. Oh, and by the way, customer satisfaction is
9 very high because people rather than operating in
10 entitled fashion are actually operating in a market
11 fashion. And the response and the focus of the provider
12 community, in that respect, is on the patient because
13 that's who is paying the bill.

14 What we're doing as a company is moving in
15 that direction. We have said that our fundamental
16 business proposition going forward, the value that we
17 have, is to individuals and it's not been between the
18 individual and their provider. It's to facilitate that
19 relationship. To provide tools and information to help
20 people and members of their family who navigating care.

21 And we believe that the lessons of history will tell us
22 that in fact we can over time increase the satisfaction
23 of individual patients by establishing a relationship
24 and at the same time bring more fiscal and economic

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1 discipline into the individual relationship, into the
2 point of service.

3 In the near term we'll probably continue to
4 sell primarily to large employers or small employers or
5 state entities. But our hope is that those entities
6 will also see that the primary value proposition for the
7 long term is focusing on the individual member and
8 helping them become better, more disciplined shoppers of
9 their health care. And that the overall system, as it
10 does it any other market-based system, will respond to
11 that and we will create a more consumer focused system
12 and one that better controls its costs.

13 If we do not that, then I believe that
14 merely throwing more public money at it or changing who
15 the payer is, or you in a sense pandering to an
16 entitlement mentality, we will never have enough
17 financial resources. And given the movement of the baby
18 boomers into retirement years, we will be in for a
19 perfect storm.

20 So I'll stop there and take any questions.

21 VICE CHAIRPERSON McLAUGHLIN: Thank you
22 very much.

23 I do have a question of, you know, this
24 balance between having it patient centered, consumer

1 centered, the consumer responding to incentives that you
2 articulated and at the other end a more paternalistic
3 setup where it may be the government, it may be actually
4 the physician that your father used to be taking care of
5 the patient and getting to know the patient and really
6 being to diagnose the patient. Sort of how that balance
7 is. And I say that because we do have a lot of research
8 that indicates from the RAND Health Insurance
9 Experiment, which is the only one we really have on a
10 large enough scale from in a randomized control scale to
11 really understand how people respond to financial
12 incentives, such as you mentioned, that particular for
13 the low income participants in that study when they were
14 faced with a HSA kind of high deductible they made
15 choices that didn't reflect what your father would have
16 recommended. They were not able to discern between what
17 was effective medical care and what was elective.

18 DR. GANZ: Right. Yes.

19 VICE CHAIRPERSON McLAUGHLIN: And, in fact,
20 the study that is most often cited involved parents who
21 had children, that they were just as likely not to take
22 an infant suffering from severe dehydration due to
23 diarrhea to the emergency room as an infant who just had
24 a bug bite or some sniffles.

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1 So how do you when you're thinking about
2 this from your perspective, what is your recommendation
3 of how do you adjust for that in your situation where
4 you're wanting to have more financial responsibility and
5 the fact of the matter is not everyone is going to be
6 able to engage in the conversation you were able to
7 engage in with your physician in terms of running that
8 particular test? Where is that line drawn and what
9 potential role is there for the physician?

10 DR. GANZ: Okay. Good question and one that
11 we've given a thought of, and I'm not going to presume
12 here to tell you I have the answer.

13 VICE CHAIRPERSON McLAUGHLIN: Why not?

14 DR. GANZ: You know my sense is, and maybe I
15 didn't say this before, but I think the first thing that
16 we have to do here is we have to establish true north.
17 We have to know what direction we want to take. In a
18 sense, what kind of health care system do we want for
19 our kids and our grandkids and how do we want that to
20 look? Because right now we haven't gone through that
21 work as a nation. And because of that, I think
22 different people have different visions. And therefore,
23 the activity is not necessarily all moving in a common
24 direction. And I think part of that is simply because

1 we haven't taken the time to sort of -- there hasn't
2 been enough maybe humility in the process for people to
3 say, first, you know there is a problem here and I'm
4 part of it, whatever part I may be within the system.
5 And I've an contributor to that. And why do I do what I
6 do and why am I driven to that and how much I change.
7 And then really look at developing a common vision about
8 where we need to go.

9 So that's not a direct answer to your
10 question, but I'm just saying that that is -- I think
11 within our own company we've done that and it's moved us
12 in a direction. Why I'm here is to help advocate for I
13 think a much broader progress because I know that the
14 answer doesn't lie within us alone. It's far bigger
15 than just us, and it's far bigger than just Oregon,
16 Idaho, Utah and Washington.

17 But let me go philosophically at your
18 question. I think one of the big issues is I'm probably
19 a little more education about health care than others,
20 because I work in the system. The one thing I've
21 learned is that I'm also a babe in the woods in terms of
22 having a level of sophisticated knowledge that would
23 help me make good decisions.

24 First, I would say I have a lot of trust in

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1 the average consumer to learn what they need to learn in
2 a system where it's demanded that they learn it. That
3 generally we as Americans when we have needed to learn
4 something in order to be able to operate within an
5 economic system, we find a way to learn what we need to
6 know. And it doesn't guarantee that we're going to
7 always make good decisions. But I would submit that
8 under the very paternalistic system that we have today
9 there are a number of bad decisions being made, whether
10 they're made by the patient or whether they're made by
11 the person who is acting in a paternalistic fashion
12 toward that patient. And that that will never be rooted
13 out of the system. But I would rather cast my lot on
14 the individual to make choices and free in making those
15 choices rather than have somebody else who presumes to
16 have greater knowledge telling them what they can and
17 cannot do.

18 What I do think in a system, for instance as
19 our company, what we need to do is not be cast in the
20 role that we have been in the past, which is what I
21 would call "traffic cop," administrator. That our best
22 way of functioning is as facilitator. In other words,
23 get information into their hands and be very skilled
24 about it. And that's an entirely different competency

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1 than what we've built up over the years.

2 I mean, our customer service department,
3 whether than merely being kind of a yes or no, yes you
4 can do this/no you're going to do this, needs to have a
5 level of competency that can actually help guide people
6 through a decision making process and give them
7 information so that they can make better decisions.

