Well, good morning everyone. That's a little bit like a class when the professor walks in, all of a sudden it got a little quiet. It is so good to see you all here this morning. I'm Kellye Testy, the Dean of UW Law and it's a great pleasure to welcome you. We really appreciate you joining us so early for this program on "Health Care Reform: What Is It And What It Should Be." I want to let you know as we begin this morning that it's just so good to see so many of our alumni here today. So good to see both people that have graduated recently, alums who have been working in Seattle for quite some time. What a wonderful group.

I want to thank you all, too, while I'm here today. I have so appreciated the very warm welcome I received to the School of Law this year. We are just having a terrific year, really gaining our momentum. I absolutely love being at the University of Washington.

Even though I have been here in Seattle for some time, I think I even underappreciated the wonderful resource that this university is to the state and this nation, and indeed, the world.

I know our Law School has so much happening, not only in the State of Washington, but across the country and in many other countries as much of our international work through the faculty proceeds.

So I just wanted to take a minute this morning to tell you that it's great to see you, to thank you for the warm welcome, and let you know that things are going very well at the Law School.

Any time there's an area that we are working on that you would like to know more about, or would like to talk to me about any aspect of our program, as I often say, I am a little bit embarrassingly easy to find these days as we do a lot of promotion of the School of Law. I'm really always happy to connect with you. So, great to see you today.

I want to introduce the moderator of today's program and she'll then introduce our panelists. I want to remind you as I do that, that CLE credit is available for our program today at the registration table outside.

Our moderator today is Professor Pat Kuszler from the Law School. I want to take just a minute before I turn the program over to her, and just thank her for her leadership. She is our leader in the Health and Global Health area for the School of Law, both in the JD program and also in our graduate program. We launched an LLM in Global Health this past year and that is really doing exceptionally well.
We are fortunate to have Professor Kuszler on our faculty. I have known of her and known her for quite some years and admired her work very, very much. She is both a JD and an MD, so if we were back in those formal days, I guess we would have to have a Dr. Kuszler, Esquire kind of title for Pat.

She received her medical training at Mayo, law training at Yale. Not too bad of institutions if you can't go to UW, I always say.

[laughter 0:02:46]

So let me not take any more time, but just thank Pat for her exceptional leadership in this area. She is a great scholar, a great teacher, and really one of the finest institutional citizens this Law School has the privilege to call its faculty member, so Pat, it's all yours.

[applause 0:03:03]

Patricia Kuszler:

Well, thanks for the nice introduction, Kellye. Today we have the great good fortune to be talking a little bit about Health Care Reform: What It Is And What It Should Be. I don't think anybody in this room has to be informed of the fact that this has become an incredibly controversial topic. In the sense that we have had controversy, complications, compromise -- the President and Congress have tried to address some of the issues. As we see it begin to be rolled out, we see that there is marked division within the public in terms of this particular reform.

Today, we have the great good fortune to have three wonderful panelists who are going to provide us with three different perspectives. First of all, we have Professor Frederick Chen. Dr. Chen works with our family practice department where he does a lot of teaching, conducts health policy research, and also sees patients, of course.

For our purposes, one of the reasons he is such an ideal panelist for us today is that Dr. Chen is the guy who is the medical director for the Washington State Uniform Medical Plan where most of us get our insurance. He is the guy who decides on our claims and sees all of those claims come through the system and has an idea of what the status of cost, quality, and access are.

We have Taya Briley on the far end here. Taya is both a nurse and a JD and one of our alumni. Taya is the General Legal Counsel for the Washington State Hospital Association where her practice focuses on legislative and regulatory issues related to hospital and clinical operations, legal issues affecting non-profit organizations, and a wide variety -- truly a wide variety of health law and policy issues. As I mentioned, she's one of our alumni, she's also an alumni of our nursing school.

And last, but not least, we have Professor Sally Sanford. Professor Sanford teaches a broad array of health law topics both at UW School of Law and at our School of Public Health. Her research interests include the Health Care Delivery System, Health Administration, Health Administration Law, Medicare, Medicaid, Comparative Health Law, and Medical and Administrative Ethics.

Prior to joining us at the Law School, Sally represented UW Medical Center, Harborview Medical Center, and UW's Health Sciences School as an Assistant AG.
So today, we're going to start with Professor Chen and he is going to spend a few moments talking about what the status of cost, quality, and access are that Congress was forced to deal with when it finally began to settle down and do some kind of reform. So let me turn it over to Freddy.

