UNITED STATES OF AMERICA

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

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CITIZEN'S HEALTHCARE WORKING GROUP

PUBLIC MEETING

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Monday, April 11, 2005

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Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, Maryland

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8:30 a.m. - 5:00 p.m.

MEMBERS PRESENT:

RANDALL L. JOHNSON, Chair
CATHERINE G. McLAUGHLIN, Vice Chair
FRANK J. BAUMEISTER, JR., Member
DOROTHY A. BAZOS, Member
MONTYE S. CONLAN, Member
RICHARD G. FRANK, Member
THERESE A. HUGHES, Member
PATRICIA A. MARYLAND, Member
ROSARIO PEREZ, Member
AARON SHIRLEY, Member
DEBORAH R. STEHR, Member
CHRISTINE L. WRIGHT, Member
MICHAEL O'GRADY, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services

STAFF PRESENT:

LARRY PATTON, Senior Adviser to the Administrator, Agency for Healthcare Research and Quality
Ken Cohen, Department of Health and Human Services
ANDY ROCK, Department of Health and Human Services
CAROLINE TAPLIN, Department of Health and Human Services

SPECIAL PRESENTERS:

SENATOR ORRIN HATCH
SENATOR RON WYDEN
CAROLYN CLANCY, Director, Agency for Healthcare Research and Quality

CITIZENS' HEALTHCARE WORKING GROUP
April 11 and 12, 2005
Agency for Healthcare Research and Quality
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AGENDA

P R O C E E D I N G S

(8:42 a.m.)

CHAIRPERSON JOHNSON: Good morning, everybody. We'd like to welcome you who are members of our Working Group to our meeting this morning, and those of you who are not, we'd like to welcome you as well, and we're looking forward to a great time as we think through these important issues of health care together.

My name is Randy Johnson, and I work with Motorola, but I am also pleased to be chair of the Working Group, and my colleague Catherine McLaughlin on my left will be serving as vice chair. We will introduce ourselves a little bit later in greater detail, but why don't we just go around the table and those of you who are sitting along the edge of the table, if you will put your name tags out so they look like this (indicating) instead of this (indicating), that will help all of us up and down the row to be reminded of who you are, and we'll proceed with that.

Our agenda this morning will initially call for us to be sworn in as a Working Group, and we're going to ask Cassandra Browner to do that in

just a second, and then we're going to hear from Senator Orrin Hatch and Senator Ron Wyden regarding their perspective on the Working Group as well.

But before we proceed further, let me just ask each of you to introduce yourself, those of you who are Working Group members, and where you come from -- no more than 10 seconds each and we'll give you more time later -- and then we'll ask Cassandra Browner to introduce the oath of office to us. So, Christine?

MS. WRIGHT: Chris Wright, Sioux Falls, South Dakota.

DR. SHIRLEY: Aaron Shirley, Jackson, Mississippi.

MS. STEHR: Deb Stehr, Lake View, Iowa.

MS. PEREZ: Rosie Perez, Houston, Texas.

MS. MARYLAND: Patricia Maryland, Indianapolis, Indiana.

MS. CONLAN: Montye Conlan, Ormond Beach, Florida.

MS. HUGHES: Therese Hughes, Family Clinic, Los Angeles, California.

MR. FRANK: Richard Frank, Boston,

Massachusetts.

MS. BAZOS: Dorothy Bazos, Concord, New Hampshire.

DR. BAUMEISTER: Frank Baumeister, Portland, Oregon.

MR. HANSEN: Joe Hansen, Rockville, Maryland.

MS. CLANCY: I'm Carolyn Clancy, the Director of the Agency, and you'll be hearing from me a little bit more formally later today.

VICE CHAIR McLAUGHLIN: Catherine McLaughlin, Ann Arbor, Michigan.

CHAIRPERSON JOHNSON: Well, thank you very much. Cassandra, we will turn the next part of our meeting over to you.

MS. BROWNER: First off, thank you all so much for having me out this morning to do this. After 37 years of doing this, I still get excited. Thank you all so much on behalf of Stephen Perry, our Administrator. We certainly do appreciate you all letting GSA take part in providing this administrative support to the Working Group. That being said, would you all please stand, those to be sworn, please raise

your right hand. After "I", please all repeat your names and the oath after me.

(Whereupon, the members of the Working Group was sworn in en masse.)

MS. BROWNER: Thank you all so much. Would you please sign now your "Oath of Office". And again, on behalf of our Administrator, we thank the Working Group, and if you need anything from us in the administrative area, please, we are just a phone call away. Thank you.

CHAIRPERSON JOHNSON: Thank you very much. Well, thank you each again for joining us. We have had a number from Health and Human Services who have been working with us and helping us get started, and we also want to thank David Walker and Marjorie Kanof from the Government Accountability Office for their role in getting this project moving forward as well. But there were two people who worked to develop the concept of the Citizens' Healthcare Working Group earlier than any of us, and that is Senator Ron Wyden and Senator Orrin Hatch.

And just briefly, I'd like to introduce you to them, and then we'll turn our meeting over to

them to share their perspective on this Working Group.

Senator Hatch has been a member of the Senate since 1976. Now, when I think of that, that's almost 30 years. And I can remember, Senator Hatch, when you were dealing with health care in the '80s, and Senator Hatch has been a significant contributor on health care initiatives over his years in the Senate. A graduate of Brigham Young and the University of Pittsburgh, on a variety of committees that deal with health care -- the Senate Finance Committee, the Senate Health Committee, the Judiciary Committee, as well as on the Joint Committee on Taxation. So, we are just delighted that you are here today to share your perspective, and we honor you for your role in serving U.S. citizens in terms of health care and other issues nationwide.

Senator Ron Wyden came to the United States Senate in 1996 after serving 15 years in the House of Representatives. Graduate of Stanford, with a law degree from University of Oregon. Anybody who knows Senator Wyden understands his sense of passion on the health care initiatives, and we are the beneficiaries of that this morning. So, we thank you,

Senator Wyden. Serves also on the Senate Finance Committee, Select Committee on Intelligence, the Budget Committee, the Special Committee on Aging, and there's another feature that I found interesting in looking at his background, it's more important to me as I go year by year, and he's been a professor in the subject of gerontology over the years. So, we're glad you're here. And, Senator Hatch, since you have the seniority on Senator Wyden, we'll ask you to go first if you would, and we're just glad you're here, and we'll take whatever time you'd like to share your perspective.

SENATOR HATCH: Thank you, I'm delighted to be with you. I'm very respectful and appreciative of your willingness to serve on this committee. And of course, I want to particularly welcome Randy Johnson, the Chairman of the Citizens' Working Group, and Catherine McLaughlin, two excellent people who I think will do an excellent job helping us all to understand health care better.

I want to compliment Senator Wyden. He came to me a long time ago and said, "I have a really wonderful idea". And the more I looked at it, the more

I thought about it, I thought, well, you know, it's not a bad idea. Let's get a citizens' group that can work outside the congressional box because, as you can see, we've messed up a lot of health care in this country. We'll work outside that box, be independent, and really look at the real problems of health care in our society, and not be subject to parochial interest, and try to come up with a way or set of suggestions, or legislation, if you will, that will help us to save our health care programs in America. It's no secret that we're going downhill rather rapidly.

The President has mentioned that Social Security is a very, very serious problem as it is. There's no question we need to resolve some of the problems and conflicts of Social Security. But compared to Medicaid and Medicare, it's a zero problem. I shouldn't say zero, but it's a 1 on a scale with 100 being the most important. The fact of the matter is that we could find ourselves over the next number of years actually not being able to give the health care that we give today, let alone giving better quality health care for people down the line.

So, the assignment you have is a very,

very important assignment. The first thing you should do is ignore Senator Wyden and me. We should not be giving you our ideas, although we'll give you plenty of them this morning probably. You should ignore anybody and just look -- ignore anybody and pay attention to everybody. In other words, many of you have had distinct experience with some of the federal health care problems, but it isn't just the federal government, it's the State and local governments as well. It isn't just the large pharmaceutical companies, it's the generic pharmaceutical companies as well.

Long ago, we worked hard to pass in 1984 the Hatch-Waxman Act which created the modern generic drug companies and industry. At that time, generic drugs were like 16 percent of the total output of prescription drugs. Today it is over 50 percent. And we have saved consumers $10 million a year every year since 1984, and probably more than that today because of thinking outside the box and getting one of the leading liberals in the House, Henry Waxman, and one of the conservatives in the Senate, Orrin Hatch, to get together, bridge the faults and the problems and

the irritations and the complexities and the partisan politics, and do something that really does work.

Now, some people think we should adopt what I would call socialized medicine--that means everybody would get the same care-- but I think you ought to look at that very carefully. Others think we ought to adopt a total private system.

Doctors complain that they don't want to make Medicaid patients anymore just because of the paperwork. That's a big problem. If there's a way that we could somehow alleviate a great deal of the paperwork, we'd save a ton of money in the health care industry.

I might add that one of the biggest problems is something I had expressed when I was a younger practicing lawyer -- I defended doctors, hospitals, nurses, health care providers, et cetera, in medical liability cases. We would tell doctors when we lectured to them, "You should make sure you have everything in your history that could possibly go wrong, that you've examined that, so that your history shows you did not only the standard of care in the community which back in those days was the legal

liability, but that you went way beyond the standard of care.

Consequently, we all like defensive medicine, we all want defensive medicine. We want doctors to do their best to help us to rule out any and all possible problems -- but because of that, I estimated 25 years ago that there was $300 billion spent on unnecessary defensive medicine. We all want defensive medicine, but there's a difference between necessary defensive medicine and unnecessary medicine, and drawing the line is a very, very difficult thing to do. And I can't blame any doctor for wanting to go the full length of medical services to make sure to rule out any possible problem that might exist.

In the old days, if you came in with a common cold like I have -- they'd say take two aspirin every six hours, drink all the liquids you can, and in seven days you're going to feel better, or if you don't do anything, in seven days you'll feel better.

Today, if you go in with what you think is a common cold, they may have a whole battery of tests that they're going to do that run costs up tremendously because they can't afford to take the

chance that this might be the one in a million case where they miss some dread disease or some dread allergy or some dread problem that can lead to a lawsuit.

Now, if the American Medical Association estimates that there's about $67 billion in unnecessary defense medicine, can you imagine what it must really be, because they are never going to admit how much it really is. On the other hand, there are cases that really deserve huge settlements. I personally have seen -- these are top doctors, by the way--the wrong eye taken out, the wrong leg taken off, the wrong kidney taken out.

Now, I think we'd all agree that you can't have a $250,000 or $500,000 or $750,000 lid on damages, on noneconomic damages, if you have that kind of a problem. I had one of the top medical liability lawyers come to me recently and he said, "Senator, the only way to solve this problem is to have specialization" -- in other words, one must qualify to bring about a medical liability case -- because that gets rid of all the attorneys who are advertising for these cases, who really aren't good trial lawyers for

the most part. I would never go to an attorney that advertises, because if they have to advertise, they're not very good, to be honest with you. Now, there may be some good ones, but I haven't seen any.

The fact of the matter is that if you specialize, according to this top lawyer, you get rid of about 90 percent of the cases that are basically frivolous. Why are they brought? Because it costs between $50- and $100,000 to defend a medical liability case. Now, what does that mean? That means that if you have 10 or 20 of those a year as a practicing attorney, you don't have to be very good because the insurance company is going to want to settle for $50- to $100,000 rather than go to a trial and get a runaway jury that might hit them for hundreds of thousands, if not millions, of dollars.

Now, this is a problem that we have to resolve somehow in a fair decent way. It's one that you're going to find continually crops up as you go through the reviews throughout the country. You're going to listen to everyday people who are going to say that their biggest concern is health care. They don't know what to do. Some of them can't afford

insurance. Then you have our young people who think that they're going to be able to go on forever without any problems, so they don't buy insurance. Then again insurance is now costing an arm and a leg.

I remember about seven years ago, the head of IBM -- I was sitting at a dinner with him -- and he said to me, "Senator, we're paying $7,000 a year per employee for health care. If it goes any higher, we're just going to give them the $7,000 and say 'go find your own'". Now, they haven't done that, to my knowledge, but that's how serious it was then. Can you imagine what is it now where health care is approaching $12-1300 a month?

Now, I don't know of a group in my time in the United States Senate or in my work as an attorney that has a greater potential, or a greater obligation, or a greater hope than this group right here. You really are important. This isn't just another run-through. There are a lot of commissions that are ignored in the breach. You cannot be ignored if you really do this job well. And it can't be a liberal approach, can't be a conservative approach, it's got to be a right approach.

There are so many aspects of health care that we could discuss, and I've taken enough time. I just wanted to get out here, pay my respects to all of you for your willingness to serve, to our two co-chairmen for their willingness to serve and to hold these hearings all over America, to their company and university for being willing to let them do this, and for all of you because you are all busy people, that's why you're picked. Do you realize that of 500 applicants, you are the 14 who were picked--and you were picked because we think that you can do the job. We think that when you get through, you come up with a bunch of suggestions, Senator Wyden and I are willing to carry the ball and see what we can do to get those through.

Now, I haven't even touched on mental health. We're living in a day and age where we have a lot of mental health problems. I haven't touched on a lot of health problems, but mental health is one that could eat us alive if we don't learn how to handle it well. Even the medical school approaches are serious approaches. When I went to the University of Pittsburgh, it was one of the top medical schools in

the country – it still is -- where they were finding all kinds of breakthroughs. The University of Utah is also one of the tops in the country. One of the interesting things about the Huntsman Cancer Institute in Salt Lake City is that because of the LDS Church, the Mormon Church -- called the Church of Jesus Christ of Latter Day Saints -- which church has the best genealogical system in the world. They can go back generations in order to trace their illnesses. And so the geneticists are attracted to the University of Utah and Huntsman Cancer Institute because they can trace these injuries and these genetic markers all the way back. We need more of that kind of research. And as you know, there are some very, very important aspects of medical care that I'm not even touching on.

You really have an opportunity here, and both Senator Wyden and I are very serious about leaving you alone. We don't want the Congress of the United States to start dictating to you what you should look at or what you shouldn't look at. And we're happy to answer questions. We're happy to give you support, but really the best thing you can do is ignore us and every other member of Congress. That

doesn't mean you shouldn't read our articles or you shouldn't read what we have to say, but you should ignore us personally because you're more important than we are.

We haven't been able to solve these problems. Now, we've done a lot of good things. I can name a lot of health care bills that I've passed through the years, and a lot that Senator Wyden has passed. And in every case, we think they're pretty good bills. But it's clear that we haven't solved the problems. It's also clear that we're not in a position to solve those problems without help, but we are in a position to solve those problems if the ideas that you come up with are really great ideas, and they've got to make the practice of medicine, the practice of science, very attractive in the end.

As you know, our young people aren't going into science, engineering and science programs today, and engineering is a very important part of medicine, as you know. They're not going into it today. It's too easy to become lawyers. Some think it's much more lucrative to become lawyers. We've got to find some way in our educational processes to get young people

into the field of medicine, into the field of science, into the field of chemistry, genetics, and you name it. Maybe you can come up with these answers, and I think you can. And I want to compliment Senator Wyden for his dedication to this group. He really feels very deeply about it, as do I. He's an excellent Senator, and we're both going to be there as kind of adjuncts to make sure that we can break through some of the problems that might exist. If you have problems, all you have to do is get with us and we'll see what we can do to break through.

Now, last but not least -- there are a lot of other things I'd like to say, but I've taken enough time and we might want to have some questions. Last but not least, it is important that we analyze all of our current health care approaches not only from a Federal Government standpoint, but from a State and local standpoint as well. It is important that we find some way of encouraging the best of the best and the brightest of the brightest to go into these fields of science and medicine.

It is important that we think outside the box; and that even though an idea might sound screwy

at the time, it might turn out to be the burgeoning genesis of something that might answer a lot of problems. We hope that you'll send us things from time to time to keep us up to speed on what you're doing because we're the two who believe more in you than anybody else in Congress, and we're going to try and help you in every way we can.

Again, I just want to thank you for being willing to serve, for the expertise that you've acquired over the years, for the faithfulness to our country and to the people in this country who need help, and I just want you to know that we're very grateful to you. So, with that, I'll end and let my colleague Senator Wyden take over.

SENATOR WYDEN: Well, Senator Hatch has said it very well, and probably the only thing I differ with him a little bit on is: feel free to ignore me, but pay a lot of attention to what Orrin Hatch says.

SENATOR HATCH: Well, I can agree with that.

(Laughter.)

No, ignore me, too.

SENATOR WYDEN: If you look at the last 20 years in terms of health legislation, what's passed has been important, nearly always has Orrin Hatch's name on it including the Children's Health Initiative and generic drug legislation. He's played down his role in community health centers, which I think all of us would agree has been an extraordinarily important part of the health care safety net. So, you can live without my various and sundry proclamations, but you ought to pay a lot of attention to Senator Hatch as we go through it.

Let me pick up on what Senator Hatch has said and tell you that to some extent I see this effort as the equivaqlent of hiking in the health care Himalayas. You are out there trying to find a path through frozen debates that we have been having for decades. The way we got into this -- and Frank Baumeister, my old friend from Portland, knows about this because in Oregon we've had some experience trying to walk through choices in health care and I've spent about two years after the debacle of '93 and '94, the Clinton Plan, just kind of gnashing my teeth, I was so frustrated, as Senator Hatch was. Senator

Hatch and I wanted to get something done. We were so frustrated because we really felt there was a time when we could have done it. And I spent essentially two years going back and reading everything I could to try to figure out what went wrong. And I came to the conclusion that we basically tried the same thing for 60 years, six decades, and that's what we hope all of you will change.

If you look at the last six decades, and you can literally go to Harry Truman in 1945, and the 81st Congress, and compare it to Bill Clinton in '93 and '94, and literally for six decades the same thing was tried, and I would describe it as somebody important -- a president, or a chairman of a committee -- writes a bill in Washington, D.C. to provide health care to everybody. Tremendous fanfare.

The American people look at this legislation, kind of scratch their heads and go, "Boy, this is complicated, I can't figure this stuff out". Then the special interest groups attack the bill and each other, and it all dies. And it is just remarkable how for 60 years you're getting exactly the same thing, literally six decades worth, from Truman

to Clinton.

So, trying to build on some of what I'd seen in Oregon in terms of -- Frank, I think, will be invaluable to you in giving you some of that history -- Orrin Hatch and I started talking about something very different. It starts with something that nobody has ever done, which is to actually tell the American people where the health care dollar goes now. Nobody has ever done that, ever, ever, ever. It's astounding. Never been done.

So, because of the tenacity of Randy and Catherine along about the late fall -- I think Randy and Catherine are talking about October or something like that -- the American people will for the first time get this breakout where the health care dollar goes. They are going to be able to get it online. Nobody has ever done that. I think that's going to be attractive. But for the many people who are in senior centers and grange halls and the like who might not get it online, they are going to get it the old way, hard copies. So, that first step, which I suspect is going to be when people really see how incredible your work is, is going to be a very important kind of

process.

Then of course that triggers all of the steps in the statute. In fact, there's even a beginning step before the report, which is you have some hearings to educate yourselves and to gather information for the report so that the country knows a bit what you're up to as well. Do that first, then the report, then the public participation process. Two parts to the public participation -- one, the initial part after you come up with some preliminary findings, then you go back to them when you're essentially ready to report to Congress. Then you get to the last part which I think hasn't gotten much attention, but the statute says the committees of jurisdiction have got to hold hearings within 60 days after you're done. So, that means that if you follow the steps, we have an exercise, as Senator Hatch has said, that is not some setting up a commission on acoustics and ventilation or something -- you know, another federal commission -- but you have had public involvement and political accountability. Those are the four words that I try to use to describe the statute -- public involvement, political

accountability.

Now, nobody can force Congress to do anything, but what we hope is that we will have a citizens' roadmap at the end of this. We will have so much involvement from people in every part of the country that Congress will get this citizens' roadmap from all of you, and Congress will say, "Hmm, here's something now that we could really write a law that would provide health care for all Americans and the President of the United States would sign". So that's a very important point that Senator Hatch touched on. The idea is not to please Senator Hatch and Senator Wyden, the idea is to come up with a proposal that's going to provide health care for all Americans that Congress will pass and that the President will sign into law, and Congress will say out of all of this public involvement and the fact that people have been told how health care dollars are being spent--reforming the health care system without the information is like getting dressed in the morning in the dark. How do you do it? Well, that's what you have a chance to give folks the opportunity to do.

Now, I want to just give you a few of my

thoughts, just as Senator Hatch did, that come with the right to exercise your constitutional right to ignore.

The first is I come to this with a sense that we're spending enough money today to provide health care that works for all Americans. Last year we spent $1.8 trillion on medical care. You divide $1.8 trillion by 290 million Americans, and you could send every family of four a check for $24,000 and say, "Here, buy your medical care". What that means is that we could go out and hire an internist for every four families in the United States for the amount of money we're spending. That's an astounding thing. Go out and hire an internist for every four families in the United States and say, "Here, here is your personal internist. He or she does nothing except work for your four families". That's how much money we're spending on health care.

So, I come to this -- again, your right to ignore it -- with the sense that the biggest issue in health care is not should we spend more, but can we spend the dollars that are out there in the system sloshing around in a more cost-effective kind of way?

Can we get more for that $1.8 trillion than we're doing today?

A second part of this picks up on something Senator Hatch said as well, and that is that I think that one of the factors that has derailed health care reform in the past is what I call the "blame game". If you go to a meeting about health reform and legislators show up, they'll say, "Glad you're doing it". And if they are Republicans, they will say, "Ron, go to it, you're a good guy, independent, go to it, we can reform this health care system, just nail the trial lawyers. If you get the trial lawyers", the Republicans say, "that will work great". Then you go to a Democratic meeting to talk about health care reform. They say, "Oh, you're a good guy, got a lot of energy, we can get this done. Nail the insurance companies. If you get the insurance companies, that will do it". So, the Republicans say it's the trial lawyers' fault, the Democrats say it's the insurance companies' fault. Right away, the first thing that goes on is the blame game.

My sense is that part of what we need to

do to get health care that works for all Americans is try to persuade all of these powerful interest groups they are going to have to accept some measure of reform, but we're not going to tell one of them they are at fault. We're not going to get up one day and say it's the drug companies' fault, it's the insurance companies' fault, it's the trial lawyers' fault, it's the providers' fault.

If you want to play the blame game, there's enough to go around. I think that if you want to go that route, you can do it. My sense is that any successful effort will get beyond that kind of consideration.

The personal responsibility aspect of health care strikes me as very important. I think that's what the debate about health savings accounts has been all about, and flexible plans and the like. I'm sure each one of you has your own ideas about personal responsibility. One I'm attracted to is if you want to make it simple, have somebody pay on the spot every time they use a medical service in the United States, unless they are destitute. If they are destitute, you don't take any money from them, but if

they're not, somebody pays something when they walk into a doctor's office, a hospital, a clinic, something like that. You all have your own ideas about personal responsibility.

Something I feel very strongly about is cutting the administrative costs of health care. The literature says that people who are conservative think that administrative costs are maybe 6-8 percent. People who are liberal, who are for single-payer systems, say it might be 50 percent. Well, maybe it's a third. You all will make your own judgment about that. But if we're spending a third of the health care dollar on administration and it's $1.8 trillion we paid out last year, that's $600 billion on forms and paper and bureaucracy and red tape. I bet you all can tell us a lot more horrifying stories than we know.

I think that part of this has got to focus on what works in health care. I hope that you can be a force post-Terri Schiavo in helping to bring the country together because I think we understand that the country is polarized. Much of the health care dollar gets spent in the last few months of somebody's

life. The best doctors and the best hospitals tell us that in many of those instances they can't be medically effective and they can't do anything to make the quality of the person's life better. So, what you all recommend to us in terms of spending on what's medically effectively, what produces better quality of life for our citizens, I think would be very important.

It was difficult three months ago, I think it is even more difficult now, given the divisions in our country with respect to this tragic case involving Terri Schiavo, but I think this is an area where you could make a big contribution.

Finally, I think there's a great opportunity just in terms of getting understandable information out to citizens about health care as part of a reform effort. I mean, health care doesn't even resemble English, when you look at it. When you look at the verbiage and the words in the contracts and the like, and you'll have your first crack at doing that in terms of the health care report, but again you'll have much better ideas than I can convey in a few minutes here, but making this understandable to people

is obviously a big part of this.

Randy and Catherine, of course, your point people, are going to have their hands full, and we're grateful that they've been willing to do it. I met with Secretary Leavitt, who is of course a close personal friend of Senator Hatch. I think we're very fortunate to have the Secretary's support.

Where is Larry Patton? Larry has just been fantastic. Pattie DeLoatche and Stephanie Kennan, from Senator Hatch's office and my office, are available to you as well. Both of them have good radar in terms of what somebody in Congress might think about something, so if you're ever interested in that, if you pick up a particular idea or not, I'd urge you to call Pattie and Stephanie and take their temperature on something.

Carolyn Clancy, many thanks to you for being so helpful, between you all and Larry, the detailees, are being brave and jumping in where nobody has gone. I will tell you I personally think we've got an opportunity that you don't get and isn't going to come around again anytime soon.

When I was director of the Gray Panthers

for seven years before I got elected to Congress, I sort of dreamed that I could be part of this. And after six decades, folks, of trying the same thing -- I'm going to close with this -- what we want to do now is to figure out a way to build the public in and to make it so attractive that after that citizen involvement aspect, you then have the kind of political accountability where great coalition-builders like Senator Hatch -- I mean, what will really be the litmus test to this is if the kind of product that comes from the citizens has the most influential people in the Congress, people like Senator Hatch and Senator Kennedy, say, "We can work with this. We can really make something out of this".

Nobody builds a coalition in the United States Senate better than Senator Hatch. Senator Hatch and Senator Kennedy have done it time after time. There are some young Turks like me that can be of help to them, but that's what I hope we will do, is to get a kind of citizens' roadmap so that Senator Hatch and Senator Kennedy and people in the Congress with gavels in their hands are going to say, "This is really something we can build on". I personally think

we could have done this in '93. In fact, you'll probably see -- Catherine has seen it -- floating around in the files, a letter from Bob Dole and Bill Bradley who were then on the Senate Finance Committee, and Bob Dole said, "If we had done this in 1993 and 1994, we'd have gotten a bill. We'd have made it happen". That's what people who were there then have said.

So, end of my speechifying, and many thanks to all of you. Buckle your seatbelts, folks, this is going to be a different sort of ride, but one where I think there's a chance to produce something very exciting, and thrilled all of you are going to do it.

SENATOR HATCH: We'd be happy to take any questions that they might have.

CHAIRPERSON JOHNSON: Just before you do, let me reintroduce Pattie DeLoatche, who is kind of walking across the back of the room, who is a very capable individual working with Senator Hatch, and Stephanie Kennan over here, who is similarly capable of working with Senator Wyden. Both of you have been very helpful, and we appreciate your contributions to

our group already, and I just want to make sure the Working Group connects the name with the face before you leave.

Questions for Senator Hatch or Senator Wyden?

(No response.)

I'll get the ball going a little bit, Senator Wyden, with you. I've heard you say on a couple of occasions "tell us where the dollar is going for medical care". I'm assuming that you mean it's going this amount to trial lawyers, and this amount to -- more than this amount to trial lawyers and this amount to insurance companies. Can you build on those comments a little bit, please?

SENATOR WYDEN: Randy, you know, my sense is you'll start with sort of the big areas -- Medicare, children, private insurance, various government programs -- and then I hope as you all go forward you can get it down to areas where there's overlap and duplication and places where people might say when they see it online, "Holy Toledo, we've got to change this". I mean, people like Frank Baumeister and physicians -- my sense is if you have a clinic

with five docs in it in Iowa or Oregon or somewhere, you might have two people who do nothing except sit on the phone trying to pry information out of insurance companies about their matrix to figure out what they're going to cover.

So, I think, Randy -- and I want to hear what Senator Hatch thinks on this -- the idea of starting with the big areas, the big ones up on the canvas -- what employers are paying, and what's paid for Medicare and VA and Medicaid -- and then to sort of break it down from inside with a particular eye on areas where you think there are inefficiencies and duplications, and the opportunity to produce savings. My guess is that particularly in administrative areas, -- I mean, people tell me now that as we go to electronic medical records, for example, just the fact that we have had such a crazy quilt of rules and programs, that we've got a lot of systems that aren't interoperable and we're wasting money just there. But start, in my view -- and I want to let Senator Hatch speak on that -- with big items and then sort of break them down. Orrin, do you want to add to that?

SENATOR HATCH: Well, one of my very close

friends was building the first fully digital integrated hospital for Health South, when Health South went south there for a while. I was really interested in that because I wanted to see if they could actually put it together so that they could save an awful lot and be much more accurate in prescriptions and other health care approaches.

There's no question we're going to have to go to a system that really works. And I don't disagree with Senator Wyden that you start with the big programs-- I mean, let's face it, Medicaid and Medicare are in trouble. They are very, very important programs for our society. But I was shocked -- my wife recently had a knee replacement, and I was absolutely shocked at how much that cost. I hadn't heard of many people having knee replacements until she had hers, then almost everybody I knew had a knee replacement, and those costs were multiplied extraordinarily. It's going to be very, very difficult to come up with an overall approach that basically saves money, makes the system very efficient, and gives incentives to people to be part of a system, and that's going to be a very tough job for you, but it's

one I think you can handle.

Some people think, well, just have universal health care. Everybody does the same thing, we all get the same health care. Then there's a tremendous argument against that on the other side. We found many times in Congress bridging the gap between the private sector and the public sector is very important.

I'll give you another illustration. I was at dinner not too long ago with a bunch of hospital leaders in this country. One was from HCA, the largest hospital chain in the country. And I asked him, "How much uncompensated care do you give a year?" And he said, "$800 million a year", that they have to absorb in their system. You wonder why you're paying four bucks an aspirin? Well, there's your answer. I probably shouldn't have chosen that illustration, but literally these hospitals are giving a whopping amount of uncompensated care because people don't have insurance. On the other hand, some of the people who don't have insurance could afford to have it.

One reason that I and Senator Kennedy came up with the CHIP bill, the Child Health Insurance

Program, was because these were the only kids left out of the system, they were the children of the working poor. Everybody else -- the poor were taken care of by Medicaid -- but everybody else was taken care of. That system has worked very, very well, but I can remember the tough time we had to bring that through.

The new litigation -- just so you know this -- the new litigation that's going to cause health care plenty of ulcers is the fact that a lot of nonprofit hospitals have been paying huge salaries and putting monies offshore in the Cayman Islands and elsewhere, while at the same time giving uncompensated care but then dunning the poor to death trying to make sure they never come back. In other words, they scare them to death so they don't come back. Now, that's the new tobacco lawsuit.

Now, I don't mean to bring things down to such a base level as that, but that's something we're going to have to face -- how do we solve this problem of uncompensated care and be fair to those who provide it, without having government put more and more regulations on everybody so that it costs an arm and a leg? These are tough problems. And I have to say

I've spent 28 years -- I'm now in my 29th year in the Congress -- working on health care problems, and I haven't been able to solve them all, and neither have those who have worked with me and with whom I've worked, neither has anybody else in Congress.

So, we're giving you an overwhelming responsibility that I really believe practical, decent, down-home citizens could help with. Fifteen years ago I passed a bill called The FDA Revitalization Act. The FDA is in better than 30 different locations over the Greater Washington Area. Some of them in converted chicken coops. You wonder why they haven't hired a top researcher in the last 40 years? That's the reason. They want to go to NIH, they'll even go for less money than they can make in the private sector because of the prestige of working for NIH, but they don't want to come to the FDA. So, the FDA now takes up to 15 years of patent life and a billion dollars for a prescription drug to come through the process.

So, what I did is, I said, "We need to revitalize FDA and create a central campus with state-of-the-art equipment, digital equipment if you will,

among others, that will entice the best of the best to come work for FDA. FDA handles up to 25 percent of all of our consumer products in America. We treat it like an illegitimate step-sister. Well, it just started. We dedicated the first building in December of 2003. But it's going to take ten years and probably $3 billion to get it done. It would have taken ten years and $1 billion if they had moved right in after Congress, once we passed the FDA Revitalization Act.

Can you imagine what that would do to maybe bring drug costs down if we had more efficiency in the system and we could bring that loss-of-patent law? You wonder why drugs cost so much? Basically, drug companies have five years to get their research and development costs back for those billion dollars that they spent over 15 years, with 6,000 missed and failed experiments to get to the 1 success. Now, these are the kind of practical things that you're going to have to get into. Plus, the new world of science and medicine that is way beyond what anybody in this room thinks today. You're going to find that is going to crop up, too, as you meet with the top health care providers.

You have some terrific support with your staff and others on this Working Group. I am very excited about what you're going to do. I really believe that you, with your practical wisdom, knowledge, and expertise, will be able to make some very profound suggestions, maybe even create an actual set of bills or bill that we might be able to carry, Senator Wyden and I, and really put the pressure on the whole Congress.

