Sallie Sanford: So, welcome everyone to this discussion of health reform 2009. It might seem like this topic is endless, like haven't we been talking about it for months? In many ways, it really is just about to get started. There are five major pending bills, and the last one should be voted out of committee tomorrow. At which point, it will go before the full House and the full Senate to debate in probably a robust and conflicted way all of these different issues that have been floating around and try to agree on two bills and then merge them. It's a great time to be talking about this.

The plan for today is that I will talk for about 25 minutes about why health reform. What are the problems facing ailing Uncle Sam and what are the proposed treatments in the major bills before Congress right now.

Then we have a variety of experts from the School of Public Health and the School of Law who will pick up and talk for a few minutes each on specific areas of controversy in the legislation. Then we welcome questions at the end.

Just starting out, so this ailing patient; what are his chief complaints? Basically, costs, access, and quality. Health care in this country, the costs are too high, the access is too limited and the quality is too variable.

Turning to a quick review of systems, what evidence is there to support these complaints? This is the cost curve. You'll hear a lot of talk about can we bend the cost curve? This is what it's referring to. This graph shows the rise in health care expenditures per capita in this country from 1990 through 2018 projected.

This year, it's projected that we'll spend about $8000 per person on health care. That's about 16.2 percent of our gross domestic product. You can see this curve is rising faster than inflation, faster than incomes. It's also substantially higher than any other wealthy country. It's about twice the average of the 30 OECD - Economically Developed Countries - and much higher than the nearest, most expensive countries; Norway and Switzerland spend substantially less than we do.

Costs are high and they're having significant, arguably unsustainable impact, but only on individuals. Corresponding with this rise, health care premiums have almost doubled in the past 10 years. So now the average cost of a family policy in this country is $13,000. About what somebody working full-time, minimum wage, would make over the whole year.

Difficult for individuals to afford. Also for businesses who bear a substantial portion of premiums for employees if they do provide insurance. And also for the government. It's not often remembered, but even in our country, about 45 percent of health care expenditures are spent by either the federal or the state government; largely Medicare/Medicaid.
So, it's really a big burden on government budgets. So, it costs. Then turning to access, where do people get their health insurance? In many ways, health care reform has become health insurance reform.

This chart shows where people get or don't get their health insurance. Most people under age 65 get insurance through their employer. We have a heavily employer-sponsored, dependent insurance system.

About 15 percent, 45 million people in this country, don't have any insurance, private or public. An increasing share gets their health insurance on the individual market. That's where you don't have an employer, large group, getting it for you. You buy it individually.

Typically, the coverage is not as good, often more expensive, and that's where you have those concerns, especially about pre-existing condition limits, recession, they come up especially in that market. That's the access issue.

Then in terms of quality. Our quality data overall, despite how much we spend, is not very impressive. We are ranked middling in terms of outcomes data for most major measures - life expectancy, infant mortality, treatment of curable diseases - a middling fashion compared to other developed, wealthy countries.

We do have some pockets of very, very high quality, both regionally and also certain areas, certain types of cancer treatments, we're way up there. Innovation, in terms of pharmaceuticals, devices, surgical techniques.

One challenge in the quality arena is to improve access and reduce costs, but not sacrifice our real areas of quality. To keep that in mind as we consider what the possibilities are.

What are the goals of treatment? These goals have been set out by President Obama, also by the democratic leadership in both the House and the Senate. What are they trying to accomplish in this major, historic health reform process?

One, universal coverage. That means that everybody, or nearly everybody, has some form of health insurance - public or private. Every other wealthy, industrialized country provides universal coverage. That's one of the key goals of this process.

Secondly, to bend the cost curve under the idea that, it's just going to get more and more unsustainable unless we can bring costs down a little bit or slow the rate of growth. So, to bend the cost curve, to do it for less than $1 trillion. That's become this magic number. Whatever, has to cost less than $1 trillion over 10 years.

It's got to be budget neutral. Whatever is spent to achieve these goals has to have corresponding savings or revenues to make it balance out.

Finally, no radical surgery. That is, the patient has no stomach for a single-payer system, no stomach for a Canada or a British system. Those ideas really aren't on the table right now. Got to maintain, in some fashion, our current, multipolar systems.

What are the proposed treatments? These are drawn from - as I said, there's five major bills, three in the House, two in the Senate. The one you've probably heard the most about is the Baucus Bill, and that's in the Senate Finance Committee.