You can just sit there.

Frederick Chen:

OK, super. Thanks very much for having me. Not an alumnus of the Law School, but happy to be here. Let me give you the quick overview of Health Policy. I teach Health Policy for the Medical School along with Pat, and really we break down the Health Policy issues into three major themes; cost, access, and quality. I think those three major themes also are what drove much of the health reform debate over the last year. Really, the one that was the biggest driver was cost. I'll just review a couple of numbers with you. That the United States, by far, spends more per capita, and more in total, than any other country in the world on health care.

In fact, we spent last year almost $2.5 trillion on our health care system. That accounts for about a little over 17 percent of our GDP. You do have a slide set in your packet, we didn't include a diagram that showed the line or sort of the graph of it. Suffice it to say, it looks like this for the US, and this for the rest of the country.

This graph can actually be percent GDP, it can be per capita spending, it can be the total amount of spending. It looks fairly similar regardless of which of those measures you're talking about.

Unfortunately, it can be argued that even though the cost was one of the biggest drivers of the health reform debate, it's probably the one that's least clear in terms of what exactly we got out of the health reform legislation in terms of the impact on cost.

The other piece, of course, with the cost is that those costs and that spending really did translate into impacts on average Americans. We know that over the last 10 years there's been an increase in health insurance premiums of about 130 percent or so. The actual amount of worker contribution towards their health care costs has also increased well over 100 percent, 125-130 percent.

That, as a very basic starting point, was one of the main issues; the amount that we spend and the cost issues there. Of course, there's some discussion there about how much of this is actually about prices and what exactly are the true prices versus the true cost of health care.

The second major theme in health policy is around access. You could argue that access is probably the one area where we actually made some progress on in this health reform legislation. The biggest issue with access is that ours is the only Western country that doesn't provide universal health insurance coverage to all of its citizens so that has always been a sticking point for our health care system.

In fact, leading up to this debate, we're looking at numbers of about 46 million people in the United States who did not have health insurance. There was a much larger number of folks whose insurance was considered inadequate--underinsured folks. For most health
policy debates, the bulk of the access discussion is around insurance, and it's a very important issue.

Not having health insurance can be related to your risk of dying. It can be related to whether or not you get needed health care in time or not, your overall health status.

All those outcomes are quite important when it comes to having or not having health insurance. The other piece that I added, the debate about access, is that having health insurance isn't the only piece of access that's important to think about, especially for our region.

Things like being in rural areas, versus urban areas. Geographic disparities are important when it comes to access. There are racial and ethnic disparities that are important factors in access, too. General inefficiencies with our healthcare system also impact access.

But, having said that, generally the biggest piece of access has been around what are we going to do with these 46 million folks who are uninsured. That seems to be one of the real areas of progress that we were able to get to with this legislation.

Finally, a word about quality, which has been another big sort of health policy watchword for the last decade or so—I think where that comes in is, while we sure do spend a lot of money on health care, what are we actually getting for it?

That's when some of these challenging numbers, like being ranked number 37 in the WHO global health rankings, which include measures of not just access to health care, but our actual health outcomes. The fact that our infant mortality is quite poor compared to other countries. Our life expectancy is not as you would expect, given the amount of money that we spend on health care.

Those issues around quality have actually come home to the healthcare system in a number of ways beyond the access and cost issues, but really around what do we actually do on a day-to-day basis, in our delivery of care?

What are the gaps in quality of care delivery? Unnecessary treatments? Why is there such a wide variation in treatments that happen, whether it's cancer or heart disease, or even immunization rates? Why is there so much variation? Why are there high-performing areas and low-performing areas?

All three of these big areas--cost, access and quality--fed into this health reform debate this year. As I said, we certainly seem to have made some good progress in one of those areas, at least. And there's some quality stuff in there, too.

I think the big question which we'll also like to try to address this morning is around what are the cost implications, and where are we really going to try to make some progress in that moving forward?

Patricia:

OK. With those introductory comments on how we got to the issue of health reform, the debate about cost, quality and access, we're now going to turn to Professor Sanford, who's going to give us a little bit of a capsule approach to what the actual health reform plan is. A couple of you in this room have the great, good fortune to actually have to read
and dissect this plan, which is many hundreds of pages long. Of course, we'll just be covering the high points today. Let me turn it over to Sally.