It's amazing to me how many people decried this Working Group at first, but how many of them are now looking, sitting back and saying, "Gee, I hope it words", because if it works, you will have saved America, at least in health care, but I think in much more than health care. Ron was right in how much the total costs of health care really are in our society today. It's unbelievable how high it is. And like you say, the answer is not to give everybody $24,000 and say "get your own health care", the answer is for us to find a system that's efficient, scientifically sound, workable, with a minimum of bureaucracy and paperwork, that encourages people to get into the field and where we have a system that might help solve

this medical liability problem that is a much bigger problem than most of my colleagues really understand or think.

And it isn't just as simple as trial lawyers and insurance companies; Ron knows that as well, we both know that. It's a very, very serious problem. If you can solve that problem, you may be well on your way to solving many, many other problems in health care that drive across beyond across beyond where they should be driven.

We are both going to take a great deal of interest in what you do. I hope that you'll keep us informed through Stephanie and Pattie. They are two of the best health care people on Capitol Hill. They both work their guts out. These are not 40-hour-a-week jobs, these are like 100-hour-a-week jobs, and these two are so dedicated that we want them to listen to you, not tell you what to do. And I don't want to tell you what to do, and neither does Ron. But this is really important. This is the first time we've tried this. And if you hold these hearings all over America and you hold them with everyday people, but also the top scientists and the top medical researchers, the

top computer specialists -- I can see one on the Redmond Campus with Microsoft -- I can see you going to IBM to find out what they've got on their minds. I think you're going to be so fascinated with this, that some of you may get lost in it; it will be so interesting to you. But the key is to come down with practical solutions in the end that will help us to maybe carry the ball and, if in the end you get something done here that we can carry the ball on and get enacted, you're going to go through the rest of your life saying "I did it, we did it, and we've helped save our country."

So, this is important, and I just appreciate all of you. We're taking too much time to answer these questions.

CHAIRPERSON JOHNSON: Well, are there other questions? If you have a couple more minutes, few more minutes, other questions from our group.

VICE CHAIR McLAUGHLIN: I actually have a question that follows from what you were saying. The reality is we have two years to do a lot, and some of the examples the two of you have given are at a very global level, and some are, as you just said, at a

very specific level.

Is the expectation that we come up with recommendations as specific as some of the examples that you have just given, or -- do you understand -- or a more global set? I worry that if we get too detailed, that not only will we have the problem that Senator Wyden mentioned of the public saying "what is all this", but if it's not detailed enough, it's too easy for it not to go anywhere?

SENATOR HATCH: Well, you have to do both. There's no question you have to look at it globally, but you also have to look at practical solutions. If we don't have any practical solutions come out of this, then your work will be wasted. If all we have is esoteric concepts, our difficulties in getting a health care bill through will be magnified beyond belief. Then we've got to do all that work. Now, I'm not against doing all that work if you can tell us which way to go and so forth because we do it all the time, but I'd sure like to have the best suggestions you can possibly give us, and I think you've got to do both. You can't ignore the global, but you can't ignore the finite either. Then again, we can't expect

you to be saviors from on high to solve every problem in health care in just two years.

VICE CHAIR McLAUGHLIN: But we're hiking through the Himalayas.

SENATOR HATCH: That's what Senator Wyden says and, if he says it, it must be so.

(Laughter.)

SENATOR WYDEN: I want to make the trek with all of you and Senator Hatch. Here's how I've come to feel about that, Catherine, and it is something I've given a lot of thought to, as has Senator Hatch. You're trying to strike a balance between asking people in Des Moines and Tallahassee do they want to pay 6.2 percent FICA or do they want to pay 5.8 percent FICA, which obviously nobody can sit out there and ask themselves this kind of thing, and going the other way, do you want quality health care for all Americans -- those are the two extremes, micro detail and essentially platitudes.

What I hope you'll do -- and we can give you some of this in terms of what we saw in Oregon which was a different setting -- is to try to give people enough information so that they can understand

the choices and the tradeoffs. I mean, a big part of this, folks, is walking people through the choices and the tradeoffs in a big picture sort of way. For example, if you want this particular service and you want to stay within the confines of the amount that's being spent, are you willing to give up something else. And I think if you do it that way, you can get in the ballpark of what Senator Hatch is talking about.

It's enough that it's really helpful for the Congress without bogging people down in things that are just incomprehensible. That's why areas like administration and shared sacrifice and the like -- I think we ought to learn something. I think that after the Terri Schiavo case we'll see that more people want to spend more on hospice and programs that unite people rather than the divisive ones. I think this is, in my view, about giving people enough information so that they can really make choices and tradeoffs. I mean, would they be willing to pay more out-of-pocket, for example, in order to get a richer benefit for people? There's a perfect example of a kind of tradeoff that you would have to make. We all know

that we want Cadillac health care for Studebaker prices, I mean, that's kind of how we got into this, but I think --

SENATOR HATCH: Studebakers are pretty expensive today.

(Laughter.)

SENATOR WYDEN: Now you can't get anything in health care or anywhere else for those kinds of prices. I think there's a reason for the title in this bill called "Healthcare That Works For All Americans". It took Senator Hatch and I three months just to get the title of the bill, if you can believe it. Some people said it should be "Access", some people say, "Oh, some kind of National Healthcare", well, "Healthcare That Works For All Americans" was agreeable to all concerned.

This is not, as Senator Hatch has said, just about the uninsured or about technology, all of those are parts of it. This is about healthcare as an ecosystem. What you do over here affects what you do over there -- I think, Catherine, to the extent that you can walk people through the choices and make sure that they come to these hearings and say -- this is

one of the things that I woke up a few times as we did it, at night saying, "My God, are people going to come to these hearings and say, 'I really like Senator Hatch, I really like Senator Wyden, and I want a lot of chiropractic', and then people in the audience who like chiropractic clap and everybody goes home?" That's not what the community meetings are about.

The meetings are about trying to get people to swallow hard and say, "I'm trying to think about what it's going to take to create healthcare that works for all Americans, and I showed up in this drafty hall in Minneapolis or spent 45 minutes online, with the idea being I think I've got to say we're going to give this up in order to get that", and that's right, to me, at the heart of this exercise, is it's kind of forcing all of us to do what we've never really wanted to do in health, where we just say we want it good for our families and our loved ones, we want them to have good care, and we want to have a lot of it, and now we're trying to tell them it can't really be that way if you want healthcare that works for all Americans at their choices.

MR. O'GRADY: Back to Senator Hatch's

point for a second about this idea being both general and specific in terms of just trying to think of what that might look like at the end of a couple of years. If there was something like nine principles, things that focused on major things like making folks more prudent consumers of their own healthcare, health IT, some of those sorts of things, and then underneath sort of those more global principles there were four or five very specific steps that could be taken. Is that the sort of product at the end of this process that would meet their needs?

SENATOR HATCH: Go ahead.

SENATOR WYDEN: I just don't want to filibuster. I don't think that maximizes --

SENATOR HATCH: I don't know why he doesn't want to filibuster --

(Laughter.)

SENATOR WYDEN: I don't think that maximizes your potential. I sort of started and walked backwards. Here's where the $1.8 trillion goes, and then just make a list almost at the beginning of all the areas where you might spend it more efficiently. In other words, if you did nothing

else, you said here's where the $1.8 trillion is today. You tell everybody here are some opportunities for changes and the like, and then you start with a list of things where you might end up spending $1.8 trillion. If you start with something like that rather than with the principles, that would be my sense in terms of trying to strike a balance. But you all are going to find your own way on this. It is, kidding aside, in the Himalayas, and nobody has found the right path, but you know some things, for example, about why people are falling off mountains in the past, and some precautions to take and that kind of thing, and that I think would be my seat-of-the-pants, and maybe Senator Hatch has a different thought.

SENATOR HATCH: I appreciate all that Senator Wyden has said, he's an excellent leader in healthcare. I don't think there's any one way you can do this, and you're going to have to come up with a way of doing it, and you have to make those decisions. But I remember -- just one illustration. I remember in India people would line up for their prescription drugs 500 at a time every morning until they charged a quarter. The next day there were only five. You

don't even have to get into mundane things like should there be a co-pay to make the system fair, so people don't over-utilize the system.

That's a very modest thought, but it's a very important one -- should we have a co-pay? Should this $800 million in uncompensated care that HCA goes through every year, shouldn't those folks have to pay something as they go to those emergency rooms? Should they have to at least sacrifice something? To me, and to those who think like I do, it doesn't have to be very much, but it has to be something that says to them "this is costly".

Now, that's a whole discussion that you might want to go through, do we have co-pays and, if we do, how do you make them fair and how do you do it? You'd be shocked how many people go to multiple doctors for pharmaceuticals that may be playing against each other. You know that, Doctor, but it's shocking. What do they say, 45 percent of America is on prescription drugs? That's shocking when you stop and think about it, yet you reach my age and you're bound to have to take some prescription drugs, there's just no question about it. But all of this, of course,

causes the cost to rise.

Now, I think you've got to look at it globally, I think you've got to look at it narrowly, I think you've got to look at it pre-enterprise, I think you've got to look at government's role, and hopefully you can balance all those interests and come up with a way of making a system that will not be overutilized by people but will take care of those who truly need care.

Again, I cite to you the overwhelming problem of mental health in our society today. We haven't been able, as members of Congress, to come up with answers there because the costs are always so expensive. Senator Domenici, who is an advocate – as am I -- gets depressed every year -- to use a mental health term -- because he can't get his legislation through because the costs are so overwhelming in this day and age, and yet we're finding we have the greatest pharmaceutical help for mental help that we've ever had in the history of the world.

So, how do we afford those? How do we get the cost of drugs down? How do we get the cost of healthcare down? How do we get the paperwork down?

How do we get the Congress to be more responsible? How do we get the medical liability problem solved so that it's not eating the system alive? This is exactly what's happening today, in my opinion, and it may be partly the insurance companies' fault. There's no question in my mind, as a trial lawyer, that it's definitely partly the trial lawyers' fault. I think a lot of that started when trial lawyers were able to advertise, when the Supreme Court said they could advertise rather than practice the profession without advertising.

So, you may come up with a suggestion that lawyers should not be able to advertise. Now, the Supreme Court says they can, so you'd have to come up with a very, very unique suggestion to get around that problem, but I'm just throwing out a bunch of ideas that are on the surface just to kind of get you thinking how important your job really is.

Now, what I don't want to have happen is that you get discouraged because of all the crap we're throwing at you because we're throwing a lot of stuff at you, and you think, "Holy cow, they can't do it and there's 535 of them and there's only 14 of us." Well,

I'll guarantee you, the people generally can do things better than Congress as a whole, I'll put it that way, but Congress can do some wonderful things if they are given the right ideas. So, you're our key to the right ideas. And I for one am so grateful to all of you for being willing to serve, and I hope you'll make every meeting. If you can't, we understand, but I hope you make every meeting. I hope you'll participate.

I hope that you'll take it upon yourself to realize -- sometimes you don't want to speak up because you might think they think your comments are not important. Don't ever think that, all comments are important. And you'd be surprised, if this is going to work, it's going to be because people are concerned about the average American, not the average Senator or Congressperson. I just want to thank you for your service.

I certainly want to thank Senator Wyden, who I happen to love and care for very much, for his zeal with regard to this Working Group, and I think you'll find that I'm just as zealous as he is because when I get the bit in my teeth, there's nothing going

to stop me from getting it done. And I'm hoping that you'll put the bit in our teeth and help us to get this done in the interest of our country. It's the difference between saving our country or having us go the way of all flesh, like some great countries have gone in the past. We've got to solve this problem, it's absolutely monumental.

MS. MARYLAND: You mentioned I am actually sitting here a little overwhelmed with the task that we have before us, and I am a little concerned then over the two-year period of time that we're to put together a report, I hope there is an opportunity as we start to present or start to formalize some of the recommendations, that we have an opportunity to bring those forward to your group, and maybe even to see if there is some support perhaps in Congress to start to have these ideas presented to them --

SENATOR HATCH: That's a good point.

MS. MARYLAND: -- because what I would hate to see happen is after a two-year period we've done all this work and it's like in '93, it would be a failure. That would be very disconcerting to me.

SENATOR HATCH: Well, that's something you

should always keep in mind because '93 was an overreach in the eyes of most people, I think including Ron and myself, and it was a move towards what the Republicans thought was socialized medicine. But there were many good ideas that came out of that, some of which are law today. There were a lot of lousy ideas, too, in my humble opinion. But I think it might be good every once in a while -- I don't want us to interfere with your work at all -- but if you felt like you wanted to come down to Capitol Hill or here and just pick our brains, we'd be happy to do that. But I'm going to try to not tell you what to do. I mean, I've given you a lot of suggestions on what you might consider doing, but I'm not going to tell you what to do unless you ask me. Now, if you ask me, I'm going to tell you what to do because I know how to do it all, to be honest with you.

(Laughter.)

I'm just kidding. Nobody knows how to do it all, that's why you're here. And, frankly, each one of you brings to this table and to this Working Group a whole set of life experiences that could benefit the whole country, if you can all work

together. If I hear of any fistfights -- even that's good sometimes, but not very often -- but I just think that nobody should be afraid to speak his or her ideas. Sometimes the greatest ideas come from the most simple practical suggestion, and I can give you a lot of bills that are law today that came from simple practical suggestions from experts like you.

So, you know, we sometimes get lost in the thickets in the Congress because of all the conflicts and problems that we have. But you'd be shocked, if you come up with a really workable approach that America can accept, the whole Congress is going to be afraid to ignore what you come up with. And Ron and I will make sure that they are afraid, we'll see to it for you. And I think the key is to be open, to be open to all ideas, and to not think anybody's idea is stupid, and of course to have regular working meetings where you're just sitting down and brainstorming together as well. That's up to your two co-chair people, but I think you can do a lot in those type of meetings as well, after you've had a lot of hearings and so forth.

But I just want to again thank Senator

Wyden for allowing me to work with him on this and for the hard work he does in Congress, especially in healthcare, and I want to thank each of you again for your willingness to serve. This is a terrific thing, I'm really caught up in it myself.

SENATOR WYDEN: Randy, can I pick up on this just for a second because I think Senator Hatch really was instrumental as we wrote this bill in making sure that you went in with a clean slate. For example, along the way I would have one idea or another, Senator Hatch would sort of take me aside and say, "Ron, that's a good idea, but you can't start skewing the kind of process, this is supposed to be a clean slate for the citizens". So, this is not something like in '93 and '94, Bill Clinton produced 1,290 pages that was so dense it was sort of incomprehensible, and that was a big factor in it not going forward.

You can bounce ideas at any step along the way off us, and Pattie and Stephanie are available to do it. Randy and Catherine, as we talked, we found that Senator Dole and Senator Kerrey, Bob Kerrey, are available to have you bounce ideas off them, and both

of them have been involved in talking with Senator Hatch and I about it, and you can just call them up and say "what do you think" about this or that.

SENATOR HATCH: Both of them are very innovative as well.

SENATOR WYDEN: They are both innovative, they both have indicated that you can just pick up the phone and they'll be happy to take your ideas.

And I guess the last point that I want to mention goes back to your point about sort of how do you deal with principles and the like. If you almost draw a sheet of paper right down the center, and you say here is what we want people to have and here is what chunk of the $1.8 trillion we are willing to devote to that, I think that might be a way to get into this that helps to simplify it. And the two of us are available particularly on this point because how you go to people and talk about it in something resembling English that they can participate in is key. As I've been listening this morning and thinking about your question, this is what the Working Group says you want citizens to have in this country for healthcare that works for everybody, and this is what

portion of the $1.8 trillion you are willing to devote to it. Those kinds of things might be a way for you to take this extraordinarily complicated exercise and put it into a manageable package.

SENATOR HATCH: We've taken too much of your time. You were supposed to have a few minutes to relax before -- and after listening to us, I'm sure you need a few minutes to relax --

CHAIRPERSON JOHNSON: Well, we want to express appreciation to both of you for joining us and for initiating the legislation and for your foresight in inviting participation from American people as well, and we'll do our best to represent the intent of the legislation and come back to not only you, but others on Capitol Hill and with the Administration, with a product that will represent the American people as well. So, thank you very much.

SENATOR HATCH: Thank you.

SENATOR WYDEN: Thank you.

(Applause.)

MS. CLANCY: Before you two leave, I've been asked to ask you if you would please stand with the group for a photo.

SENATOR HATCH: Sure.

(Whereupon, a short recess was taken.)

CHAIRPERSON JOHNSON: Okay. While we are reconvening, let me introduce to you the staff who have been working with us and will be working with us, in addition to those we've mentioned already. The first some of you have talked with already and met -- Larry Patton, who has been assigned to work with us on a variety of issues, and we've gained a whole lot of input and excellent consultation working with Larry already.

Ken Cohen, who is sitting in the back row over here -- that's the "sinner's row" in many churches -- Ken's a good guy even though he's sitting in the sinner's row -- and he's going to be working with us in a variety of ways; Andy Rock and Caroline Taplin, over here as well, working with us from the staff. In addition to that, Mike O'Grady, who is from Health and Human Services, is going to be representing Secretary Mike Leavitt on our Working Group, and we're pleased already just on the conversation that we've had, Mike, that you are with us.

Larry, just to make sure that we're all in

sync and we're doing what we're supposed to do on these forms, do you have any further instruction or are there any questions regarding these forms that we're in the process of completing?

MR. PATTON: I am just going through the forms, just double-checking to make sure everything is done, and what I'm giving you one by one now are just your W-2 withholding forms for the pay that you'll receive from here, if you want to fill it out. If we have a State form for you to reflect the State withholding also, and hopefully we've done that right and matched up the States. But that's the only other thing that we'll want -- and if anyone did not have a chance to do direct deposit and wants to send it to us later, that's fine, too.

MS. HUGHES: I don't have the W-2 form.

MR. PATTON: I'm giving those out now one by one. I'm just going through the folders and pulling them out because we didn't have -- the one thing that I wanted to stress is that the race form and the disability form, it's only until they put it into the system to try to assess ongoingly the fact that commissions are appropriately representative.

The information about you is destroyed as soon as it's put in. It goes in anonymously. They are just verifying that we've collected it from the people who are here. Other than that, it gets destroyed.

CHAIRPERSON JOHNSON: And later tomorrow, Larry will be updating us on even more information regarding how we'll coordinate with some of the government in terms of travel expenses, ethics, and so forth. In fact, that gives us a good opportunity right now.

Why don't we look at the agenda together and we can talk about how we're going to proceed, and I'll do this initial discussion, and then Catherine McLaughlin, who has been working carefully and closely and collaboratively with us, will also share some of her thoughts and welcome as we get started. But we'll do that, and then what we're going to do is we're just going to walk through the legislation requirements. Some of you have seen it, some of you have looked at it in layperson's language, but we'll walk through the agenda of some of the legislative requirements.

Following that, what we're going to ask you to do -- and you can begin to think of it -- is

ask you two questions: What made you decide to apply to be part of the Working Group? And then, what are the issues that you see in healthcare today? What are the healthcare issues that are faced by American citizens? And Senator Hatch and Senator Wyden have already shared some of their perspectives, but we're going to ask you for yours as well. And we'll actually collect your ideas, your input regarding that, and that will then serve as a foundation for some discussions later on today in which we talk about what are some of the initiatives that are out there already that we see addressing some of the issues?

Toward the end of the day, we have asked Carolyn Clancy to join us, and she'll be sharing some of her perspectives from the Agency of Health, Research, and Quality, and if you haven't already learned, you'll find that Carolyn really is expert on this whole subject of healthcare quality and research. So, we're looking forward to that.

Tomorrow we will reconvene and we'll spend most of the day talking about what's our approach to this task. And Catherine and I will be just taking us through some dialogue with you regarding how do we

approach the task that's in front of us, and we'll focus principally tomorrow on the hearings and the potential initial paper.

Now, there are other discussions that we'll have with respect to community outreach, town hall meetings later on, so forth, but tomorrow our focus is this initial series of hearings and the initial report that we develop, and some of the logistics that will be surrounding that.

Toward the end of the day tomorrow, Larry Patton and others will brief us on things like something called FACA. If you don't know what FACA is, we're going to learn more than probably we want to know, but it's important to know it, because we're going to have to comply with it. We're going to ask that you participate carefully on that. What are documentation requirements, some of the ethics rules that we'll need to be considering and following as we're participating in the Working Group, and then travel arrangements and so forth.

So, that's our agenda. We'll deal with other organizational matters tomorrow afternoon before we adjourn at 3:00 o'clock. Any questions regarding

the agenda at this time?

(No response.)

You want to add words of whatever?

VICE CHAIR McLAUGHLIN: Of welcome?

CHAIRPERSON JOHNSON: Yes.

VICE CHAIR McLAUGHLIN: I guess as some of you have already heard that after hearing this morning, I'm not sure whether all of us should flee for the door with our hiking boots on, for the Himalayas.

But when I first read this public law, I must admit I was overwhelmed by the list of things that we were to look at, and it never occurred to me that I would end up being on the group that actually has to do all this. I suspect all of us are facing this with that same ambivalence. We're really excited and flattered and thrilled that we were called to this task, but also somewhat concerned about our ability to do this. And I guess in the last couple of weeks that Randy and I have been talking and meeting and meeting with the staff, I've become more and more convinced that we can do this, and I'm not sure what the "this" is yet, but that's part of why we're here, and I am

excited to get going. As some of you have met me know, I'm one of these people that puts on running shoes and just gets running. And so I am really looking forward to this and have been -- all of us I think have been excited about meeting here today and starting to get some ideas going.

I am going to be looking at a lot of the stuff to go into the report, and I just want to make it clear, echoing what Senators Hatch and Wyden said, the staff really need input from all of us. I think the only group that's not represented around this table are the young people. Senator Hatch was talking about the young people who think "why do I need insurance", and I guess they just decided not to have a 25-year-old on the Working Group, but we really need to all give our input to Ken and Andy and Caroline and other staff as they come onboard, to make this really work. So, I hope that all of you are going to be active and not just come to the meetings, but send e-mails and telephone calls and contribute.

CHAIRPERSON JOHNSON: Okay. Thank you very much. Why don't we just go through the legislation, make sure that we all understand it, and

if you have questions, please raise them, and if Catherine or I are not able to respond to them, we'll ask Larry or Ken or even Senator Wyden, who remains with us at least right now, to share thoughts and so forth.

So, first, the legislation that we have in front of us has come out of the Medicare Modernization Act, and it calls for a nationwide public debate about improving the healthcare system to provide every American with the ability to obtain quality affordable healthcare coverage and, at the end, to provide a vote by Congress on the recommendations that will result from the debate.

As a result of that, we are asked to hold hearings to examine a list of subjects, and we are going to show you the list of subjects on which we'll hold hearings in the legislation. The subjects are listed in the legislation. However, we can add additional subjects to that, and we'll be talking about that as we move forward.

And then we are asked to prepare and make available to the American public The Health Report to the American People, and as we've already heard, it's

our intent to communicate that using a Web site and other methodologies, and we'll talk more about how that might happen as we move into our meetings.

Another phase is to hold healthcare community meetings throughout the United States, and those meetings will be what I would call Phase 3 of our initiative, and again we'll talk more about those as we get into our discussions and, ultimately, to submit recommendations to Congress and the President for their review of our findings.

Some of the subjects to be considered in the hearings as directed by the statute are: First, the capacity of the public and private healthcare systems to expand coverage options, what kind of capacity is there to expand coverage options; to learn about local community solutions to accessing healthcare coverage; third, efforts to enroll individuals currently eligible for public and private healthcare coverage; fourth, to look at innovative State strategies to expand healthcare coverage and lower healthcare costs; further, to look at innovative State strategies to expand coverage; cost of healthcare and effectiveness of care provided at all

stages of diseases; strategies to assist purchasers of healthcare, including consumers, to be more aware of the impact of costs and to lower the cost of healthcare; and the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology and supporting providers in improving quality of care and lowering costs.

So, those are some of the subjects that are required by the statute. In addition, the statute says we may hold additional hearings on subjects other than those included in the statute, so long as we determine that they are necessary in meeting our charge and, secondly, they don't delay the other activities of the Working Group.

So, as we proceed later this morning and this afternoon and tomorrow, we'll be kind of beginning to think of what other subjects we might want to hold hearings on. Yes, Aaron?

DR. SHIRLEY: Quick question. For the purpose of the statute, define "coverage".

CHAIRPERSON JOHNSON: For the purposes of the statute, define "coverage". How do I respond to

that? Let me see if I can start and see if we're going to answer your question. There's a difference between care and coverage. Coverage, as I understand it, typically means those who have some other organization bearing the risk. Care means providing the actual healthcare, the delivery of the medical treatment or prescriptions or preventive care itself. Have I responded to your question?

DR. SHIRLEY: Yes.

MR. O'GRADY: Can I just -- I think it's still an open -- I mean, it's an evolving definition, I think. When we do our large national surveys of who has coverage and who doesn't, what's the number of the uninsured and who isn't, what becomes quite clear is that there is this middle ground that is sort of -- I mean, using a community health center, is that coverage or not? Most of us would say not real insurance coverage, but it's certainly some access to care. The Indian Health Service, VA, are we counting that as coverage or not? How do we think about those things? And what is becoming clear is there are these other mechanisms that people use to get access to care. And of course access to care is the real policy

goal, coverage is just the way most Americans get access to care.

So, I think I wouldn't limit the group in terms of the way you think about these sort of things and the traditional ways of thinking about things like coverage as just a BlueCross/BlueShield card, is that what we mean by coverage. I think there's a lot of other ramifications to it.

CHAIRPERSON JOHNSON: Not differing with Mike, but we do want to look at providing coverage in addition to just the care. When I'm thinking of access, I'm thinking of how do we provide coverage as well as care. Now, we'll talk more about that, already we're getting into some dialogue, and that's good, but we'll continue to address that. Thank you for raising the question.

By the way, we do have folks who are, No. 1, recording our discussions, not necessarily for CBS News or anything like that, but they are being recorded, and notes are being taken of the meeting as well. It's part of the overall legal requirements for our meetings, so feel free to understand that there will be good records of our discussion which we might

have to come back to, and want to come back to in the future, but also speak using the microphones, if you would.

Phase 2, a list of summaries that are to be included in the report. First, healthcare and related services that may be used by individuals throughout their life span. And some of the data show that we use an awful lot of the dollars during our lifetime in the latter stages of our career. Those of you who are working in the medical profession especially know that, even more than some of the rest of us. That's a very significant item, and that's one of the cost items, I believe, that Senator Wyden will be - and others - will be looking to hear about.

Cost of healthcare services and medical effectiveness in providing better quality of care for different age groups. Healthcare costs containment strategies. Information on healthcare needs that need to be addressed. Further, summary of sources of coverage and payment including reimbursement for healthcare services. Reasons for which people are uninsured or underinsured and the cost to taxpayers. Purchases of healthcare services in communities where

Americans are uninsured or underinsured. Further, the effectiveness of healthcare of and cost when individuals are treated in all stages of the disease.

Also some items to be included in the report. Examples of community strategies to provide healthcare coverage or access. Information on geographic-specific issues related to healthcare. And information concerning the cost of care in different settings, including institutionally-based care and home- and community-based care. Some other items: Summary of ways to finance healthcare coverage, as well as the role of technology in providing future healthcare, including ways to support the information needs of patients and providers.

So all of these are the items to be included in the report, and let me stop and see if you have questions or observations regarding this Phase 2. Other than the point that Catherine made, it's an overwhelming kind of, and that's why we have staff people like Ken and Andy, Caroline and Andy to help us in our initiative here.

Phase 3 would begin next year, as required by law, but we may want to start earlier than that. Yes?

MR. FRANK: Can I ask a question about Phase 2?

CHAIRPERSON JOHNSON: Sure.

MR. FRANK: That set of issues is very, as you say, daunting, but we're not the only ones who have ever written about this. So, I was just wondering, for example, the IOM just came out with a series of reports on the uninsured and the health -- to what extent are we dovetailing with that and sort of using that information to help us do our work?

VICE CHAIR McLAUGHLIN: As the person who has been doing the most thinking to date about the report, let me respond, Richard. Tomorrow we are going to spend quite a bit of time talking about the hearings and the report as we've been conceiving it. Right now, just setting out, all right, this is what our charge is, this is what we were told to do. Then we can say, all right, what do we as a group -- how do we think we should implement it?

The report that we'll talk about tomorrow, you'll see that we have on there absolutely have staff do a critical synthesis of the literature that's already out there, the evidence, et cetera. So, no,

we definitely are not going to reinvent the wheel.

CHAIRPERSON JOHNSON: Let me just build on that. Already, we have made two reports available to you. If you haven't picked yours up yet, they are on the back table. Excellent reports put out by the Agency of Healthcare Research and Quality. We've also sent you another report of a forum that was conducted last year by the Government Accountability Office. It's not our intent to duplicate those reports. We may take data from those reports and condense it and use it here, but we don't want to duplicate the efforts of others, but we want to provide, as Catherine suggested, consolidation of some other information plus the hearing information. And one of the differences that we'll talk about later, in the hearings that we'll conduct is that we expect not only to do hearings in Washington where we'll have some of those who have provided information in the past, but also look at the possibility of doing hearings outside the Beltway with practitioners in different areas of the country, provide information based on their findings and their experience. So, thank you for your question, Richard. Other questions on the

hearings?

MS. PEREZ: How would you determine where the locations are?

CHAIRPERSON JOHNSON: We'll talk about that tomorrow, if that's okay. We'll share some information with you and gain your feedback as well, but that's still to be discussed. So, no decisions for sure have been made on that, just some ideas generated and so forth.

Okay. The community meetings -- and we're continuing just to share with you ideas that are in the statute, comments that are in the statute. We will potentially build on some of these, but the required topics are: what healthcare benefits and services should be provided; how does the American public want healthcare delivered; how should healthcare coverage be financed -- now that's a subject of a report that could be thousands of pages in itself, right -- how should healthcare coverage be financed. And then Senator Wyden made this fourth bullet a point of his conversation earlier with us, very important point -- what tradeoffs are the American public willing to make in either benefits or financing to ensure access to

affordable high-quality healthcare coverage and services -- what are the tradeoffs, what are the tough decisions that we'll make, and we're going to not make those decisions ourselves only, we'll get some input from the American people, but what are the tradeoffs that the public are willing to accept in terms of benefits, financing, and so forth. And again we might include other topics other than these that are the required topics for community meetings.

Questions or comments on that?

(No response.)

Okay. The community meetings must be initiated by next year, but hopefully we might be able to get moving with some of them before that time since this is going to be such a significant endeavor that we're going to have to go through. They must be sufficient in number to represent diverse populations, represent and reflect geographical differences throughout the United States, and reflect a balance between rural and urban differences. So, already when we're thinking of our responsibilities next year, we're contemplating how do we make sure that the meetings that we hold are going to be sufficient to

represent all of those differences.

In terms of our participation in the meetings, the regulations or the law says that we'll have at least one Working Group member attending each community meeting. So, I don't know if we're going to do a meeting in Montana, or California, Wisconsin, New York, wherever those meetings are, we would have one person attending that meeting, and the Working Group member would chair each meeting, although the statute does indicate that a State Health Officer may be asked to facilitate some of the meetings.

Also, that the Working Group encourage public participation through information technology and other means. And earlier today again, Senator Wyden talked about using technology and many of us are doing that in our own work world and public life, and there are some ideas that we'll be contemplating, sharing, discussing, regarding how do we use information technology in getting some of our messages across, and hearing from people as well. So, those are some of the things that we're looking at doing.

What we are going to do is prepare and make available to the public an interim set of

recommendations not later than 180 days after the completion of community meetings, allow for a 90-day comment period, and then put together a series of recommendations to the Congress and the President. The President will have 45 days, according to the statute, to look at our report and then submit a report to Congress within 45 days that will include his own views and comments and recommendations for legislation and administrative action that he believes is important.

And, finally, to hold hearings, and at least one hearing on the President's report and our Working Group recommendations would be conducted by the Senate committees that deal with healthcare, as well as the House of Representatives committees that deal with healthcare, and those would be expected to be held within 45 days after receiving the President's report.

So, that's a summary of the plan. The timetables kind of look like this, the one-sheeter that indicates all of these steps that we've been discussing, and our agenda for today is primarily to develop this preliminary list of major issues that

we're facing as a healthcare system in the United States, from your perspectives. And once we've done that, to identify some initiatives designed to deal with major issues. Questions or comments?

(No response.)

Well, if there are none, we will just proceed, and I'm sure that we will have questions and comments as we go along.

SENATOR WYDEN: Randy, can I just make a very quick comment and response to Dr. Shirley's point about coverage just because it's fresh in everybody's mind and I mentioned it to Mike.

When I met with Secretary Leavitt, we talked about that. And at one point the Secretary and I said, you know, if we were to do nothing else in the United States -- nothing else -- other than make it possible for people to have a card so they could go see a community health center, and to have a catastrophic healthcare benefit, those two steps alone would be a huge and monumental step forward in terms of coverage. And the irony, of course, is that both of them are really cost-effective and would provide a significant level of protection to everybody, and you

have the Secretary of Health and Human Services and a Democratic United States Senator saying, wow, there's real potential there. And so I think those are the kinds of things that you all -- and that may not be where you want to end up. I'll tell you, I thought Mike Leavitt made a lot of sense when he talked to me about it, and he seemed to think I was talking about something that was plausible to him, too. I'd just bring that up, and this is really going to be the last you're going to hear from me this morning.