One reason why it's gotten so much attention is because it is, in many ways, the most conservative, spends the least amount of money and, therefore, is considered perhaps the most likely type of reform package to get 60 votes in the Senate, which is the magic number to avoid a filibuster.
The Baucus Bill is supposed to be voted out of committee tomorrow. There are four other bills with a variety of different measures in them. The four others have already passed out of committee. I'm going to list several of the elements of these and I've divided them up into your less controversial prescriptions and the more controversial ones. Keep in mind that nothing is not controversial.

[laughter]

**Sallie:** it's just all relative. Some of the less controversial elements that are common to the bills are: One, to expand access to insurance, try to get more people covered. There's a variety of ways to do this. One is to prohibit pre-existing condition limits. Can't have those. Guaranteed issue means that an insurance company has to sell a policy to anybody willing to pay for it. No lifetime limits, no annual limits, no rescission if you didn't disclose something because there's no pre-existing condition limits. Changing what the policies can legally do.

Also there are requirements on what at a minimum they have to cover. So, minimum baseline coverage would also be part of the effort to expand access.

And this idea to create insurance exchanges; this gets at the idea that individual insurance is typically much more expensive than big group purchased insurance. If we have exchanges, that way individuals and small groups can come together and get some of the benefit of a large group and also create a place where there can be easy comparison amongst plans. These don't exist and they would either be state-wide or perhaps regional insurance exchanges.

And then of course, because the average family policy provided through an employer now costs $13,000 a year, there has to be subsidies for middle and low income people to afford to buy a policy, realistically.

And then also another way to expand access is to expand Medicaid. Medicaid is a Federal-State program, which varies significantly from state to state. And this change to expand Medicaid to cover everybody below a certain income level - typically it's 133 percent - would have the effect of bringing in a lot of adults, especially a lot more childless adults, a lot more men would be on Medicaid than are now. So, expand Medicaid, which has significant costs for the states, so then you will have to have the Federal Government picking up some of that portion.

And a variety of measures that aim to improve the efficiency and quality of care. And there are a whole bunch of test programs and pilots and various incentives to try to encourage better coordination of care, so we don't have so many separate silos of a physician, a hospital and a nursing home. But, to somehow improve the coordination and try to ensure that more efficacious care is provided, there are a variety of measures with that focus.

And also to try to boost primary care. There's a shortage of primary care in this country. And then as always, more money to root out fraud and abuse - fraudulent billing, unnecessary care.

So, these are some of the key and less controversial aspects.

So, turning to some of the more controversial prescriptions; whether to have an individual mandate? You might recall that President Obama as a candidate did not favor this. He now this.

This is the idea that if insurers have to sell to anybody - with no pre-existing condition, no life-time limits, no annual limits - you don't want people waiting to buy it until they're sick. You need to have an insurance pool that spreads the risk out. And to that economists and insurance companies argue persuasively you have to have a mandate. Everybody has to buy insurance or else it messes everything up.
So, whether to have an individual mandate, what the penalties should be and who should be exempt from it is a big issue. And certainly the amount of subsidies, what's an affordable amount for a person or a family to spend, is very controversial.

Whether to have an employer mandate? I mentioned one of the goals is to somehow maintain our current heavily employer dependent system. But, what if employers decide not to provide coverage? This is the idea that they have to and if they don't they pay a penalty. The Baucus Bill does not include an employer mandate and the others do. So, that will be a big point of contention. And how much the penalty should be? And who should be exempt?

And of course how to pay for it? A trillion dollars over 10 years is a lot of money, and I'll talk in a minute about what the different elements are for how to get that amount of money. And then there are a bunch of contentious issues that don't get at the whole structure of reform, but are very important to certain populations and we're going to see discussed a lot.

The abortion one, for example, and we're going to talk about these in a minute, but the abortion one deals with a federal law that currently exists which prohibits federal money being used to pay for most abortions. So, states that do pay for abortions under Medicaid do so using only with state dollars. You can't use federal dollars.

So, what to do about private insurance plans that receive a subsidy from the Federal Government? Some people argue forcibly that if you get a federal subsidy the plan cannot cover abortion. The other side argues that right now most private insurance plans do. So, that's going to be a debate.

And the medical malpractice one is an interesting one that relates to federalism. In our Federal-State system, medical malpractice is a state issue. And these reform bills have various proposals to try to change the medical malpractice systems in states to reduce those costs, both of defensive medicine and of premiums. So, those are some of the big contentious issues that we're going to hear talked about a lot in the coming weeks and months.

And of course whether or not there should be a public option? This was thought to be dead because it's not included in the Baucus Bill, but apparently it's coming back. And there's some word that the House will pass a bill that does not include a public option, but the Senate won't pass one that does.