**Sally Sanford:**

Thank you. As Professor Kuszler said, I'll attempt here to cover some of the high points of the new law. But I hope there'll be a lot of questions about those aspects, and also other aspects of this new law. In some ways, it seems like this reform debate has just been going on and on and on and on. And that's because it really has. There have been attempts by the Federal Government to deal with our healthcare systems going back to the turn of the last century.

Focusing just on this past year, it's just been a busy year. The initial goals of this health reform, as President Obama set them out about a year ago, were as Dr. Chen said, to control, to bend the cost curve. To try to do something about the rapidly escalating health care costs to try to bend the cost curve to approach universal coverage.

That doesn't mean, and it didn't mean, a single-payer system, but that every citizen has some kind of health insurance coverage.

So, try to reach some universal coverage. To do it for less then a trillion dollars became the magic number, over ten years, and to not radically change the system.

There really wasn't a strong push for, say, a Medicare for all, or a single-payer system. But from the very beginning, there really was an idea to maintain the current, employer-based, largely private system for those under 65.

Some would say that as the year progressed, the goal just became, "Enact something. Anything. Get enough people to sign on." That partly explains some of the way that the law actually ended up.

Trying to summarize some of the key points of the Patient Protection and Affordable Care Act: it's a couple of thousand pages long, and cross-references a lot of other statutes.

As Dr. Chen pointed out, the most immediately significant parts of the new law have to do with access, with trying to achieve close to universal coverage. The other aspects, to control quality and bring down costs, are less immediately significant, although they may end up being significant.

On the access front, one you've heard a lot about is the individual mandate, the requirement that almost everybody will have to have some kind of insurance coverage, starting in 2014.

All citizens and legal residents will have to have coverage, either through Medicare, Medicaid, an employer-provided insurance system, or individually purchased insurance.

There are exceptions in the law for a variety of things: financial hardship, and that will need to be defined; religious objections; and a couple of others, including if the least expensive policy available to you would cost more than eight percent of your income. Then you don't have to purchase insurance, or get it through your employer.
Also under the law--and this is a significant part of the mandate--there'll be subsidies available for many people who end up having to buy insurance on their own. People who aren't eligible for Medicaid or Medicare, or employer provided insurance.

If they have to buy insurance on their own, there are sliding-scale subsidies available for people whose incomes are between 133 percent and 400 percent of the federal poverty level.

Right now, and it changes, the federal poverty level for a family of four is about $88,000. So, there'll be sliding-scale subsidies available, both for the cost of the insurance, for the premiums, and also for cost sharing.

Most people know that if you end up being very sick or very injured, the coinsurance and copays can add up pretty quickly. There'll also be subsidies for those income levels for those kinds of out-of-pocket costs.

What if you are required to have insurance, and you don't? You don't fall under the exceptions. There are tax penalties for not having required insurance. I've heard this called the slacker tax, that if you're required to do it and you can afford it, and you don't.

Those tax penalties, they phase in over time. Ultimately they'll be, starting in 2016, a yearly tax of $695 per person, maximum of $2,000 per family, or 2.5 percent of income. That would increase, based on cost-of-living adjustments.

So, whichever is greater: basically, $700 or 2.5 percent of income. Whichever is higher, you'll have to pay that tax. These requirements to purchase insurance, and subsidies for it, are really quite linked with another big part of the statute that has to do with new restrictions on health insurance industry practices.

They're quid pro quo and quite connected, the variety of new restrictions on what health insurance practices can be. Some of the key ones are, when it's fully phased in, no more pre-existing condition limits, meaning insurance companies will have to sell to people, even if they have had cancer, or had a C-section, or high blood pressure, whatever.

They cannot decline to sell them a policy based on health status, also cannot charge a different amount based on health status. So, the pre-existing condition limits apply in both of those senses, and historically those have mostly come up in the individual market. But anyway, no more pre-existing condition limits when it is fully phased in. Also, no more lifetime limits on coverage or annual limits, or what are called "Essential Benefits," and that will be a big change.

There are a variety of other insurance limitations, including for example limitations on what is called "Rate Banding," how expensive the most expensive policy can be compared to the least. So, basically rates can vary depending on age. Older people can be charged up to three times as much as younger people.