(Laughter.)

Thank you, Randy.

CHAIRPERSON JOHNSON: Okay. Why don't we then go into introducing ourselves, and then talking about what some of the issues are that we face, and we're going to ask that you limit your time to ten minutes, and some of us could talk for probably some hours on some of our thoughts on the initiatives and so forth, but if you would be kind to kind of monitor your time and limit your comments to ten minutes.

I think to kind of get us thinking, I'll start, and then maybe we can just go around the table this way, if that would be okay, and everybody share

their thoughts.

Well, my own personal background is that I have been involved with employee benefits for more than 30 years, from a company perspective. I got into employee benefits through the bank in Detroit before I knew what benefits were all about, and initially I was asked to review claims that employees would submit to the healthcare company. Well, today, I'm not sure how that would be perceived, but that's what was done a number of years ago. And more recently I've been working with Motorola, for the last actually 22 years, and every year I've been involved with the benefits function there, although my current role is to be involved with more than just employee benefits, but for my first 18 years I led the benefit strategy development at the bank, or at Motorola.

Part of my involvement has also been to work with other organizations to think about healthcare policy, and my current role is to serve as a spokesperson on human resources issues on behalf of Motorola. And I used to think, well, would I want that job? No. I like what I'm doing better. But then when I got to thinking about it, I thought to myself,

Social Security needs to be fixed, and Medicare needs to be fixed, and retirement plans need to be fixed, and healthcare really needs to be fixed, and maybe I can take some of my own experience and share some of that. So, that's how I got involved with my current role, and basically it's that background that has caused me to apply to be part of this Working Group as well.

Initially, when I saw the notice of the Working Group being formed, I said, no, I'm not going to apply for anything. They know where I'm at if they'd like to talk with me, and of course I figured no one would ever want to come and talk to me, so I decided I wouldn't do that.

But a few people, like probably some of you, asked me to apply to be part of the Working Group, and so I did. And the reason is, I really think we are in a very, very serious situation in our healthcare needs today. I wrote down some numbers, and I'm not asking anybody else to do the same thing, but I wrote down some numbers, and maybe you can read them in the back -- can you see them okay? 10-15 percent, 25 percent -- what do you think that is?

MS. MARYLAND: Percent of GDP spent on healthcare.

CHAIRPERSON JOHNSON: Pardon me?

MS. MARYLAND: Percent of GDP spent on healthcare.

CHAIRPERSON JOHNSON: This is really, typically in the last several years, the rate of healthcare increases -- the rate of healthcare increases absorbed by the first numbers are large companies, and the last number is some of the smaller companies -- $6400, anybody know what that number is?

(No response.)

That's the average cost per person in the United States today -- $6400. Senator Wyden made the reference to that earlier when he talked about $24,000 for a family of four, well, that's the cost, the average cost. And for a person who is my age -- that is, between 55 and 65 -- the average cost today is double. So, if I were to buy healthcare on the open market, the cost is $15-18,000 a year for costs that many of us now enjoy -- not everybody enjoys, but many of us.

Now, when you think that the average

401(k) balance today for people 55 and 65 years old is $50,000, that means they have three years of their life savings to spend for healthcare if they are going to retire before 65, and then they're going to live on Medicare and Social Security for the rest of their life. And of course today we're living in the 80s, and sometimes many of us beyond that. So, huge issues.

$11,045, that's the number that the average cost is projected to be by 2014. Well, imagine that. If you're a family of four, $44,000 per year for healthcare costs. In my estimation, we can't continue to absorb these kinds of costs, and so we need to find some solutions.

98,000 and $29 billion -- 98,000 is the number of lives lost each year in hospitals due to medical errors. So we're not only talking about a cost issue, we're talking about a quality issue.

The 50 percent is the percentage of us, who get the right care at the right time at the right place when we seek medical coverage every year -- 50 percent of us. So, if Catherine and I are both going to go to the doctor, the data says one of the of two of us are

going to get the right care at the right time at the right place, and I hope it's me, but that's not good quality.

VICE CHAIR McLAUGHLIN: Remember we were supposed to talk about shared sacrifice, Randy.

CHAIRPERSON JOHNSON: Yes. 90 million, that's the number that the U.S. Surgeon General -- 90 million people his report said in the United States are healthcare illiterate, and $58 billion is lost each year because of that illiteracy. So, those are some of the issues that we're facing, and I personally believe that we have a real challenge to overcome some of those. Now, I didn't put the 44 million people who are not covered today. That's another statistic that just rings out at all of us whenever we're reading this.

So, we have some real issues. We'll talk about some initiatives that are used to address those issues, but that's a little bit about myself and why I asked to be involved. Joe, how about you? Can we move to you next?

MR. HANSEN: Thank you, Randy. I don't think I'll take ten minutes. I'll introduce myself

first. My name is Joe Hansen, and I am President of the United Food Commercial Workers International Union. It's a union of almost 1.4 million members in the United States and Canada, and we represent people in the retail food stores, in meatpacking, poultry and food processing. We also have a sizable number of members who are providers in the healthcare industry in hospitals and nursing homes, and some other facilities. So, I get a perspective on healthcare because part of the union's job, when somebody asks what a union does, they say, well, you deal with wages, hours and working conditions, and we bargain over that, and we represent people over that. But in recent years, our bargaining has really come down to the crisis in healthcare, and that's basically what we're bargaining over as far as monetary, shifting costs, and the benefits.

I additionally serve on the Executive Council of the AFL-CIO, and I get a perspective of not only the industries that I represent, but other industries and similar problems in different industries, so I get some viewpoints from there.

An odd thing that I do -- it's kind of

odd, but it gives me a little bit of a background coming into this type of meeting -- I serve as a pension trustee on the Wyeth Pension Fund, and I've done that for a number of years, for ten years, so I get some perspective from the drug companies and, of course, they get very involved when there's initiatives about cost of prescription drugs and they have their viewpoints about research and stuff like that, and some intelligent people that I've been exposed to.

So, I have kind of a broad background as I come into this. I asked to be on this committee for two reasons, really -- it applies to the work that I do and the responsibility I have to the members that I represent, and how do we keep providing coverage and the issues that come up at the bargaining table, and also I have a personal reason. I have four kids and five grandkids. And what was normal for me when I entered the workforce in the '60s was, you took healthcare for granted and you expected decent care. The same expectation is not there for them as we go into the future.

Some personal experiences I have -- and I

was reading through some of the backgrounds -- and the concerns I have about healthcare and how it changed, and what we used to take for granted. We represent people in the grocery industry, but we also represent people in the meatpacking industry, and in Sioux Falls, South Dakota a number of years ago, one of the biggest employers there was Morrell Packing, and they were one of the first companies that jettisoned retiree healthcare, which now has become more and more the practice as the expenses go up, and I think that is part of the problem of what we do with our elderly and how we cover them and keep putting all the costs onto Medicare and Medicaid and that type of situation.

Basically, I think that, first of all, I'm very pleased to be on this committee. I think the challenges are daunting, but I don't think we have any choice. I think that we have to find out a way to fix it or, as Senator Wyden and Senator Hatch said, the economy and the life style and the greatness of our country is going to be in real jeopardy. I'm not trying to be dramatic, but I see it as that big a problem.

I am daunted. I tried to break down as I

was listening to both the Senators, how you address this, all the different categories, the cost category and the problems, and you've got insurance and you've got the prescription people and you've got the lawyers and you've got the providers and the educators and the research people and the government, and the Chair and the Vice-Chair have got a difficult job of leading us through there, but I think it can be done. So, I'm pleased to be here, Randy, and look forward to participating.

CHAIRPERSON JOHNSON: Have we captured your primary issues, would you say?

MR. HANSEN: That's it.

CHAIRPERSON JOHNSON: Okay, thank you. Well, glad you're here, Joe.

MR. HANSEN: Thank you.

DR. BAUMEISTER: I guess I'm glad to be here. And I say that honestly. I'm a physician. I'm a gastroenterologist. I've been in practice now in Oregon since 1970. I go way back. I graduated from medical school in 1961. I was at Jackson Memorial Hospital when they integrated the hospital. I served in the military. I was a lieutenant colonel in the

Army for four years. I actually served as a gastroenterology consultant for Europe in a time when all the Regular Army people were serving in Vietnam. And I have practiced and been a leader in the medical community where I practice. I've been president of the hospital staff, president of the Oregon Medical Association, I've been a delegate to the AMA. I'm a liberal Democrat, my mother was a precinct worker for Claude Pepper, who was a proponent for socialized medicine back in the '40s, and I still share those beliefs.

I was active in the formation of the Oregon Health Plan and saw it essentially die, and I still think it was a wonderful plan. I think it could be applied on a national level. What we are hearing and talking about this morning is much of the principles of the Oregon Health Plan that grew out of the Oregon Health Services Commission that came up with the benefit package and sort of the cooperation between the business community and the public financing the healthcare.

As a physician and as a representative physician, which I've been, I hear things like $98,000

deaths due to errors. I'm not really sure that's accurate. I read the Institute of Medicine's report. I don't know what the answers to any of this are. I've worked in a Veteran's Hospital. I've worked in a military hospital. I've worked in a county hospital where it was all charity work. I've been a very successful practitioner of gastroenterology. I see next door they are advocating colon cancer screening for every citizen, so my financial security is set.

(Laughter.)

But I think when we get into these discussions, I think of a couple of things. I think of Oscar Wilde's definition of a cynic was somebody who knew the price of everything today and nothing. And I think of Joni Mitchell's song, "Don't you know it seems to go" -- what is it -- "you don't know what you've got 'til it's gone: they paved paradise and put up a parking lot" -- and I think we've got to watch out that we don't throw out the baby with the bathwater here in dealing with American medicine, but I still think it's the best in the world. There is some uneven distribution, but there is incredible uneven distribution of every facet of American life.

The haves are getting to have more, and the have-nots are sinking deeper into the abyss, and healthcare is one of those issues, and we're here to address that, and I'm going to do what I can to help it, but we're dealing with a society that's in chaos, not just healthcare, and I'm here to contribute what I can.

CHAIRPERSON JOHNSON: Frank, thank you for your comments. What I'm hearing you say is that this is a huge complex issue, and there's a distribution issue on healthcare that's reflective of society in general. That's what I was about to put down here based on your comments.

DR. BAUMEISTER: Absolutely.

CHAIRPERSON JOHNSON: Would there be other issues that you would like us to include? Well, first, is that correct?

DR. BAUMEISTER: That's correct. I agree emphatically with Senator Wyden who said this morning that we are spending enough on healthcare. The $24,000 apiece seems to be sufficient. But we've got to figure a better way to -- I think it was Coleridge that said that prose was words in their best order, poetry was the best words in the best order, and we're

looking at just poetry here.

CHAIRPERSON JOHNSON: Thank you. Dotty?

MS. BAZOS: I hate to follow Frank; I won't be quite as eloquent. When I initially was asked to apply to this committee, I was actually going to say no. I just have been -- I'm a nurse, I started my career as a nurse, and then finished my degree and taught. As soon as I was married, when I was young, I went overseas, and I lived and worked overseas for a period of 15 years, sometimes in European countries, often in third-world countries. And when you stay out of the United States for a long period of time, you get a very warped view of what the U.S. should be. And when I came back, I just believed that we were the best country, the best nation in the world, and I was shocked. I actually was just shocked.

You go through a tremendous period of culture shock when you come back here because you do believe that everything is perfect. And I went back to work in our healthcare system, looking for a place where I wanted to work. And I couldn't believe that we had not solved the issues that I saw when I was a young nurse, the issues of educating consumers, the

issues of poverty, the issues of access, that we were still debating the same old things.

So, I believe that more education would help me begin to help this country to develop a better system, so I got my Masters and did my graduate work at Dartmouth, and looked at the research and was again shocked that we've been having the same debates for a long, long time, but we're not coming up to any solutions.

So, I weighed that when I was asked to join this committee, thinking that what I really wanted to do was to work with populations that had nothing, but then decided that if there is a chance in the United States to help citizens of the United States develop some political will about moving forward to make certain that everyone in America has the right to basic healthcare, that I wanted to be a part of that. Although, after listening to the Senators today, now I want to go home.

(Laughter.)

So, I'm hoping that I can offer a little bit to the discussion that we have. Some of the issues that I think we have are, first, that we don't

really have a healthcare system. If you ask policy students to describe the system, they give you all these answers, but everyone usually agrees that there is no system, and I think that's part of the complication of actually fixing what we call a broken system because we don't actually have a system.

I asked the question to the United States, who is actually responsible for the health of the population of American citizens. Sometimes it is government, sometimes it's State, sometimes we have the expectation that as individuals -- where I work in communities, communities want to be responsible or think they should have some responsibility, but no one really can answer the question. And since no one can say who is responsible, it's often very difficult to know where to point the change. And in my own research, I've worked with communities thinking that that might be the place where the rubber could hit the road, but what we found is there's no data for communities to really look at as far as the capacity utilization and outcome of their healthcare systems locally. We don't have good data. So, it becomes very difficult to change a system from a local level,

although people who I work with at a local level think they want to be part of the change. They are very interested in it. They feel that top-down approaches don't work, haven't worked for them, that local solutions may work, but they are grappling with not wanting to have change for change sake, so they need data to do that.

Another question that I think about a lot is, what does it take really to produce health? I mean, I think that's what we want when we talk about what does it cost, do people have access, the outcome we're looking for is health, and what does it take to produce that, and I think for different populations it takes different things, and I don't think the healthcare system itself should be the center of the issue. We know from research that there's multiple determinants of health, and we know that for some vulnerable populations, they really need us to consider funding some kind of resources around the social determinants, around their education, those types of issues. So, I hope we don't lose track of that as we narrowly focus on these costs of our system per se, because I don't think we're going to get the

outcomes that we want. So, I'd just like to keep thinking a little bit broadly.

And then in my graduate work, I also have grappled with the big issue in the United States of whether the American public really believes -- and I think that sometimes they do -- that more is always better. More healthcare is just always better. Some of the preliminary data is showing us that, in some cases it's not, and I think that we really need to look at that, but also to very methodically and carefully help to educate the public about what it is that will really help them when they are sick, and what do we know that will really help them when they are sick.

So, I'm happy to be here, and I hope that I can contribute something.

CHAIRPERSON JOHNSON: May I ask a couple questions to clarify?

MS. BAZOS: Sure.

CHAIRPERSON JOHNSON: Can you talk about what I put down here as the big issue, health itself. Can you build on that a little bit, your comments just before you got into more is better?

MS. BAZOS: The big issue is health, defining health, or how we want to produce health? Well, I think people have grappled with the definition of what is health. For everyone it is different. The IOM has a definition that actually is very, very broad, and if you use a very broad definition of health -- that is, that people will be able to function as best as possible in their own communities so that they are productive, productive human beings living with the best quality of life that they can have.

Then you really need to think about, how are you going to get people there. And it isn't always that for some people you're going to just put all of your focus on funding a healthcare system. When we talk about tradeoffs, we have to think about what tradeoffs we're going to make. The tradeoff you might make for somebody is that you need to focus upstream. You need to really focus in the education system. You need to focus in the job market. You need to focus on getting that single mom a babysitter so she can actually go to work. And all of these things actually will eventually -- you know, they sort of

have an impact on a person's health. I'll just give a quick example. In the '70s we told everybody to exercise, and we began to make the American public believe that it was an individual responsibility to exercise and lose weight.

Well, if you think about some of our elders who can't walk outside, they might live in neighborhoods that are violent, they might not have transportation to get to a place. We need to think about all of these things when we think about producing health. All of the answers for producing health aren't in the healthcare system. That's what I meant.

CHAIRPERSON JOHNSON: Okay. Thank you. Richard?

MR. FRANK: I'm an economist by trade. I'm a professor of health economics at Harvard. Most of the time, I'm a pretty nerdy guy, meaning I do research, I teach, and I co-edit one of the journals in the field. My research areas are mental health and substance abuse, the economics of the pharmaceutical industry, and sort of how you pay providers for performance are the three areas I work on most.

Over the years, I've done a few policy things. I was a regulator in the State of Maryland. I served on a regulatory commission there that regulates hospitals -- I guess it still regulates hospitals there. And I --

MR. O'GRADY: Here.

MR. FRANK: Yes.

VICE CHAIR McLAUGHLIN: We're in Maryland.

(Laughter.)

MR. FRANK: I learned a lesson in policy failure by serving on the Clinton Healthcare Task Force, and I've spent a number of years working on various Institute of Medicine type committees over the last seven or eight years. Perhaps my most formative experience related to this committee happened about a little over a year ago when my wife was diagnosed with breast cancer, and through serving the role of the informal case manager, I got to see all the pathologies, and also all the greatness of the healthcare system sort of right next to one another. At the end of the day, she got terrific care, but the amount of chips I had to call in, and battles I had to fight, and tantrums I had to throw in order to make

sure that happened was just stunning to me. And it was stunning just because the results were so good and the process was so difficult. And so I got to see the impact of incentives information and kind of human fallibility all sort of come together in a very sort of unique way. So, it actually gave sort of a new perspective to what I'd been studying for a long time. And when somebody suggested to me that I think about applying for this commission, I hadn't even heard of it. I will admit to having cheated and only read the summaries of the MMA and not every single page -- the Kaiser Family Foundation highlighted things in the summary, so I wasn't really aware of it. But then I went and looked at the legislation and I said, this is a very new way, and it seemed that my own experience is so salient about understanding some of the pathologies of the system, that if people got out there and understood that in a more personal way, you might get more attraction.

So, going to your main question, Randy, what is sort of the big issue for me, the puzzle that I've been sort of, both on the research front and the policy front, been thinking about for a while is, why

is it that after a doctor and a patient get together and they go their separate ways, too frequently the patient didn't get good advice from the doctor in terms of what the best thing to do was, and when they did, too frequently the patient doesn't follow it. But at least it's extraordinarily expensive to do all that, and there's just a whole bunch of incentive, organizational, informational, and psychological things at play here, that I think are what make this problem difficult, but I think the heart of it is, a lot of this is about how doctors and patients interact and the sort of environment that governs that interaction.

CHAIRPERSON JOHNSON: Richard, I've put down several things, although even though you said this was your principal issue, what I thought I heard you say -- and maybe I didn't, that's why I'm asking -- earlier in your discussion I thought I heard you say some inappropriate incentives, I thought I heard you say lack of information available, I thought I heard you say -- you didn't use these words, but the bureaucracy of trying to move through the healthcare system as you experienced yourself, and then toward

the end, in the patient/doctor relationship, oftentimes poor advice is given. But in addition to that, when people get advice, patients get advice, they often don't follow that. Have I captured your thoughts here?

MR. FRANK: Yes, although on the second one, I wouldn't say that, it's not so much -- I wouldn't be blaming the patient that one way or another they wound up not following it, not necessarily only because of an act of volition on their part, but for a variety of other reasons.

CHAIRPERSON JOHNSON: Can you build on that?

MR. FRANK: Well, the most obvious thing is, they haven’t got the money to pay for some things.

MS. PEREZ: Prescriptions.

MR. FRANK: Yes, that would be at one extreme. On the other extreme, the doctor didn't ask him a question, and so when they tried to pursue a treatment, it really wasn't practical for them for a variety of reasons. And then there was just the "I'm scared, I'm nervous, I don't want bad news, I'm not going to follow up on this." So, there's all of those

things, some of which are things that the patient owns, but many of which are not.

CHAIRPERSON JOHNSON: Thank you. Okay. Therese.

MS. HUGHES: I'm sort of at a loss of what to say, and this may be the only time you'll find out that I am at a loss.

(Laughter.)

So, first of all, I'm from California. And I wrote down seven lines, just with very few words on it, when I was coming across country, to say who I was or who I am, and so this is what I wrote. I work for the Venice Family Clinic. We're the largest free clinic in the nation. I'm responsible for advocacy, government relations, and legislative analysis on all matters affecting our clinic, and in healthcare policy, as well. I have a Master's in environmental analysis and protection in social policy from UCLA. I'm involved in healthcare because the issues are part of my passion, which is where institutions fit in the built environment, and do we pay attention to where those institutions occur, or are they just randomly placed throughout the built environment.

After hearing these people before me speak, I want to say that I'm here because this is one of my life goals, and it's going to sound kind of hokey, but when I was 14 I saw the Table of Life in Life Magazine, but my husband says it's the Table of Seven. It was six men and one woman who were -- they showed the tabletop and their legs only -- who were the individuals who decided who got dialysis across the United States. And I took that picture to my mom and I said, "When I grow up, I'm going to work to make this different." At the time, I don't know if I was looking at having more women at the table, if I was looking at having people of color at the table, or if it was directed towards healthcare, I really can't say that, but I knew that I wanted to work, and I do believe that it was healthcare, and the reason I say that is my father sold life insurance for New York Life, health and disability, and I did the same when I first graduated from college.

But more recently, the reason I decided to do this, apply for this committee, is because I'm one of the people that had a very difficult time in the system. I was diagnosed at a very young age with

kidney disease. I was given six months until I had to go on haemo-dialysis. I understand a lot of how the healthcare system works for someone who has health insurance and who meets terrific barriers in trying to access care for the product which is going to be very costly for that company, but which is going to "save my life," and that is dialysis. The barriers were very tremendous, and perhaps that's what, you know, in the "Great Plan" in the universe, directed me towards looking at health policy when I was in graduate school.

I had the incredible opportunity of serving as a summer Fellow for Senator Ted Kennedy and worked on transplantation issues. I am now transplanted seven and a half years. I ended up getting a living related kidney, which is the best of all opportunities. But there are still, of course, all these remaining issues.

I am absolutely thrilled and excited to participate here because it is a life goal, because this is part of who I am, having been in the system. I work now for Venice because they offered me a job. Actually, Venice and the Westside Family Health

Center, community clinic and a free clinic, wanted some advocacy done, and I didn't know how to create an advocacy department for them because my position had been a position of a patient, of a mom that stayed at home that did representatives and advocate between government and business and people, citizen, and back and forth in those different categories over 20 years, and what I found out was what they wanted was oxygen in my blood, and which of course, like this committee -- this is why I'm thrilled about this -- this is oxygen in my blood. I don't pretend to have the answers, but this I understand, and I understand it in ways that I don't know how to articulate.

So, I think that -- I'm just really thrilled about being here. I have two children who grew up with me being ill, so I bring another perspective of a parent that raised children with an illness, and they were young, very young, who are now doing extremely well. And I have a husband who is just like, incredible. So, I also had the privilege when I was at UCLA to have Frank Correll, from the Robert Wood Johnson Foundation, as my mentor, and who helped move me into this arena of healthcare, but

perhaps the most was my physician, Dr. Rodriguez, who said, "Therese, you have a voice, and you must speak for those without a voice." And at the time, I kept pushing him off because I was on the edge and I didn't want to think about people not having a voice, which meant they had no insurance, which meant they had no access, which meant there were barriers, when I was having such a difficult time myself.

I now, at the Venice Family Clinic, have been able to help work on a bipartisan level at the State and at the Federal level with different legislators, although not with Senator Wyden here, but have been able to effectively create networks to look at the issues of providers of the uninsured as well as the issues of need regarding access and barriers for uninsured patients themselves, which brings me to your question about issues.

I think that from where I am the first issue that comes to mind is the issue of patient compliance, which is a part of the system that is talked about but which equals to me patient education. I was on peritoneal dialysis, which at the time meant I dialyzed every four hours around the clock, and the

idea was for me not to have an infection over the years that I was on dialysis. That's patient compliance, because I understood what an infection could do. I was educated by this physician to say, "If you think you are harmed now, you need to know that by not being compliant you will really harm yourself." So, for me, the first issue that we look at, or I hope we will consider, or somewhere on the agenda is patient compliance as equaling patient education.

The second is the underinsured, and I put this in this category because patient compliance and education go across the board, but if you have insurance and you don't know that you need to take care of your high blood pressure or else you'll end up on dialysis like I did and that that bites, you don't know to do that, you are underinsured and you have under-access. So, I think that those two really go hand-in-hand.

Chronic illness is a result of being uninsured, being underinsured, as well as -- for me, it just was something that happened, but now it ends up that I've been a chronically ill patient for quite

a few years.

And then the third issue is one that the clients that I represent have, and that is that at our clinic there are over 20,000 patients that live at 100-percent Federal poverty level, and they are working poor. They have two, three jobs that they hold, and yet none of their positions offer them the ability to get access to healthcare, so they show up at our clinic. And they come back because we provide a continuum of care in a clinic setting that is primary care, that is mental health care, that looks at issues of a whole system, and so the clinic system that is in our nation today is a system that provides whole-healthcare in many areas, and I would like to suggest that that is something that we need to look at as well.

But then from the employer side and the economic side of my job, uncompensated care, uncompensated adult care -- and by adult care, that's anyone from 19 to 64 years of age -- is the largest cost factor in our clinic, and the reason is because we have to raise money to provide the services for these individuals, and that's over and above accessing

our homeless healthcare grants, that's over and above accessing other foundations for programs that we can set up for three or five years to start a program because we then have to carry it on, which means that we have to look at a provision of economic value as well for that. So, I think that those are perhaps my issues that I bring.

CHAIRPERSON JOHNSON: Let me see if I've captured your comments. What I heard you say right at the start was there are terrific barriers to accessing care. Cost is a major one of them, but I wasn't clear -- it didn't seem to me like that's the only one, and I'll ask you to comment on that in just a second.

You said there's a combination of patient compliance that's an issue because oftentimes of patient education -- and those two go pretty closely together -- patients complying with medical care prescribed. Many times that doesn't happen, I understood, because they are not educated as they should be regarding the impact.

The underinsured, people must know what is available to them and how to go about getting the kind of care that they really need to have. Coverage for

the working poor is an issue. Need for whole-healthcare, we haven't focused as much on that as much as we focus -- and I'm putting some words in your mouth to see if I'm understanding -- haven't focused on whole-healthcare as much as we have focused on treating illnesses.

And, finally, what I thought I heard you say was another issue is uncompensated care, and what I thought you were implying was resulting in cost-shifting to some others. Have I heard you correctly?

MS. HUGHES: Absolutely. Absolutely.

CHAIRPERSON JOHNSON: So, is there anything I haven't captured that you'd like us to make sure we've heard you on?

MS. HUGHES: I think that the clinic system in our nation needs to be looked -- no, you've captured it. That's fine.

CHAIRPERSON JOHNSON: This kind of represents it?

MS. HUGHES: Yes.

CHAIRPERSON JOHNSON: Thank you very much. Okay, Montye, you're next.

MS. CONLAN: Well, I guess I have a very

personal story. I'll touch on some of the things that some of the rest of you have mentioned as I go along because it has triggered things in my mind.

I think for many years I saw myself -- and maybe I represent those young people -- as a completely healthy person. Sometimes I had healthcare coverage and sometimes I didn't. It seemed irrelevant because I could probably count on one hand the number of times I had to go to the doctor, and that's even including having a baby. I used a midwife and had my child at home. Of course, I took her for care at an early age, but my family really had minimal use of the healthcare system, and that seemed to work real well. I thought I had it figured out -- lots of exercise, good diet, sometimes -- I lived out west and did a lot of hiking, so all the experience with that -- and I think I represent the innocence of many Americans and certainly many young people.

That worked well until about the age of 45, and then something was different. And I continued on my same course of, well, more exercise and better diet, and all of that. But the thing that was different is I started going to doctors, many doctors,

and I was misdiagnosed. There were many tests, many misdiagnoses. Eventually, I became very sick. I was partially paralyzed on one side, lost some of my hearing, a lot of my vision, and could only work part-time, but I still got up every day and went to work even though I had to live with my parents. They provided all of my care so that I could go to the job and work part-time.

I ended up hospitalized for quite a long period of time, with many tests. I was diagnosed with MS. I was very sick, and asked my employer for a reasonable accommodation to come back to work, was denied that, and then promptly fired, and I was plunged into this world that I really had not experience with, and it was very rough going for quite a while. I like the way Senator Hatch acknowledged the need for mental healthcare because I certainly needed a whole lot of it at that time. I became very angry and very isolated in trying to access the system. I also didn't work for a year and had no income, and in that way depleted all my personal savings.

At that time, I became eligible for public

healthcare, Medicaid first, and that is administered through our Department of Children and Families, a bunch of very jaded, cynical people who were very suspicious of me. They were sure that this was all a ploy to scam the State of Florida.

So, anyway, I became a beneficiary of Medicaid. So then I applied for disability and went through that horrible maze and gauntlet, and after a year I received disability. I had to go through many hearings, fight every step of the way. You see, I didn't have a significant other, I had to do all the fighting myself when I was at my sickest in my life. So, that made me very angry and very needy for mental healthcare, and I acted out a lot. But eventually things got better. I was on disability, and then after two years I was eligible for Medicare. So, at this point I'm a dual-beneficiary. I do have Medicare, but I am so affluent now, I don't qualify for regular Medicaid, I qualify for what is known as the "Medically Needy", or "Share of Cost", and that is a wonderful program, and that provides coverage for catastrophic care. I do have my prescription drug costs covered. I am dependent on expensive, self-

injectable drug, $1300 a month, and the Medically Needy Program does provide that to me.

So, becoming a Medicaid beneficiary, I -- again was very angry -- until I met up with Florida Legal Services. They are a wonderful advocacy group for people like myself in the State of Florida. And they really taught me how to advocate for myself. Not only that, they started asking me to come to Tallahassee to advocate for others because each year we have a ritual in Florida when the State Legislature comes into session for 60 days and is looking at balancing the budget. They always pick on the Medically Needy Program because it's a very expensive program, and that triggers all of us -- organ transplant survivors and people with MS and others -- to go and carry on and act out, and then ultimately we usually get our coverage, although it is whittled away. Each year, we lose a little ground, but we seem to retain the most important features.

So, that has been my life for quite a while, and it's been a healing process. Normally, when someone is diagnosed with a chronic disease, I understand it's about one to two years until they come

to accept it. Well, it's probably been -- I'm a slow learner and, you know, that youthful attitude -- it's taken me about five or six years, so I'm at the six-year mark now, and I've just started to regain that desire to be actively engaged in life again. And when the notice came across the Internet from Florida Legal Services that this group was forming and soliciting applications, they sent it to every Medicaid patient that was in our chat group, and I don't know how many applied, but I certainly did. And I didn't think I ever had any chance of being called or interviewed or anything. I was going to check at the end of the month when it was designated that word would come out, but I had no idea I would receive a call. But I am very pleased, and I want to bring the voice of the dual-beneficiary.

I also now, since I am disabled, spend a lot of time around senior citizens because we are in the same little niche. We're out during the daytime and we're involved -- I'm very involved in exercise programs at the YMCA, as are many of them, so I'd like to bring their voice and bring the voice of the dual-beneficiary. This is part of the healing process for

me, and I'm proud of myself that I applied, and I'm even more proud that I've been accepted, and I guess life goes on.

CHAIRPERSON JOHNSON: Before that, you were a highly qualified math and science teacher.

MS. CONLAN: Yes. You know, I was thinking about that earlier. I had no great desire, as a child, to be a science teacher. I started working -- we lived in Montana for many years. Came back to Washington. And there was a sign at the National Zoo one day, "Come work at the Zoo", and kind of on a lark, I said, I'd like to do that. And then I started getting more and more involved in the work there, and I was open to the possibility when they approached me about teaching classes for children. I really had had no other experience in the teaching area. And one thing led to another, and I ended up a science teacher. But I think the message there and what I was thinking of earlier is that I was open to the possibility. I feel the same way here. I'm open to the possibility of this process, and I have a lot of faith that good things will come of it because that's been my personal experience in the past. If

you are open to the possibility and you're sincere in it and you work hard, and with the wonderful seed that's been planted, if we nurture that, I think good things will come.

CHAIRPERSON JOHNSON: Montye, I've captured a few of your thoughts, but would you like to be more specific than I have been in articulating what you perceive to be the principal issues that we're facing? Maybe I just haven't -- I don't want to surmise based on your comments.

MS. CONLAN: Well, I do think that I said that I was in charge of my health, and also I think that I continue to be a completely healthy person. I'm a very healthy person. I have this little electrical problem that -- on the nerves running from my brain to my legs in particular but I'm really interested in this wellness approach because I think it has carried me throughout my life. I'm in charge of my health. I'm interested in wellness. I am a healthy person. And at this point, I still continue to be in charge, but the game has changed a little bit in that I have to use my ability to scope out and access the best healthcare coverage that I can. I

currently go to the Mayo Clinic in Jacksonville, and they accept dual-beneficiaries such as myself.

In Florida, the legislators have a different saying, why provide Cadillac coverage to people like me when a Chevy will do -- not Studebaker -- but I happen to think I'm going to seek out places like the Mayo Clinic, and there are other places that I have gotten healthcare recommendations to develop a management plan. I've gone to the Heuga Center in Colorado. It's kind of like MS boot camp. And there were 45 practitioners there. They assessed me from top to bottom, and I left there with a management plan, and now I'm invested in that management plan because I understand it. They educated me. They gave me personal counseling so that I understand why I need to manage my MS. Things like infections are very critical to me, too, and why I need to now follow up on all those infections. Dental care is really important. So, I understand in terms of my chronic disease how to better management and why it's a lifetime pursuit. So, I think those things are important, too.