8 So the RAND study, I think, probably
9 reflects more about what is wrong today as opposed to
10 what may be possible tomorrow. Because I don't believe
11 that health care is so different than anything else that
12 we purchase or anything else that we interact with in
13 our economy that it needs its own completely different
14 set of rules. I think the reason it operates the way it
15 does is merely almost an accident of history. That
16 needs to change.

17 And the real key is how do you bring people
18 who have been subject to a paternalistic system to a
19 different value. And I think a lot of that is helping
20 reeducate people as to their role in that and giving
21 them the tools to be able to be as good as decisions as
22 they are. I'm not suggesting that it's going to be
23 easy. I'm just saying that that is the general path we
24 need to take.

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1 Was I responsive?

2 VICE CHAIRPERSON McLAUGHLIN: I mean you
3 were. I mean, we could engage in this conversation all
4 afternoon, I suspect.

5 DR. GANZ: Yes.

6 VICE CHAIRPERSON McLAUGHLIN: But I want
7 other people to ask you some questions.

8 Pat?

9 MS. MARYLAND: What are your thoughts about
10 pay for performance, you know, in terms of providers
11 that provide care and that quality is there?

12 Patricia Maryland. My question is what are your
13 thoughts about pay for performance, relating quality, if
14 you will, now comes to reimbursement.

15 DR. GANZ: Well, first off, there's a
16 concept of pay for performance. I've always been -- I
17 believe a market works when people get paid for their
18 performance. And then if they don't perform, people
19 vote with their fee to go somewhere else. I mean, that
20 is a market at work.

21 I'm somewhat suspicious of pay for
22 performance if it's a situation of institutional
23 leverage where one institution says I'll pay you if you
24 perform to my standards, not to consumer standards, my

1 standard or I won't pay you or I'll pay you less if you
2 don't perform to my standard. I think that just leads
3 to the continuing argument, if you will, between doctors
4 and insurers or doctors and their own licensing
5 qualities. And it will be a field day for the lawyers,
6 you know, because of the lawsuits it'll generate. But
7 I'm not sure that the consumer is going to be better off
8 at the end.

9 Again, the concern I have with it is if it's
10 not consumer focused, then it's just warmed over same-
11 old-same-o.

12 So as a near term measure I think pay for
13 performance may be one of those pieces of a bridge that
14 we might to say, yes, let's do that. Let's try it if it
15 has some validity or helping us get to the ultimate, you
16 know get on the path toward true north. But as a long
17 term proposition, if it's the sort of institutional kind
18 of pay for performance conversation, I think it has a
19 short lived usefulness.

20 If it spurs the notion of sense of the
21 patients paying for performance in the long term or
22 patients and insurers together in some partnership
23 fashion, then yes. Maybe it adds a longer term
24 significance. Because ultimately you should get paid

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1 for your performance.

2 VICE CHAIRPERSON McLAUGHLIN: Montye?

3 MS. CONLAN: I guess I'm interested in your
4 thoughts for a person like myself. I have multiple
5 sclerosis, very expensive to treat, complicated
6 sometimes in the treatment. And so to a certain extent
7 I play the role of lesser in society, if you will.

8 The point of what I'm saying is my options
9 are a lot fewer than yours. So you can educate me and,
10 you know, put me in the role of empower me but I still
11 have very few options.

12 DR. GANZ: First off, at the personal level,
13 I obviously I don't walk in your shoes because I don't
14 have multiple sclerosis. And I can only imagine because
15 I do have friends of our family that have gone down the
16 same path you have. I know something, but obviously to
17 not have been there, not have it happen inside my own
18 body, I can't. So I'll start from that premise. Fair
19 enough?

20 I would submit that individuals in this
21 country who suffer from long term chronic illnesses are
22 served by the same system, the same broken system that
23 everyone else is served by. And that the notion is the
24 need to -- what I'm arguing is is that the system

1 doesn't function sufficiently and that it drives cost
2 beyond what is appropriate or in your illness as well.
3 And that what we're trying to look at, or at least at
4 drives my philosophy is, without pulling a particular
5 kind of view or looking at any particular -- like how
6 does the system function. And if it doesn't function
7 well, then those with chronic illnesses are going to be
8 pushed out of the system probably faster than the rest
9 because they will not be able to afford the care they
10 need because they need more of it.

11 So to me when I talk with members of our
12 company, employees of our company who are dealing with
13 chronic illnesses, that only heightens my resolve and
14 belief that we need to get at this current Commission.
15 And that merely trying to figure out how to put more
16 money toward funding care of chronic disease isn't
17 enough. We've got to fundamentally change what drives
18 that cost that causes it to be so expensive in the first
19 place.

20 Does that make sense?

21 So, you know, I don't know if I'm being
22 responsive to what your particular concern is, but I
23 wasn't suggesting in my comments that -- I guess what I
24 was trying to get at is is that the system isn't

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1 sufficient. And if it drives costs and it pushes people
2 out and makes it unaffordable over time for people, it's
3 only going to be that more for people that are your
4 shoes, and that we'd better get at it.

5 MS. CONLAN: Well, I guess the reality for
6 someone like me is that of course related to public
7 health because private insurers don't want to touch me.
8 I have a preexisting condition. A lot of doctors
9 don't accept Medicaid, which I'm a Medicaid beneficiary.
10 So that's what I mean by fewer options.

11 DR. GANZ: Yes.

12 MS. CONLAN: You know this market kind of
13 economy that you're describing, I just don't have the
14 same kind of experience. And I think there are many
15 others like me.

16 DR. GANZ: Yes.

17 MS. CONLAN: It's not just about MS.

18 DR. GANZ: Yes, I would agree. And I would
19 say that you described to a great extent what's wrong
20 with the system and why it must change. That's my
21 point. Because I'm not suggesting -- I don't think the
22 system functions in the market today. I've been using a
23 couple of examples of where it can function in the
24 market effectively. But my point was it doesn't

1 function at a level of market today, it doesn't have
2 those dynamics. So it pushes you into a public funded,
3 it cuts off choices because it becomes almost an
4 implicit ration because of the way the economic rules
5 are set up; that's what I think needs to change.