When I described this to students, they were very concerned about the high costs. So, this group may have different issues about the rate banding. Also, there can be adjustments for if the person is a smoker or not. So, those are some of the restrictions on insurance practices.
So, another big access issue is where people who have to buy insurance on their own will go, and that's the creation of these insurance exchanges. Under the final law they are state-based, and the idea is this is a place where you will have what is called "Managed Competition."

Insurance companies will go there to sell on the individual market, and will sell a standardized product, up to four different types of insurance; bronze, silver, gold, and platinum, and then also a catastrophic plan that will be available to certain people under 30, and those who can't afford the others.

So, on this marketplace there will be these standardized, theoretically, easily comparable plans that an individual could go and buy a policy. There will also be a similar exchange for small businesses, who now have a hard time finding affordable coverage.

So, the idea is that the states will setup and regulate these, much like the Massachusetts Insurance Connector, but under the law if they don't, then the Federal Government will do it. So, those are the state-based health insurance exchanges.

The final significant access provision is the expansion of Medicaid. So, under the Patient Protection Affordable Care Act, Medicaid eligibility will be expanded to include everybody under 133 percent of poverty. So, as you might know right now, Medicaid has categorical eligibility, so you both have to be both income, and it varies from state to state, and also in a category.

Typically, it's people over 65, people with qualifying disabilities, pregnant women, and lots of kids. Very few childless, non-disabled adults are on Medicaid, especially in some states like Texas. I don't think you can qualify for Medicaid in Texas if you're a childless adult without a disability, who's under 65. So, anyway, that will really change eligibility for Medicaid, vastly expanding it.

Now, one immediate problem that the state's are going to think of is, "That's going to cost a fortune," because Medicaid is a joint Federal-State Program where the Federal Government provides matching dollars. So, our state is one of the wealthier states, so we have a 50/50 match. Every dollar we spend, the Federal Government gives us a dollar. But still it is a dollar that the states spend, and it is one of our biggest budget items.

So, under the new law, for the newly eligible people, the Federal Government will pickup 100 percent of the tab for the first years, and phasing down to 90 percent. So, that's the Medicaid Expansion. As of now, you can't qualify for Medicaid unless you're a citizen or a legal resident, or some very limited categories for refugees.

So, all told, all these access provisions, the Congressional Budget Office that they'll increase the numbers of insured by 32 million people over ten years. So, it won't achieve fully universal access, but pretty good.

It will cost close to a trillion dollars. I don't know where that magic number came from, but that was the 'can't get to a trillion' over ten years. Also, the Congressional Budget Office estimated that over ten years it would reduce the Federal deficit by more than $100 billion dollars.
I don't know if I should talk in a minute about where the money comes from, or we can leave that for questions, but just one quick thing, so the law doesn't kick in all told immediately. Some aspects do, and that was part of I think how the law got passed.

So, a couple of things do kick in this year. Most aspects don't kick in until 2014. A couple of the things that kick in this year are subsidies in the Medicare Part D donut hole, letting kids up to age 26 stay on their parent's insurance plans, and prohibiting the application of pre-existing condition limits on children in the insurance market.

So, maybe I'll just end here, and then hopefully there will be some questions about specifics or if you have any questions about how it is paid for. I also included in the materials a nice summary from the Kaiser Family Foundation of the law, for those of you who don't want to read the whole law. Kaiser, it's www.KFF.org. They do a really nice job I think of summarizing different issues, and also now of summarizing provisions in the statute.

Patricia:

OK. Now, we move onto Taya. Taya is going to talk about now what? Some of the legal issues that have appeared as a result of our Health Reform passing, and some of the anticipated legal issues that will flow from it in the months and years to come.

Taya Briley

Thank you. I think speaking to the legal issues involved with the Legislation, it is hard not to start with the question that has been called about the "Constitutionality of the Legislation." At the law school, a week or so ago, there was an excellent panel that spoke to the Constitutional issues involved with the Legislation, and whether there could potentially be a challenge brought related to the 10th Amendment or potentially the Commerce Clause. I heard Professor Sanford on NPR speaking to the Constitutional issues not too long ago. So, I'm going to consider her the expert on this issue. If she's been on the radio, she must be.

So, to get into one of the other issues related to medical liability, I wanted to kind of take a little bit of a backdoor route. Professor Kuszler talked about my nursing background, so I think that some of that kind of comes into play here. So, I wanted to talk about some of the provisions of the bill that get to the quality issues that Dr. Chen discussed, and then I'll bring that back around to medical liability.