CHAIRPERSON JOHNSON: I've added these two

things that capture some of your thoughts. Okay. Thank you. Glad you're here.

MS. CONLAN: Thank you.

CHAIRPERSON JOHNSON: Pat?

MS. MARYLAND: I'm Pat Maryland. I've been in healthcare for about 26 years. Just to share a little bit about my background, my father was in the military, in the Air Force for about 31 years, and we lived in probably four different countries, and probably in total count about 12 different places by the time I was 18 years of age. Born in England, went to high school in West Berlin, Germany, lived in places like Cheyenne, Wyoming, California, so I've been all over. And I share that to show a little bit of my experience and how that weighs into the type person I've become today.

I have a Doctorate Degree in public health from the University of Pittsburgh, started my career really off in the math area, Bachelor's Degree from Alabama, Montgomery, Alabama at the university in applied mathematics, and went on to get a Master's Degree because I'm real interested in wanting to somehow bridge the -- take the quantitative experience

and knowledge and apply that to the field of medicine in biostatistics. I have a Master's Degree in biostatistics from the University of California at Berkeley. And I knew that I wanted to do something in terms of management, really getting more involved in how do you take these disparate areas and pull them together in a way that's coordinated and provide more comprehensive care to patients. And so I thought I'd like to make that next move to healthcare management, and moved to the University of Pittsburgh and took the advanced degree in actually health services administration.

I've worked in places, with very well-rounded experience, starting off at the Cleveland Clinic Foundation, worked there for about 15 years in planning hospital operations and then in corporate development, and then moved from there to Detroit and worked as president at a hospital within the Detroit Medical Center, and really became exposed to the opposite end of the spectrum from the Cleveland Clinic Foundation. It was great in terms of grounding, taking me back to my roots, if you will, in terms of understanding the needs of a number of citizens who

were either underinsured or uninsured. And then most recently, I moved about a year and a half ago to St. Vincent's Hospital in Indianapolis, Indiana.

What's interesting, while I was at the Detroit Medical Center, I became very frustrated that we were dealing with a significant number of issues in terms of the uninsured, but really didn't have a plan in terms of how to manage those patients. We sucked it up. We tried to take as much as we could. We went out, holding our hands out to State and others to try to give us more money to pay for this uncompensated care, but really did not have a proactive plan in place to really address the needs.

What intrigued me about the move to St. Vincent -- St. Vincent's Hospital in Indianapolis is part of a larger system called Ascension Health. It's the largest Catholic health ministry in the country. And what impressed me with the Ascension Health system was that it truly had a mandate to look at three key areas. One is, create a system across the country that provides healthcare that works, that's efficient; healthcare that's safe -- looking at the medical errors and really create through IT, information

technology, ways to be able to address those needs -- and then most importantly to me, healthcare that leaves no one behind. The whole issue of the uninsured is a major issue.

I was reading -- and I wanted to share a couple of things that I found very interesting. I was reading a study that was published in Health Affairs last week that projects by the year 2013 that more than 28 percent of our population will be uninsured -- 11 million more people by the year 2013 will be uninsured, a third of our population uninsured. At this rate -- as you said, Social Security is important -- but this is even more far-reaching than that. It's just hard to fathom the statistics.

I am hopeful, after hearing some of the stories and hearing a lot about the background of our members of the committee, that we can put faces to these numbers, if you will, and it's important for us to come up with some practical rational recommendations that hopefully can be implemented and accepted by all groups that will be nonpartisan recommendations that we can move forward on because it is very personal.

And my personal story as to why I'm interested in healthcare and why I wanted to bridge that gap between the quantitative to the medicine area was because my mother, as with most African Americans, was obese, had nutritional problems. Her obesity led to Type 2 diabetes, that then led to congestive heart failure, and then to renal failure, and then to subsequent death. Very typical in African Americans. And I really believe that if there had been earlier intervention and better education and more understanding from the family's perspective, educating the family about the need, that my mother should have been more concerned about compliance to medication protocols, that she would be alive today. And I think that lack of coordination between the caregivers and the lack of comprehensiveness of the care that she received is part of the explanation. Yes, there should have been some personal responsibility, but I think it starts with the educational piece.

So, I'm hoping that with the process in the committee, we'll use within our own areas concrete examples of programs that seem to be working, that maybe we can take and develop and really replicate at

a much larger level.

I'm thinking about one program in central Indiana now, it's called the Central Indiana Help Underserved Access to Health Program that's a part of our St. Vincent Health System. This is a program that's truly in partnership with the Federal Government, it's a program that is funded by Ascension Health, but also funded by the Federal Government. So, it's a private and public partnership, if you will. It has moved primary care services from the emergency rooms to the clinics, to a primary care setting. We are taking care of a large number of Hispanic patients, so we've provided translation services to address the whole issue of patient education. And we've also provided support for the prescription drugs.

What's important about this program is several things. One is that there is personal responsibility because there is a sliding fee scale where if you can pay based on income, we expect some payment be provided for the services rendered. And I think that personal responsibility translates into compliance, quite frankly. But at the same time,

we're providing services that are truly needed, and we're removing the patients to a setting that is less costly. So we believe that it's going to have an impact, and we've seen some initial results -- and I'd like to share those maybe at a future meeting -- specifics in terms of the results where we've actually seen improved outcomes. And I believe it's through those partnerships that it can make a difference in terms the type of programs or recommendations that we might be able to come up with that could be replicated at a more national level.

So, I'm excited about being a part of this process. I believe that one of the things I want to make sure we capture is that whole issue of information technology. Our industry is so far behind other industries in terms of making use of technology to coordinate the care better, share and move information along so that we're more efficient is an area of great frustration. I've made this statement before, when you go to the airline industry and you look at what they're doing with technology -- you come in and you can use your debit card just to get your electronic ticket -- why can't we have a card

available where you have all the information, all the past medical history about that patient and just update it, and that it continues with that person. If other industries can be more sophisticated, I don't understand why we can't catch up. It's just a big frustration. So we really need to look at how do we capitalize on the technology that exists to make ourselves more efficient and reduce costs overall.

And the final statement I want to make is that we are spending a lot of money for healthcare, and it has truly not translated into the type of outcomes when you look at other countries. We can do better, and we can take those same dollars and be much more efficient in terms of the management of those dollars.

CHAIRPERSON JOHNSON: Okay. We'd like to come back later to hear more about some of the solutions you've just touched on, but let me see if we've captured your issues. Starting at the bottom, what I heard you say is at the end we need better quality outcomes. We're behind in the area of IT, why can't we bring the medical system up to speed in the use of information technology, probably including the

electronic health record, but we need to be much more efficient in that area.

We have, I think I heard you say, not only a lack of coordination, but a lack of comprehension. What I thought you intended by that is an understanding between the caregivers of what one is doing and the other is doing, and maybe that gets down to this is a potential solution for that.

And I put down transfer of numbers to be personal, and what I thought I heard you say is we've talked about these big numbers -- and I used a bunch to start with -- but oftentimes those are distant to us. They don't always apply personally. You've shared a little bit about your experience with your mom and how this has become personal to you. And I think all of us would share certain examples. Senator Hatch talked about some of his colleagues who have had medical errors in which they have been involved. But you're not only reflecting on that, you're saying let's take some of these -- what I'd like to do is make sure that we're making some of the numbers that we're talking about felt personal to us as we're going through this process.

MS. MARYLAND: The other comment I made was that it was personal responsibility, too. That was another piece that you might include in there. If you're personally on the hook for paying some portion, given what you can afford based on your income, that translates I think into personal compliance.

CHAIRPERSON JOHNSON: Another thing I thought I heard you say at the start was we did have -- where I was before, we did have a plan to cover the uncompensated care. We weren't doing that in a financial and viable method.

MS. MARYLAND: That was my frustration with the Detroit Medical Center, and they're an important system to Detroit, but there was a lack of pro-activeness, I think, in that system, other than asking the State for more money for Medicaid funding and increasing that pool. To me, that's not proactive. What I've been impressed about when I made the move to St. Vincent is that the system that we belong to, Ascension Health, has been very proactive, that we are responsible for making sure that healthcare is provided and it leaves no one behind, but let's be more proactive about it. Let's have a

shared type of way of being able to address the needs of the uninsured.

CHAIRPERSON JOHNSON: Thank you. Rosie.

MS. PEREZ: I'm Rosie Perez, and so far everyone has said a little of something I wanted to say, so that's cut down my list a little bit, so I thank you for that.

CHAIRPERSON JOHNSON: Well, don't hesitate to repeat the issues that you're facing so we really capture them.

MS. PEREZ: I've been a nurse for 19 years. I was counting up, and actually a few minutes ago, it kind of took me by surprise that I've been a nurse for 19 years. It kind of freaked me out that I'd been doing this for that long, but started out very young. Started out in a suburban hospital, worked trauma, ER and, as Dorothy had mentioned, I thought, well, all these people coming in accidents, if they would just wear their helmets and put their seatbelts on, we wouldn't have these issues.

So, then I made the transition to try to do more public health, community health, believing if people just had the information we'd be better off,

but that hasn't worked either because then you get into other issues of they can't read English, or they don't have access to care, or they can't afford to pay for care, or a doctor gives them a prescription for a pill to take three times a day with meals and maybe they're lucky if they get one meal a day, and so now that person is, like, "They said three times a day with meals, so now what am I supposed to do?" so that's been kind of my work for the past 11 years as Director of Community Outreach at Christa St. Joseph Hospital. We're the seventh largest Catholic healthcare facility, with Ascension being the first.

But that has brought a different perspective as well because our mission to extend the healing ministry of Jesus Christ makes it very broad as to what we do, and the expectations of a faith-based healthcare facility, people come in and you're the Sisters of Charity, or you're Christas, or you're faith-based, you're supposed to give the care for free. Well, our Sisters fortunately have stayed in business for over 150 years and they didn't do that by just giving away free healthcare. So, how do we kind of balance some of those issues.

My family has been in Texas forever. We have a saying that the border crossed us, we didn't cross the border. So that's another piece. We talked about the uninsured, but I'm going to put it out there. One of my major issues and concerns is how do we pay for healthcare for undocumented people? That's a reality. That's something that we're coming to terms with. I know in Houston that's a backlash. If we didn't have so many illegals -- I don't care for that term, I'll use undocumented -- if we didn't have so many undocumented people here, we'd have healthcare for everyone. But the reality is that we've created a culture that brings them in, we use them for our workforce, we need them for our workforce, but then we don't want to offer them the services that are due everyone else. So, that's something that we have to come to terms with.

They can't apply for prescription programs because they don't have a Social Security Number. Well, we want them to pay taxes, but then we don't have a system set up for them to do that. So, I think it's all kind of interrelated and we need to know how we're going to come to terms in dealing with these

populations, and then there's others. There's other immigrants who have come here to the country and their coverage is spotty. Some people will qualify for Medicaid by virtue of their visa status, or they won't access certain benefits that are due them because they are afraid that's going to affect their citizenship applications. And so we kind of have just made it very difficult for a lot of people to access services.

In Houston, believe it or not, we just found out what federally qualified health centers are, and we've just gotten our second one. So, yeah, everyone else in the nation has got 15 of them, and we've just now got our second one, and we have several communities that are working on FQHC status if not look-alike status. Why is that? Well, we have the Texas Medical Center, so I think there was a perception that we had this world-famous medical center and people were accessing healthcare and the latest technology and access to the latest research when that is not the reality. We have the worst health outcomes in Texas and Houston for immunizations down to cancer. Fortunately, we have M.D. Anderson and Dr. Lovell Jones, who sit on the ICC Council

examining the unequal burden of cancer, a minority group making a lot of changes, but the reality is that still we have large groups of communities and people that do not access that care in the medical center. So, they're excited about FQHCs.

Another issue and concern is we have a lot of those communities, where the initiatives for applying for those statuses comes out of, again, a faith-based coalition. So, a lot of them have issues with the government and the requirements to apply for federal funding, which would be the family planning issues, so have to struggle with whether they're going to make the decision about going after federal funds being that there are certain requirements built in that it's all or nothing. So people are trying to work around some of those issues and trying to provide access points in communities to reach people.

I think another issue that I find of great interest is the nonprofit status for hospitals. In Texas, if you want to be a nonprofit, 5 percent charity care is the requirement. Some hospitals would choose to do that right off what comes in through the emergency room. Other people will say, "Oh, it's

health fairs out in the community." So, there are thiese differing criteria as to what charity care is or what needs to be given. And of course there are also disparities in that a lot of hospitals will pretty much stick to 5 percent, and then there are healthcare facilities such as mine and others that will give upwards of 13 percent.

So, again, there's no one saying, "Hey, you're doing more than your share, it's time for other people to come up." We've started this, we're in this, we're committed to this, so now we can't cut back and say, "Well, everyone else is only giving 5 percent, so now we need to cut back and make a little money ourselves."

So, I have an interest in how these systems are created and how they come to be, and if there's anything we can do to change that.

I think everyone has talked about personal responsibility, and I think that's very big. And I think something that maybe I haven't heard yet because it's all come up in forms of payment, monetary payment, but I run a free clinic in a community out of a church, and we have plenty of people that come up

and say, "I really can't afford to pay anything." And I visit these people in their homes as I'm delivering their free medications, and they are living in Third World conditions. They have no running water, they have no electricity, they have no food. The food that they get -- talk about nutrition education -- they're going to pantries. They don't have choices about what they're going to get. But they come back to the clinic very willingly and say, "I don't have any money to offer." Some statements are, "I don't know anything, I'm stupid, I'm illiterate, but I'm here to help, whatever I can do -- if it's to take out the trash, or if it's to sign in people, or if it's to file -- I want to give back." So, I think we also need to look other ways of having people pay back into the system other than monetary.

And they're very concerned about Medicaid. On the plane over here, there was a report released in Texas, and the number of providers that are accepting new Medicaid patients is dwindling. Fortunately, in Houston, we're still like 36 percent of the providers will accept a new Medicaid, but we have other large cities in Texas, like Austin and

Dallas, where 76 percent of providers are not accepting new Medicaid or, if they do, it's because of a sibling or it's very limited services that they are providing. So, I think that that's some issues that we'll start to deal with as well.

CHAIRPERSON JOHNSON: Is that both Medicaid and Medicare?

MS. PEREZ: Medicaid only.

MS. BAZOS: Would you talk a little bit about the reimbursement in your region to put up on the board for Medicaid?

MS. PEREZ: Well, it's not enough. And that maybe extends to CHIP. We had our major Texas Children's Hospital who aggressively went into communities of color and underserved communities to sign up children for CHIP, and we assisted in doing that. And then a year after that, they're kind of like, well, the $18 reimbursement per child isn't enough, and of course you have people like me saying, well, before you were getting zero, so this is something better than nothing, but they don't see it that way.

So, obviously the amount, and then the

paperwork. We have providers that won't even apply for the Vaccine For Children Program which gives free immunization because of the paperwork. They say they'd have to hire another staff just to keep up with the paperwork and the inventory and the reports, and it's the same for Medicaid. So, big issues.

CHAIRPERSON JOHNSON: Here's what I heard. Let me test. Patients can't read English, so how can they follow the instructions that they're given? Poverty makes it difficult to comply with prescriptions, and would it be not only prescriptions of medication, but maybe other types of prescriptions of care, but what you pointed out as an example was "I'm supposed to take my medication with food three times daily, and I only have one or two meals a day".

Just plain uninsured, that's an issue. Payment of care for undocumented folks. They can't apply for assistance, or they won't apply for assistance. They may not be aware -- we, or others, or some of us may not be aware of assistance programs already in place. There are programs that might be out there and funded, but either we as individuals or maybe even certain groups aren't aware of programs

already in place available to help people, which implies maybe marketing of those programs might be helpful, I suppose.

Availability of federal funds for faith-based programs. What I thought I heard you say is that there still are some issues having federal money available to faith-based programs because they happen to be affiliated with a church or synagogue. And, finally, what I heard you say is there a reduced number of doctors accepting Medicaid patients, and I suspect we will find the same issue relating to accepting Medicare patients, although we haven't addressed that so far. But the number you talked about was 76 percent are not accepting in your area.

MS. PEREZ: Right. And that was kind of an important thing because I think up on one of the slides it talked about educating and enrolling people about existing programs. Well, that's great, and if you put all that resource and money to doing that but then they don't have a provider to go to.

CHAIRPERSON JOHNSON: Okay.

MR. HANSEN: If I could just add something that goes along the lines about the comment of society

that Frank made, but directly to Rosie's point about the undocumented. And we deal with tens of thousands of those in the poultry and the packing industries, and there are literally millions in the United States. But a lot of the companies -- and they're here -- I don't like the word "illegally" here, but they're here without papers, and you have to sign up for the insurance. And sometimes, and more often than not, they are told to sign this, it goes in the record and all that stuff, so they don't, and that adds to the uncompensated costs. And where a lot of these plants are, they are in small towns in rural America, and it really drives up some tremendous costs and I think leads to a lessening of quality care, from our experience anyway.

CHAIRPERSON JOHNSON: Thank you. We're at 12:15, but I'm just pointing that out to you not to push you along because if we don't get through each of you before lunch, we'll take some time after lunch, so we want to hear from each of you.

Deb, why don't we continue with you and Aaron, Chris, and Mike, and Catherine as well.

MS. STEHR: I'm Deb Stehr. I'm from Lake

View, Iowa, which is a very rural community in northwest Iowa, population of about approximately 1200 people, and like no jobs. The jobs that are there don't have health insurance. I'm married to my husband now for almost 27 years. We have two children. Mike is 25, and he is one of those young adults who doesn't have health insurance. And our youngest son, Jonathan, is 22. He was born prematurely, in December of 1982. We didn't have health insurance. He was born en route to the hospital in a car, in intensive care for six weeks in Children's Hospital in Des Moines. We didn't have health insurance, so not only were we very worried about this sick baby, we were worried how we were going to pay for this because I can remember the bill was like far more than what we would make even in a year.

My husband is self-employed, he has an auto body repair shop, so he pays for the business, all the overhead for the business. So, when John was growing up, it took basically two of us to take care of him. Even today he pretty well needs 24-hour care. So, I waited tables at night, and my husband

worked the business during the day, and we shared the role of childcare. It didn't make sense for me to work during the day because you never knew when he was going to be sick. He was sick a lot, and in and out of the hospital for surgeries.

He's doing quite well today. He's a Medicaid recipient. He's an adult. He's actually his own guardian, which is kind of cool, except we, through the whole Terri Schiavo thing, realized we do need to make sure we have some authority over his medical care because there are decisions he's going to make that may not be the best. I'll admit he's a little hypochondriac. He watches too many of those drug advertisements on TV every day, and he's convinced he's got acid reflux disease, now he's got kidney problems. I mean, he sees the stuff on TV, he will actually go to the doctor and say "I want this drug", and I'm going to the doctor "No, no, no, he doesn't need it".

CHAIRPERSON JOHNSON: He's just like the rest of us.

(Laughter.)

MS. STEHR: Yeah. And I think it just

goes to show a good point about the whole advertising thing. And I guess Jonathan has really changed my life a lot, like not having the health insurance. Because of him and seeing what we went through with him and him on Medicaid, it makes me far more interested in what's going on with the healthcare system.

I got very involved in a Citizens' Action Organization ten years ago during the first major attack on Medicaid in 1995, had spoken out -- actually have my ten-year anniversary coming up of public speaking when I spoke out at a press conference in May of '95 and shared my personal story, and I've literally been at it ever since.

I'm concerned about the healthcare system. I literally applied for this Working Group more or less out of like sheer frustration. I applied on a whim out of sheer frustration thinking, I'm not going to get it anyway, and applied. And after going back and reading more on it and talking to people, I thought, wow, this is such a wonderful opportunity. So, I bring to the table what it's like to not have health insurance, and to live in rural Iowa where

there's not a lot of doctors.

And I can also look back 20-25 years ago, we were lucky enough to have those good hometown family doctors. They would see you, and if you didn't have money, you still paid for it, but you paid a little bit. You paid it when you could afford it. They were really open about giving you drug samples. A couple of us would go in together and they might charge for one office call. Or even if there was an emergency -- my 25-year-old had attention deficit disorder and he was a hyperactive and really risk-taking kid, so we spent a lot of time in what might have been emergency rooms, but because we had this great family doc and his office was two blocks away, we could get in on a Sunday, or at night. He'd make a point of coming and providing healthcare, and that doesn't happen, I don't think, anymore.

I don't know, it's just like I said, worried about Medicaid, worried about cuts. I know Medicaid doesn't just pay for the healthcare, it's all those additional services that come with it. For someone that has severe disabilities and needs the extra care -- he uses a lot of home computing based

services, he's on the Medicaid MR waiver, so through the years he's had supportive community living, we've accessed respite services, and he currently uses CDAC, which is Consumer Directed Attendant Care, and we went to that system because he was using nursing after a major, major surgery when he was laid up for six months after he'd had his spine straightened for scoliosis, but we got to the point where a healthcare agency wouldn't take us, the home healthcare agency wouldn't take us because he had grown and was a high care level, so we went to CDAC.

We lost our provider shortly after he graduated from high school, and I ended up becoming a Medicaid provider, and I am now his CDAC for life. I get paid for five hours a day, I'm with him 24 hours. And it seems to be working. Most of the time it works. He can get pretty stubborn at times. He's threatening to fire me if I'm going to be gone too much. It's like, "Okay, Mom, you've got this job. I'm going to fire you". I'm like, "Jon, I'm not going to be gone that long, don't worry about it". It just makes me more aware how important Medicaid is, and I don't think it's taken into consideration the

different needs and how they impact the different families. And also with his disability, it would be hard to get him health insurance. And like I said, my family being uninsured, as I've gotten older it really scares the hell out of me I don't have health insurance. I can't think of anything else to add, so I hope that we can accomplish something really good and get something done.

CHAIRPERSON JOHNSON: Let me see if I've captured some of your thoughts. The challenges of actually being uninsured go beyond just being uninsured.

MS. STEHR: Yes. Well, you can access care, you just can't pay for it.

CHAIRPERSON JOHNSON: Secondly, you talked about the drug advertising, and I don't know if that was just kind of a throwaway comment or --

MS. STEHR: I think it's a problem.

CHAIRPERSON JOHNSON: You think it's an issue.

MS. STEHR: I think it's a problem. And now they are even advertising artificial joints, knee replacements. They advertise knee replacements on TV.

It's insane. Some of the stuff just doesn't need to be advertised, the advice needs to come from the doctor, not off the television.

CHAIRPERSON JOHNSON: Well, even Jane Fonda this last week has kind of promoted that business, I think. Availability of Medicaid docs, someone mentioned that earlier, but --

MS. STEHR: Well, not just the Medicaid, the doctors in general, particularly in your rural areas, it's hard to recruit them. We had a wonderful doctor that came into our rural clinic, and he was there two to three years -- he just went to Florida -- so we're back to we don't have a doctor again. You know, they come to rural areas, they work -- they're required -- I suppose there's some minimum requirement they need to work, and then they leave. So, that's a problem.

CHAIRPERSON JOHNSON: And then what I heard you say is there's a difficulty in obtaining healthcare coverage not because of the cost only, but the availability if you've had a history of health challenges can be a problem -- the ability to get the coverage even if you could afford to buy it.

MS. STEHR: Yes, the pre-existing conditions.

CHAIRPERSON JOHNSON: Have I captured your issues, or are there others that I missed?

MS. STEHR: That's pretty well it, it adds to what's already up there, and I'm sure other people are going to throw more.

CHAIRPERSON JOHNSON: Thanks, Deb. Aaron?

DR. SHIRLEY: I'm Aaron Shirley. I'm a pediatrician by training. Prior to becoming a pediatrician, I was one of those frontier doctors who made house calls, delivered babies, did a little of everything.

What got me there, I went to school on a State scholarship that required me to spend a minimum of five years in a rural area in Mississippi. I ended up in Warren County, Mississippi, which is part of the Mississippi Delta, and that's where I practiced for five years.

I always wanted to be a pediatrician. Oh, by the way, I accepted cash, live chickens, as payment for services, and I did get a lot of that. My kids were used to me bringing home live animals from the

office, and they liked that a lot.

I always wanted to be a pediatrician, so when I completed the five-year obligation, I applied for a pediatric residency at the University of Mississippi Medical Center. To my surprise, (as my surprise with being named to this group) I was accepted as a resident, and I was the first black resident in any discipline that they'd ever had, and that was 40 years ago. And for ten years, I was the only black pediatrician in the State. And what that meant was the University, being a teaching hospital, received patients from all over the State. We have 82 counties.

So, people from every county knew me if they had had a child hospitalized at the University, by virtue of the fact that I was black and I stood out, and they knew me. And what that did was, when I was chief resident, one night I lost 11 babies, and I lost them to conditions that could have been prevented. In those days, infectious diseases -- we lost babies from infectious diseases, severe dehydration, two of the major reasons we lost them.

We had antibiotics back then and we knew

how to treat those conditions, but in many of the communities where those babies were coming from -- they saw the University as a place for sick kids -- so they didn't apply -- because the individuals were poor, they didn't apply the knowledge and the technology that they had, they just shipped them to the University. And that had a lot to do with formulating what I would do once I completed the residency.

I had planned to do the residency, enter private practice, and be a comfortable practicing pediatrician. But having been exposed to those conditions that I saw as a resident, I decided that there had to be a better way.

So, I completed the residency, opened up a private office, but at the same time started pursuing alternatives, and this is when I learned about the community health centers. So I set out to develop that concept in Mississippi for the first time, and to my surprise it was a concept at that time that was opposed by the local and State health officers, the governor and key policymakers because the community health center concept was a little foreign from the

typical AMA type provider, it was viewed more as somewhat of a type of socialized medicine, and that it was the government interfering.

The governor at the time had veto authority over those community health center grants, and the governor would summarily veto the grants that had been approved. We had then what was called the Office of Economic Opportunity, and the Office of Economic Opportunity had the authority to override the governor's veto. And each year -- the funding was on an annual cycle. Each year, as long as the authority for community health centers was within the Office of Economic Opportunity, the governor would summarily veto the grant, and we'd have to go through a process of justifying and refuting what the governor and the medical society used as justification for vetoing the grant.

All that did was to kind of make us more determined. So, instead of ending up with one community health center, I got involved in developing four or five other community health centers in other parts of the State.

One interesting thing about that in

today's world, the person who had the authority to override the governor's veto at that time in 1970 was one Donald Rumsfeld. And I got to know him at that time because we would have to write him to justify his overriding the governor's veto, and on one occasion he did make a visit to Mississippi and visited with us and looked at the health center and decided that we were doing what we were supposed to do, doing it right, and he overrode the veto. So, every time I see him at the Department of Defense, I think, wow, he's come a long way.

I applied to become a part of this group because I wanted a second chance. I did spend time with the Clinton Administration efforts to implement a program. I co-chaired the Subcommittee on Vulnerable Population, and that is my concern as we move forward, the population that's vulnerable. And you say, "Who are they, what makes them vulnerable?" Well, things that make them vulnerable are race, poverty, geography, and I think the most dangerous, troubling feature that makes them vulnerable is -- and it has to do with what I think contributes to some of the disparities that we see, and I'll use a personal

experience to explain that.

Several years ago I got careless cleaning fish and I cut my hand in the middle of the night, and I went to the emergency room and they sewed it up, did what an emergency room is supposed to do. About three or four months after the wound healed, I lost some flexion in this thumb. So, I pursued a solution to it, and it was determined that a tendon had been severed and it wasn't sewn back.

Now, where my office is located is in a medical facility, and just around the corner from my office is a hand clinic, it's a group of doctors who specialize in treatment of the hand. So, I go around to the hand clinic -- it's part of the University's teaching component -- and I go around to the hand clinic to request an appointment. And the question was, okay, what's the problem? I told them I couldn't bend my thumb, and they said, okay. Well, we can get you an appointment next week. What's your method of payment? I pulled out my BlueCross/BlueShield card and said "here it is". They said, "Oh, we can't see you here, you have to go to Providian". I didn't realize this. I worked for the University, I knew

there was a Providian, but I also knew that there was a clinic right next to me. And they said, "You have to go to Pavilion because we don't accept private insurance here".

CHAIRPERSON JOHNSON: That was another clinic of some sort?

DR. SHIRLEY: No. "You'll have to go to Providian." I said, "Well, who do you accept?" They said, "We accept only Medicaid and uninsured". So I put on my arrogant hat, and I said, "No, you're going to see me here".

The point I'm making is we have a dual system, and I wonder if dual systems inevitably contribute to some of the disparities -- racial disparity, economic disparity -- because if a physician is trained in an environment that segregates on the basis of pay status, whether that doesn't carry over in some respect as to how that patient is viewed, and whether that physician once he completes his training, a Medicaid client walks in, having been exposed to a system that systematically segregates people based on that, whether there are some subconscious desires -- maybe not desires -- some

subconscious element that determines how that patient is treated. And I find it difficult to separate out how a person can say if you are Medicaid you are treated over here, does that make you less worthy than if you have BlueCross/BlueShield. What is the reason for restricting -- I'm talking about access -- I was restricted access because I had good insurance. That's one.

And the other has to do with so much that others have mentioned, the Medicaid -- the other Medicaid situation where fewer physicians accept Medicaid. Here we have physicians who accept them, but in different parts of the healthcare system.

You mentioned Medicare. In Mississippi, there's a growing number of physicians who are limiting their Medicare practices now. And most of that is driven by paper regulations and the level of payment. In rural Mississippi, there are fewer and fewer physicians to speak of, and there are fewer and fewer physicians who routinely accept Medicaid, and that's been mentioned before.

The next concern I have is we, as other States, have a major crisis in Medicaid funding, and

there are some deliberate barriers being implemented to reduce the number of individuals, first of all, who will apply, to modify the eligibility criteria, and as far as the Child Health Insurance Program, the CHIP program, all outreach efforts have been curtailed because it was too successful. There were more kids enrolled than had been anticipated, so it is viewed as contributing to the financial crisis of the program.

CHAIRPERSON JOHNSON: Have I captured your comments?

DR. SHIRLEY: That's basically it. Most of whatever else I had has been covered already.

CHAIRPERSON JOHNSON: Okay. You'll have another chance, I suspect, along with the rest of us. Pat?

MS. MARYLAND: I'll talk to all the doctors now, MDs in the room, no one has mentioned medical malpractice and the escalating cost of that. I'm just throwing that out as just a comment.

CHAIRPERSON JOHNSON: I was thinking about the same thing, and I wondered, well, should we address that, ask the question now. So, maybe we'll take lunch, and we'll come back and ask, especially

those of you who are physicians, if you have any comments on that as we get started this afternoon.

It's about 20 to now, 20 to 1:00, and I'm wondering if this would be a good place to take a break, and then Chris will come back and ask you to start, so maybe when we reconvene at ten after 2:00, if that's okay -- ten after 1:00, I beg your pardon.

(Whereupon, at 12:41 p.m., the luncheon recess was taken.)

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

(1:20 p.m.)

CHAIRPERSON JOHNSON: You'll notice that what we're doing is we're putting the issues up on the wall over here. And when we're through going through each of us raising our issues, we're going to actually go outside and talk about them.

(Laughter.)

No. I'm looking at another group that's sitting out here, and I'm thinking to myself, why don't we do that? We'll be thinking through some of these as we're going through the next session of what are some of the initiatives already in place or we think would potentially help us here. But we'll proceed, and I think, Chris, you're up next.

MS. WRIGHT: I'm up next, to start us off after lunch.

I'm Chris Wright, a registered nurse from Sioux Falls, South Dakota. I have a few years lead on you, Rosie, in that I've been doing nursing for 28 years. You will notice a little bit of a varied accent when I talk. I can say "dawg" because I'm really from New Jersey, but I lived 27 years in

Florida, so I also say "y'all". I moved out of central Florida, Orlando area, in 1996, to Sioux Falls, South Dakota, and what a difference in healthcare. We went from HMOs to PPOs to very little penetration in the South Dakota area, to actually going back to your internal med/family practice docs. They do, even in Sioux Falls, still make home visits. Some of our oncologists have to make home visits. We also have physicians that do outreach into a lot of the rural areas in our tri-state area.

Sioux Falls is in the southeast corner of South Dakota. The other side of the state is Mount Rushmore, so we also include parts of Iowa and Minnesota. There's a large ruralness. We are the largest -- I work for Sioux Valley Hospital and Health System, the largest healthcare provider in the state. The state population is 750,000, with the town population of 135,000. There are only three major healthcare systems in the state, and we are one of the three. In the whole State of South Dakota, Sioux Valley is the second-largest employer, with the state being the largest employer. John Morell's is in town, so we do work with them and have those issues.

I have a varied background in nursing but I currently am Director of Oncology Services and Radiation Therapy at Sioux Valley Hospital. We've built that center from the ground up. I have past experience as an emergency room nurse, trauma nurse, and EMT. Therese, I did 12 years on dialysis. I've worked with end-stage renal disease and know that part it inside and out also. In fact, we're applying to do renal transplants at our hospital, so I'm lending my expertise, or at least some knowledge, I should say, to that area.