6 VICE CHAIRPERSON McLAUGHLIN: Well, actually
7 I thank you for reminding us what we started off the
8 morning with with Governor Kitzhaber that we always have
9 to think about the counter factual. We have to think
10 about well what's the alternative? What else is happen
11 if we don't go this way? So those are some of the tough
12 choices that we're going to have to make in this next
13 year as we talk to the American public of not
14 everybody's going to get everything and you have to say
15 well it could be even worse, which is partly what you're
16 saying. If we keep going the way we're going, it'll be
17 even worse.

18 So thank you for reminding us of that
19 cheerful note. No. But it is something that we need to
20 keep in mind, so I thank you very much for your
21 comments.

22 DR. GANZ: Okay.

23 VICE CHAIRPERSON McLAUGHLIN: Next we're
24 going to be hearing from another person --

1 DR. BAUMEISTER: I have a question.

2 VICE CHAIRPERSON McLAUGHLIN: Ops, sorry.
3 Can it be quick?

4 DR. BAUMEISTER: No.

5 VICE CHAIRPERSON McLAUGHLIN: Can you try?

6 DR. BAUMEISTER: Employer based health
7 insurance.

8 DR. GANZ: Yes.

9 DR. BAUMEISTER: Is travelling away, at
10 least the prediction is is that less than fewer and
11 fewer employers are offering insurance. And so I just
12 wondered what percentage of your business is through
13 employers?

14 DR. GANZ: The vast majority.

15 DR. BAUMEISTER: And your premiums are going
16 up and up and up?

17 DR. GANZ: Yes.

18 DR. BAUMEISTER: And up?

19 DR. GANZ: Yes.

20 DR. BAUMEISTER: And my question is I would
21 like you to tell me what you're going to do about that?

22 DR. GANZ: Okay. Do you have the rest of
23 the afternoon? First off, I don't think so much of
24 myself to be able to say I know exactly how it ends,

1 this way out.

2 What I would say in terms of the employer.
3 I'm not sure that the employers response to health care
4 the way we see it today is what we're going to see in
5 ten years, and I'm not sure we should see it the same
6 way.

7 My view is is that the system needs to be
8 responsive to individuals. The reason that I think
9 employers continue to sponsor health plans is -- but I
10 think they also view it in a paternalistic fashion, and
11 I don't think this is a bad thing. I think people's
12 hearts are in the right place. That they want their
13 employees to be able to have access to health care. They
14 see how expensive it's becoming and they want to try to
15 structure it so that they can keep the costs as low as
16 possible for themselves and their employees. That it's
17 sort of this notion of trying to do something within a
18 system that really isn't working.

19 And then there are other employers that are
20 kind of trapped or they feel that they're trapped, would
21 just as soon get out of health care benefits but because
22 of either union contracts they have or relationships
23 feel like they can't move beyond their current reality.

24 I think that will create distortion and

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1 could only make things worse if we don't -- I mean,
2 it's again why we need to step back and say what is a
3 more rational way to structure the system in this
4 country.

5 I guess I would rather see a situation in
6 which employers facilitate rather than dictate what kind
7 of health care or health care plans people get. And
8 that people be allowed to -- but also with the financial
9 account that goes with that -- to choose more what
10 structure their health plan or benefits more to what
11 meets their individual needs as opposed to sort of
12 buying into a broad base. And that health plans, like
13 us, need to compete on an individual level and not at a
14 group level. So that maybe the group qualifies us to
15 say yes, okay, we meet certain levels. But that
16 ultimately who we're marketing to is to the individuals.

17 Because I think that, again, turns our focus and keeps
18 our focus there. Not just at the employer.

19 But I think in terms of the whole health
20 care premiums going up, that is a direct reflection and
21 is directly driven by the cost of the underlying care.

22 Our company, our administrative costs for
23 example are a very small percentage of the overall, you
24 know what we take in. We basically take in for every

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1 dollar and we pay out in actual benefits approximately
2 .90 cents. It's in that .90 cents that that's where --
3 I'm not suggesting that we don't have to continue to
4 watch our administrative costs, and we do. And that
5 needs to be highly exposed, and it is. And if we don't
6 do a good job of that, then we deserve to pay the
7 consequences of that. But where the real money and where
8 the real focus needs to be is what -- this ever
9 increasing .90 cents that just gets bigger and bigger
10 and bigger every year. That's why I'm suggesting a
11 radically different approach to how we structure health
12 care benefits and why I'm suggesting.

13 DR. BAUMEISTER: Well, we were meeting in
14 Boston and we had a public meeting. And the room was
15 stacked with single payer people. And they came well
16 prepared. And the mantra that was chanted that night was
17 that .39 cents of every health care dollar in
18 Massachusetts goes for administrative costs.

19 And we heard this morning Senator Wyden
20 quote 35 percent. And then had a caveat, I don't know
21 if it's true or not, but it's out there. And that's a
22 lot of money.

23 DR. GANZ: It is.

24 DR. BAUMEISTER: For administrative costs.

1 DR. GANZ: I don't subscribe to that number,
2 unless you also include all the administrative costs
3 that every health care provider and their clinic and
4 hospitals and the like; maybe you might be able to push
5 it to that level.

6 DR. BAUMEISTER: Right.

7 DR. GANZ: But if you go to a single payer
8 or whatever, you're still going to have that kind of--
9 those costs are still built in. If you're looking at
10 the cost of what, you know, insurers put into it the
11 cost is a lot less. At least I can only speak for us as
12 a not for profit company. That I know we watch that
13 very closely.

14 But again, that feels a little bit more like
15 pointing the finger and saying someone's a fault.

16 DR. BAUMEISTER: Right.

17 DR. GANZ: A particular party is at fault.
18 And I think what we really need to do is step back and
19 in a sense if you look, everyone's at fault and no one's
20 at fault. Because we have a system that really isn't
21 very accountable in the way that it's set up. And the
22 worst evil that you can create is when you have really
23 good people who create bad outcomes because the system
24 in which they work creates that with all the best of

1 intentions. And I don't think it has to be that way.
2 And I believe it can be different.