And what the public option idea is is that within this insurance exchange that has all these different private insurance plans somebody could choose from, should there be a public plan? Say like a Medicare. Medicare is a single payer system for those over 65 and some disabled people.

Should there be a public option for people under 65? That will probably be the lowest cost option, very low administrative costs. So, is that a backdoor way to change the whole system to a single payer, not well-funded medical system? Or is it a way to keep the insurance companies honest? So, that's going to be a big issue.

Paying for this treatment. I broke it into different categories. One big category is savings in Medicare and Medicaid. Two huge federal programs and there are a variety of proposals to save money in those programs. That's where you hear complaints from people on Medicare: they're trying to kill Medicare.

Reduce payments to Medicare Advantage plans and these are private plans that provide managed care, provide all the Medicare services, to beneficiaries. And they got a huge boost from the Medicare Modernization Act a few years ago that effectively pays them about 112 percent of what the government would pay if these people stayed in traditional Medicare.

And the reason for that was to encourage vibrant private competition and to make sure we have lots of Medicare Advantage plans, many people now argue that it's kind of a give away to private
industry. And so there are significant cuts to those programs, savings in the pharmaceutical benefit, some shift in reimbursement, including the creation of a separate commission to look at how Medicare reimbursement works. So, we have a lot of savings from Medicare and Medicaid.

Also, some revenue sources within health care. I mentioned that if there's an employer mandate there'll be a penalty. So, that's some money for the Federal Government. A tax on what are called "Cadillac Plans," very generous health insurance plans, under the theory that they actually encourage wasteful health care spending. Many unions oppose this tax because some small companies with older workforces actually have very expensive plans.

And there is tax code changes that will bring in some money. And then of course the big controversial area is whether to raise taxes generally? The proposals to add a surcharge for people, I think its individuals making more than $280,000 a year have a surtax. And then some sin taxes - pop, alcohol, junk food.

And then also the idea of if we do bend the cost curve that will end up saving the Federal Government's money, as well as everybody else's.

So, does it all balance out? All these different ways to increase access, and hopefully improve quality, and all the different ways to pay for it over 10 years: does it balance out? And a big answer was provided last Thursday when the Congressional Budget Office said the Baucus Bill does balance out. In fact, it would reduce the deficit by several billion dollars anyway. But, that's going to be a big question: do we have the savings and the revenues to pay for all of these different elements of the reform plan?

Particularly where if the Baucus plan leaves some 17 million citizens and legal residents without insurance... So, 17 million is a big number. The other bills would cover more people but at a much higher cost. So, what's the trade-off? What do we mean by universal? Is universal less 17 million citizens, universal? That would be a big question.

I'm almost done here and I'll turn it over to people on the panel to chip in on different elements. Since we're at a law school, it's important to mention that there are a lot of big legal issues that are going to come out of this debate. Certainly can't ignore constitutional - where's the constitutional authority to do the individual mandates or to require the states to do something rather, to require the states to act. Is the commerce clause big enough for this? The federal spending power? Interesting.

And general issues tied to Federal-State balance. Whose responsibility is it for whatever aspect for these various proposals? And certainly, there will be a lot of proposed changes in other laws. For example, there are several laws that effectively provide barriers to some of the innovation that's proposed in these bills - anti-trust issues, tax, fraud and abuse. Those will be some legal issues that we'll be hearing about, probably in the implementation phase.

And then certainly, just a political question: is it possible to get a good bill out of this divided, fractious family? And what will it end up looking like? Whatever passes, certainly it's going to increase government spending and power. Certainly increase insurance coverage and security. People will know that if they lose their job, there will be somewhere else to get viable health insurance. Whether it'll bend the cost curve or help improve our quality outcomes is a big question.

I hope you have a bunch of questions, but save them until the end because now we'll turn to experts from the School of Law and the School of Public Health. Experts both in health reform generally and also as to specific issues.

Pat, are you going to go first?

**Patricia Kuszler:** I can go first, sure.
**Sallie:** Pat Kuszler is from the Law School.

**Patricia:** Well, we all [inaudible 0:21:11] this up and decided to each take an issue that was of particular interest to us. My issue is the individual mandate. Many of you who are past the first quest of youth may remember that back in the nineties, individual mandate was also discussed during the health reform debate of the nineties. And it was pretty similarly dismissed as a possibility. At the time, I think that America didn't have the stomach, so to speak, for such a mandate. But, now it's a prominent part of the health reform debate. And if we look at these individual mandates there are a couple of big legal issues that come out and some even more important policy ones. First of all, when we take a look at the big bill that is going to be voted on tomorrow - the Senate Finance Committee's bill - as we look at the individual mandate, it doesn't kick in for some years. And it's relatively minimal. For example, it maxes out at $750 per person in 2014.