The way I got involved with this group is I actually got an e-mail -- I'm the Healthcare Policy Liaison through the Oncology Nursing Society for our State of South Dakota, and we get on conference calls at least quarterly, and also get e-mails from them, and the local Washington representative did go ahead and e-mail to all the state health representatives that application. And I sort of took a look at it and said, I can do this, for numerous reasons. I first and foremost thought about my clinical side and my expert side, but also thought about personal experiences that I can bring to this, and what I've

seen even recently with family issues.

I think some of the healthcare issues concerning America today are, No. 1, we take a look at our eldercare and numerous issues that the elderly have. I have an 85-year-old mother who is healthy except for blood pressure medicine, who does live with me and has lived with me since 1989. It has been my philosophy, though, that she will continue to live with me, and that we need to take care of our senior citizens and not -- I hate to say -- dispose of them in nursing homes, but we too much turn to nursing homes. Certainly it is not an obligation of the children or a family then to go ahead and take care of their parents, but in some way we need to get back to the basics there.

I have seen her issues, too, with even the elderly on their own with medication, and she just takes hypertension medicine, but the cost of the medications today for the senior citizens where it really hit me that it does have to come down to a choice of do they buy their medications or do they buy food for the table and get something decent to eat. So that is a tough choice.

There is VA care. Certainly in the State of South Dakota there is the Indian Health Service which serves a large Native American population, and they are an interesting, diverse culture to work with and with their beliefs. It's interesting because their service is provided by the government, but the funding comes in in one lump sum in the beginning of the year, so that towards the end of their fiscal year when they run out of money, we are having problems getting those people to our tertiary hospitals for care, such as renal dialysis. Who provides that transportation? So the funding is not there.

The affordability I said of prescriptions, the affordability of hospital bills and costs. I have personal experience in navigating through that system. I had personal experience with my husband in two ways, in that he had some major surgery, but also then my in-law who had cancer, also in another State, but to get them through the system by saying home health is available, palliative care is available, hospice is available, they can bring in this for you, they can bring in that for you, you can get so much per day, or whatever.

Since that time, I guess, word has sort of gotten out on a personal level, and I have numerous people, my associates in the hospital, that call me for their relatives that are out of state saying, "My father-in-law is dying of cancer, what can we do", and that type of stuff. So helping someone actually navigate that tremendous web of our healthcare system, and understanding the bills and understanding what the payment is.

The uninsured. Taking a look at not only the diverse groups we have, but our state is largely rural, in that they are mostly farmers and ranchers, so they are a single independent business that have no insurance whatsoever, and one hospitalization, the old saying is, can literally cost them their farm.

Also seeing no standardization of payment with insurance companies beyond the opposite end now, with your major payers and your intermediaries, where one may cover a chemotherapeutic drug and another large company will not pay either as much or disallows it altogether, so there is no standardization of payments received and what is allowable.

I have recently, in the past four years,

gotten involved with palliative care and built a palliative care team in our hospital, which I could talk about forever. But, again, that is sort of the way I see it going where you actually take that person -- I've heard a lot of it here today -- where you take that person in the beginning of their chronic illness. We don't wait for the last six months to try to get them into hospice and get the care, but actually at the beginning of that chronic illness, throughout the trajectory of the disease, walk with them hand-in-hand to provide that support and medical need and education and guidance of nutrition and therapy and that sort of thing.

The other part, on a personal note, that is really scaring me these days so much is that I'm on listserves where I get news about different hospitals and different happenings going on throughout the United States and the number of mental health hospitals that are closing down, and the access to there.

My husband was diagnosed in 1999 with bipolar disease, and it has been, to say the least, quite an interesting and challenging battle to get

help and services and medication, and get Social Security income for him -- you're talking about a man who has a Bachelor's Degree, who worked in law enforcement for 30 years -- and to see a change in that. So you wonder, because I am an ordinary citizen, how other ordinary citizens are coping and managing and doing that. Again, thanks to the job that I have and the salary that I make, I was able to support us. It took us three years to get his Social Security income accepted and now through the state, but I'm able to support him. But my fear was what would happen to me -- because I am the caregiver for him and for my mother, what would happen to them, what would happen to our house, those payments, if I became majorly ill and that type of stuff.

The VA system. We have a large VA Hospital also in South Dakota, right in Sioux Falls, and don't have access problems like I know of and have heard of in other states. Again, coming from Florida, you call the VA, and you used to have to wait several weeks, if not months, to get into that system to take care of those servicemen and women that have paid their dues for our country and joined the military

services and protected and defended our rights. I think there is an amount that goes back to them that is needed for access to care.

Costs. Again, back to costs and the cost of pharmaceuticals. Being in oncology, we certainly encourage research and new programs, new drugs, and obviously that research is how we get to our new standards of care for today, through that research, but the amount of money and time that goes into research and development and then finally coming out with that high cost of the drugs makes it impossible for some of the people, even insurance companies, to go ahead and pay.

When we talk about one chemotherapeutic drug costing about $60,000 a month for treatment, it's beyond reasoning. Again, going back to my husband's personal experience with some back surgery, even though I had insurance, he had insurance at the time, the hospital stay didn't go as well as we planned. We expected him to be in and out in two days. He wound up on a respirator in the intensive care unit for five days, in a neuro-acute unit for four more days. The 20 percent of my bill that I would have had to have

paid was $80,000. And I sit back and think, it is just phenomenal how even at $80,000 and the salary that I make per year, how other people can afford that and afford to pay that. So it is time to go ahead and take a look at this -- obviously, way beyond time -- and I am excited to go ahead and do that.

I was quite surprised I was chosen. I hope it was, again, the geography, the ruralness of the state, the diversity in the state with Native Americans, plus also then the urban background that I bring in, along with my nursing career.

About ten years ago, I decided I couldn't see myself at the age of 60-something pushing a medication cart down the hallway. I didn't think physically I'd be able to do it, so I did make myself go back to college, and was thankful that I did. And actually this is quite useful because my undergraduate degree and then my graduate degree turned out to be in public administration, so it does go quite hand-in-hand.

CHAIRPERSON JOHNSON: Okay. Chris, we heard you talk about just briefly at the start some issues for Native Americans. Can you just share a few

more thoughts on what you are perceiving the needs for those citizens to be?

MS. WRIGHT: If you take a look at the reservations in South Dakota, they are in the rural part of our State. You can say, okay, whole state is rural, Chris, but truly the western part of the state. The reservations are out there by themselves. There is no business. They have no economy. So you go to the Indian Health Services, and you see in their hospitals and clinics where they want to eradicate alcoholism. Our fetal alcohol syndrome baby rate is horrendous, the teenage pregnancy rate, the drug and alcohol abuse, but there is no industry on the reservation.

A lot of them think, and still think, and thought maybe, that the cure-all and end-all was to get casinos on the reservations. Well, it's nice you have these casinos on the reservations, but they are literally in the middle of nowhere with nothing else around it. So people come and spend the day, but then leave because there is nothing around it. So the housing conditions.

Some of the hospitals they have are

absolutely gorgeous and they are trying to bring the best services and equipment there to them. But, again, they are a secondary hospital; they are not a tertiary hospital.

Their dietary habits. We do have a high rate of diabetes. We have a high rate of end-stage renal disease that goes along with that.

CHAIRPERSON JOHNSON: Thank you. And then what we heard is that you believe that we have an issue with eldercare, and my sense was you weren't talking about elder healthcare. You're thinking about care for the elderly, like long-term care and so forth, and healthcare for the elderly as well. And then what I thought I heard you say was for some of us who have out-of-state parents, there can be issues as to how we coordinate for them hospice care or appropriate nursing care, nutrition, therapy, and so forth. Did I hear correctly there?

MS. WRIGHT: Truly, the way I defined that is navigating. How do we navigate the system?

CHAIRPERSON JOHNSON: Okay. Thank you. And then we talked a little bit about critical care in the rural areas, and that applies to both Native

Americans and others in places like South Dakota, Iowa, other areas. I'm sure Mississippi. The lack of payment standardization. You're not sure, if a doctor treats someone, whether or not it is covered by the health plan.

MS. WRIGHT: That we can very easily check on. It is different health plans, your major health intermediaries are covering different things, especially taking a look at some of your new treatments that are coming out where BlueCross and BlueShield may very easily accept payment, but even BlueCross of Minnesota is not paying the same or would recognize --

CHAIRPERSON JOHNSON: Different exclusions. Closing of mental health care facilities, and the cost of pharmaceuticals. Then you talked about some potential issues in the VA system, and you said yours is working pretty well, I think, but are there others --

MS. WRIGHT: I do see other large ones throughout the United States where there's a long wait, and it's a tiered system so that, again, it is by percentage of disability or based on a percentage

of the years they served or whatever. So if you're at 80 percent, you can come in; if it's 20 percent, don't even bother coming in.

CHAIRPERSON JOHNSON: Okay. Thank you.

MS. BAZOS: Could you just add an interface with the VA system? Would you add Medicaid and Medicare to that, the Medicare-VA interface, just so we don't forget to talk about that later, because that's important.

CHAIRPERSON JOHNSON: Thank you.

MS. HUGHES: Excuse me, Randy. Would you also, with the Native Americans, put down mental health because I know in California we're working with mental health issues that are specific to Native Americans, not to leave anybody out, in terms of mental health needs.

CHAIRPERSON JOHNSON: Thank you.

DR. BAUMEISTER: The insurance variability is a huge issue for practicing doctors. I have to be very careful with Senator Wyden sitting back there thinking I'm going to get into the blame game here. But if you have 15 or 20 different insurance companies reimbursing you for your fees, every one of them is

different.

MR. O'GRADY: At the same time, when she was talking, I was thinking we could be very uniform and just say, no, it's not covered. I mean, you want to be careful how you -- I mean, to a certain degree, the situation of which BlueCross you're dealing with at least allows some window of opportunity to try new things and do different things. I mean, it cuts both ways was all I was thinking while she was talking.

DR. BAUMEISTER: You're right, but it's very interesting.

CHAIRPERSON JOHNSON: Maybe we'll move to health information technology that will help us with that, but before we get there -- Frank, I don't want to minimize your comment.

DR. BAUMEISTER: Oh, sure. I understand.

CHAIRPERSON JOHNSON: Mike O'Grady is from HHS and has been designated by Secretary Leavitt, Mike Leavitt, to be working with us and share his expertise. And having been in just a few meetings with Mike prior to today, I have an increased appreciation for the expertise he brings. So, Mike, we're glad you're here, look forward to your counsel

as well as your participation with us, and please do what we've been doing.

MR. O'GRADY: Thank you. I'm Mike O'Grady. I'm the Assistant Secretary for Planning and Evaluation at HHS, and as you saw in the enabling legislation, there are the various members and then the Secretary of HHS. And hopefully we'll get Mike Leavitt out for some of these, but in the meantime I'm sitting in that chair. And there's a number of different things that I'd like to bring up in terms of listening to everybody talk and thinking about how to do this.

One of the reasons that Mike Leavitt asked me to do this other than one of the other assistant secretaries is that I've had a fair amount of experience with commissions and these sorts of groups over the years. I was on the staff of what's called the Medicare Payment Advisory Commission -- I was a senior health economist there -- and I was also a senior health analyst on what was called the Bipartisan Commission for the Future of Medicare, a somewhat contentious commission that many people thought was not particularly bipartisan. So there're

a few lessons to be learned in terms of commissions, and there're certain "rules of the road", or let's just say best practices, things that worked and things that I've seen that haven't worked, so I'd like to share some of those with you.

At the same time -- everybody has sort of run through their bios a little bit to give us a feel from where they come from -- I have a Ph.D. in political science from the University of Rochester, and I've been with the feds for about 25 years, mostly as a civil servant but in the last five or ten as a political appointee. And I come out of a research background. I spent a number of years at the Congressional Research Service, then over at the Medicare Payment Advisory Commission, the Bipartisan Commission, and then to the staff of the Senate Finance Committee. I worked for Chairman Roth. You all remember his IRA. He's no longer in the Senate, but he's in the dictionary, which he took great pride in, that he is in there as the Roth IRA.

So there's a number of things that I've seen evolve in health care over the years, and certainly you can hear the tone, and what are the

themes as they've sort of evolved as different people talk, and there's always this balance that goes on. And I think that if I had to predict the kind of things we'll confront over the next couple of years, balance and sort of finding that right balance between these sort of competing factors will become very important, very key to what we do. There certainly is this notion of helping those that need help the most, and how do you perceive that, how do you think about that, and how to go forward, and that's clearly always balanced by who pays for it, how much is affordable, how you can do that, and what compromise you reach between those.

We certainly have heard the idea of how you protect people, but then we've also heard the themes about people being sensitive to the cost of things and what they really cost, and certainly you can see that in benefit design -- deductibles, co-pay. There's this sort of notion. which we've heard a number of times, about people should have to pay at least a little something to know that this is an expensive procedure or whatever, expensive service, at the same time not wanting to ding those who really are

not in a position to be able to pay very much.

We've also heard the theme, which I would agree with, of personal responsibility. That takes many different forms in my experience. It takes a form in terms of people thinking about themselves as consumers of their own healthcare. One of the things in the work I've done and the research I've done over the years has focused on the notion of the approaching demographic of the retiring of the "Baby Boom", and there's a number of aspects of that that will have fairly serious triggering events that will go on. Clearly, this idea of what you can provide and who will finance it is going to only accelerate in terms of the hard choices and the various conflicts that will come up.

The patient-doctor relationship. As, in effect, money gets tighter and tighter, we're used to a situation where the patient and doctor -- their interests are aligned very closely in terms of health care. We've heard from a number of people that that relationship isn't always as smooth as we would like, but the idea of when you think about, as financing becomes tighter, the relationship between -- I

wouldn't say physicians -- I would say providers in general and their patients, economically they're going to be more and more -- there will be pressure that they be on opposite sides of the table. You can see this now in terms of the announcement of increased beneficiary premiums for the Medicare program. What caused that? Increased payments to physicians. The beneficiaries pay 25 percent of the cost of any increase, and they said, "Whoa, why did this go up 12-15 percent last year?" The answer from the AARP or anyone else, or the Congressional Budget Office, is, if you're going to pay physicians more -- because there was a question about whether the payments were too low and therefore not adequate and people were starting to be concerned that there would not be access -- somebody has to pay for that, and that comes out of -- in Medicare anyway, a quarter comes out of the beneficiary's pocket, the other 75 percent comes out of the taxpayers. So, again, these balances are going to become more and more -- not only are they always underlying, but they will become more heightened, I think, as the Baby Boom continues to retire.

Some of the very good things that we've seen, that you've heard from a number of different people here, is the notion of pushing health care out of a clinical setting. Don't wait until they get to the emergency room, think about prevention, think about different things like that, and that's part of personal responsibility, I think, too, as you've heard other people talk.

Now, I've been a Type 1 diabetic since I was a teenager, and there certainly are a number of things that I have found kind of pertain to this sort of where we're going. One is personal responsibility, and you very quickly learn with something like that that this lovely endocrinologist is not going to lose his eyesight or lose his kidneys or lose his toes, it's going to be you. So whatever advice you get from your physician, we know who the final person who pays the price is going to be. And, therefore, if you don't like your physician, you better find yourself another one fast. And so if you ever talk to Type 1 diabetics, you'll find that they tend to be very prudent consumers in terms of that sort of stuff. And there's a very important area especially living with a

chronic illness of not ending up in a position where you find yourself perceiving yourself as a victim. So there's some of that sort of ramifications of personal responsibility.

There's a number of things that I think are real opportunities for this commission to sort of delve into areas that are not -- to look at them in nontraditional ways. You've heard a number of things here from other people about uncompensated care, often in a hospital setting or a clinic setting. There was a policy decision made in this country 20-30 years about the way that we would deal with uncompensated care was to make payments to hospitals, disproportionate share payments, those sorts of things. That's the way we tried it, and it's worked to a certain degree.

There are other people now that are talking about do you want to not reprogram that money and give actually the uninsured health insurance with that same money. It's fungible. Now, that, I think, is sort of worth thinking about. At the same time, I think it is an example of the sort of stuff this group will hit. If you're talking about a change where

you're actually talking the kind of stuff that Senator Wyden was talking about of actually moving money around on the board here a little bit, you have to know you're coming up against some very strong vested interests in terms of how that money is currently -- and people have gotten used to that money and dependent on that money. And these are not mean people; these are good people trying to do the right thing. And, therefore, change is difficult.

There's also questions that came up about access and whatnot. We have a certain policy in this country having to do with the supply of providers, how many new doctors come out every year. That's not set in stone. Those are open questions that go on. How we finance graduate medical education. It's done a certain way. Is that the most cost-effective way?

Senator Moynihan used to argue very strongly that it was a public good, like a lighthouse, to have the public finance the education of doctors. Other people have argued that there is clearly a very large private market that would loan medical students a fair amount of money to pay for their medical training and that there would be a pretty good

likelihood of paying back those loans later on.

So there's a number of these issues that are conventional wisdom of how we do things in this country, and part of what I've heard today is that part of this group's charge is to think about, well, is that the way we want to continue to do them, or are there other things that we want to think about how to do that sort of stuff.

Another one is Senator Wyden brought up Senator Bob Kerrey, who was on the Bipartisan Commission and just a really good innovative thinker. And he must have made the point any number of times about how you think about categorical eligibility for things. We talked about S-CHIP, we've talked about Medicaid, we've talked about Medicare. We have a system in this country that basically looks at certain criteria -- your income level, whether you've fought in a war, what you did -- and then it determines whether you have health care or not.

A big forgotten population, I think, are the people we normally think of as the homeless. If you are an unmarried man or woman or a childless couple in this country, you can be at 2 percent of the

poverty line, and unless you have a particular disability or some other triggering event, you're not going to get Medicaid, you're not going to get these other things. We have a notion of categories of people that we tend to go on, and those are -- I mean, they're perfectly good policy reasons why we set up programs for the disabled, programs for veterans, but it has ramifications when you think about who slips through.

I wanted to talk to you a little bit about the idea of, like I said, what I think of as commission lore and lessons that I've seen from watching them on, as I say, two or three of them over the years.

Each of you has, in effect, two roles. You have a representative role in terms of being picked because you had various experiences, or are from a union, or you're a doc, or you're from a hospital, or however you think about that stuff. That's an expertise you bring to the table that is an attempt to make this a representative body.

At the same time, you have a role as a trustee. And the ones that I've seen that have been

effective commissions and work groups are the ones where the members can step beyond their constituency, step out of not just being the hospital guy, or the doc guy, or the HMO guy, or whatever, can look at the situation overall, and that's what I call a trustee, be a trustee of the overall -- whatever the question that's being answered.

Now, you're certainly expected to be able to bring to the table your expertise in terms of your particular area and speak to those, but it's a very delicate balance. I've seen too many that have gone south very quickly because the nurse stands up and says how great nurses are, and the chiropractor stands up and says -- okay. We can all do ten minutes of how great whatever our particular point of view is, you know, but that's not going to move the ball forward in reality.

There's also a notion of consensus and diversity, and I think that one of the things I noticed certainly in my time working on the Hill was that the United States is an extremely diverse country. And I don't mean necessarily racially or ethnically, but even just the way you think of things.

And the media I think does a real disservice by implying that this is sort of bickering. But if you go and talk to a group of people and you ask them a question about, like, the uninsured, and you ask a group of a dozen people in Massachusetts what they think and what is the right solution, and they'll come up with a solution, and it will be pretty obvious and slam-dunk. And you go to Texas and you ask another dozen people and they'll pretty quickly, after a day or so, come to a conclusion. They could be a 180-degrees apart in terms of what that is.

And I'll take a little chance here with Senator Wyden, but if you look at what the Congress does, what they really have to do is to find that middle ground across those very, very diverse ways that Americans look at things like their health care, what they think their relationship should be with the government. And I can assure you the dozen folks in Massachusetts are going to have a very different notion of the government role than the dozen folks in Texas are going to have, much less the dozen folks in Alaska, or the dozen folks in Florida, or however you think about that.

So there's a wide diversity out there, and the ability of a group like this to be able to step out of their own shoes for a little bit, have a little different perspective, at least will help to be able to bring to bear and come to a point where you can at least understand where the other person is coming from and why some things seem such a slam-dunk when you talk to people who tend to agree with you -- you know, and why can't we just do blah. You see lots of ideas like that never really take hold -- don't really get the momentum that they need. And if this group is going to be successful at pulling together things that then the Senators can run with and do something with -- you know, the charge is to be innovative and to come up with new things, at the same time they have to be, I think, practical enough that they have something to work with when we're done with it.

I say there's also this notion of what I tend to think of as left brain/right brain kind of stuff. A number of people have talked about putting a human face on things, or a personal -- that's absolutely true. And if you ever look at a congressional hearing, there's always a panel of

people who actually have whatever or have experienced whatever. And when I used to do hearings, I would have to set up what I would call a "wonk" panel. You know, it was the next group of people that were sort of, okay, now technically how do we do this? How do we change payment policy or coverage policy, or how do we do this? And I think a group like this has an opportunity, has a potential to be able to do both, and I don't know how, if you can't do both, if you can't put a human face on it, but also be practical enough to say, okay, who's eligible, who's going to pay for it, how is it going to work, is this sustainable. I don't think any of us wants to be known as the "great founders" or the "great thoughts" behind a program that is constantly bankrupt. You want to think about how you do these things in a way that really works. And if you look across different government programs, you'll see some that are well-designed and whatnot -- Social Security is catching fire to a certain degree right now. At the same time, if you look at it from -- and I'll put words in Randy's mouth. If you look at it from sort of the way it benefits people -- you know, the notion you have a

government program and then you have private programs through pensions, and if those two programs line up nicely and one adds to the other in terms of just providing a higher income level for the retirees, there's other programs that we have -- we've talked about Medicare and Medicaid and private health insurance -- you can see those three, two government, one private, they tend to bump into each other and not integrate in as smooth a way as we would like. So design is important, I would say, in this sort of stuff. And I guess that's it. I'm sorry I didn't have a good wrap-up there at the end.

CHAIRPERSON JOHNSON: Thanks, Mike. I appreciate it. I've captured some of your ideas here. I think, at least, you talked about the parent-doctor relationships, how Baby Boomers entering retirement ages are going to be increasing costs because we cost more as we get older.

MR. O'GRADY: Yes. And it's also -- I mean, I think what is sometimes missed in the debate is that Boomers are right now at their peak earning years. So some of the money coming in, you know -- you've caught them at the crest of their wave. So the

idea of -- the point I was trying to make, this point about kind of triggering events -- if they are now paying their highest taxes and the highest amount that they are able to put away, they are doing that now. But once they hit that 65 and they start to retire in big numbers, that's when you'll see the sort of stuff that the President is putting out -- you know, we used to have 16 workers for one retiree, now we have two workers -- how that whittles down pretty quickly.

CHAIRPERSON JOHNSON: And then increasing costs in terms of premiums. Premiums are going to continue to go up, co-payments and co-insurance are a problem because they are increasing, but they are also having us focus on the cost as individuals, overall. We have a need for a personal responsibility, I think I heard you say that. Payment for uncompensated care, something we've talked about earlier and we need to focus on. Supply of new providers. Specifically, I think you mentioned doctors, but those of you who are nurses probably would suggest that nurses fall in the same category, a shortage there. And then how do we care for the homeless. Those are some of the issues at least that --

MR. O'GRADY: I would change that to "categorical eligibility" for the homeless one. It's more the notion that many homeless fall between the cracks, and that we provide entitlement in this country based on category, not always need.

CHAIRPERSON JOHNSON: Thank you. Okay. Last, but certainly not least, is my esteemed colleague.

VICE CHAIR McLAUGHLIN: I feel like I'm sort of a clean-up person here.

CHAIRPERSON JOHNSON: And that's a good sign when you're clean-up. But two other things I'd like to just kind of get on our agenda when Catherine is done. No. 1, Senator Wyden, you've sat here listening. If you would like to bring up any other comments or issues that you're hearing among your constituencies we haven't identified, appreciate that. And then at least a couple of you -- Richard Frank and Aaron Shirley -- were on another commission, and if you would come back to us and share what are the lessons learned from that. You said you wanted a second chance. Well, how is a second chance going to be different than the first one? And, Richard, if you

will share some of your thoughts, how could we be successful if, in fact, they weren't as successful as we might have wanted them to be. If you'll give some thought to that, we'll come back to you in just a little bit.

VICE CHAIR McLAUGHLIN: I was thinking about -- you said everybody here is representative of something. I'm not sure what I'm a representative of. I've been listening to all these stories going around the table, and they're really wonderful and fascinating.

I'm an economist, like Richard, and so my professional life is as a researcher and as a teacher. I'm on the faculty at the University of Michigan School of Public Health, and I teach in the Department of Health Management Policy, which is the oldest and largest program in teaching health management/health policy in the country, and for decades has been ranked No. 1. I had to throw that in, Richard, I'm very sorry.

So we come from this premier program, sometimes called "The Michigan Mafia" because we have trained so many -- see, Pat knows about this -- we

have trained so many hospital administrators and managers and HMO managers who do this that we've really influenced how this is done. So it is with some chagrin that we hear the health system is broken and everything is terrible because we feel as if our alum have failed us, which means that we have failed.

We're in the business of curing ignorance, so I guess we didn't cure as much ignorance as we tried to. But one of the reasons that I bring up the fact that we're in the School of Public Health is because even though we teach management -- and as an economist, I'm part of the group that teaches economics -- we have more required courses in economics and strategic planning and operations research and finance and statistics than any other program in the country. It has a very strong analytic bent. But we're not in the Business School; we're in the School of Public Health. And even though the Business School at Michigan just got a $100 million gift and we get $100,000 gifts and get excited, we stick in the School of Public Health. And that's because, as we tell all of our Masters students who come, we're not only trying to teach you how to do

well, we're trying to remind you that you're in the business of doing something good.

And I think that is one of the drivers for this committee as well. We can't ignore the fact that we have to look at efficiency issues and survival issues. And you talked about your hospital, that if you didn't charge for things, you couldn't survive. You're supposed to be a faith-based initiative, but if you didn't charge, the Sisters wouldn't be able to do good anymore. And so I do think we have to keep this in mind, this symbiotic relationship between doing good and doing well, that you can't help anybody unless you also are doing well. And so I think that maybe as an economist, and Richard also, that's part of what we bring to this committee, is just the economist's vision of efficiency and production, but the reminder from the rest of you as well as our own personal experiences, that we're not producing shoes, we're producing something that's terribly important to individuals.

Maybe another thing that I'm a representative of and didn't realize until I listened to all of you is that I'm married to an immigrant.

He's documented. And in fact he was sworn in as a U.S. citizen on July 4th, 1976, so he's even what's known as a "bicentennial citizen". But I think because of him, I also have a full understanding of what's good in our health care system. And I keep hearing us list all those things that are bad, but I guess I'm one of these people that sees the glass half-full rather than half-empty, but I do think we need to build on what's good in the system, and I think that's partly what Frank was saying earlier, that we can't forget that there's a lot of things that this country's health care system does very, very well, and we don't want, as he said, to throw the baby out with the bath water, which is one of my husband's favorite phrases as well. We want to make sure that we understand whatever recommendations we make are going to have what economists sometimes call "unintended consequences", that we have to think through the sequelae of how are people going to change to these new incentives, how are people going to change to these new regulations, and are we sure that what we are recommending isn't going to make things worse off than they were to begin with because we

neglected to do that, we neglected to see that. So I think we have to remember that.

As an example, too, we brought my in-laws to this country about eight years ago, as senior citizens, but they are not eligible for Medicare. They are not eligible for Social Security. And when you have 84- and 89-year-old in-laws, you really have a full appreciation of how wonderful Medicare and Social Security are relative to what could exist. They were in a country with neither, and they also were in a country with really horrid medical care. Some of the things that they were recommending for my in-laws, my husband would be flying down there saying, "No, you cannot do this, it is really quite appalling". And his aunt -- and this is strictly relevant today -- his aunt recently died of Parkinson's in Warsaw, Poland, and I'll tell you one thing, the Pope had a lot better care than his aunt did in Warsaw. Earlier when she needed a heart valve, they only had three sizes of valves in Warsaw. And if the hole in your heart just doesn't quite fit, they make it fit.

We ended up flying her to this country, to

New York, where because of my husband's cousin -- he's the Chief of Thoracic Surgery at Mt. Sinai Hospital -- we were able to get free care for her. She's a Yad Vashem Award recipient, so at Mt. Sinai, they provided her free care as a payback for what she did. It's sort of "you saved our people, now we're going to save you". But she was stuck in Warsaw with Parkinson's, and her daughter had to bring sheets. The hospital doesn't supply clean sheets. You just lie on a mattress.

So let's not forget some of the wonderful things we do do here, I guess is what I'm saying, but at the same time I agree with what was said earlier, we can do better. And the fact of the matter is that there are people in this country who are experiencing care like my husband's aunt did in Warsaw. They are getting truly horrible care. And something that Senator Wyden and several people referred to is the fact -- he said we're spending enough, and that may be true, but we certainly need to redistribute it. And that's when the political headaches begin, which is what Mike referred to, because you are talking about shared sacrifice and having to couple that with shared

gains. So we have to make clear to people that we are recognizing shared gains as well as shared sacrifices.

One of the things that I do think we need to look is the tie of coverage to unemployment, and this may be because for the past three years I've been the Director of Economic Research Initiative on the Uninsured, and so I've been doing a lot of studying about the uninsured. And economists generally talk about the fact that having such a strong employment-based system -- we're talking about Medicare and Medicaid -- but having such a strong employment-based system leads to distortions in the labor market. Okay, fine. But it goes much beyond that. It means that our insurance system is tightly aligned with the economy.

Michigan just last week came out as No. 1 -- we're No. 1. Unfortunately, what we're No. 1 in is the unemployment rate. And so at a time in which tate budgets are being squeezed for Medicaid coverage, our state is having the highest unemployment rate, and therefore people have lost their coverage, and they've lost their coverage at a time when the government can't step in and help them.

In addition to that -- as Richard knows well from his research and this was alluded to by Montye -- often when you do lose your job and are unemployed, you have mental health problems. And so it's this double-whammy that they can't get back on their feet. And so I think it's not that we have to turn the system upside down, but we have to build on what works. But understand that as long as we link health insurance to employment, we have to have some kind of system for those gaps, some kind of system to complement the swings of the economy. And whenever you have that, you're going to have these problems of just when the pressure point is the greatest on the public purse, is when the public purse is the smallest. So we have to just recognize that and talk about some kind of system that can even out those flows over time, instead of this roller coaster that we tend to be on.

I think I would like to see us redefine the services covered. Several people have mentioned mental health, and I think we need to stop thinking about physical health versus mental health and start realigning services according to chronic and acute,

according to medically effective versus questionable, children versus adults, I don't care, but the physical versus mental health division I think artificially separates that, and I think that's what gets us into the trouble that we're in now of the mental health coverage not being there as several people have mentioned, and so we need to think about how we specify the services that are covered, along what lines. Do we make this what I think of as an artificial separation between mental health and physical health.

And then the final thing is that the uncompensated care problem that several people mentioned is not uniformly distributed, and there are certainly some providers who are really hit hard by uncompensated care. But some research indicates that 90 percent of the providers have a very small, very manageable burden of uncompensated care. And so, again, it's the shared sacrifice/shared gains, that there are some physicians who are really doing as much as they possibly can, and some hospitals that are doing as much as they possibly can, but we haven't asked for others to step up to the plate. And I think

some of this is fear, quite frankly, fear that once they open the door, they're going to be drowned. And I was thinking about this a little bit yesterday morning when I went into a Starbucks at home to get something to help me get to the office at 7:30 on a Sunday morning and get work done so I could come here today, and I walked in the door, and because it's one of the few places open at 7:00 on a Sunday morning, it's often a place where homeless people come to sit in comfortable chairs, listen to nice music, often there are papers lying around. And I walked in and there was a fairly disheveled looking older man sitting in a chair facing the door, and as I came in he looked up at me with very bloodshot eyes and missing teeth -- and so I don't want to assume he was homeless, but I'm pretty sure he was. And he said, "Do you have some spare change". And I think most of us tend to say no , and I thought, well, we're told not to do that, Ann Arbor being the kind of town that says "Please don't give money to the homeless because we're afraid they're going to use it for drugs or alcohol or whatever", and instead we have a food gatherers program, and we have shelters, and we have free

clinics, so refer them to the clinic". I guess each consumer is supposed to walk around with a little piece of paper and say, "No, but here you can go for food".

But I walked over and I got my tea, and I also bought a cup of coffee. And I walked over and I said, "Here's a cup of coffee, and there's a lot of milk over there, and sugar, so I got you an empty cup. And what you need to do is stretch this cup of coffee for quite a while". "Oh, thank you, thank you, thank you. Oh, God bless you, have a wonderful day". And then as I was walking out, he said, "Oh, miss", and I turned around and he said, "Could you buy me lunch?"

(Laughter.)

And I'm not making this story up, this is for real. And I think this is what a lot of providers are worried about, you know, if I take this, then it's going to be that and that. And if I help you with your hand, then when you come in with a leg, it's the leg. And then it's -- you know -- and then you're going to tell your neighbors, and they're going to tell -- so I think we really need a way to think about distributing the sacrifice more equitably in order to

relieve the burden on those safety net providers that really are being pushed beyond where they can be pushed, and try to get everybody to share the blame -- excuse me. See, this is the blame game -- share the sacrifice, but also impress upon them that this is really seeing the glass half-full, that there are gains that we can all share from, too.