3 So I guess in closing what I would say,
4 because I know that Jean is waiting to get here, is I
5 want to applaud you for taking this on and for taking
6 time out of your busy lives to do it. It is a worthy
7 thing. And I urge you again to keep your perspective as
8 a citizen. As you become more expert, as you already
9 are becoming more expert, don't start acting like an
10 expert. You know focus on it from the line sight of you
11 as a patient and as a consumer. And I think if you look
12 at it from that perspective, you're going to find the
13 answers that will have the most long term sustainable
14 good.

15 Thank you very much.

16 VICE CHAIRPERSON McLAUGHLIN: Thank you for
17 your comments.

18 DR. BAUMEISTER: Thank you. Thank you.

19 (Applause).

20 VICE CHAIRPERSON McLAUGHLIN: Next we're
21 going to hear from Jean Thorne, who is currently the
22 Administrator for the Oregon Public Employees Benefit
23 Board, which is responsible for the design, purchase and
24 administration of benefit plans for all state employees

1 and their dependents of 100,000 members. So bringing a
2 complimentary perspective to our discussion.

3 Prior to this, however, she was the Director
4 of the Department of Human Services here in Oregon. And
5 before that was the state's Medicaid Director from 1987
6 to 1995 and was thus responsible for leading the
7 implementation of Medicaid reform under the Oregon
8 Health Plan. And in fact one of her numerous positions
9 was working as a policy advisor for Governor Kitzhaber.

10 So we're sort of ending where we started,
11 and we welcome you and look forward to these last words
12 of advice and experience that we're hoping to get from
13 you.

14 MS. THORNE: Thank you very much. It's been
15 like a trip down memory lane today. Dr. Santa called me
16 and asked if I would kind of finish up, so to speak,
17 since I had been the Medicaid Director during all the
18 Oregon Health Plan and now I'm really on the purchaser's
19 side and to offer whatever lessons I learned. It is
20 interesting after having been through all of this and
21 having seen so many old friends and colleagues who have
22 been part of a really phenomenal process in Oregon.
23 Sometimes we get so caught up in doing it we don't step
24 back and recognize what we've really done here. And I'm

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1 really proud to have been part of it.

2 It's been interesting. I started as the
3 state Medicaid Director just as the decision had been
4 made to discontinue funding organ transplants, as
5 Governor Kitzhaber talked about. We really learned a
6 lot during that time as we went through the development
7 and the implementation of the Oregon Health Plan. So
8 I've been asked to talk about what it's like to go
9 through all that and then to reflect back on what I
10 think we've learned.

11 It was in 1987 that the coverage for
12 transplants was discontinued. At the same, though, the
13 legislature also had utilized those dollars and other
14 dollars to expand coverage for pregnant women and
15 children who hadn't had it up until then. But then, as
16 Governor Kitzhaber noted, it was done very quietly. It
17 wasn't until we began denying requests for transplants
18 that the public and the press really became more aware
19 of what was occurring.

20 And certainly we began trying to talk about
21 the trade-offs. And that was very difficult when we
22 were being faced at the same time with a child or others
23 who potentially could have benefited from the organ
24 transplant and trying to put a face on the other people

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1 who had no health care coverage.

2 Then-Senator Kitzhaber was on one side of
3 the table and I was on the other as we went through a
4 number of legislative hearings. And I think in 1988
5 what was very interesting is that out of that really
6 came much more of an awareness in Oregon that we don't
7 have a health care policy. We had legislative hearings
8 where I had to explain that you can do this under
9 Medicaid, you can't do this under Medicaid. No,
10 Medicare is something different. And, at that time there
11 were 400,000 people without any type of health insurance
12 in Oregon. And they were really astonished by that.

13 The press picked up on that as well. And
14 once they moved past the issue of there being a child
15 who died who potentially could have been saved, they
16 really began looking at the underlying issues as well.
17 And I remember the local NBC affiliate aired a
18 documentary -- this is 1988 -- about the health care
19 crisis and the lack of a system that we have in this
20 state and this country. And this was really far before
21 there was a national awareness.

22 In 1989, as Governor Kitzhaber noted, the
23 framework for the Oregon Health Plan was passed. I
24 remember sitting with him as he said well we should do

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1 this, this and this. I said you can't do that under
2 federal law. And he said then let's go get waivers.
3 Okay.

4 We spent the next four years working on
5 those federal waivers. The original legislation, which
6 was passed in '89, said we'd have the program up by July
7 1990. And I remember saying to Governor Kitzhaber are
8 you out of your mind. We can't do that by then. He
9 said well if we said 1992, it would be 1994. Well, it
10 was 1994.

11 We dealt a lot with the subject of
12 rationing. We had a lot of representatives of national
13 advocacy groups who focused on that and who said we were
14 going to ration health care. And it was interesting to
15 me that advocacy groups, especially, were not willing to
16 look at the people who had been rationed out of the
17 system entirely. And we really talked about how we were
18 trying to bring rationality to the rationing that is
19 occurring right now. And many of the groups who were
20 critical had concepts of what the list was without
21 really knowing what the list was. It got explained,
22 as Dr. Kitzhaber noted, that we had life saving
23 treatments that were sure to work in restoring health at
24 the top of the list and at the bottom of the list you

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1 had treatments that were futile or for conditions that
2 were self limiting. As we spent more time talking to
3 people about the reality of what was on the list it
4 really opened up the discussion more.

5 The national press focus was certainly
6 initially on rationing. And I remember many, many phone
7 calls asking about how many people are going to be left
8 to die if we implemented the list. And I often had to
9 try to turn that around to how many people are dying
10 right now because they don't have access to some of the
11 basic care that others may have.

12 I think that what you heard here today was
13 that Oregonians, whether they were public citizens being
14 part of some of the Oregon Health Decisions group, the
15 numbers of physicians and other providers that were part
16 of other processes, really were involved in creating the
17 plan and having ownership in that. That meant as Oregon
18 approached the federal government for the waivers, we
19 really were approaching it as a united front. It wasn't
20 the bureaucrats going off to try to get waivers, it was
21 Oregon -- Oregon as a whole working on that.