Essentially, the penalty for not purchasing insurance or getting into an insurance pool in some way, shape or form is relatively minor. It's $0 in 2013 and then very gradually it goes to a maximum of $750, which as you know from the price of the policies that Sallie's talked about, it's probably just a tiny little drop in the finance bucket. Moreover, even if we take a look at some of the more aggressive bills, the penalty for not adhering to the mandate, goes up to about $900.

In fact, up until a couple days ago, the Senate bill had a $900 mandate, net $900 penalty, but it was watered down because the idea was that it would be more palatable to Conservative Democrats and Republicans with less of a mandate. What does that mean? That means that people who are not required to purchase insurance or who are required and believe that they'd be better off going bare for a period of time, will choose to do so.

These would be young, healthy people who would simply not purchase coverage, probably until the penalty got high enough until it hurt. And as I said, the penalty may be so low that it may never hurt. This huge subset of healthy population will not engage in the system. And as a result, we will not have the Law of Large Numbers on our side, and so we will not be bettering our situation in terms of universal access, or in terms of the financial basis on which our plans will float.

The other thing that's tricky about this, as you take a look particularly at the Senate Finance Committee bill, there's virtually no employer mandate. And most of the other bills have very weak employer mandates. And the problem here of course is if employers are not required to provide coverage, what will they do if there's an individual mandate?

They will stop providing coverage, though we have the potential that employers may decide, "Well, as long as there's an individual mandate, why should I pay for coverage if I don't have to? I will simply become an employer who doesn't offer health coverage."

We may actually have a larger subset of the population in that territory of persons who are touched by the mandate but may not choose to participate in it. One of the criticisms of the current bill is that the mandate is so watered down that it's not going to impact and actually the costs will not be contained and nor will the universal coverage idea be substantially furthered. Some experts say as many as 25 million may remain uninsured.

The other issue worth touching on for the law people is this issue of constitutionality. There's been lots of talk about how the individual mandate is unconstitutional. Several very good constitution scholars have looked at this and on basis because of the breadth of the Commerce Clause, because of the breadth of the Tax and Spending Clause, because of the fact that this touches on what we call on non-fundamental kind of right - indeed if there's any kind of right at all, to be uninsured - there is pretty clear that an individual mandate would survive a constitutional scrutiny, if it were tested in the courts.
Let me turn our discussion over down the line here to Steve.

Steve Calandrillo: Thank you Professor Kuszler and thank you Professor Sanford for organizing this panel. I enjoyed your slides particularly. My name is Steve Calandrillo, I'm the Associate Dean for the Faculty. I apologize for my voice, I'm getting over a cold. I have young children and I spend the entire fall season trying to dodge their colds with very limited success. Thankfully this is not Swine Flu, so I'm covered... [laughter]

Steve: ... Or we would be here either. But, I enjoyed learning a little bit about this. And I've been asked today to speak about the end-of-life issues and specifically, as you saw in the last cartoon, the death panel myth. This dominated a lot of the summer conversation, at town hall meetings. Everybody was concerned that President Obama was about to pull the plug on Grandma. So, the recipe of the people for the death panel myth was first, you need change. Right? Change is scary. Secondly you have death. Right? Death is scarier. And then you combine change and death with heath care reform, you have a powder keg ready to explode. And you have a lot of people worried that Obama and Congress is going to pay for the cost of this health care reform by ending senior's lives earlier.

It is true that the last years of life are very expensive. One of the ways we could control cost is just kill people six or 12 months earlier. And that way we'll pay for our bill!

[laughter]

Steve: ... Right? How are we going to be budget neutral just is to stop [inaudible 26:50] a year before, they otherwise it's going to end. So, if you look at the Healthcare Reform Bill, section 1233 is the section that is in controversy. And Section 1233 allows for advanced care planning consultations. Representative Dingle referred to the Healthcare Reform Bill and the idea was to allow for reimbursements.

This provision allowed reimbursement to physicians who provide counseling for their patients, for the Medicare patients, [inaudible 27:18] decision making; talk to them about living wills and advanced directives and power of attorneys.

And for the first time, it would provide some reimbursement to these physicians because previously there was no provision; under Medicare you do not get reimbursed for having this type of conversation with your patients.

Senator Isakson of Georgia included this in the Senate bill allowing Americans to obtain assistance in preparing living wills or durable power of attorneys. And the purpose with all of these bills and provisions was to encourage physicians to have the conversation with their patient.