So I just close with: Ron, we share this interest in history, only I beat you. You went back to the Truman era in preparation for this, and partly it's because of the tie to Michigan, the Michigan program was started seven years ago by Nathan Sinai, who was a primary contributor to the Committee on the Cost of Medical Care, and we actually have his notes and records in the library at Michigan, and they came out after five years of study and investigation, with the Medical Care for the American People final report, in which they start off talking -- they start off saying "Today, there is a vast amount of unnecessary sickness and many thousands of unnecessary deaths" -- this is 1932. "We know how to do many things which we fail to do or do in an incomplete and often most unsatisfactory manner. As a result of our failure to

utilize fully the results of scientific research, the people are not getting the service which they need, first, because in many cases its cost is beyond their reach and, second, because in many parts of the country it is not available. The cost of medical care has been the subject of much complaint. Furthermore, the various practitioners in medicine are being placed in an increasingly difficult position in respect to income and facilities with which to work. The report which follows presents many phases of these various problems." This is 1932.

So here we are, 70 years later, and we can do better. And so I'm thinking a lot of these problems are still there, but I'm really hoping that we can do better.

CHAIRPERSON JOHNSON: Well, Catherine, this is what we put down based on your comments. Let me see if we've heard you correctly. Need to balance doing good and doing well. Cost for care for senior citizens who do not have Medicare. You shared a personal experience with that, but there are others. We're spending enough, we need to redistribute some of the spending, or maybe find -- you didn't say this --

but maybe find ways of more efficiently spending some of the monies we're spending. Healthcare spending coverage tight, the economic cycle. And what I heard you say is that we're having some layoffs in Michigan. Car companies are big in southeast Michigan especially. They have wonderful healthcare coverage, but when they have layoffs there are some potential issues that have rippling effects. Artificial separation between mental health and med/surgical care.

VICE CHAIR McLAUGHLIN: Well, physical, but -- that's different.

CHAIRPERSON JOHNSON: And uncompensated care --

VICE CHAIR McLAUGHLIN: Unequal burden.

CHAIRPERSON JOHNSON: -- unequal burden. Okay. Well, thank you very much.

Well, Senator Wyden, you've been sitting patiently for a high energy person. It's a challenge, I think, for many of us to sit and listen, but each of you have been, and you have been included in this. Are there issues that you're hearing about that we haven't addressed so far?

SENATOR WYDEN: I'll tell you, I've been excited over the last three and a half years about the possibilities of what could be done here, but figuratively you could be pulling me off the ceiling right now because I am just really awed by the kind of talent and energy that is around this room. I thought we were going to get good people, and this has so far exceeded my expectation. For example, in the last -- I guess it's now been three and a half hours -- nobody has once committed "healthspeak". I mean, there has not been any example of arcane health babble that nobody could understand. That alone makes you unique in terms of people who are involved in healthcare.

I was sure that Catherine was going to bring up this question of the history in the 1930s. Catherine, we've really been going back to Otto von Bismarck to talk about this.

(Laugher.)

I've got only just a couple of --

VICE CHAIR McLAUGHLIN: Yes, but can you quote some of that?

SENATOR WYDEN: Yes. First, I think Mike made a really important point about trying to find

consequence in this really diverse country. This is such a gargantuan education task. I don't know how many of you saw it, but Health Affairs did an article not long ago that said that most Americans believe that we're spending more money on children than we're spending on the elderly today. Now, that's where we're starting as we go out on the education process. And of course kids don't have "Kiddiecare". Seniors have Medicare and kids don't have it, so we're spending vastly more, of course, on seniors than we're spending on children, but that's where you're starting in terms of this education kind of task.

And one of the things I'm really hopeful is that we can get this report, which will probably be the first thing that people see in a sort of broad-sweeping way out as wide as possible -- Catherine mentioned Starbuck's, Howard Schulz and Starbuck's wants to get this in Starbuck's, for example. I think the Internet will be a huge opportunity for all of us. I mean, I can see small business people, members of the NFIB, National Federation of Independent Businesses, that wouldn't go to a drafty hall, asking their members to sit there at the laptop and sort of

walk through some of the choices, which nobody has ever done before. So, I think the first point is the education task is enormous. It's going to be the first thing that people are going to see, and your ideas and suggestions to -- Randy and Catherine -- I think will be extraordinarily important there.

Second is, I think there's a chance to sort of grow coalitions and sort of grow ideas that seem to have common ground. We go back to Mike's point about how the Congress is going to look at it. I told you about the conversation I had with Mike Leavitt, where the two of us were excited about the idea of sort of starting with community health centers and a catastrophic benefit.

Well, just visiting with Dr. Shirley for a minute, he just said how could faith-based programs that don't necessarily fit into the community health center definition, could they sort of be deemed to be part of that network? Well, I can't speak for 535 members of Congress, but I've got to think that's an idea with some legs. I mean, that's something where people could say, we've got these faith-based programs, certainly some like them more than others.

We've got community health centers. Couldn't we carve out an opportunity to sort of grow that kind of concept, and I think it goes to Mike's point about what might actually be movable in Congress.

I mentioned to Joe during the break that I think we're at a tipping point with employers and labor in terms of what's going on in the private sector. If Joe and Randy say, "Let's see what our people think in terms of the labor business piece, in terms of some kind of common ground, and cost containment and the like", Joe and Randy kind of start a little coalition there, and something that you can fold into what you're doing.

Only other two points are, first, keep in mind the timetable. We've basically got two years in terms of what Congress thinks it's appropriating money for. Actually, you can probably take a little bit more time if you think about it in terms of the statute, but the Congress thinks it's going to be asked to put out money twice, and we ought to kind of keep that in mind as well.

And the last point is, I wouldn't be reluctant to take on some of these sort of big seat

powerful interests as long as you can find something that really allows us to say at the end of the day, "Look, we didn't just spend our time scapegoating one side", and that's why I said there's enough blame to go around here, folks. If you want to like just say it's the trial lawyers' fault, the insurance companies' fault, the docs' fault, the consumers' fault, we can do that all day, there is enough blame to go around here. And I think a lot of this, particularly in terms of public health policy, just sort of came up because nobody really kind of thought it through.

Stephanie found the other day, as we were getting ready for a speech to talk about the post-Terri Schiavo kind of politics, that the hospice benefit is set up to tell people they've got to give up the prospect of a cure in order to get the benefit. Now, I've got to tell you, I don't think anybody got up in the morning and said "I want to be rotten to suffering people, and tell them to give up hope in order to get the benefit", but nobody really thought it through in terms of how the American people, as we've now seen after the Terri Schiavo case, they want

both. People want to have the chance to dream about a cure, they want to have a chance to get the benefit. Easier said than done, no question about it, but it's the kind of thing that can be part of your effort to look at end-of-life issues, and I wouldn't be reluctant to take on big interests and concepts that probably came into law because nobody had thought of them. And you've got to be bold in order for the Congress to be bold.

And I will tell you that there are only two ways that we'll get healthcare that works for all Americans. Maybe some knight on a shining horse will go down to 1600 Pennsylvania Avenue and say, "Here's my plan", and they will ride that horse all the way through the countryside, and they will go to every corner Mike is talking about -- Texas and Massachusetts and the like -- we can wait for that.

Personally, I think that this working group's process is just as likely to do it, where we walk people through the issues and then we go get many knights on shining horses to follow up in the Executive Branch and in the Congress. And I think by your doing all this heavy lifting -- in a lot of ways

we've got an opportunity here. I mean, we can have a conversation. You do not have 12 television cameras thrown in your face when you turn around. This may be the exact kind of environment needed in order to be able to do what everybody thinks is impossible.

So, I'm available to you all 24/7. I consider this the most important thing I have been part of in public life, I'm telling you that. This is what I want to do more than anything else, and people can get me through my office, half of you have my e-mail and cell phone, and I am available to you. And Senator Hatch and Pattie DeLoatche I think will be extraordinarily responsive to you, and since we have folks here from HHS, I couldn't be more appreciative of Mike Leavitt. He talked at his first hearing about -- I think his words were a "transformative dialogue" in terms of health, and by God, that's what you're doing, and thanks for being part of it. So, you'll see me often, and this is going to be a good ride. Thanks.

CHAIRPERSON JOHNSON: Thank you. Aaron and Richard, you participated in at least one other commission -- and, no, we're not called a commission,

but we have similar objectives -- talk about what you thought were the challenges and issues that might have resulted in not moving forward as might have been hoped, and what you think we might do differently. You want to go first, Aaron?

DR. SHIRLEY: The thing that stands out the most for me right now is we then, in '93 and '94, placed so much dependency on experts. We commissioned papers by experts. We had experts come in and talk to us. We would work from 8:00 in the morning until 11:00 at night digesting all kinds of information that was being produced by others and given to us. And then our responsibility was to react and to tweak it into some kind of legitimate language. And it wasn't until maybe three months of this type of dialogue that we'd go out and talk to the people. So we were top down. And when we got out to the people, the special interests that had different views had prepared for that, and I know I traveled all over the country attempting to promote the thing, but I would run into groups and opposition types that I'd never heard of whereas I believe if we had come more in the direction that we are doing now in which people will be talking

to us hopefully more than the experts, then we'll come up with some potential solutions that the people have bought into. They then will deal with the special interests or help deal with the special interests for us.

CHAIRPERSON JOHNSON: Let me see if I've heard you correctly. What I've heard you say is there were people who are known experts, who came and testified before the commission, and that testimony was heard not only by the commission, but by others as well. And that testimony also was then used to mount opposition to some of the things that you as a commission thought might be necessary or helpful.

DR. SHIRLEY: That was part of it, yes.

CHAIRPERSON JOHNSON: And so what the implication of that is what we can do differently is not only hear that testimony -- now, I'm going to try to put some words in your mouth and see if you agree -- go ahead.

DR. SHIRLEY: Not so much from the experts, but we were relying too much on the people who already knew what we needed and how to do it. And we were trying to respond to the need of the uninsured

across the country. We heard very little from them before the fact. We told them -- ended up telling them what they needed and what they should have, rather than their telling us what they needed and how best to provide it.

VICE CHAIR McLAUGHLIN: Did you have hearings at all? You talked about papers, you commissioned papers. Did you have hearings early in the process or -- you were saying that the commission had a lot of papers written and that you would be there from early in the morning until late at night reading the papers. Did you -- I mean, I know there's been a lot of criticism that it was behind closed doors, et cetera, et cetera. Was most of it internal paper-reading and -- or did you actually have hearings at the beginning of the process?

DR. SHIRLEY: There were about 400 of us, and we had several different components, and we would have some insurance, some purchasers, then others would come in. We would commission somebody to go and do some research on this particular topic, bring back the latest information. And we as a group would listen, and they would help us to interpret the data

and information, and we crafted our recommendation around that information. And then it was our task to go out and sell it after the fact whereas the way we are going here, we're more inclined to listen to not just the experts prior to developing any paper.

CHAIRPERSON JOHNSON: One of the things that Catherine and I have talked about, along with some of our friends from HHS such as Larry and Ken and Caroline and Andy, has been the possibility of doing hearings outside of Washington so we hear from practitioners such as yourself, as well as more what I'll call theoretical or research folks in Washington, or who come to Washington often.

Richard?

MR. FRANK: I met Mike O'Grady for the first time during Health Reform. He was the CRS analyst who is doing several parts of the cost including the mental health piece which I worked on, so I've known Mike a long time since then. There he is.

Mike, I was just saying that I met you during Health Reform.

MR. O'GRADY: Yes, you did.

(Laughter.)

Still bear the scars.

MR. FRANK: We both do. I guess one thing actually, from what Mike started off with, which had to do with kind of facing up to certain realities and certain facts I think was a problem. I think a lot of the jumping off point for Health Reform was something of a delusion, which was that managed care was going to save enough money so that you could finance the whole thing at zero cost. And when you're working on that presumption, it so distorts everything that you have to do that that it starts to create all sorts of design challenges and things like that.

So, I think there was a jumping off point that was not sort of grounded in reality and the data, that I think was a real problem from the get-go.

There have been books written on this, I'm not going to sort of go through it all. I'll just say I think the issue of essentially sunshine instead of respect for the diversity of opinion is sort of an important piece. I think that, you know, everyone is sort of paranoid anyway, and I think that absence of sunshine makes it worse, and so just kind of being

open, having things on the table, I don't think it hurts you very much to do that. It hurts you a lot, in retrospect, not to do that. So, I guess that's a second lesson that I walked away with.

Third is making sure of your facts. I think it's easy to organize opposition, it's easy to be critical when the facts are either murky or not well documented or organized, and I think kind of being meticulous, but the positions that you're taking and having a very solid grounding in fact really helps as a jumping off point. And also I think it forces you to be very respectful of the other opinions. You take them seriously and you say, okay, we investigated that, here's the way it shakes out, and you may not like it, but at least we've done due diligence. And I think people sort of at least somewhat respect each other in the morning when that happens.

There are lots of other things. Something that we don't have to worry about is kind of managing Congress. I mean, if you can imagine this -- and Mike I'm sure remembers it -- they didn't know what committee to put the bill through, and so they put it through, what, three?

MR. O'GRADY: Yes.

MR. FRANK: And they didn't know which way -- they had no management plan for --

MR. O'GRADY: They walked away. Just dropped it and left.

MR. FRANK: Right. They had no management plan for the committee. Obviously, that's not the same point here, but it's sort of a shocking piece of history when you think about that in retrospect. I guess that's it.

Actually, going to Aaron's sort of observation, I think that taking people's ability to -- on one hand, you have people easily getting wrong impressions about how things work and the facts and stuff. It doesn't mean that when given the opportunity to think hard, they won't come up with sensible things. And I think perhaps what I hear is helping us engage in a process that will make regular people think hard about these issues and not say, okay, well, they can't think hard, let's just give them the right slogans and things like that. I still have my “healthcare that's always there” card, but --

CHAIRPERSON JOHNSON: Do you still have

yours?

MR. O'GRADY: That and my Mickey Mantle baseball card. With inflation now --

CHAIRPERSON JOHNSON: Well, thank you both for your input. One of the things that I'm sitting here asking myself -- and we'll take a break in just a second -- I'm sitting here asking myself, we've got all these issues that we've talked about, which implies that we need more of this, this, this, this, this, and this, but the cost today per person if $6,000-plus per person. And if we continue under the same trends, it's $11,000 by 2014.

Some of Joe's colleagues in the union world are negotiating with Big 3 automakers, and we've seen the signs of the Big 3 in the paper because they spend more than $1,000 of every car that we buy for healthcare. And those that are spending that kind of money are losing market share to those who have lesser healthcare programs and who are not providing retiree medical coverage to the same degree. And we see companies who are moving some of their businesses offshore, some of their employees offshore, because the cost of labor -- one of the reasons, not the only

reason -- because of the cost of labor is less expensive offshore.

Senator Wyden suggested and the legislation talks about, well, what are the tradeoffs that we are willing to come up with? And that's going to be a subject I suspect that we're going to have to spend quite a bit of time on.

And the other subject that we haven't talked about but we're going to have to have in the back of our minds, I think, is what kind of initiatives that we would potentially, with citizens around the United States input -- what kinds of initiatives would make it through Congress, and would make it through the White House, whoever is in the White House. So, these questions, I think, are some of the questions that we're going to have to give some thought to.

Someone earlier talked about administrative cost. In my health plan, 8 percent or so of the total cost is spent on administration. The rest is on medical claims. And that 8 percent goes toward network management and medical management, disease management strategies, processing the claims,

answering all the questions. It's 8 percent. Now, that's not -- there are other insurance companies who will spend more, maybe because they've not been as efficient, and that will be up close to 20 percent in some cases, but typically between 8 and 22 percent for administration, based on my own experience.

There's got to be more that we address than administrative costs. And yet we've talked about giving healthcare -- we haven't spent as much time today talking about wellness initiatives and healthy people as I thought we might have, but that might be something that we're going to have to address as well, as we're moving through some of our dilemmas and criteria for improving the system.

But I think we've spent all day so far talking about the issues. Before we close off this part of our discussion, are there any other comments that any of you would like to make?

MS. MARYLAND: Not being able to put aside my administrative hat for now, I just want to add to the table specialty hospitals and the impact on potentially the shifting, if you will, of patients is a major issue that's out there that's sort of starting

to surface.

CHAIRPERSON JOHNSON: Shifting of patients?

MS. MARYLAND: There's a school of thought, and it hasn't truly been validated, that with the advent of specialty hospitals -- and I'd like our physicians maybe to weigh in on this issue -- orthopedic specialty hospitals, cardiovascular specialty hospitals, that what tends to happen is those are hospitals that are physician-owned. The potential exists that there could be some skimming off the cream, if you will, and shifting to the acute care hospitals the burden, especially with the noninsured uncompensated patients.

I know that a number of studies have been conducted, but I don't know if it's been truly validated one way or the other, but I want to put that on as just an issue because it certainly could affect what happens going forward, to acute care hospitals.

And then the other issue is the issue of increasing cost of medical technology. Senator Orrin Hatch talked about his wife and her knee replacement, titanium versus ceramic implant, and with younger

patients actually there's been a real push to go with the more expensive ceramic implant. I mean, that's really increasing the cost, if you will, of those cases, and a lot of it is not always reimbursed, and how do you control that? So, it's just a general statement about the increasing cost of technology and its impact on the overall cost of healthcare. It's something that we haven't talked about really, and I just wanted to make sure it was at least thought about.

DR. BAUMEISTER: Well, it's already happened with endoscopy centers and surgery centers where they skim off the payers and send the welfare patients to the hospital.

MS. MARYLAND: I just think it's something we need to look at in more detail.

MR. HANSEN: Well, isn't there -- a personal example. My wife has got leiomyosarcoma cancer, and she takes advantage of all the new technology, and newer technology comes out all the time, much more expensive. So, it is a choice, it's a choice between life and death.

MR. O'GRADY: But we have seen changes. I

mean, when you look at the new Medicare bill, you'll see that no matter how much they've spent, there's always a 5 percent paid by the Medicare beneficiary, and that came right out of CBO, and it had to do not so much in terms of the beneficiary's behavior as it had to -- if you're a drug company and you're about to introduce a new drug on the market, and you have a choice between introducing it at $10,000, $15-, or $20-. If some third-party payer, government or otherwise, is picking up 100 percent of the cost, you would be irresponsible to your stockholders not to put it at the very highest price. So, the idea there being that you didn't want to ding people too badly, but you wanted at least something there all the time to make them somewhat price-sensitive. Now, is that free? By no means. You're going to have some people who are just going to be hit with 5 percent of a very, very large bill, and the only solace they can take is that the taxpayers picked up another 95 percent, and that's certainly better to only pay 5 than 100.

I'm trying to look at this 10, 20 years out. Boomers retire, all these pressures hit. The notion of technology and what we do with technology --

now, we've grabbed on to information technology because that's the first bit of technology we've seen in a while that might actually save a little money as well as improve care. The other definitely improves care, but it costs us an arm and a leg. So, we're kind of hoping that that one will really -- but the other kind of two types of technology, the one that is breakthrough but really expensive -- but people get up out of their wheelchairs and walk now -- and the other one which is sort of what I think of when you're using the knee example.

It's the sort of stuff we had before, but only a small percentage of people -- it may even drop the unit cost of it and that means everybody gets arthroscopic now, and so all of a sudden we're generating a lot more money even though we took arthroscopic from $10,000 down to $5,000, we've proliferated it now in such a way that again it's a technological improvement that drives additional spending.

But we're trying to think about where the whole system is going, we don't want to be locked into today, and technology and how you deal with that, it's

going to be key, there's no doubt about that.

MS. MARYLAND: And I just wanted -- not with any personal opinion -- to put these additional issues on the table for us to consider because I think they are just in the forefront of what we know are challenges facing us now.

CHAIRPERSON JOHNSON: Thank you. Therese, you had a comment?

MS. HUGHES: Well, actually it had three parts to it. The first was I just wanted to say that there's an awareness. In California before the Legislature there's a bill that because of the problems that we had with our emergency rooms and the number of hospitals that are closing their emergency rooms because of the cost of uncompensated care, is that they are trying to create a system where you get seen in triage, and then you get shifted around through -- well, let's look at L.A. County -- gets shifted around through L.A. County based on how -- for lack of a better word, how important it is that you get immediate care right now, which I think is part of this problem because, to me, I see the shifting of the costs going to those with money, those with insurance,

and then those that could need this care immediately but may not present, or they may present but enough attention isn't given because they are uninsured or they are underinsured, that they end up being out here in the tailspin where they don't have the access to care. So, I'm just giving that as something in response to what you said because I certainly think that -- when I spoke to the author of the bill and his staff, he said, "Oh, but, Therese, that's not our intention". And I said, "But I think that it is possibly an unintended consequence based on the reality of finances and economics of healthcare today".

So, just having said that, the next thing I wanted to just say is that technology -- the one technology -- I think there may be technology out there today, medical technology as well as IT technology, that is working but is not either known or is not allowed for some reason to be put into the universe of care-- and by that I mean for years everybody thought the best way to have dialysis was haemo, and peritoneal dialysis was used in hospitals for emergency situations. Well, peritoneal dialysis

is a better way of providing dialysis because it's continuous and because patient have responsibility for themselves and can take care of themselves. So, what took it so long to get out to where now -- nephrologists have to bring up the issue of peritoneal dialysis to their patients instead of automatically putting them on haemo-dialysis. And I think that the cost up front is more maybe, but I think extended over the period of utilization for the patient it is less -- well, this is just my experience. So, I do think that there's technology that's being utilized in certain areas like that.

CHAIRPERSON JOHNSON: That can bring greater efficiency even though there's an up front cost.

MS. HUGHES: Exactly. And I don't know -- I can't pretend to know what they are, but I do know that that CAPD, continued ambulatory peritoneal dialysis, is one that sat a long time in a hospital, were in the hospitals or in that setting, that once it came out to the public was --

MR. O'GRADY: That's the essential dynamic of what Randy was talking about before, prevention.

If you're going to get your folks in, you're going to get them screened, you're going to get your chronically ill guys to get the kind of testing they really need so they don't end up showing up in the emergency room -- it's not a free lunch. It's going to cost you up front. If you can avoid one hospitalization, you've probably covered the whole thing, but I get a little nervous when I see -- I mean, we're having a big push on prevention, and we think it's the right thing, but there's an up front cost, there's no doubt about it.

MS. HUGHES: Absolutely, and that's what I'm saying. I mean, I think that there's this technology there, but I also am aware that there's that up front cost that we'll have to count on.

And then the other thing is - and this is all that's being said, we're talking about rationing healthcare in a different way than the way it's rationed today. Transplantation is the perfect issue of rationing healthcare that is top up front rationing in terms of our healthcare system, and it's a difficult subject for me to talk about, but there are some benefits to some of it, and I recognize that

there's something close to rationing.

CHAIRPERSON JOHNSON: Thank you, Therese.

DR. BAUMEISTER: I have to put in a plug for Oregon here again. I can't help where I come from. But ambulatory peritoneal dialysis has been used in Oregon widespread for a long time because Drake, a friend of mine, along with an engineer in his garage, developed the first dialysis machine, (inaudible) machine, and it's very popular in Oregon.

CHAIRPERSON JOHNSON: Well, thank you very much for your input. One last comment before we break.

MS. CONLAN: Oh, well, I have two. When I was listening today, I just wanted to offer some comments about Medicaid. In my county, once I got Medicaid, there were no neurologists that were accepting Medicaid, and at an uninsured rally and press conference, a doctor told me that it wasn't about pay, it was about having to sign a form assuming all liability, and doctors were reluctant to do that. So, I think it's not just a matter of payment, it's that additional liability.

And in Medicare, there was something I

wanted to offer. Mayo Clinic, the doctors voted and they do not accept Medicare assignment anymore. So they are forcing patients to pay up front the Medicare assignment plus an additional cost, which Medicare still controls, and then the patient has to do a lot of the administrative work of sending bills to Medicare and doing what doctors have had to do in the past. Patients seem to be balking at that, they don't like that. Imagine that. Doctors didn't like it, and patients don't either. But I think it's having an effect on them as far as their business.

CHAIRPERSON JOHNSON: Okay. Thank you. Well, we're going to take a break right now instead of waiting, and we'll take a 15-minute break, if that's okay, and then when we return, we're going to start to try to get on the solution side of some of these issues. By the way, I don't think anybody expects that we'll have all of the answers, but we can begin to think about them.

(Whereupon, a short recess was taken.)

CHAIRPERSON JOHNSON: If you'll have a seat, we'll reconvene and get going. We have a few people who aren't here, but they can join us in just a

minute or so.

First, I'd just like to thank you for your dialogue and your sharing and your willingness to participate in not only this meeting but this initiative. And I think already we've got good input and helpful ideas as we're beginning to move forward.

What we thought we would do between now and when Carolyn Clancy comes at 4:30 is just begin to share some of the ideas that you have, your observations on initiatives that have worked. Already we've heard Frank inching in some of his ideas from Oregon, and we're looking to hear about those. And some of you have some community initiatives that have worked. Aaron, I was in a meeting last week where I heard a person by the name of Janice Bacon, who was on a panel. The room was probably 500 people, and she had more questions asked of her regarding her initiatives than any of the other speakers. And so we know there are initiatives that are already beginning that direct attention to some of the issues that we're facing, and we're not going to cover all of these issues today, but at least we'll get a start maybe in

addressing some of those.

Really, we don't have a mandated organization by which we sort through these issues. Over here, we talked about some numbers. And we have some issues that are duplicated, but maybe we can just take a look at these, if you would, and you start where you think we should be starting, some initiatives that you've seen that really have been working or have great potential to help attack some of the issues we've addressed today. And I'm not going to take notes up here, that will slow us down too much, I think, but we'll have notes taken and we'll share those with you. Who would like to start and share some ideas regarding some of the initiatives that we've talked about? And those of you who are on this side of the table, we apologize because they're here on the wall at your backs, but when you start speaking, if you will speak into the microphone, that will be helpful.

MS. PEREZ: I think maybe just one of the most simple things when I think of educating the consumer, patients can't read, and learning how to

communicate with a medical provider -- I think in our area, the use of a health promoter, or what we call in Spanish a promotora de salud. It's a peer person from the community that is used by community clinics or different kind of healthcare programs. Hospitals are now beginning to use them. Just to be able to have that peer relationship to get that patient to understand how to navigate the system -- the term Patient Navigator is used as well -- but how to access healthcare systems, help them access healthcare systems, sit down and say "This is what diabetes is", "This is a nutrition plan", "This is what you're going to have to be doing for the next several weeks", you know, pamphlets, brochures, how to fill out information for everything from CHIP to everything else, it's always lots of papers that need to be filled out. So those kind of programs.

It's one thing for me as a nurse to hold a little session and say, "Okay, this is what we're going to do today", but then to turn it over to someone that comes out of their same community and then really say, "Rosie said this", or "the doctor

said this", so let's just have a little bit more discussion about it, and what are we going to do to address an issue. So, a health promoter program, promotora de salud, community health workers – people use different terms -- is great to get some basic education.

In the State of Texas, we do have a certification program for them. Other States, other communities don't. And then we adapt them into our system to say this is what they need to know, just something that's very basic and very simple and just something to kick us off in this discussion.

MS. HUGHES: Who pays for that?

MS. PEREZ: A lot of times they are volunteers, so they will come in -- like, at my free clinic, they started off as patients in an effort to give back, so they will not accept any funding. Some programs will write into grant requests and they'll be funded by foundations. And then there are some -- we have healthcare systems down in south Texas that actually pay the salary, and that's along the lines of a minimum wage, benefits and health insurance

included, but for the most part it's a volunteer. A lot of them are volunteers.

DR. SHIRLEY: There's some effort by the Center for Sustainable Health Outcomes, that's an agency that's promoting that concept, and they have been pursuing the possibility of some third-party reimbursement for that type service. Many of the facilities would like to implement, but where they don't have a grant they aren't able to do it, so they are pursuing some type of reimbursement for that -- the Center for Sustainable Health Outcomes.

MS. PEREZ: Then you get a little pushback because then the nurses and the doctors are saying "I don't get reimbursed for that", but then you're going to reimburse maybe someone that doesn't even have a high school education or formal training. I know in Texas we had some of that type of discussion, but I think we need to discuss it.

MS. BAZOS: In New Hampshire, we've been very successful using the Medicaid program actually to do something similar, but New Hampshire by the charge for developing the family support system that started

in the '80s, providing support for families who had someone with a developmental disability. I worked in the '90s to use that as a model to develop a system of support for families who had children with chronic health conditions. And the notion was that many of these families, because of their need to be home and provide care, become very isolated. Mothers were often depressed, not integrated well with their community or their community support and did not know about supports that were available to them. Actually, the program that I worked with was funded through a Medicaid administrative contract. Medicaid can be very flexible at times. We're worried now, of course. But through that contract we really did outreach to families, first to make sure that children were getting the medical services they wanted, but then to support the family in areas to help them get jobs if they needed to support their family, to provide respite care for the family, and those types of things. New Hampshire now is looking at that as a model for elders, to help elders stay at home, be supported, get the right medical care, that type of

thing. But that's all under Medicaid.

CHAIRPERSON JOHNSON: Same subject

MS. HUGHES: Yes.

CHAIRPERSON JOHNSON: Okay. Thank you.

MS. HUGHES: At Venice, one of the things that we're doing -- well, we have promotoras that are patients. We have promotoras that we pay to go out into the community to do health education outreach, and they go to the job centers and different parts of the community that are known to have people that do not have normal access to healthcare. But we have a new program now where we're using the promotora. The promotoras that go out to the community, we pay them a salary.

We have a new program that we're just initiating now, and this where we have a doctor who goes with one promotora every week, and we have a selection of asthma patients who have had high incidences of repeat need of immediate medical care, which indicates that they are falling off their regime, and so the promotoras and the doctor are going through a group of I believe it is 50 of our patients,

to the families, to the homes, and they make home visits once a week to the different patients, in the hope of showing how they can keep their care better inside their own home environment. And this has been -- it was initiated six months ago, and we are just starting to get results in where there's reduction of emergency room visits by many of our parents who have children with asthma, which is critical in our area -- well, it's actually critical everywhere. So, that's an initiative that we're looking at that. I know that our asthma one is I believe the first one that's being tried, but using the promotoras model as well the physician going out to the homes to help the patients.

MS. CONLAN: I just wanted -- this is a little different, but you mentioned about thinking out of the box -- talk about the Heuga Center again because it's an experience that I had. It was a full week and it was very intensive. But I think there's a really long life -- you know, it has a long half-life, this program. Twenty-five people came for a full week, with our significant others -- could be a family member, spouse, child -- and we had educational

programs. We had evaluations and testing in terms of our disease. Sometimes they broke the significant others off into another group and they had their own counseling sessions and we had our own counseling sessions. I had one person who was -- I call her my mentor -- and over the course of the week -- she's a physical therapist and she guided me through that week-long process, making sure that I learned what I wanted, met with the people -- we had the practitioners that did classes, but then they were available to meet with us individually -- day-long programs for a whole week. And then, like I said, at the end they had our lab results, they had our test results, and they developed a management plan.

The only thing on my management plan I've never been able to accomplish was the one they made as a recommendation for mental healthcare. But then the patient has a battle plan. That management plan is sent back to a primary doctor or a neurologist with recommendations for referrals in the local community. And there were many things that my doctor said, "Oh, I didn't know you thought you needed that", or "I can

do that for you". And so that furthered the process of management of my disease.

Then they have a booster shot that they do a few years later when you can come back. The first program is called the Can Do Program, second program is called Can Do Too, so that if you forget or you get slack or whatever, or you need to ask more questions, you can come back. So, it's an intensive program. It's more costly than what you're talking about, but I think it's very longlasting because I thoroughly understand what I need to understand, and then I'm empowered to go about getting the things that I've learned about and know that I need.

CHAIRPERSON JOHNSON: Good. Mike, you had a comment?

MR. O'GRADY: Yes. It was just that Dorothy had brought up before about Medicaid and flexibility, and that brings up a couple of things that we've started to see because we've tried to do different things as waivers and allowing same amount of money and see what you can do with it. And one of the problems that at least Medicaid waivers have

started to crack a little bit is the idea where we have these different eligibilities for different programs.

So, you'll see a family where,two parents, two children, and especially if immigration is part of the calculation, you could have a situation where dad has employment-based, and one kid is S-CHIP, one kid is Medicaid, and mom is uninsured, and that's certainly not great public policy or great healthcare.

And so through some of the waivers -- I think they are called HIFA, and don't ask me what HIFA stands for -- but that idea of can you in effect take that pot of money and figure out a way to either buy everybody into SCHIP, or buy -- use the SCHIP and Medicaid money to buy them into family coverage through the employer.

And right now some of that stuff is limited somewhat because it has to budget-neutral -- and not so much in terms of just the per capita spending, but we're trying to push a little bit to say, you know, if mom and dad wanted to put in the

difference, or the employer is willing to do it -- and part of what is being negotiated between the Feds and the governors right now is how much do you do on that sort of stuff. But it is an attempt to say, can you open this up a little bit in terms of just not be so inflexible, and allow different States to do it the way they think they want to do it.