22 What we tried to do was to raise the issue
23 of the need for trade-offs. I think one of the first
24 questions you asked this morning of Governor Kitzhaber

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1 was that you need to find out what services people want
2 or need. And his reply referred to a need for first
3 providing a framework. People need to understand and be
4 part of trying to understand there are limits, there
5 have to be limits. There are right now. And what has
6 happened is that we have excluded people from coverage.

7 How do we within the context of limits make those
8 trade-offs?

9 I remember I spent a lot of time with the
10 national press. I remember getting a phone call from the
11 *National Enquirer*, it was the research department, and
12 they wanted me to be part of a point-counterpoint. And
13 I said, well I didn't really want to do that for the
14 *National Enquirer*. But I did find myself, when I
15 thought that *National Enquirer* was going to be covering
16 it, at the grocery stand trying to look to see if it was
17 in that issue. I didn't want anyone to see that I was
18 actually looking at the *National Enquirer*.

19 But there was a lot of public discussion.
20 And I think what was especially telling and that to me
21 said we were really doing a good job of telling the
22 broader story was when the waivers were initially denied
23 in August of 1992. When we received the press clippings
24 from the clipping service within a few weeks after that,

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1 there were 38 editorials from papers outside of Oregon;
2 36 of them said Oregon should have been permitted to do
3 this.

4 What we continued to try to do during that
5 time was to say that if your alternative is to do
6 nothing, are you really satisfied with the status quo?
7 Is it good enough to say there will be some people who
8 will get just about everything and some people who will
9 get nothing? So certainly having that broader
10 perspective and articulating those trade-offs is
11 critical to be able to move forward within a context of
12 what it is that Americans want from the health care
13 system.

14 As we implemented the Oregon Health Plan in
15 February of '94 it was quite a time. We had basically
16 had funding approved by the legislature for staff
17 positions in August of '93 and had to fill positions and
18 implement the plan by February of '94. There were three
19 things we were doing in Medicaid.

20 We were fundamentally changing how benefits
21 were designed by using a prioritized list, which meant
22 we had all of the systems issues of condition and
23 treatment pairs and a lot of provider education around
24 that. We were working to establish and then transfer

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1 almost all the Medicaid recipients into managed care
2 plans. And we were also expanding eligibility to the
3 federal poverty level, so we had to establish all the
4 mechanisms to enroll members as well.

5 About a week after the legislative session
6 ended -- which at that point was the longest session on
7 history -- I had systems staff come up to me and say
8 "Well, we don't know that we can get it done by
9 February." And I said "No, you will get it done by
10 February."

11 We had been talking for five years about the
12 fact that there were people's lives at stake. There
13 were people dying right now because they weren't able to
14 access health care. And it was going to be important
15 that we got that program up. Frankly, we brought all of
16 our stakeholders into that and said it's going to be
17 messy. We are going to do what we can, and that meant
18 everyone else had to be with us on that, putting in
19 place what we needed to put in place to bring the
20 program up in February. That meant constant
21 communications with our managed care plans, with the
22 advocates; keeping everyone in the loop.

23 Basically I think the approach we all took
24 was we're all in this together. This is not going to be

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1 perfect. Yes, we were pioneers in many ways trying new
2 and different things. We needed to work through this
3 process together.

4 As we started the plan in February of '94,
5 we knew we were going to be in the national spotlight,
6 both from those who wanted us to succeed and those who
7 were expecting us to fail. I think we had planned, but
8 we weren't prepared in many ways for what we ended up
9 hearing.

10 We had contracted with a call center, and we
11 had 1-800 lines where people could call in and get basic
12 information for their application. We had estimated we
13 would have 5,000 calls in the first month. We had 4,000
14 per day for at least the first couple of weeks.

15 The callers didn't realize they were going
16 to end up talking to people in California. We had to
17 give people down in California lessons on how to
18 pronounce the cities so they thought they were talking
19 to someone from Oregon.

20 We had thought on the new eligibles, those
21 who were newly eligible for Medicaid through the Oregon
22 Health Plan, that it would take us 17 months -- by June
23 of '95 -- to get 70,000 enrolled. We had 85,000 within
24 the first six months -- by August of '94.

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1 People were calling in tears. And having to wait
2 a long time on those lines. And saying I have not had
3 coverage, I need to see a doctor so badly and this is a
4 life saver for me. And we were able to put faces then
5 on those who hadn't had faces in the past.

6 Those who were looking for the big stories
7 of health care rationing, actually didn't find it. I
8 think two or three days after the program started I had
9 a call from a reporter from the *San Francisco Chronicle*
10 and he said "Has anyone died yet?" And I said, "Well,
11 not that I know of." And he said "Well, have you had
12 any requests for anything?" I said, "Well, yes, we
13 have. I know we received one that was turned down."
14 And he asked, kind of salivating, "What was it for?"
15 "Well, it was for a circumcision." And he decided it
16 wasn't that big of a story.

17 And really what we then saw was the change
18 in the press focus from what are people losing to what
19 are people gaining. I think that spoke a lot also to
20 the list. The people who had worked on that, and they
21 were volunteers, are heroes from my perspective. They
22 really put together something that could stand up to
23 public scrutiny.

24 Yes, we had a lot of kinks to work through.

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1 We brought this up quickly with a lot of changes. But
2 again, I think all of those who were part of it thought
3 we were in this together, we will make this work.

4 We had a lot of advocates involved,
5 especially a few months later when we then rolled in the
6 SSI population. They were part of working with us and
7 with the plans to make sure we had sure plans that were
8 responsive to the needs of persons with disabilities.
9 The Health Services Commission had really worked to
10 incorporate at appropriate places treatments that were
11 especially important to people with disabilities.

12 Again, I think all of those were involved in
13 Oregon really took pride, a feeling like they were a
14 part of this, whether it was the data entry operator in
15 my office, or it was a physician in the community.
16 People felt that this was an important change that
17 Oregon was part of and that we really were trying to
18 help Oregonians institute it a rational way.