These conversations are very difficult to have. What do you want to have happen at the end of life if you are not in very good health, do you want a "do not resuscitate" order? Do you want a living will? Do you want an advanced directive? Do you want to sign a power of attorney so someone else can make some of these decisions?

These are very difficult conversations to have. And they often never happen. And then what happens is you have a loved one, your father or your mother or grandparent, whoever, who is facing a horrible illness at the end of their lives and the decision on what to do falls to the nearest family member.

They struggle with this and they debate, what do I do? Do I pull the plug? Do I withhold hydration? Do I withhold the feeding tube? These are extraordinarily painful decisions to make. The idea was to encourage patients while they are still competent to have a say. So, empower them and exercise
their own autonomy to make it known ahead of time what they would like to occur in their end of life situations.

Unfortunately this provision was seized upon by opponents of the bills. And the idea that this provision that allows advanced care planning consultation was really just a way to encourage patients to end their lives earlier in order to cut costs. Hence, Obama is going to have death panels lined up. You know, killing off our seniors earlier than they otherwise would be.

And I did say at the outset, the last year of life is expensive. Twenty seven percent of all Medicare costs come in the last year of life. So, that's the kernel of truth to the issues is that it is expensive to care for people in their last year of life.

But, really the critics have just grossly distorted the advanced care planning provision. I have some quotes here from some of the famous critics of it.

Betsy McCoy was probably the first to out there in the mainstream media. She's the former New York Lieutenant Governor, outspoken critic of the Clinton Healthcare Reform Proposal. She went on the radio three days after the first bill came out, this event [inaudible 29:44] planning directed. She has been on the John Stewart show.

She's been in the "Wall Street Journal." She's all over the media and this was her quote three days after the provision was announced. "The House bill will make it mandatory, absolutely required that every five years people on Medicare have the required counseling session that will tell them how to end their life sooner. How to decline nutrition, how to decline being hydration, how to go into hospice care." "This is going to be mandatory and you are going to be forced to do this."

John Boehner, a Republican from Ohio released a statement the very next day urging slippery slope problem that Americans now face. "Such counseling may place older people in a situation where they feel pressured to sign end of life directives they would not otherwise sign. This provision may start us down the treacherous path towards government encouraged euthanasia if enacted into law."

Now we're all the way down to euthanasia and then Sarah Palin most famously on her Facebook page, ever the opportunist wrote, "The America I know and love is not one in which my parents or my baby with Down's Syndrome will have to stand in front of Obama's death panel so the bureaucrats can decide based on their subjective judgment of a level of productivity in society whether my kids are worthy of health care. Such a system is downright evil."

Rush Limbaugh, Glenn Beck and many other conservative critics added to the fire and eventually the urban legend was so strong that you saw it dominating these summer town hall meetings. The government is going to be pulling the plug on grandma.

It's very disturbing that the death panel myth got so out of hand. We saw the president in his prime time speeches trying to put... It's almost amazing that the president extending from America trying to convince America that he is not trying to kill our senior citizens. But, he did his best to assure Americans of that.

And you know, the truth of the matter is obviously nothing in the bill requires that the conversation even occur in the first place. It's just that you can receive reimbursement for this conversation once every five years. Nothing requires a patient to have a DNR order or advanced directive or a living will, ending lives or refusing extraordinary treatment.

Even if they do enter into one of these living wills, they have obviously the right to change their mind at any time. If they are competent, they have the right to tell their physician exactly what they feel. The idea was just to empower patients and take some of the burden off families and allow some reimbursement to physicians.
But, the media firestorm that resulted was just truly outstanding. And so you saw the death panel myth really dominate. And it would be easy to laugh it off, but it's easy to say, well that's just some whack job that the government is going to pull the plug, but there are real consequences to this type of distortion of the truth.

The consequences are that the provision for advanced care planning is going to be stripped from all the bills. It's not like we could ever make it into the light of day, because nobody wants to face that type of heat. Nobody wants to take the death panel myth onto their shoulders and bear the responsibility for it.

The fact that the provisions have been stripped from the bills has motivated critics even further, because they take it as a government admission that they were telling the truth, that the government really was trying to pull the plug on grandma and now government has backed off of doing so. It's only motivated the opposition even further.

So, as a consequence we see lies and distortion work. Bills change because of them. So, we can't just laugh this off. This does change what public policy looks like in America and what does legislation will look like in America.

Patients will know less about their end of life options. Families will continue to bear the brunt of these decisions and opponents are even more motivated to come up with every other lie and distortion they can come up with because they see that works. So, that's my take. The end of life issues and the death panel myth.

OK, now I'll turn it over to Professor Rivin.