MS. BAZOS: Well, the other thing is Medicaid is the way you do get into the system, and then -- you know, some people, through poverty -- so then they are in, and then they get a job and get bumped up a little, then they're off, then they're in, then they're off -- so some way to bridge that gap through the system actually would be another thing that --

MR. O'GRADY: Right. Now, there is some of that -- and I wouldn't say that there are not bumps in the road, but part of Welfare Reform '96, almost ten years ago, was that idea -- it used to be that Medicaid was really only if you had the old AFDC, so if you were on welfare, you got Medicaid. That was being linked with the notion of you didn't want losing

Medicaid to be a disincentive to finding work.

Now, in different places it takes -- like I say, I wouldn't imply that it's seamless, but there is some improvement. I guess one of the conflicts that we have in this country is do we like the idea of innovation that would allow New Hampshire to handle it, what works well for New Hampshire? At the same time, we also have these concerns about equity in terms of if you were eligible for something in New Hampshire but you might not be in New York, how comfortable are we with that.

At the same time, you know, most healthcare tends to be local, and many questions related to the uninsured and these sorts of dynamics are very local, and therefore there is this balance. You'd like a State and the governor to be able to do what fits for their circumstance. But at the same time it does end up with the cost issues that they are working on right now. And part of that tradeoff is more flexibility -- but you also have to agree to hit certain savings targets, so every negotiation has its two sides.

But I was just trying to point out, in this HIFA waiver discussion, the States who tried it---- and it was a little different in every State, but they had a lot of ability to be a little more rational, let's either get them all employment-based insurance or let's get them all State-based, but whatever it is, let's not have four different members of the family with four different coverage.

CHAIRPERSON JOHNSON: Rosie, what I heard you starting off with is talking about a program that involved either volunteers or paid people to kind of act as a Big Brother/Big Sister appear to others, and I was wondering, as you were discussing that and as we were having some follow-up discussions, if there's a potential of that's a foundational idea for some things we could do in the future because as some of us are entering retirement ages, we're going to have many people who will be looking for things to do to find fulfillment. I'm wondering if that's a resource of people on a volunteer basis, if not on a paid basis, that could help do something like that.

MS. PEREZ: Absolutely. And in Harris

County, as a result of -- we had the big tropical storm Allison -- and I think it made a Movie of the Week just recently -- but our medical center -- and downtown was flooded out. I mean, talk about crisis in healthcare -- because of the flood -- we were shut down, medically we were shut down. Ambulances couldn't get in. Power was out. You know, stories of people trying to carry patients from the sixth floor down to the second and were using stairs -- I mean, it was just a really horrendous situation. And to know that it was shut down -- then we found out we couldn't communicate with each other. We have 23 mobile clinics that could have been dispatched out to the areas that were suffering in the community, and we didn't have that technology, the capacity to be able to do that.

So, out of all of that we started to work on some of those issues that came out, but one of them was a volunteer health corps where it was made up of doctors and nurses and plain regular people that would sign up, and it was volunteering time. So, we waived things like medical privileges at hospitals because if

my doctor could not get downtown and he was available for service, then let him go into the hospital that was nearest him to be able to provide services. So, we kind of allowed a little flexibility for those kinds of things.

And then the executives -- they were like "I'm flooded out of my building at" -- you know, Enron or wherever – “but I can type, I can answer the phone, I can do whatever -- I can direct people places.” And so we came up with this volunteer corps within Harris County to be able to fill in the gaps for crisis situations or just in general, and we've been looking at it at the local level for just the simple "One Stop Shop" -- you know, they come in for a Diabetic Day clinic, the nurse and the doctor are tied up with the lab work or whatever, we don't have a salary because we are free or nonprofit or whatever -- so let's put them in a room and let's discuss all the other aspects of it. So they are going to leave with the information that they need because we don't know when we're going to see them again.

CHAIRPERSON JOHNSON: Also, one of the

things I've heard in our discussion so far is that we have complexity in our delivery systems and, Mike, your comment regarding -- I think it was you -- multiple people in the family having different options for coverage or care or whatever.

Would something that we might want to address be how do we deal with those complexities? Are there some potential solutions to take away from some of the bureaucracy that providers and hospitals face, to see if we could combine some of those or simplify some of those as opposed to compartmentalizing all of these kinds of programs.

Similarly, there are some who have felt that in the insurance world one of the issues on coverage -- we haven't talked about this yet -- one of the issues on coverage is there are so many different State regulations and so forth. What is the possibility of having a uniform set of rules so that if, let's say, Pat is working in Indianapolis and has some relatives in Detroit maybe, they would be under the same set of rules as in each State. That gets at the idea of simplicity, but it gets at also then what

is the State authority, and how do we develop regulations and so forth?

MR. O'GRADY: To a certain degree we're talking about a State flexibility to do what fits in in a particular State, and at the same time can we have a uniform national standard for certain things.

MS. PEREZ: Some States do that in regards to like nursing licensure and -- like I've got a partnership in Louisiana and some other States, so if I wanted to get a nursing job, I don't have to take their State exam. I mean, there's some leeway on some things between certain States -- not all across the nation, but some States kind of buddy-up to make things a little bit easier.

CHAIRPERSON JOHNSON: Well, Mike is right. I've just talked about different kinds of approaches, and I'm just not identifying solutions, just asking some questions.

MR. O'GRADY: Can I refine that a little bit? I mean, there are some things we've seen in terms of -- when you think about national standards versus otherwise -- that there comes a question of who

is setting them. Now, there's an awful lot of stuff that we do through Medicare, but I'm not sure why we do it through Medicare. Why is Medicare the guy who decides about -- you know, restraints in nursing homes.

Now, we are a payer. I know that much has evolved from logical policy analysis, and maybe horror stories of restraints in nursing homes-- but there are times when you're thinking about what the different actors in a system like this do and do well, and I'm not sure -- I mean, what do you want the government to be? Do you want the government to be a large insurance company? Do you want the government to be a regulator? And so it ends up with these contradictions. I mean, right now the government is a major purchaser of healthcare and at the same time it's a major regulator of healthcare. I don't know if we were starting with a blank sheet of paper that that would be our ideal design to go from.

So, it's just sort of how you think about these different things. Do you want a uniform national standard, or do you want to allow this

geographic variability either by State or county or however you want to think about it? It may depend on the particular policy issue you're going after, whether you really -- I mean, I think we want things like eligibility for Medicare to be nationwide. Other things like flexibility -- we talked about New Hampshire's ability to go off and use their Medicaid dollars, as long as it stays within some general federal guidelines that the Feds are comfortable that their share is being spent right. Why would you stop New Hampshire from doing it?

CHAIRPERSON JOHNSON: I think Joe has a comment, then Richard. By the way, if you have a comment and you want to talk, I'm not seeing you want to talk, you want to stick that up, that would be fine, we don't need to be formal about that, but if I'm missing you, feel free.

MR. HANSEN: Mine was more of a question, and I think it goes to what Michael was saying. As I understand Medicaid and the State's argument, different programs in different States, but I thought what you were getting at when you talked about

standards for insurance that cross State lines is private insurance, but we are not

CHAIRPERSON JOHNSON: Well, my comments were intended to be more open than that, but that's one area where potentially there could be some simplicity of the total system that would allow increased access. And we could talk more about that at a different time. Richard?

MR. FRANK: I just had an observation which leads me, I think, in a direction that's not very specific, which is if you look at the last 30 years -- well, certainly 20 years or 25 years -- the only time that I can remember us making progress on coverage and reducing the uninsured was during the sort of middle part of the '90s. There was just a jolt in the way we dealt with healthcare at that point. And that coincided with managed care. On one hand, we didn't like it, but on the other hand it did contain costs for a while, which then allowed more people to buy into insurance, but it also gave people optimism and so led to the passage of CHIP -- you know, the economic boom and all that stuff -- and it

was an historic departure from all the cost trends, from the uninsured trends, all of those things changed dramatically. And it, at least to me, suggests that you've got to think about, at the very least on the Medicare side and on the Medicaid side, but probably more broadly thinking about something on a cost-containment front so that you have something to (a) to prevent the uninsured problem from getting worse, going to 28 percent, and then possibly give people enough optimism that they can handle this thing so that they are willing to do something else because right now everybody is just battening down the hatches. Just that historical observation -- it's striking.

MR. O'GRADY: I'd say, just to support that a little bit and to tie in the article that she's talking about-- his previous piece on this was looking at those folks right on the cusp, sort of employers who were offering but -- you know, if things got any worse, they were going to have to drop, or employers who were doing pretty well and were about up to a point and they were growing their business, that they

were ready to start thinking about offering coverage. And not to pick on him because he described it as sort of insight into the obvious, but he tried to put some numbers on this idea that, yeah, in 12-15 percent premium growth years, those two subpopulations of employers are going to be more likely to drop or less likely to start offering, but in a 3 percent year that's a whole different calculation.

MR. FRANK: Yeah, but the big fact that sort of goes along with that is that in recent years it's the take-up rates that have been going down, which has been a big -- I think it's what, like two-thirds or something like that, of the growth in the uninsured or something -- I mean, you know these numbers, right, isn't it something like that?

VICE CHAIR McLAUGHLIN: Particularly among low-income people, the take-up rates have really been dropping. So, more than employers stopping -- offering health insurance, it's been passing on higher percentages of premiums, and then a reduction of pick-up rates.

MR. FRANK: Right.

VICE CHAIR McLAUGHLIN: But I think, Richard, part of your point, too, fits into the comment I was making earlier about the relationship between the economy, labor markets, unemployment, lack of coverage, Medicaid -- I mean, all of those things -- and this is what both Senators were saying this morning -- I mean, it's like a plumbing system -- I mean, the water is just flowing in and out of these pipes, but it's the same amount of water, it's just going up and down. And so there has to be some way -- I think what you were suggesting -- to smooth it out.

MR. FRANK: Right. I thought you were actually -- I'll come back and put what I thought you were getting at before back on the table, which was isn't it odd that the sort of safety net which is Medicaid suddenly has become pro-cyclical rather than counter-cyclical.

VICE CHAIR McLAUGHLIN: Right, that is what I'm saying, but what you brought up is part of that same --

MR. FRANK: Right, everything is pro-cyclical, which is bad. You want negative correlation

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MR. O'GRADY: Well, it's certainly good that the entire safety -- you know, from the work I do on welfare and -- you know, I mean, it's the same sort of thing. States -- you know, when they are in the worst spot is when they are -- you know, they got the lead money, that's when they're going to spend more.

VICE CHAIR McLAUGHLIN: Right. This is what FDR's policies were all about, right, is to make the government counter-cyclical, right, which is --

MR. FRANK: Earlier on, Medicaid was counter-cyclical, it's only recently that it's --

MR. O'GRADY: Well, it is, but that's States deciding that they wanted balanced budget amendments in their States, and so the Feds are the --

VICE CHAIR McLAUGHLIN: We're not doing the blame game, we're just --

MR. O'GRADY: No, no, no, but it is that idea. But Richard's point about how you -- and it gets back to the earlier point about the Sisters of Charity, that idea if you can do this efficiently, if you can be as cost-efficient as possible, that frees

up resources to be able to do more good. I think that's absolutely right. And if you look at this long-term -- you know, part of the stuff I have to work on is the Medicare Trustees Report -- boy, when you look at the 75-year estimate, boy, it just makes your eyes roll in the back of your head -- 85 percent of the economy will be healthcare? You couldn't sit in the doctor's office that many hours of a day.

(Laughter and simultaneous discussion.)

MR. FRANK: Medicare starts to bite in 2007. I mean, that's scary -- the big jump in percentage of the budget going to Medicare starts in 2007, right?

(Simultaneous discussion.)

CHAIRPERSON JOHNSON: Okay. What I'd like to do here is kind of move us towards some potential solutions, or initiatives -- that's a word I'd prefer to use. What are some of the initiatives that you have observed that deal with some of these issues that we've talked about? And by the way, I'm not belittling any of the comments that we have on our current situation. We do have some real issues, and

Medicare is one of those. But what are some of the current initiatives that you see working in your environment, that have begun to attack some of these issues?

MS. BAZOS: I'm just going to mention Bob Masters' work that he did -- and maybe we should write down two people because -- I mean, I haven't been involved in his work other than -- he did a lot of work, again, using Medicaid as a way to help patients with end-stage renal disease and HIV/AIDS stay out of the hospital, to decrease their hospitalization.

CHAIRPERSON JOHNSON: Who was this?

MS. BAZOS: Bob Masters. He sort of built this program using practitioners -- it's a carve-out program with Medicaid, and same thing using Medicaid in a very flexible way to pay various practitioners to make home visits, to actually again provide those support ancillary pieces of care that people need to actually allow them to stay home and out of the hospital. And he did find cost-savings, unfortunately, in negotiated contracts he never got, and so those dollars went back into his program. And

they said, "Oh, you found cost-savings, well, you're only going to get this much next year then". So, he's written about this.

MR. O'GRADY: Along those lines also is a cash counseling program -- have you ever seen that one -- it has to do with, again, disabilities and the ability to in some way -- it's particularly successful in rural areas where you are, in effect, kind of cashing out. You have a counselor that works with the person in terms of their Medicaid money, but it is the idea that if you need a care provider who is not from a traditional sort of home health agency or whatnot, you have the flexibility to go out into the community you live in and find someone to come into the home or whatnot. And we got write-ups on that, too. That's four States, I think, five maybe.

CHAIRPERSON JOHNSON: Aaron.

DR. SHIRLEY: My State Medicaid program implemented a disease management product two years ago that's budget-neutral to Medicaid, and it's built around a nurse call center and community nurses being available to Medicaid beneficiaries with the diagnosis

of diabetes, hypertension and asthma. And the first analysis of cost-savings to Medicaid is showing something like for asthma and hypertension a 2-to-1 cost benefit.

And the education component that we talked about, the nurses are available to eligible Medicaid clients 24/7, and when the individual has difficulty understanding the instruction, the advice that the physician or provider gives, that individual can call a nurse. When the physician has a noncompliant patient, the physician can call the nurseline, and the nurseline in turn contacts the patient to see if the patient understood the instructions, and if the patient needs help the community-based nurse can make a home visit. And it's beginning to show some promise both in terms of better control of the diabetes, fewer ER visits for asthma, those kind of things.

CHAIRPERSON JOHNSON: So, diabetes, asthma and --

DR. SHIRLEY: And hypertension. They are about to implement a similar program in Texas.

CHAIRPERSON JOHNSON: May I follow up a

question with you, Aaron? How do doctors -- and, Frank, you as well -- how do doctors feel about disease management strategies provided by health insurance companies or others such as you've just identified? Are they supportive? Do they like them? Do they dislike them?

DR. SHIRLEY: Once they got beyond the notion that the disease management company was interfering with their relationship with their patients and the patients became more compliant, that they could recognize and they accepted pretty well. The main concern now is that whereas paper already was a burden, this program has added additional paper.

CHAIRPERSON JOHNSON: Thank you.

DR. BAUMEISTER: I haven't had that much experience with it, but what I anticipate is another industry developing, that is a disease management industry that will contract to provide the services, and if you could work it out somehow within the medical community, I think it would be a better program.

DR. SHIRLEY: I should have mentioned that

this is a contractual arrangement-- the State Medicaid has contracted with a company to do the disease management.

CHAIRPERSON JOHNSON: Thank you. By the way, employers have put in place disease management strategies. We've had them in place since 1997, and we've had very good response to them. We've done it earliest with pregnant women, to avoid premature births, low-birth weight babies, really significant. It's a win-win there. But in other areas as well. Montye?

MS. CONLAN: One of the things I participate in on a regular basis is teleconferences. Often they are sponsored by the drug companies, but sometimes they are sponsored by other groups. And they will typically have a doctor, often a nurse-practitioner, that will speak on a particular topic of interest to all of us, and then afterwards take questions from the people that are listening. They open up the lines and they will take questions. And sometimes they get more or less personal, but generally the patients feel that the questions are as

informative as what the doctors are presenting because it shows that there's some common ground there, and things that are "my concerns are not just my problems but are common", and so some good is done there. But that's another forum besides having volunteers come out to the home or whatever, is these teleconferences.

CHAIRPERSON JOHNSON: Thank you.

MS. HUGHES: In the 1995 L.A. waiver, one of the things that was required of the county was that they form a public/private partnership with the safety net providers of the uninsured. And I think of all the things that I'm familiar with with that waiver and the subsequent 2000 waiver, the single most successful item in the waiver is the public/private partnership. And just to give you an example, in '95 they started out with they gave a dollar amount per patient per number of visits per year, and that has been what has happened actually up until right now, which is being renegotiated -- not the waiver, but with the county, the public/private partnership. And now the public/private partnership is looking at the clinics, and the clinics are looking at kind of a block grant

idea, and then the money -- for instance, there's a group that's asking if they can use the money for diabetes care, for disease management in diabetes and asthma, and so those are two areas that some of the clinics are looking at to see if they can negotiate the money and so that we have a better -- we have more control over what the dollars are that are coming into the provision of care.

There are several layers to the program. There are strategic partners, and the strategic partners meet the highest quality and the highest county requirements, and probably federal requirements, for what the clinics are, what they provide, if they have a doctor in place. Some of our clinics have a doctor onsite two days a week, so they are clearly not strategic partners, but they would move down the line. And then the percentage of money that is allocated to the different levels of partnership also depends on the amount of -- if there's improvement in care. And that is something that I think has been very successful and it's done at the clinic level.

We've been trying to work with the current administration in California to look at that on a Statewide level because it's something that works. I mean, it's worked from '95 on, and actually in L.A. County the clinics have honed what are good practices in cooperation or hand-in-hand with the county, and I think it's an effort -- and by public it means there's public monies coming down to private organizations where we provide the care, it's not public dollar and private dollar, it's specifically meaning foundation dollar. Does that make sense?

MS. MARYLAND: Let's talk a little bit about -- and actually picking up from your point, Therese -- Ascension Health, as I indicated earlier, currently funds a number of demonstration practices across the country -- actually, seven different States at this point in time -- called HCAP, Healthy Community Access Programs -- and I want to talk specifically about what's going on in Indianapolis.

We have a number of rural counties in Indiana. And if you know anything about Indiana, everything -- the epicenter is in Indianapolis and

everything else is rural essentially. And the health system consists of 16 hospitals that represent most of central Indiana.

A number of our hospitals are critical access hospitals, and within those communities there are variable populations, particularly Hispanic patients, that have significant needs similar to what you talked about in terms of Texas. And what this program essentially provides is that there's a partnership including the Butler School of Pharmacy where they send pharmacists out to rural communities to work with these clinics, along with the administrative plan that's called Advantage -- they handle the managed care aspects of this -- along with funding that's provided by Ascension Health, and also federal dollars that are matched. So, this is sort of a private and public, but joint, investment of dollars coming together to provide support. And some of the resources that these dollars pay for would be outreach workers, as we talked about before, that are bilingual, and they go out -- and they are like system navigators. They go out and identify families who

have no primary care. And the goal is to try to get them connected to some type of primary care clinic, physician, specialist, and will oversee that they are going -- that that family unit is going in for care. And also working on development of the disease management programs. The one that they've been very successful is the cardiovascular disease management program. And really with this population because of the high risk in terms of hypertension, cholesterol problems, obesity, felt this was a key area that needed to be focused on.

And then to link that with Butler School of Pharmacy means that there is a pharmacist out there making sure that they understand how to use their medications and that there's follow-up, that they are complying with taking their medication on time. We've seen some great results in terms of how often they use the emergency department. We have actually a database set up for each of the family units, tracking the use of how often do they go to their primary care physicians for follow-up visits, are they complying when they are called in for their follow-up visits,

and how often are they now going to the emergency department in lieu of going to that primary care physician or clinic. And we've seen some great results -- and I don't want to go through the detail at this point, but we can certainly share those results -- that are showing that this investment is paying off and that we're seeing certainly a huge reduction in emergency room visits, a reduction in preventable hospitalizations also, and there's some basic counts of how many people have been served, the community that is at-risk, what percentage of that population are we actually reaching.

I think this program, which is one of the seven States where Ascension Health made this financial investment along with the federal dollars that we've received, to really make this -- and then dollars are coming from the Health Resource and Service Administration of Department of Health and Human Services. This HCAP program is, I think, very effective, and I would like to have you consider it as a potential model. It could be expanded further and replicated in other areas.

CHAIRPERSON JOHNSON: Do you have an explanation you can share with all of this? Do you have a written explanation of --

MS. MARYLAND: Yes, I have the data.

CHAIRPERSON JOHNSON: Can you get that to maybe Ken, and can you make sure that Pat has your e-mail address and then get it out to all of them?

MS. MARYLAND: I can do that.

CHAIRPERSON JOHNSON: Thank you.

MS. PEREZ: As Pat was talking, I was thinking of the reverse, too, to use that similar program to identify those patients that -- I hate the term "frequent flyers" -- but they are frequent visitors to the emergency room. They are using that as their primary care because they may not know about resources in the community -- so to use it on the flip side and identify those patients that come in through the emergency room, and partner with a knock on their door and say "are you aware of all these other resources and enrollment and programs", and try to figure out why it is that they are showing up in the emergency room. So, it could go the other way as

well.

MS. MARYLAND: And those system navigators or outreach workers really have been very effective in identifying those family units, and with that those "frequent flyers", and really working with them to get them into a primary care setting so that they go on a routine basis. And the responsibility from the physician's perspective, primary care physician, is that you go out and you are connecting with that family on a routine basis and say "did you bring the children in for their immunization, did you follow up in terms of this", and then the pharmacists are back with them in terms of -- you know, "the cardiovascular disease management protocol says the following, are you following these prescribed requirements?", particularly in terms of drug compliance, medication compliance.

CHAIRPERSON JOHNSON: Okay. Thank you. So far, I think we've spent more of our time talking about access issues. In our earlier discussions, Catherine has been talking to me and others about looking at not only access, but quality and cost

issues. And maybe we can focus on those as well.

What kinds of initiatives have you seen, or worked with, or heard about, that get at the quality issues that we've talked about or the cost issues that we've talked about here?

VICE CHAIR McLAUGHLIN: Actually, I wanted to add one -- I think several of these examples that were given of initiatives are wonderfully illustrative of how those three things go together -- access, cost and quality. A lot of these initiatives were proposed to improve access for people of different cultures or languages, or people who are disenfranchised. But in so doing, you are improving the quality of the care that they are getting, and the coordination, the continuity, hopefully the health status all together, which in turn in the long-run will save costs. So, actually saw those as examples of how all three of these things are knitted together.

MR. FRANK: There are a number of pay-for-performance schemes underway. They're sort of the solution du jour for that quality problem. I think the idea is promising. I think the evidence is it's

less so at this point. I think that the sense to almost all of us suggesting that you pay for quality makes good sense, and that you pay for performance. However, I've been involved in the evaluation of a couple of them, and I think it's very hard to do in our type of health system, and I think it's also complicated and we just haven't gone very far down the learning curve.

The CMS program that just got underway for hospitals will be pretty instructive, I think, but CMS is in a unique position compared to like --

MR. O'GRADY: Good or bad.

(Laughter.)

MR. FRANK: It has a lot more clout. Nobody is going to ignore CMS, no hospital is going to ignore Medicare whereas it's pretty easy to ignore PacificCare even if you're in California because they are only 15 percent of your action. And so I think there are some issues there, and I think people are learning a lot, but I think so far the evidence has got to be -- (a) it's not all that cheap -- you can't do it on the cheap easily, and you can't do it small

scale are at least the two lessons I've taken away from the things that I've looked at. And also there's this big philosophical issue which is do you pay for performance or do you pay for improvement? If you pay for performance, then you give all the money to the guys who have been good forever, and so you're just making the rich richer. And if you pay for improvement, then you're sort of ignoring people who have done good deeds. So, it's figuring out what that balance is. I think that's what I know about today. But the folks out in California -- I think it's under the Pacific Business Group on Health -- have started a pretty large-scale pay-for-performance for doctors, and PacificCare started one a year earlier. And we're just finishing up the evaluation of PacificCare one, but the really big thing is probably another year or two away.

CHAIRPERSON JOHNSON: Does anybody want to talk on those?

MR. O'GRADY: Yes, I just want to follow up. To a certain degree, Richard has hit on a couple of the big points: he laid out there the idea that we

saw a good four or five years where managed care really did flatten this growth rate for us in a way we really hadn't seen for a very long time, and then there was a managed care backlash that we see in employees and other subscribers who were just not interested in that kind of level of gatekeeping and whatnot.

And so there's two things that, as far as I can see, have grown out of that, and they make sense if you think of healthcare spending, anyway, as this expense curve where you know that you have an awful lot of people that are down on an end –but they are not your big high-cost cases, and then you've got 10 percent of your people who may be 40 percent of your total spending.

And so you see two movements coming out of that. If you're not going to use a gatekeeper, well, then you start moving -- especially if you're a small business -- you start moving towards high deductibles because you know that a lot of people spend an awful lot -- you know, still a lot of your money goes to routine care. And you say, well, this is insurance

against really bad things happening to you. If you have just a doctor visit or two a year, you pay for it. It will make you more cost-sensitive to what a doctor visit really costs, and we're not that worried about the bad end, it's when you get into really serious trouble that we're going to provide the insulation. And the other side is just what we're talking about here in terms of focusing on how do you drill down on the 10 percent that is 40 percent of your spending. You do it through disease management and you do it through pay-for-performance.

And it brings up some of the other stuff we talked about here like the program that Richard was talking about, where the physician practices in California have started to have some pretty nice results. One of the real tools they used there was health IT. And so you say, well, -- how do you get to pay-for-performance?

Well, the first thing is -- especially when you start identifying three or four major groups -- diabetics, congestive heart failure folks, and your -- you know, different key subpopulations of who, if

you get a better handle on it, you can both deliver higher quality healthcare and save some money. So, it's sort of your key target subpopulations. And part of what they do is they first set up a registry so -- I mean, it may sound a little simplistic -- so they at least first know who their diabetics are in the practice, and then are they getting their recommended tests, and then the final stage is do you have enough of the health IT to be able to know -- it's not enough that your diabetics are getting their hemoglobin A-1cs two or three times a year, but how are they doing on those? And so it does get to that sort of thing.

Now, there have been some questions, early results look good, but we're talking about California where 200 guys in Bakersfield where they all work out of the same company-- that's a little different than if you're the two-man operation in the Outer Banks of North Carolina someplace, and how much these models convey -- and that gets back to -- but that's one of the uses I've seen that health IT has really shown at least some early promising results, although I don't

know how to project it to -- I mean, when you think about what you want: Is the outcome there? What is the policy goal? It's the higher quality care and a little smarter about how you've spent your money.

If the guys in the Outer Banks can do it, sending Mildred to the back room to go through the files and she figures out their diabetics and sees what -- you know, how am I invested in health IT? I mean, you want to get to the point of the higher quality healthcare and spend your money in a smarter way. If health IT is the tool to get you there, great. If it doesn't, it's a tool. And that's another question-- are things like health IT an end in themselves, or are the simply tools to get you to a greater goal? But it is part of this whole notion of if you're not going to do managed care anymore, at least hire a gatekeeper, what are you going to do? So, it seems to me there's this two-pronged approach, one end of the distribution and the other.

CHAIRPERSON JOHNSON: Maybe I can share -- I'd like to step out of my facilitator role here for just a second and share what larger employers are

doing because it gets to this subject that Mike has talked about. And there is a perception based on the studies that have been done and provided by and for employers that mentioned earlier, 50 percent of the care is not delivered -- and that's a report by the IOM, that's not employers saying that -- but if you and I go to the doctor, we really don't know who are the good doctors and who aren't. And Medicare and Motorola, University of Michigan, pays the same for every doctor whether or not they are providing outstanding care or they are not.

And so what's happening in the employer community is the larger employers are kind of leading this, but others are beginning to think about it, and that is what we are going to do is, No. 1, we're going to push for the measurement transparency and disclosure of healthcare outcomes, and we're going to use nationally accepted standards to do this -- risk-adjusted data, sex-adjusted, age-adjusted, risk-adjusted as well. So that's the first part.

The second is moving more and more towards consumers. And what employers have done up until now

-- I call it the Studebaker, to use a widened reference -- the Studebaker method of healthcare cost management is just to share higher cost with the patients or with the employees, but that doesn't help control the cost. I just charge more to Mike's kind of premium every month, that doesn't help control the cost. They don't have any visibility for that.

So, what we're moving now more toward is consumerism, and what we mean by that is giving strategic decisions with tools employees or patients, so that they can make better decisions when the buy healthcare.

Now, will that help out the emergency case? No, not so much, but it will help on preventive care and it will help get the chronic care that Mike O'Grady has been talking about, and especially there. We think that as we -- and we've seen other companies move in this direction -- as we identify better providers and as we identify disease management strategies that work in collaboration with the doctors -- not excluding the doctors, but in collaboration with the doctors -- and then in addition to that, if

we pay the doctors based on their performance. So, now we have the reports, we have the consumerism, we have the patients going to who are the quality doctors, efficient doctors -- by the way, hospitals and treatment plans as well -- patient satisfaction, and equity -- that means treating people along racial lines and ethnic lines and socioeconomic lines -- and all of those performance ratings would be available.

Now we'll have physicians who have not known in the past how they've been performing, they'll be able to see their ratings. And we'll see hospitals who haven't known in the past how they've been performing -- am I better than St. Vincent's or not as good, and how do I compare. And then what we'll see --

VOICE: It's in the newspaper.

CHAIRPERSON JOHNSON: That's right, it will be public, and we'll provide information to the doctors as well to the hospitals, as well as to the patients. And we think that that will help us re-engineer the system, and the data seems to say about 30 percent of wasted medical dollars could be recovered.

Now, that's a direction that employers are moving. And we see a little bit of that with CMS and programs that Mark McClellan and Leslie Norwalk have implemented as demonstration projects. So these are not pie-in-the-sky, they are initiatives that have already been established.

Aaron, and then down here.

DR. SHIRLEY: I didn't quite get clear, who is going to define the standards by which the quality --

CHAIRPERSON JOHNSON: If you didn't hear Aaron back there, the question is who is to define the standards? And there's an organization -- by the way, I'm going to back up and say two things first. I think there are some things that have come out of prior commissions, and one of those that came out of the Quality Commission during the Clinton administration, I believe, was the formation of the National Quality Forum, and we can come back and talk about that. But there's another new thing that I believe has come out of the recent MedPAC Commission, and that's a recommendation that Medicare doctors be

paid based on their performance and improve the SGR, the Stabilization Growth Rate, so that we have a new methodology of paying doctors. I think those are significant contributions by other commissions, and the reason I mention that is I'm hoping that we'll come out with at least those kind of good quality ideas.

But to answer your question directly, Aaron, the National Quality Forum is the organization that these employers are pushing to be the evaluator of the measurements. And just for others who may not be as aware as Aaron probably is, the board or stakeholders on that, primary stakeholders are providers, researchers, patients or consumers, and employers or purchasers. So, it's broad stakeholders, and that's why we think if those measurements are used, that would be moving in the right direction. Now, it's not -- when I'm saying "I", I'm saying as one of many large employers.

MS. MARYLAND: I wanted to just add something for clarification in your comment. When you said that employers were looking to -- I believe I

heard you say that employers were looking at providing information to the consumers on the cost of what their healthcare plan may be.

What size employer are you looking at as providing this sort of benefit to consumers?

CHAIRPERSON JOHNSON: Well, right now I'll respond -- I'm happy to respond on all of this, but I don't want to personally dominate the conversation. Just briefly, there's an organization called Bridges to Excellence and another that's called Leapfrog. Leapfrog is dealing with hospitals, Bridges to Excellence is dealing with doctors, and the Bridges to Excellence has primarily been working with large employers, but it has now been licensed by United Healthcare which I think has something like 50 million members, and CIGNA, which is another large nationwide carrier. And they will begin to move forward with those kinds of initiatives. Of course, those organizations are dealing with small as well as large employers.

MS. MARYLAND: Two additional thoughts. One that not only are employers looking at

performance, if you will, but so are the major carriers. For example, Wellpoint in Indiana reimburses its carrier rate level given the outcome, so they do look at risk-adjusted clinical outcomes to evaluate what level are they going to reimburse you for services rendered.

The only other point I'd like to make is the concern that I brought up about specialty hospitals earlier knowing as you start to look at the report card for acute care hospitals, where there are specialty hospitals within the region because what tends to also happen is there is a transferring or shifting of those patients when they have morbidities and complications, to those general acute care hospitals. And when you put together that final report card, mortality and those complications may not be on the books of some of those specialty hospitals. So, that's a major area of concern as we look at markets where there are other specialty hospitals in a region.

CHAIRPERSON JOHNSON: That's why the validity of the data, and the reliability, is going to

be so important, to make sure it is adjusted for risk and so forth.

MR. O'GRADY: One of the things I think that Aaron said -- when you asked who is going to set it, that sort of sent shivers down my back. I think we've seen different things. We can point out the things that you certainly have to be very careful and you have to be very rigorous on those. I think that the Centers of Excellence Program that was attempted by HCFA in the old days, and of course if you have five hospitals in a city and one gets called a Center of Excellence and the other four go, "What the hell are we, Centers of Mediocrity" -- you know, it's sort of the notion of a panel in Baltimore -- the government deciding -- that rubbed people the wrong way, so certainly it has to be done very carefully.