19 Let me just talk a moment about the use of
20 the list. It really was a tool to force explicit policy
21 choices, as Governor Kitzhaber noted. And so it
22 required the legislature to decide yes we're going to
23 fund this much, but no more. I remember in the initial
24 funding, initially the Legislature had put it at one

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1 level and said before we're done with this session we
2 want to put more money in, but we're going to need to
3 decide how far beyond we can and should go given our
4 other needs. It really did allow policymakers to reduce
5 services if necessary in a much more rational manner
6 than you normally have available under Medicaid.

7 In Medicaid, you throw people off, you
8 discontinue whole categories of optional services. This
9 brought rationality to it.

10 I think what was especially disappointing,
11 though, is that even though we received federal approval
12 for the waivers, there really was an unwillingness of
13 the federal government to allow us to utilize the list
14 as a means to deal with budgetary shortfalls.

15 I remember in 1995, I wish I knew how many
16 hours we spent on conference calls with staff of what
17 was then HCFA about diaper rash treatments, because that
18 was one of the lines that was being proposed for
19 elimination. It took incredible amounts of time before
20 they finally said we'll allow you to eliminate that. I
21 went off to work for Governor Kitzhaber on education
22 issues for a while and it was during that time the
23 Administration at that time said don't even come back
24 and ask us. We are not going to allow you to move the

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1 line any further.

2 We did with the current Bush Administration
3 go back, and this was after the legislature, along with
4 input from the medical directors of all the managed care
5 plans who worked with us, had decided and made a
6 recommendation to eliminate 35 lines of coverage. The
7 physicians, the legislature, others said you know these
8 are 35 lines where it is appropriate to eliminate
9 coverage. We received approval to remove three lines So
10 it was very clear then that how we had intended to
11 utilize the list was not something that really was being
12 accepted as a tool by the federal government. And, in
13 fact, some of the decisions that we were then confronted
14 with during the budgetary shortfalls in 2003 meant we
15 had to go back to the elimination of the medically needy
16 program. We went back to eliminating whole categories
17 of services.

18 I think what that did affected not only the
19 viability of the plan, but the political viability of
20 the plan. Those who were maybe luke warm supporters in
21 the state legislature, once we had our primary tool not
22 really something you could use, then used that as a
23 reason to eliminate whole categories of people from
24 coverage. But I think the list continues to be an

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1 important tool.

2 In my current role, which I'll get to in a
3 moment, we did a request for information last year with
4 health plans throughout the state. We asked them about
5 the prioritized list. And almost all of them came back
6 and said you know physicians accept this, they're used
7 to it. And it is a legitimate tool.

8 Let me talk briefly about my current role
9 and then get back to some of the lessons learned. I'm
10 currently Administrator for the Public Employees Benefit
11 Board, which is governed by an eight member board, half
12 management and half labor. Three of the people you've
13 heard from today either are or have been on our board.

14 The Board in late 2002 was being confronted,
15 as other employers were, with increasing premiums. They
16 had seen basically in the last six years, about an
17 annual 10 percent increase in insurance premiums. At the
18 same time our cost of living increases that are granted
19 to state employees had averaged 1.7 percent. The Board
20 was recognizing those trade-offs. Whether it's from a
21 labor union perspective or an employer perspective, more
22 and more dollars were going to health care, which really
23 meant that even on the employee side, those dollars
24 weren't available for compensation. And the Board

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1 really began asking what's the value? What are we
2 getting out of our current system? And so they
3 established what they called their Vision for 2007,
4 focused on systems of care, on evidence-based treatment,
5 on outcomes rather than just provision of services, on
6 transparency.

7 One of the guiding principles the Board
8 outlined before we'd gone through a request for a
9 proposal process to begin this in 2006, was that
10 providers need to own this. We need to have systems
11 where providers are going to make the changes that are
12 necessary to focus on the patients, to focus on the
13 outcome. This can not be merely a top down approach.

14 The vision guided the RFP. We went with an
15 extensive process. We did end up with two additional
16 contractors. But it will be difficult I think for them
17 to gain the kind of critical mass that they will need.
18 We are the largest employer based purchaser in the
19 state, but the providers in those two plans were not
20 allowed by the statewide carrier to withdraw from their
21 provider panel for purposes of our employees. So I
22 think it's a real question of will we be able to be a
23 catalyst for change when we have the same providers who,
24 in essence, may be part of two or more competing plans.

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1 We also recognize we have challenges in
2 engaging our own members. We've been trying to talk with
3 them through our newsletter as much as possible about
4 the problems with the current system and the need for
5 improvements. But when it comes down to it when we have
6 open enrollment next month, it will be interesting to
7 see how many of them elect to make a change based on
8 some of the components of the vision. So time will tell
9 what we're able to do as the major purchaser in the
10 state.

11 So let me just then talk, given that
12 background, about the lessons learned. Actually, my
13 first one reflects something that Mark Ganz said. What
14 I have seen over the years is that people are trying to
15 find somebody to blame. It's the insurer's fault, it's
16 the physician's fault, it's those darn consumer's fault,
17 it's business' fault; well, we are all part of the
18 problem. We are all part of the problem, whether it's
19 our expectations as consumers of what we expect of the
20 system, whether it's what hospitals expect of doctors,
21 what doctors expect of patients, what we all expect --
22 we are all part of the problem. And any kind of
23 solution means that we are all going to have to make
24 some sacrifices. And I think that in Oregon as we

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1 looked at the original Oregon Health Plan there was a
2 recognition that whether it was a treatment that was no
3 longer going to be available because it didn't do much
4 good anyway or a provider who wasn't going to be
5 compensated for doing that treatment, the trade-off was
6 that more people will then be able to gain health care
7 coverage.

8 So we need to stop looking for the villain
9 and really try to engage everyone in understanding that
10 everyone has something, whatever their role is, that can
11 contribute to a solution.