Beth Rivin: Hi, my name is Beth Rivin and I'm going to spend the next two or three minutes commenting on immigrants and the health care reform. The anti-immigrant mood in the country has greatly shaped the health care reform debate about immigrants - legal and illegal immigrant in the country. As a matter of fact, it's very confusing because some of the debate is not clearly separating the issues between legal and illegal immigrants.

The proposals now being considered by Congress would prevent or put up barriers for legal residents and non-residents of the US from accessing affordable care and needed health care coverage.

One of the proposals leaves millions of US born children uninsured because their parents do not have citizenship papers or cannot find them easily in their house or apartment. This is sometimes a great barrier even for citizens in the United States.

Now, even if the parents are not citizens, our laws consider children born in the US as citizens. This proposal would be actually in violation of our current laws.

Now, migrant labor harvests our crops and migrant labor also works in our factories and supports our economy. They work hard and pay taxes. Current health care reform proposals, however, seek to prevent undocumented immigrant workers from even paying for private health care coverage in the new exchange on health care program.

There would be no subsidy for these people who want to pay full price, but they are still being prevented from doing this and many other proposals.

These measures will impair our control of infectious diseases and continue the growing burden on public hospitals, which do take these patients in and do care for them sometimes when they are very sick. And this will increase the cost of their health care.
So, excluding just illegal immigrants - if you want to look at that group - from the reform, ultimately jeopardizes everyone's health and perpetuates the cost of treating uninsured patients that mostly come into hospitals through emergency rooms.

So, if you stand next to someone, for instance, who has active tuberculosis because they have not been treated because they don't have insurance, then the fact that you are insured will not protect you from that TB. And that goes for all infectious diseases, including swine flu.

They are likely to spread infectious diseases and, again, this will be a public health problem and doesn't stop at spreading infectious diseases. We can also look at childhood immunizations. If children aren't immunized, then part of the population doesn't have what we call "herd immunity."

It means we're all able to more easily get that disease, and we see this with measles.

So, it would be a great risk to not have illegal immigrants accessing health care.

Our system, by the way, currently provides undocumented residents with health care. They are coming into the emergency room and they're coming with late-stage disease. So, the cost of treating these people who are coming to emergency rooms are high and that impacts the overall health care curve, as Sallie was pointing out in the slide.

By law, hospitals and other providers are required to treat all patients who come to the emergency room or other facilities and who need emergency care. So, by not covering illegal immigrants as just one group and not looking at all immigrants which may be at risk in some of the proposals, we are not only being unjust, I would argue, but we're choosing the worst option for everyone in terms of public health and cost.

**Larry Kessler:** Thank you. My name is Larry Kessler, I'm the chair of the Department of Health Services in the School Public Health. I want to thank my colleagues for inviting us up here and I want to thank you. I understand from my colleagues that this is a seminar you're electing to come to. That must mean that you're interested in health reform and possibly you're interested in health. I'm going to make five quick points and then I'll get off the stage so you guys can ask us some questions. Number one: All this talk is about the medical care system, which is not necessarily about health. The biggest health care problems we face in the United States are almost not about our medical care system.

So, enormous epidemics of chronic disease, diabetes caused by things like obesity, are about cultural and public health issues in this country and not about the medical health care system.

Having said that, that is what health care reform is about, so I'll talk a little bit about the medical care system and what it means. And first, I'm going to address some of the comments made by Pat before about the individual mandate.

This tells you what this is about. The nature of the debate about an individual mandate forcing you and me to have insurance coverage means it's about insurance carriers, means it's about the business of insurance. And it means it's about a machine that probably takes around - depending who you talk to, between 18-30 percent of our health care dollar merely to process paperwork: people in systems, people out of systems, which is largely wasted money that you don't find in most other modern health care systems elsewhere.

So, the individual mandate, the reflection of a political reality, this is about insurance care systems, including the mega systems of Medicare and Medicaid - most of which are administered by health care insurance carriers. The government systems are not completely government, never have been, never will be.
Third, a lot of this debate is about different pockets of the disenfranchised. Pat just talked about illegal immigrants. Well, other people we're talking about are college students with pre-existing conditions. If anyone in this room has Type I diabetes, when you leave college, good luck getting health care. You can't get it on some employer system.

Or, about very poor people. Or worse, strangely enough, not about the very poorest of society who have a safety net, it's the near-poor. For decades, those are people who work two and three minimum wage jobs, basically can't make a living. They are just skating on the edge and they wind up in the interesting cracks in our medical care system. And, by the way, also tend to have incredibly poor public health issues as well.