I wanted to point out another program that I saw -- and I'm blank on which of the Wall Street firms did it, but it was one of these where they basically had these big traders that were dropping like flies, basically heart attacks -- and I forget who it was, but it cost the company like a million

dollars every time one of these guys was out for eight or nine months. So, they basically bought their own cardiologist, put him on staff, and what he did is -- they'd see the claims coming in, so they'd see the different people -- who was going in, who was getting their checkups and whatnot. Now, it was the same notion of pay-for-performance, but what that meant was the cardiologist just called over to the person's internist and said, "This guy could really use a stress test", or whatnot. Now, in effect, that started out a little bumpy, but it worked out not badly -- and took it the next step -- beyond a report care in terms of you have an internist there who is not a cardiologist. And so, in effect, you're giving kind of a free consultation there -- you know, bringing in the specialist to sort of say "Are you aware that" -- for this guy, maybe a -- you know, whatever it happens to be, and especially as these guys who live fairly far out of whatever the large metropolitan area -- it was Merrill Lynch who did this, that's who it was.

So, what this sort of feedback move is doing for you is, in effect, giving practitioners access to more resources than they would have had otherwise. They had a pretty good track record. That was not necessarily telling them what we do, it was telling them what the latest thinking was, what cardiologists were doing for this guy or that kind of a case. And they were pretty happy in terms that the kept the relationship with the primary physician on more cooperative grounds.

CHAIRPERSON JOHNSON: First, Dotty, and then, Frank, you've been kind of quiet, but I know that you've got some thoughts regarding what's been done in Oregon. Would you be willing to share some of those when Dotty is done?

MS. BAZOS: I'll just be real quick. You might want to look at as a model the report card from New York State. They've been providing State level data on their outcomes for CPR surgery since I think early 1990s. And they publish a report every year. Everyone is compared to a State standard. So, you might want to look at that. And it's hospital data,

also physician level data also.

MR. FRANK: Thank you. I don't want to put you on the spot, Frank, but you kind of alluded to some of your initiatives earlier, and didn't want to miss those.

DR. BAUMEISTER: Well, a lot of what we're talking about was what Oregon tried to do. I don't know how many of you are familiar with what went on out there, but years ago, once upon a time, there was a kid named Coby Howard who had acute leukemia. And at that time the Medicaid payments came to the State as sort of a block grant type pot of money. And the Medicaid population would use the money up and then the Medicaid population was left hanging. And they either got care from kind-hearted docs and emergency rooms, or they didn't get any care at all.

And the situation came up with Coby Howard where they wanted to do a bone marrow transplant only there wasn't any money. And he had been seen by a number of physicians who had concluded that a bone marrow transplant would not be valuable, but the media got on it and there were some advocates for a hopeless

situation, and he didn't get it. And it brought a lot of bad publicity down on the State and particularly Dr. Kitzhaber, who was a former emergency room physician and at that time was -- I can't remember whether he was governor or president of the senate at that time -- but he was referred to as Dr. Death in the New York Times, and all sorts of bad publicity.

Well, anyway, they decided -- one night, he and Barney Spate, who was a health policy person in Oregon of some renown -- I think they were sitting in a bar in Salem, Oregon, and they came up with the idea for the Oregon Health Plan, which basically was -- I'll use the analogy or metaphor, or whatever you want to say, of dinner party where you had so many guests and you had so much money to spend and you had to decide on your menu, and that's what they came up with was that's the way healthcare needs to be delivered. You need to figure out how much money you've got to spend and then how you're going to divide it and what are you going to serve your guests.

And so the concept of a basic benefit package circulated around. They said how are we going

to decide what a basic benefit package is? And so this group called Oregon Health Decisions, which was -- there were several ethicists from Oregon Health Sciences University, several people from the clergy, some elderly retired physicians among whom was a psychiatrist who had an interest in public policy, and formed Oregon Health Decisions, and started a group of town meetings around the State. And it went on interminably, taking testimony from all walks of life -- farmers, stock brokers, nurse-practitioners, chiropractors, specialists, urban, rural, university, you name it. And they came up with the Health Services Commission, the Oregon Health Services Commission, which came up with a prioritized list of diagnosis and treatment payers. And I think there were 800 diagnostic treatment payers that would comprise the list, and if the State were to be flush with money, they would cover all 800 as the Legislature had to make the decision out in the open, had to be transparent. We've only got so much money to spend, so we'll only cover 700 or 600 or 500 or whatever. It would be out in the open. So, that was part of the

Oregon Health Plan, was that the Health Services Commission would come up with a list and that would be what would be a basic benefit package, but let's offer it to all Oregonians.

And the way they did that was they passed a series of Senate bills, and Senate Bill 27 covered the Medicaid population. Senate Bill 935 was an employer mandate. And small employers, as you said, were going to see their bills increase 25 percent over the next few years, and large employers up 10 percent, or whatever. The ones who would be hit the hardest would get tax rebates. So, it would be a public/private enterprise. And that was Senate Bill 935.

Senate Bill 541 was to cover all the uninsurables, and that was to be by contribution from the insurance companies that would take care of those people who absolutely could not get insurance under any circumstances. And that was the Oregon Health Plan.

CHAIRPERSON JOHNSON: Did the insurance companies provide the coverage?

DR. BAUMEISTER: They would have, yes. Well, the first thing to die was the employer mandate. Mandate is a dirty word in Oregon, as it is elsewhere. So, essentially, the Oregon Health Plan fizzled and became a Medicaid program that was embraced by the community, by the medical profession, by the hospital association, and for a while there it essentially did away with uncompensated care.

And over a period of several years, the doctors' income from those patients went up like 1 or 2 percent. The hospitals made more money out of it, and so that set up a big battle between the hospitals and the doctors.

And of course Medicaid is basically a State program where the State comes up with money, they put in a dollar and the Feds put in two dollars, and dollars got short in Oregon. And so now they've changed eligibility criteria and it's really struggling. But that was the history of the Oregon Health Plan over about an eight or nine-year period. A sad demise.

CHAIRPERSON JOHNSON: Advantages and

disadvantages, lessons learned for us.

DR. BAUMEISTER: I guess the lessons learned -- one lesson, you can't mandate anything. You can't -- people just don't want to pay for things. I mean, that's the bottom line. It never got a chance, I don't think, from the business standpoint. You've got a welfare program over here, and you've got a self-sufficient program over here, and it's hard to make self-sufficient program over here -- it's like the guy at Starbuck's who "would you buy me lunch" -- it's a real problem.

We have a mess in Oregon right now. Mental health out there is a travesty, it's a disaster. Mental health in Oregon has been turned over to Corrections. And you read about it once in a while when a policeman guns down a psychotic, and we've had three or four of those in the last few years.

The biggest mental hospital in Oregon is the Inverness County Jail. I've toured the jail. It has 78 beds, I think. I was on a mental health task force in Oregon, in Multnomah County which is Portland, and all the mental health cases from the

State migrate to Portland. You can't be homeless and sleep on the street in a small town where there are no streets. And it's a difficult situation.

But the Oregon Health Plan was a generous plan that would balance things across a wide population, which is basically what insurance is supposed to do, and it took care of the most needy of our people -- you know, the haves helped the have-nots. And it was a sad day for all of us.

CHAIRPERSON JOHNSON: Thank you for sharing your perspectives and your experience.

MS. MARYLAND: Tell me how we're going to be inspired by those --

(Laughter.)

MR. O'GRADY: I got the no-mandates message real clear.

(Laughter.)

CHAIRPERSON JOHNSON: I think actually --

DR. BAUMEISTER: We had a hard time getting a waiver, if you recall, because it was rationing.

MR. O'GRADY: It sounds now almost like

you're saying it didn't ration enough to be financially viable with the people who would have to pay for it at least within the State.

DR. BAUMEISTER: Maybe not.

CHAIRPERSON JOHNSON: Dotty has a comment.

MS. BAZOS: I just do. I did work with Eliot Fisher and Jack Wennberg, and I've worked for them for years, so I just have to bring up this question about rationing. I mean, I think when we started this discussion we started making some assumptions that there's enough money in the system to support really good quality healthcare for everyone. And before we leap to rationing, we're thinking about rationing, I just wanted to have a conversation about what we're overusing in the healthcare system. Let's not forget we talked a lot already about the variation in distribution of providers and capacity across the system. And I just don't want to lose that. I know that all the work that's been done -- they've been sort of singing the same song and saying the same things for years, and research is getting really good, but they don't have solutions yet. I would just like

to keep that on the table so we don't leap to quickly.

I do think the term "rationing" in the United States would really be a death sentence for all of us, and what you see in other countries where they do ration care -- I mean, in Third World countries -- and when I was in Pakistan with one hospital where you could get any treatment for cancer, if you couldn't pay for it yourself there was nothing. So, the people who had money went there, or they flew to the United States where we have higher technology, better care, and the poor people got nothing. So, I think we don't want to set up that kind of scenario either.

CHAIRPERSON JOHNSON: Let me respond and then we'll switch to our next agenda item. Two things: First, part of what we should be about is learning from the experiences of others. So, Frank, there might be some things we can learn that we shouldn't do, and some things that we can learn that we should do.

DR. BAUMEISTER: I think it's important to know that the plan failed when we had gatekeepers, when Oregon had the highest managed care penetration

of anywhere in the country, that Oregon's expenditures annually for a Medicare recipient is about one-third of what it is I think in Florida, New York -- I mean, we are tight-fisted out there, and part of it has to do with that tradition of our managed care -- Kaiser came to Oregon in 1945, and they played the tune and everybody else danced to it until now all the private plans have out-Kaisered Kaiser. So we have a long tradition of that, and the Oregon Plan still failed.

CHAIRPERSON JOHNSON: The other thing I'd like to end on a positive note in this session, and we're going to have to come back and talk about initiatives, was just the one you've mentioned. There are smart people -- we've talked about some of the challenges of health here, but there are smart people within the United States who have done some great studies, some great research, and the two you've mentioned are just two of those. And we're going to have an opportunity to draw on their expertise, I think, to see if we can build some of their research and some of their concepts into what we end up with recommending, or at least share with the public some

of their findings. So, I appreciate that.

And speaking of bright people, we're privileged this afternoon to have Carolyn Clancy. You know, I've heard a lot about Carolyn Clancy over the years because I've been in this Healthcare Benefit Strategy group for a number of years, but I didn't have an opportunity to meet her until within the last year. And Carolyn is a doctor. She is a director of AHRQ, was the interim director for a while, and before that director of Centers for Outcomes and Effectiveness Research, and the director for the Center for Primary Care Research, so she's got practical experience and the research experience as well. She has done a superb job, is counted on -- and typically we sometimes use the word "expert" kind of with a negative tone to it. We don't have that tone when we're introducing Carolyn to us this afternoon. So, welcome, glad you're here, and we look forward to your comments.

DR. CLANCY: Thanks very much, Randy, and it's very nice segue at this point in time. I've been looking at all of you and trying to figure out where

you are on the exhilaration-exhaustion continuum, but then I look at the list on the wall, and you have certainly identified a lot of very, very important issues.

It's an interesting segue right at this moment to have been talking about this because in many ways the agency is here because of Jack Wennberg's work. Long before you could click on the Internet and get the pretty maps from the Dartmouth Atlas, he made it very, very clear to policymakers what were the implications of variations of practice, and what is meant that we are spending much more for Medicare beneficiaries in some areas than others, and you don't have to be a rocket scientist and you don't even need the pretty colored maps, although they help, to begin to ask questions: wait a minute, how come we're spending much more over here than over here, and what are the implications? So, in many ways, that set the stage for the agency coming into being 15 years ago.

So, I just wanted to share with you a few high points of where we are now. The mission of AHRQ, as we say it, is to improve the quality, safety,

efficiency and effectiveness of healthcare for all Americans. Depending on the day, I either think of this as ambitious or psychotic, and many days I think it's right at that line. Our overall budget for this fiscal year is $319 million, which is a high-water mark for us and we're very proud of that, but if you think what we're spending -- and, boy, you're going to hear a whole lot more about what we're spending in really granular detail -- that's a pretty tall order. And the only way we believe we can do that is through partnerships with those stakeholders that actually do directly provide or regulate or purchase healthcare.

In terms of where our research fits into what goes on at HHS and what's supported, where NIH supports basic biomedical science and focuses on what can work to cure or prevent disease, and the CDC focuses on the public health system and community-based interventions. We're really focused on the effectiveness of what works in healthcare and for whom, and we're hoping to focus that work on those potential solutions and the evidence that will help people develop solutions in what we call the real

world. Now, we're not entirely confident where the real world is, it's probably not within the Beltway. So we like to say that our research is really patient-centered rather than disease-specific.

So, where NIH might focus very specifically on a particular condition like diabetes, we're focused on the people with diabetes, and that matters because a little over 80 percent of adults with diabetes have at least one other condition, so you're starting to look at co-morbidities and those kinds of intersections.

And in addition to focusing on the clinical contents, we're also focused on the environment in which those services are provided because all of us know all too clearly that how healthcare is organized and financed has a big impact on what kind of care people get. And very, very importantly -- and I'll probably reinforce a couple more times, so I'll apologize in advance -- our mission really includes both the production and the use of evidence-based information.

I see along all of your flip-charts the

theme of information in many different ways, whether it's consumers or whether it's policymakers having information and so forth. And I think in policy dialogues, we treat this as a production problem. And I would assert that it is at least as much a dissemination or communication problem as well, so I hope that you might want to consider that.

You all got copies of our annual reports on the Quality of Healthcare and Disparities in Healthcare. These were mandated by the Congress when the agency was reauthorized in late 1999, and came from very different parts of the Congress. The Quality report really came because, if you recall, this was sort of the tailend of the so-called Managed Care Backlash, so members of Congress and their staffs were besieged by constituents saying "quality of care is going to hell in a handbasket, the green-eyeshade guys have gone too far, you need to do something", and they had no framework to even think about this. I mean, all the stories sounded terrible and, indeed, were terrible tragedies for individuals, but they didn't know how to interpret it, so that's why they

really wanted a Quality Report. They were fairly confident they didn't know enough to regulate or make laws about this, but they wanted to have an annual report sort of along the lines of leading economic indicators.

That same year was a year that there was a very high profile publication in the New England Journal of Medicine. This was the study where physicians attending professional meetings actually looked at videos of actors portraying patients. Now, the genius of this study -- and there's been a lot of debate about the statistics that were used in terms of portraying the results -- but the genius of the study design itself was that every doctor saw a patient who was either 55 or 70, black or white, male or female, but they used the exact same words to describe their symptoms. It was very, very well done.

Watching these computer videos, I felt like I was in the clinic -- you know, patients had the examining gowns on and so forth -- and they could also control for socioeconomic factors and so forth. And the bottom line of the study was that the physicians

were significantly less likely to recommend evidence-based diagnostic treatments for patients who had a very, very good story for having serious cardiac disease -- much, much less likely to recommend those for older African American women. And for whatever reasons of timing with the media, a window of opportunity and so forth, this really cut the public right away -- in fact, was a cartoon within hours of publication in the New England Journal, which to me seemed like a new measure of research impact. Ted Koppel was weighing in within a couple of days, and so forth. And so that was how we got a mandate for a disparities report.

We've linked the two together very closely for one reason. Every study of quality where there's information on patient race, ethnicity, income and education has two take-home messages: One is that there's a big gap between best possible care and actual care at a population level, and the second is that, in general, that gap is larger still for people who are members of racial or ethnic minorities, low income, low education.

Now, the size of that gap tends to vary a lot by clinical condition and as -- blocking on the name -- Jim Weinstein's study looking at knee surgery in the Medicare population showed it varies a lot by community as well. So, for example, in the Bronx there are no disparities in knee surgery for Medicare beneficiaries, so that's good news associated with race and ethnicity. The only problem is the overall rates are so low that either everyone had knee surgery before they got into Medicare, or there's other factors going on there. So, you can't get away from the variations challenge. So, I was pleased to hear you say that you'll be coming back to that.

Just to highlight one or two findings from the reports, one of my personal favorites is the percentage of people who are admitted to the hospital with a heart attack, who are advised to quit smoking before they go home. It's just under 50 percent. Now, this is what you would call a "teachable" moment because -- and I'm not being sarcastic--people who are advised to quit then have a one-year quit rate of 50 percent. If you do everything right in primary care -

- and I myself have never had the opportunity of providing care in a practice that had the right infrastructure to do this, this is when you make contracts with patients and call them up to remind them, and do all the things that we know can be effective. The quit rate at one year is 8 percent. So, missing this opportunity is missing a big one.

And I know what's going on here. Every health professional thinks that somebody else is taking care of it. I think the other thing that's going on is there's not a system in place -- and it's almost an embarrassing conversation to have, right -- I mean, we've done such a good job on one level getting the message out that there's a connection between smoking and heart disease, that it's almost a little embarrassing one-on-one to say, "By the way, you know the cigarettes in your pocket you came in with" -- I mean, that's like a hard conversation to have, so we drop the ball.

In your handouts I've listed how we portray our portfolios of work rather than talking about specific research programs or specific projects,

although at a moment's notice, at the drop of a hat, I would be happy to entertain you for hours, or put you to sleep, whichever, in telling you in very fine detail about some of the work we're supporting.

But the big priorities for us right now would be improving patient safety and quality -- and Larry mentioned that earlier that the issue of safety came up -- and just to get back to the question of variations for a moment, lots of people frame quality problems as overuse, underuse, misuse of services.

Underuse of effective treatments, no problem getting a lot of convergence on that topic, lots and lots of stakeholders I think want to work together on that. And I think safety issues capture the public's imagination in a way that's very, very tangible, as in "this could be me", "this could be a member of my family". Not only does 30 to 40 percent of the public say that they or a family member have been the victim of a medical error, but about a third of doctors say the same thing. So, this is very, very real. Makes quality really kind of important for folks.

Overuse of services, I think, is very delicate. I've never been in a medical or policy setting where people don't agree that overuse is a problem, and that would be your overuse. So, I just say that in cautionary terms. On the other hand, I think no one believes that we should be paying for care that ultimately leads to harm. So, I think that in a way may create an avenue to discuss some of these issues, and I think learning from other industries in healthcare -- one message that's beginning to take hold is the idea that rework costs a lot. So, if we don't do the right thing the first time and we then have to go back and fix that problem, that costs a lot of money as well as leads to avoidable pain and suffering and so forth.

Identifying what's avoidable is not quite so easy, that is actually probably the weak link in a lot of the patient safety issues, but that's a big issue.

Another big focus area for us beginning last year, or beginning last year in a big focused way, has been evaluating the impact of selected

applications of health information technology, including some strategies that are emerging for sharing healthcare information across settings. Most information in healthcare is enterprise-specific. It stays with the hospital, it stays with the outpatient setting, the nursing home, and so forth. So, our researchers over the years, including those at Dartmouth, have gotten amazingly clever about linking datasets and so forth to essentially follow a patient.

One of the big areas focused in the Department's strategic framework is trying to figure out how healthcare information can actually follow the patient as they move from one setting to another, and for Medicare, this becomes incredibly important because there are Medicare beneficiaries routinely seeing seven or eight doctors, who don't necessarily either have a strategy or any easy way to share information, so to say that coordination gets to be a little tricky is a problem.

Now, at a policy level, of course, people are talking about IT is transforming healthcare, and that's incredibly exciting to talk about. And

Secretary Leavitt will be, I think, at the head of that parade. He's very excited and knows these issues well, so that's really exciting for us.

At the ground level, I think what's going on particularly in small practices is we're dying here. We don't know what we're doing. We've tried every trick we know to make practice work, let's call the computer guys. So, our role is somewhere between those poles, trying to figure out which applications are most likely to be successful, and not only how do I make my practice work, but how do we make sure that that leads to improvements in quality and safety. And what I've found fairly stunning recently is hearing from lots of docs who have adopted this and it's great, they love it -- quality. So, we're having a lot of fun.

And then the third big area is the evaluating what works and for whom proposition. Some of the specific mechanisms I wanted to make you aware of because we can be available to you for technical support as specific issues come up.

First, we have a long history and are

very, very proud of our work in data development and analysis. Two big data sources that we have, one is the Medical Expenditure Panel Survey. As you get more and more into the issues of the multiple payers and multiple ways that we deliver healthcare, what has always been stunning to me is that there's really one source of information that can give you national level estimates of all the healthcare that people get. If I go to BlueCross and say "what are you spending" -- I mean, in theory, they can tell me, whether they would or not is another question. Randy knows what Motorola is paying, or other purchasers know what they are paying. This is the only source that actually brings together what employers are paying, what insurers pay, what people pay out-of-pocket, and all the healthcare that they get. So, it's about 15-16,000 households that are followed continuously. If you should be lucky enough to be one of the households in this survey, you are followed for two and a half years, after which, I think you will never be part of another survey. Catherine is laughing because she has some idea of the depth in which these people are

interviewed. There's actually one household respondent for the household. For selected areas, we actually go out with supplemental surveys to get information from individuals as well. Very, very rich data source. And to keep economists happy, a lot of this information is verified because, after all, what do people know about what they are paying for healthcare? They might forget, they might get expenses confused across different years and so forth. This is all verified, so very, very rich data source, and we've got a really fabulous team of folks working here. So, that's available for additional analyses, as needed.

In addition to that, we have a partnership with 36 States where we work with them and collect their hospital discharge data and make it available in a uniform format. So you get into the intersections of federal and State jurisdiction and healthcare, it's endlessly fascinating, sometimes Byzantine, but even across States, different entity in different States that actually does this, but most States do have hospital discharge data. So, with that much data, there's almost no condition that's too rare. It's also

been a platform for us to develop some indicators for improving quality and safety and so forth. And those two data sources among many, many others are the foundation of the report. And I do need to say that we wouldn't have been able to publish either report or produce either report without help from our colleagues and the Assistant Secretary for Planning and Evaluation and across the Department.

The second area that is sort of a unique focus for us is what we call "evidence reports". When the agency was first created, there was this tension between learning more about what's going on in healthcare and where we could make a difference, and doing something right now. And that tension persists to this day.

When the agency was first created, we were in the business of supporting the development of clinical practice guidelines. Now, this was great stuff, right, it's on page 1 every time a guideline was released, and the first Administrator was quite strategic in his choice of the releases. So the first one I believe was on post-operative pain management.

Well, everyone was incredibly excited. Who was for post-operative pain? Absolutely no one. And we have some indication that this actually had an impact on hospitals purchasing and implementing patient-controlled analgesia, which if you've ever had the opportunity to have surgery, just let me tell you, having had one with and one without, huge, huge impact on post-operative pain management.

Eventually, we got to slightly more sensitive topics, and I'll just make the story short by saying we got out of the guideline business. But the core systematic review of existing evidence is something that we were consistently told was highly valued by employers, by those providing care, health professional organizations, and so forth, because they didn't have the resources to do this on their own.

Ironically, it's become almost a revenue generator for us. I mean, we spend about $3 million as part of our core budget on these evidence reports, driven by expressed needs of stakeholders in healthcare, but many parts of the Federal Government actually give us money to do them as well. So, when

NIH does a consensus conference, that's actually preceded by the development of an evidence report. In fact, the whole structure of the conference is pretty much driven by how the report is framed.

This is a systematic review that actually draws as many studies, published and published together, as possible, and evaluates the quality of that work, and then puts out reports. So, recently, for example, there was a report on obesity which found that for people with a body mass index of 40 or greater, surgery is really the only effective option, and then walked people through where we had good information and, frankly, where we needed better information for people in different categories of overweight and obesity.

So, essentially, then, what we are doing is trying to identify what are the needs of people providing healthcare, people receiving healthcare, using that to drive the development of evidence and so forth, and that really cuts across almost all of our research programs.

I've included some other specific

findings, one that I found particularly interesting, was published last fall, looking at the effect of co-payments on underuse of medications for treating chronic illness, finding that many individuals don't want to tell their doctors that "I'm not taking my medication for blood pressure", or whatever the problem may be, "because I can't afford it", so a topic that's of growing concern to lots of folks.

In the Medicare Bill that was passed at the end of 2003, we're given a new opportunity to look at the "what works" section, so Section 1013, for those of you who haven't memorized the bill, actually directs the agency to focus research and synthesis on issues affecting the quality, effectiveness and efficiency of healthcare delivered through the Medicare, Medicaid, and SCHIP programs.

Now, even at a very high level, you might ask the questions, well, haven't you been doing that anyway, and on some level we have. What's new about this section is that it actually articulates a very clear priority-setting process and directs us to address both are we doing what we know works question

as well as where there's two of more interventions, how can you produce information so that people can make informed decisions. So, this is both about developing synthesis and more evidence, but also about communicating that information effectively so that people can make decisions. I told you that I was going to come back to that theme of communication and dissemination.

I've included the priority list in your handout. You might look at this list and say, wait a minute, where's HIV, or where's infant mortality. The Department, senior level group in the Department which was the priority-setting community, informed by a very broad call for input across the healthcare system -- and, frankly, I was quite gratified by the input that we got, very, very thoughtful detailed input -- the priority-setting group in the department thought that because the Medicare drug benefit was coming online in early 2006, that the initial priority list should be driven by the needs of the Medicare program, so HIV is not on that list, but this list will be updated. It's going to be an iterative process over time.

And then at the end of the handout, I closed with a little cartoon about us all being in this together. So, I don't know if I've helped the exhilaration/exhaustion index or continuum here, but I wanted to just give you at least a brief overview of what the agency is up to, how we might be able to help with your work as you go forward over the next couple of years, and would be happy to answer any questions.

CHAIRPERSON JOHNSON: I'll start with a question, Carolyn -- actually two -- one is elementary, I think, for some of us, but maybe not for all of us, and that is, would you distinguish between AHRQ, IOM, and the NIH? What's the difference in roles between those organizations? How do you fit in with the other two?

DR. CLANCY: Really, really good question. We work very closely with the Institute of Medicine and with NIH, depending on the particular topic and so forth.

NIH obviously funds some very, very basic stuff like proteomic and nanotechnology -- notice how that rolled right off my tongue, I'm not sure I could

tell you much more about it than that -- but they are clearly focused on discovery of new interventions. Now, at the very applied end of what NIH is doing, they also have reason to worry and, in case they don't, people usually remind them -- Congress in particular -- that they need to be concerned it's not enough to know what works for hypertension, it is indeed we're seeing mortality or morbidity from heart disease and stroke increase and so forth, so the Hypertension Detection and Followup Committee is about 30 years old, a very, very concerted outreach project that's led by the NIH, that continues to this day. There's a somewhat younger version that focuses on appropriate treatment of cholesterol and so forth. But because of the way NIH is created, there are 27 institutes, centers, offices, divisions. They tend to focus on their specific area, which is fine except that of course -- I guess like disease management programs, many people have more than one of these. So, we're focusing more at the intersections. There's also something of several orders of magnitude of budgetary with them, their budget being in the $30 billion range

and ours -- so we look for leverage opportunities anytime we can.

But in the what-works question and how do we get this information out, we found lots and lots of ways to partner very effectively. So, for example, we've created some research networks -- primary care clinicians in practice, and also some networks with integrated delivery systems that are of great interest to the NIH. And next door, we're actually sponsoring a meeting with the Cancer Institute today, focusing on improving the rates of colorectal cancer screening, and one of your colleagues is there. So, sort of a small world. I told them that you were here, and so forth. So, that's where we might intersect with NIH.

The Institute of Medicine being part of the National Academy of Sciences, I think has some very unique opportunities in bringing people to consensus and making declarations that are informed to the greatest extent possible by empirical evidence, but there are situations where we simply need an expert group to come together and say "these are the priorities and this is what's important". So, I think

that's where the department frequently turns to the Institute of Medicine. So, their reports on patient safety and quality have been enormously helpful to us. They were very helpful to us in giving us advice about how to frame both reports on quality and disparities and so forth. Does that help?

MR. O'GRADY: But they're not the government.

DR. CLANCY: Yes.

MR. O'GRADY: And also there are different times when certainly we find that if you're going into a brand new area and you just need the research done, IOM can't help. I mean, you need pick-and-shovel kind of work done, not a group of 12 experts to come and give you a consensus from the experts, you need base research, going out there and surveying and doing the different stuff. So, it's which tool you bring to bear.

CHAIRPERSON JOHNSON: Other questions, comments?

(No response.)

I have one more. Top of page 8, Working

Definitions, the difference between effectiveness and comparative effectiveness. It would seem to me that as we proceed, this could be a real challenging area of discussion to become involved with. Can you share a little bit more of how you're working in this, and any comments that you have for us?

DR. CLANCY: Sure. Our budget appropriation to begin this work, and our new authority under Medicare is $15 million, now those of you who followed the Congress over any period of time will know that the difference between zero and any budgetary amount is huge. Having said that, $15 million is a really small downpayment, given that in part because of advances in public biomedical science as well as what's going on in the private sector, there are more and more innovations coming online all the time, and that's great news for all of us.

The problem is, of course, regardless of whether you're talking about consumer-directed healthcare or just any one of us making decisions on behalf of ourselves or our family members, trying to sort through that information is really, really

challenging, to put it mildly, because no place really organizes it very well for you. So, it would be nice to think, okay, great, my doctor or other clinician will guide me through this, but oftentimes they are just as clueless. So, any of you who have ever searched for information about health or healthcare know there are two possibilities and everything in between are possible. One is that you get your answer almost right away. You go right on Google, you type in an issue and, zingo, there it is, you're done.

Other times you get a little piece of the problem and you keep going to more and more sites, and at the end of an hour you look up and it's like, oh, boy, I've learned a lot of stuff, and I've learned about stuff that people are doing that, oh, my God, I had no idea, but you're not any closer to answering your question than you were when you started.

So, I think a big part of our focus in this new authority is going to be how do you organize that information in a way that brings it to bear on people's decisions.

Some of that information exists, it just

hasn't been organized, in part because the academic structure tends to reward what John Eisenberg used to refer to as "salami science", you know, the narrower the slice, the more publications you can get, and that tends to lead to promotion and tenure. And there's nothing wrong with that inherently, it's just that I would have to say that synthesis and the kind of evaluation that brings it all together isn't as inherently valued.

So, through our evidence-based practice program and other strategies, we're trying to do that. Having said that, there's clearly a huge need and growing recognition among healthcare providers and payers that they need this information as well. So, there's been some discussions with the Institute of Medicine and with some folks from NIH and with folks in the private sector about how might we work together, and that's kind of an ongoing conversation, but one that we could certainly keep this group in touch with as we move forward.

MR. O'GRADY: Can I give a real quick -- just on the nuts and bolts that highlighted this for

me as I was sitting in a meeting with an FDA guy and a CMS guy. So we're talking about, you know, is the new drug or the new tech or bio going to come through and whatnot. And the FDA guy goes, "You know, safe and effective, that's the motto of FDA -- safe and effective". And the CMS guy goes, "Well, is it more effective than we currently have, though? Is it more expensive? Is it as effective, but what is its cost?" -- I mean, there's this whole notion -- safe and effective is a great mantra to have if you're the FDA, but once you move to being a payer, whether it's an individual payer or an organized payer, there are these other questions that come up. And certainly as we see this rapid advance of technology, these questions will just come up as rapidly.

DR. CLANCY: And I guess the other point I'd make is the area that in this country has been known as technology assessment, and it's defined and operationalized a bit differently in Europe, it's a much broader category of issues in Europe, which might be called clinical evaluation sciences, as they do at Dartmouth, but it includes a much broader range. But

in this country, technology assessment, I think, has always been viewed as kind of a gatekeeper function. No innovations will be paid for until people weigh in and look at it, and who wants to be kept away from promising technologies, especially if you're near death and have a very serious illness.

So, in essence, we're trying to reframe this effectiveness question as how do you make sure that people likely to benefit get that information and that treatment as rapidly as possible whereas people who are likely to be harmed do not. And I guess Exhibit A here would be bone marrow transplant for people with breast cancer. I mean, this was a fine idea, plausible hypothesis, heavily marketed to patients, many of whom had no other options left, but at the end of the day it go so much hype that it became almost impossible to do any kind of trial. And a couple of payers tried to fund one, but by then people felt like this was an excuse to deny them treatment. By the time the trials were done, it became really, really clear that it wasn't an added benefit and, in fact, we probably managed to hasten death for

many women and to help them spend a whole lot more time away from home and family because they were in isolation after the treatment and so forth.

So, innovation is wonderful, unless it's harmful. So trying to figure out how we can make that information available for folks, I think, is one holy grail of this whole big, big challenge that you're taking on.

CHAIRPERSON JOHNSON: Carolyn, thank you very much.

DR. CLANCY: My pleasure.

CHAIRPERSON JOHNSON: We will take your invitation to call on you. I'm not sure when, but we will, and we'll look forward to your input.

DR. CLANCY: And, really, best of luck to you.

(Applause.)

CHAIRPERSON JOHNSON: Okay. We've reached the end of our agenda that's formal, but what we'd like to do now is take a minute or two to have Ken and Larry update us on logistics instructions that we may need to hear before we leave and in anticipation of

tomorrow.

(Whereupon, at 5:06 p.m., the proceedings were adjourned, to reconvene Tuesday, April 12, 2005.)