12 There aren't magic bullets. Trade-offs are
13 necessary. What we did in Oregon was to make those very
14 explicit.

15 I mentioned the prioritized list. Some,
16 even legislators today, think oh well that's just
17 Medicaid -- You go off and decide where the line is
18 drawn. And we said no, you as legislators have to be
19 accountable for those decisions. So if you really want
20 to cover something on that list, you've got to fund all
21 the way there. We said those were explicit decisions.
22 It's not to be made by a bureaucracy. It's going to be
23 made in a very public process.

24 The need for provider ownership to achieve

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1 change is critical. It wasn't the lobbyists that were
2 involved in all these efforts. It was the physicians
3 and other types of providers. Any of this kind of
4 change is messy. It will be messy. And the providers
5 can make it or break it. We are talking about changing
6 the way they do business, the way they practice and
7 interact with their patient.

8 There's the importance of credible political
9 leadership. I've been in state government for 30 years,
10 I know it's hard to believe I'm that old. And I would
11 just say this: That we happened to have been blessed in
12 1989 by having a physician who was Senate President. And
13 he was a physician who was willing to challenge the
14 health care system, who was willing to say some of the
15 things he said this morning. Who was willing to say not
16 everything we do as a physician has evidence to support
17 it. And he brought in other providers, other physicians
18 along with that who said yes that's true, that we as
19 physicians need to be part of a solution. They have an
20 expertise and he was able to bring them along, and bring
21 many other state officials together. So having that
22 kind of credible political leadership is really critical
23 to a long term solution.

24 Stakeholder groups can help. I think that

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1 in some circles advocacy groups are looked at as "oh my
2 gosh, we've got to deal with them again." Within
3 Oregon, the stakeholder groups involved in this helped
4 to make our products better, helped to make the delivery
5 system better. They helped with the national advocacy
6 groups in trying to help them understand we're not just
7 talking about those who already have coverage, we are
8 talking about a broader group of people, of children, a
9 broader group of people with disabilities and others who
10 don't have access now. We need to be thinking about all
11 of them.

12 And lastly on lessons, media can be your
13 partner. Responsible media can be a partner in really
14 helping educate. If the public doesn't accept the idea
15 that trade-offs are necessary and that there are limits,
16 it's going to be very tough to move them.

17 You know, we have a more sensationalized
18 media now, and it may be more difficult now. But I
19 think within Oregon we really found that there were very
20 credible media partners who tried to portray the larger
21 picture and to do it very responsibly.

22 On to some of the challenges. As we all
23 look towards solutions, I think in many cases people
24 come in with their predisposed idea of here's the

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1 approach, and it's a philosophical approach. We'll try
2 the competitive model. The competitive model is what
3 will be the answer. Well, in Oregon we have many areas
4 of the state -- in fact probably most areas of the state
5 that don't have excess physicians. Outside of the
6 Portland area, we basically are a one hospital town
7 around the state. And so the concept is not let's have
8 this competition, because we don't really have enough
9 providers to go around in most cases. Our approach is
10 to float all boats. How do we raise the practice level,
11 how do we raise the quality and the smart utilization of
12 health care treatments among all providers?

13 We need all providers to focus on the
14 greater good and not just what their bottom lines are.
15 I'll come back to the lobbyists again. In the 2003
16 legislative session we were faced with some very, very
17 serious financial constraints. Some legislators decided
18 they'd just get all the lobbyists in a room together
19 from all the provider groups and they'd come up with a
20 solution. Well, after weeks and weeks of evening
21 meetings, everyone was able to point to something that
22 someone else could do to save money. I think we had a
23 \$200 million hole and they came with \$3 million worth of
24 savings. The only thing that they did all seem to agree

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1 on was that obviously the bureaucracy needed to be
2 changed. So they found a common enemy in us.

3 One of the frustrations during 2003 when we
4 were facing some cutbacks, was hospitals who said no,
5 we're not willing to support the inclusion of mental
6 health and clinical dependency treatment. And I know
7 when I talked to them I said, wait a minute -- by
8 cutting these services you have more people in your
9 hospital ER, you have them coming in more seriously ill.

10 But it wasn't an issue of what was best for the system
11 and what was best for the community. It was that the
12 other provider group was going to get money. We've got
13 to look beyond that. And I think we can do that with
14 the professional leadership of our provider
15 organizations and with individual providers. This is
16 very difficult to do if you think the lobbyists will do
17 it.

18 Another philosophical approach is to just
19 let consumers decide it, that a consumer-based approach
20 will solve it. Well, our Board certainly supports
21 transparency and having more information available. But
22 I know I'm not a health care professional. My doctors
23 went to school many years, and I expect them to know
24 more than I do. Even though I could ask questions, and

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1 do ask questions, if it's up to me to go from specialist
2 to specialist, that's not very efficient either.

3 I think we really have to question can all
4 consumers or maybe how many consumers can we really
5 expect to effectively and efficiently manage their own
6 care. There definitely is a role for consumers to be
7 better shoppers and have more information. But that by
8 itself is likely not the answer.

9 Others will say that if all the purchasers
10 just asked for something, that will make change occur.
11 At PEBB, we're not that big, and we can't get critical
12 mass. Even if we got all purchasers together -- and we
13 do have a purchaser's coalition in Oregon -- can we
14 really get everyone together on a single page and ask
15 for the same things?

16 So as you look at various solutions, I think
17 that you should try to not jump to a conclusion that a
18 certain approach will just take care of it. It is much
19 more complex than that, and you know that.

20 Gaining public understanding, which is what
21 you're trying to do, of a very complex issue is a huge
22 challenge. How do you articulate those complexities so
23 that individuals really do understand the need for
24 trade-offs? Because there are limited resources. And

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1 how do we as a community, how do we ask society to best
2 spread those resources so we can do the greatest good
3 for the community?

4 And I would say that as we look to public
5 acceptance, if you don't at the front end have
6 acceptance from provider or stakeholder communities,
7 you're not going to get the public to accept the need
8 for change either. If we look at the mid-'90s at what
9 occurred in Washington, D.C., although the proposed
10 solution was comprehensive, when it was put forward, the
11 groups that weren't involved were immediately out
12 scaring people about what kind of change this was going
13 to mean.