This is about values; it's about what we value. And in this culture of our very medicalized system, we value access. Meaning, any time we want, we can pick up the phone and our local - not our primary care doc, as they might in Japan or France or Spain. But, you get to pick up your phone through the orthopedist, the neurologist - you name the specialist. That is what this is about.

And wanting care at the extremes and wanting any diagnostic test and/or any procedure at the expense of whoever else pays for it. And so it's about our values and the culture is pretty inculcated into our medical system in society that we don't want to be told by anybody what we can and cannot get.

So, I'm going to turn to the last issue for just a few seconds and comment a little bit about the CBO report. They're wrong. The system that's being created by this health reform bill is not going to have enough structure and power to change the medical care system to stop providing unnecessary and wasteful care.

You can take a look at one of the best websites, the Dartmouth website, with atlas of variations in care. You take a look and you can tell within our country where there are people practicing efficient and effective and generally low-cost care. But, it's the rare exception and not the common rule.

And the bill that's created now is not going to change the medical care culture here and so the CBO, which estimates some of these costs, they're going to be way wrong because it's not strong enough to change the medicalization of the culture here.

And finally, I'm going to address something from Steve. He is right. There are no death panels in terms of end of your life counseling, but there are death panels in another way. And there should be. It's called "comparative effectiveness research." What's happening is the folks at the Office of Management and Budget, led by Peter Orszag, recognize that we spend a third of our health care dollar with things that the rest of the world doesn't.

Why? Expensive, not proven, or poor value. And so what that means in this country is if you want an unusual procedure or an unusual diagnostic practice, you can get it even though dollar for dollar it's a bad buy. Most other countries won't provide it.

Here, you can get really outrageous kind of medical procedures on the off chance that something will work. And sometimes something does work. And sometimes we don't even understand what works. That is really where the rubber is going to meet the road if we're going to change health care systems.

We're going to find practices and procedures that aren't added value or not add them. Someone is going to complain because their ox is going to get gored, but it will be the right thing to do.

Sallie: I hope there are some questions out there. So, who would like to...
Larry: In the back.

Sallie: Yes, in the back.

Audience Member: Yeah. So, my understanding is that during the Korean War, for example, under Republican administration, the top tax bracket was 90 percent. The very rich paid 90 percent of their income. I'm not too certain about taxes, but now that's down to 40 or so, or less maybe. Most of them even avoid paying that much. So, my question is - to me it seems like that's the easy answer to this, is just generate more tax revenue. To what extent do you think tax lawyers are responsible for this situation?

[laughter]

Steve: It's not tax lawyers, that's conservatives in Congress. You're right; it was 91 percent until JFK's administration. Then it became 70 percent. JFK reduced the top marginal tax bracket from 91 percent to 70 percent, and I believe our current top marginal bracket is 35, expected to go up to 39.6 or so. But, yeah, we're still far below where we used to be, but taxing is so opposed to American values. Right? Nobody likes taxes. But, you're right. I actually like the idea of the tax on the super-wealthy.

I didn't know it was all the way down to 280,000. One of Obama's first proposals, or maybe this was in the House bill, was to go after people earning over a million dollars, and now I guess it's down to 280. I mean, Obama has drawn the line at 250. That's what he's drawn it for income tax purposes, and maybe it'll be similar to that.

I actually think the marginal value of a dollar to the wealthiest Americans is much less than the marginal value of a dollar to the non-wealthiest Americans, and that's a sensible way to make public policy. But, it never goes over well because everybody thinks they're going to be in the wealthiest one percent of Americans.

It's something like 60 percent of the public votes against the estate tax even though only half of one percent would be subject to it. So, I think it's a political problem.

Patricia: It is a political problem. It's pretty much political anathema to suggest that tax increases could cover our health care problem. I think that in some ways it's true that it couldn't cover our difficulty with health care because, as Larry so eloquently mentioned, we medicalized so many of our social problems that there's no amount of money in the world that would cover what we actually think of as medical care.

But, it's also true that when you look at other nations, they use their tax base more effectively, tax the wealthy and support their universal health care systems largely through that method.

Sallie: Yes.

Audience Member: Do you think that high might be more palatable for there to be a tax on the wealthy if it came with the public option? Because I think the reason taxes are more popular in Canada, for example, is that everyone who pays them gets services from them. They associate the fact that we pay taxes with 'I have access to this free health care even though I'm rich.'

So, what Americans don't seem to like is the fact that they're going to all pay taxes that are just going to go for services for some other guy, for the guy who's poor. Whereas, I would say, it would make a tax palatable if there was definitely a public option that you could choose to use even if you were very wealthy.
Steve: That won't work because the people who are going to be gored are not the people who would benefit from the public option.