14 Somehow bringing all of those groups
15 together to agree on a need for change, to look at the
16 greater good and to help the public understand those
17 complexities is certainly a huge challenge.

18 We learned a lot in Oregon. Often times it
19 was the hard way. We made plenty of mistakes as we moved
20 along. It wasn't just so easy as to go get some
21 waivers. We didn't plan on spending eight years doing
22 that.

23 This was doable in Oregon, given our size,
24 our demographics, our political situation, our economic

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1 situation at that time. I would say what was possible
2 ten, 15 years ago may certainly be more difficult now.
3 The politics are different in Oregon. The economy is
4 different in Oregon. But we feel we've learned a lot,
5 we continue to learn. We hope our learnings, and you've
6 heard from many of us today, can be helpful to you as a
7 struggle with these issues.

8 So thank you very much for inviting me and
9 for giving me the opportunity. It's been an interesting
10 pathway, and I really admire all of you for the time
11 you're taking and, obviously, the commitment you have to
12 dealing with these issues.

13 (Applause).

14 VICE CHAIRPERSON McLAUGHLIN: Aaron?

15 MR. SHIRLEY: A quick question out of
16 curiosity. A key prevention component of the Medicaid
17 program is the EPSDT. What impact did the waiver have
18 on that component.

19 MS. THORNE: We received a waiver from
20 EPSDT. Not that we wanted to -- we had a huge emphasis
21 on preventive care. But I think part of the problem
22 with EPSDT was that in the interpretation we were
23 receiving it was anything that potentially might be
24 needed for a child had to be provided. And, as I noted,

1 things were lower on the list that were conditions that
2 might have gotten better on their own or where there
3 were other treatments that may have done just as much
4 good. So that was a huge issue with the feds. Anytime
5 there was a proposed line change that potentially
6 affected a child, it was very difficult to get them to
7 move past that, even though we had a waiver and even
8 though there are other treatments that are just as
9 effective or maybe will take a little bit longer. So we
10 did receive a waiver from that, but certainly there is a
11 huge emphasis on prevention. It wasn't the early,
12 periodic, screening, or diagnoses parts of EPSDT, it was
13 more the treatment end, and every treatment that might
14 be possible.

15 VICE CHAIRPERSON McLAUGHLIN: Dottie?

16 MS. BAZOS: Can you tell us a little bit
17 about outcome changes after you initiated the plan, what
18 your studied, what you learned particularly with regard,
19 we'll say, to infant or infant mortality rates?

20 MS. THORNE: I think actually Dr. Goldberg
21 mentioned those -- I wish I had written them all down.
22 But certainly prenatal care and immunization rates went
23 up, infant mortality went down. There were studies
24 done; I think they're probably on the Office of Health

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1 Policy and Research website. In many cases that
2 information was self reported because we didn't have any
3 kind of predata. It was members or clients saying what
4 their experience or what their health condition had been
5 before.

6 MS. BAZOS: And can you remind me why this
7 plan isn't active now?

8 MS. THORNE: Well, kind of going back I
9 think a key piece again is the prioritized list. I'm
10 going to give you my taxation system in Oregon speech.
11 Unlike most other states, we have no sales tax. We have
12 personal income tax, but our property tax rate is
13 limited. So instead of the three legged stool, we have
14 1 1/2 legs. And a system that is based on income tax is
15 great in good times and really bad in poor economic
16 times. And Oregon took deep, deep cuts in about 2001
17 forward.

18 And I will say, I don't believe we could
19 have balanced the program by only using the prioritized
20 list, but it would have given us a significant amount of
21 savings if the federal government would have approved
22 allowing us to make the cuts that we had proposed. They
23 weren't willing to do that. And I think that not only
24 was it that, but again the political situation is

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1 different and I would say a lot of legislators by 2003
2 didn't really see some of the value and said well, the
3 Oregon Health Plan really is dead anyway because we
4 can't control the costs of it.

5 Wwhat is now called the standard population
6 or the new eligibles, by the time the 2003 legislative
7 was done, coverage for that group was going to be funded
8 through provider taxes on hospital and Medicaid managed
9 care plans. Those have been approved, but even there the
10 plan had to fit within the amount of money from those
11 taxes, so through attrition that group has to get down
12 to 25,000 people. We had 120,000 in that group when I
13 was there in the mid-90s. So I think the economics of
14 it and then just the inability to really use the
15 prioritized list as a way to help, if not completely
16 balance the budget, has made it very difficult to be
17 able to sustain the plan.

18 MS. BAZOS: Okay.

19 MS. MARYLAND: Sort of a follow-up question.
20 Some states have moved in the direction of provider
21 taxes and getting matching dollars from the federal
22 government. Has any thought been given to that in terms
23 of Oregon, and if not --

24 MS. THORNE: That is what we're doing,

1 sustaining that group. It's hospital taxes and on
2 Medicaid managed care groups.

3 MS. MARYLAND: Thank you.

4 VICE CHAIRPERSON McLAUGHLIN: Any others?

5 Well, I want to thank you very much for
6 finishing what was really a wonderful day.

7 When we went over to lunch, we were sort of
8 glad that we had to wait awhile for our food to show up
9 because it gave us a chance to talk. And we really have
10 enjoyed what was billed as a listening experience for us
11 today. We really learned a tremendous amount.

12 And I would be remiss if I didn't point out
13 that it has, to some degree, struck fear in our hearts
14 because we're supposed to do the whole nation. But at
15 the same time it has inspired all of us. And I started
16 with saying that to Senator Wyden who started the day,
17 that it gave us all a big boost. And it really has. And
18 I want you all to know that; that we heard what you did
19 here and it really has given us a big boost. We feel
20 energized and are looking forward to our community
21 meetings with more anticipation and excitement than I
22 thank we had before.

23 So this was a very worthwhile day for us,
24 and we're very grateful to you. So thank you for

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1 coming.

2 And I believe that's it. Thank you.

3 (Whereupon, the working group meeting was

4 adjourned.)