Audience Member: But, if they at least knew that they could use it...

Steve: They could care less.

Audience Member: ... don't you think that that would make a difference?

Steve: They could care less. The people who care about the public option are people who are at the margins of society who tend not to vote in numbers, don't tend to have a voice in Congress, don't tend to have a voice in our State Legislature. Take a look at the basic health plan in the state of Washington. This past year, it has been reduced from 84,000 to 65,000 or 66,000. So, 25,000 people all of the sudden have been disenfranchised. And do they care about the tax bracket at $1 million? I don't think so.

Sallie: Yeah, Mary.

Audience Member: I read that many industrialized countries have private insurance, but unlike our insurance companies, they're nonprofit. So, in Germany, in Switzerland, in Japan, all the insurance is private, but nonprofit, and that makes a tremendous difference because the insurance companies aren't trying to make money for the shareholders.

Beth: That's a great point, and Switzerland is actually a very good example because they used to have for-profit health insurance companies. And now it's heavily regulated what they can sell, and they can make a profit only on supplemental policies that don't cover the basic services. So, there are examples out there. And there certainly are examples of industrialized countries that do not include a public option amongst their insurance systems.

But, getting to your point about what if we were all in the same type of coverage, would that make a difference in somebody's willingness to pay taxes for it? In Switzerland, they don't have a Medicare so you would stay on your same private plan throughout your life, for example. There is no group that then shifts to a different type of coverage.

Patricia: In sort of a sad paradox, the trend in terms of American health plans is not been to become more not-for-profit, but to go the opposite direction. We've had countless conversions from not-for-profit, for example, Blue Cross systems, that have actually moved to mutual systems and then on a quick trip to the four profit status. So, we've actually...

Sallie: To well point.

Patricia: We've actually seen our health insurance plans going the exact opposite direction of what would make sense for a more cost effective system.

Audience Member: What's been driving that, that shift?

Larry: The desire to make money.

Patricia: Profit motive.

Beth: The ability to...

Audience Member: But who's, I mean...

Sallie: It goes back to Larry's point originally about values in society. I mean, it really does.
Larry: The big shift happened in around the 1980s. When Medicare went to diagnoses related
groups with change in payment structure; instead of paying hospitals for what they provided, you
paid them a fixed amount of money take care of a certain condition. And that was meant to drive
people out of the hospitals faster and keep utilization down, which it did. The same time, and it's
not a coincidence, companies, like the Hospital Corporation of American, incorporated and figured
out there was money to be made. This is society; if a vacuum exists, someone will fill it to make
money.

And so corporations figured out, health care could be a business and there was a dramatic change
between the mid to late 1970s early 80s, of a redefinition of medical care as a business.

In a funny way, prior to then, one of the evils of the system, fee for service, physician's have
always billed for what they provide and they could recommend more for themselves and, therefore,
recommend more for their pocketbook. That was not considered a bad system in the 1950s and 60s
because physicians were seen as an honest arbiter of your care. And it's, in a sense, felt particularly
at the primary care level were tied to your health.

That changed, became a business in the 1980s both for the clinicians who now own facilities that
they manage and make money in, own partners and investments, as well as corporations. And that
change happened very dramatically in the 1980s spurred on by a very odd confluence of factors.

Sallie: Yes, way in the back.

Audience Member: Thank you all for being here by the way. I'm in a public health degree from
working at CMS for [inaudible 52:17]. So, everyone said to [inaudible 52:19]. They also think I
want to start paying [inaudible 52:23]. But, I had two questions [inaudible 52:30] two weeks, so I
don't really know all of the [inaudible 52:33] but it seems to me that in terms of [inaudible 52:37]
whatever it's passed, the district authority like a place CMS versus, you know, Santa Barbara
Constitution [inaudible 52:47] highest level, was it actually [inaudible 52:51]. Seems like it might
be a little bit of a problem. I didn't know if anyone could be specific [inaudible 52:59]
implementation issues that would come about. And then I guess my, well that was...

Patricia: Well, in several of the bills there are complex formulas for things like the premium
subsidy if you are someone who is at a certain level of poverty level. There're complex formulas in
terms of employer contribution if there's an employer-payer provision. And these will have pretty
high transaction cost of setting up should any of them pass. So, I think that there will be some sort
of increased bureaucracy and high transaction costs that aren't necessarily anticipated at this stage
of the health reform analysis.

Sallie: It looks like we have to stop right now, but I'll stay after if anybody has comments or
questions. Well, there isn't, so we won't stay then. Thank you.

Steve: We'll stay in the back. Thank you for coming. [applause]