So, one of the things that is true about the Federal Government is that it has a lot of purchasing power, when it comes to purchasing medical services. The Medicare and Medicaid programs are able to drive change, because they hold the purse strings on a lot of the money.

So, I wanted to talk about how the Legislation potentially is going to drive quality improvements. Right now, the Medicare program in particular, is just taking some baby steps in holding hospitals and other healthcare providers accountable for the quality of care that they provide.

So, I wanted to talk about how this could potentially lead to some more significant inroads in this area. One of the things that is included in the Legislation is a 4AN2, something that is called an "Accountable Care Organization." What it allows is I think a
really interesting shift in focus from a system that is right now very focused on providing payment for episodes of illness, to actually managing a person's medical condition.

So, it allows physicians and hospitals to work together, and that reimbursement structure will be to pay those two components of the system together to actually manage illness.

I wanted to talk a little bit about a recent example that I heard about through reading some of the work of Dr. Atul Gawande, who is a very respected health policy person. He's a surgeon and I'd heard that some of his writing was required reading in the White House during the health care reform push.

So he talks about Children's Hospital in Boston and one of the things that Children's Hospital in Boston was able to do in the last couple of years is make some really important strides in reducing childhood asthma rates. And they did it by some really low technology interventions.

They used nurses to make sure that children were using their inhalers properly. They made sure that children and their families had vacuum cleaners in their homes if they couldn't purchase them to take care of the debris that would trigger the asthmas attacks. And they were able to reduce readmissions to their hospitals for asthmas attacks by 80 percent.

And that the current reimbursements structure, the thanks that the hospital got for that was the lost of a major revenue driver because for children's hospital, asthmas admits are really significant revenue drivers. So with this type of accountable care organization structure, there may be some way to better incentivize the system to manage care in a way that will not just be better for cost but better for patients and for quality.

Another example in the legislation of a way that we'll hopefully see some quality improvements has to do with readmissions and I want to emphasize this is just one quality component of many that are included in legislation. So there are a lot of different ways that the bill gets at driving quality improvements. And so looking around the room, I'm curious, most people know someone who has been to the hospital for a heart attack or has had that unfortunate experience him or herself.

And one of the things that we are learning and watching in Washington State and nationally is that when you are admitted with certain conditions, certain things need to happen in a hospital before you go home in order to make sure you don't have a reappearance in the emergency department not too long afterwards.

And so you can sort of imagine this scenario where a patient has come into the hospital. They've been stabilized, they've been prescribed medication that they're going to go home with, they have their person there that's going to be taking them home, you have a nurse who has the phone ringing from the emergency room with another admission that wants the bed that the patient is currently in. There's a lot of incentive to get that patient out of there quickly but if that discharge teaching doesn't go right, that person like I said, could make a reappearance.

So there are some certain things that we have learned for a heart attack patient, for example, that need to happen. Like if the patient cannot answer the question, what is your water pill, the likelihood that they're going to make a repeated appearance to the emergency room goes up quite significantly.
So making sure for certain medical conditions that steps are taken to prevent readmission is just one example of how quality improvements can be driven. And the driver for the federal government is if you have significant events of readmissions, you're not going to get paid for them potentially in the future. You're going to get paid a lot less for the care that you're provided.

So those are just two small examples of how this can work and I want to wrap this back around to the medical liability question because in the legislation, $50 million was provided for medical liability demonstration projects. For those of us that were following the health reform politics, it seemed pretty evident that those provisions were included in the bill basically as a nod to Republicans to provide Democrats political covers. They pushed the legislation forward and so it doesn't seem likely that these medical liability demonstration projects are necessarily going to lead to huge change in the medical liability system.

And I have watched the medical liability battles, quite frankly in this state, and around the country, and at the national level. And personal I don't hold out a lot of hope that we're going to see major changes in the medical liability system any time soon. But what I do think could potentially change the equation in the medical liability mix is reductions in the number of injuries that happen in hospitals which hopefully will then in turn reduce the number of claims for medical liability. Those are my thoughts about what comes next.

**Patricia:**

OK, so we've managed to hit some of the high points but now we are looking forward to your questions. And I'm sure there will be many questions on our new health reform so if you would please stand if you have a question so that Bev can get you a microphone. And if you have a specific person you want to direct your question to, great. Otherwise I'll direct it to who I think is appropriate. Questions? Oh, there has got to be questions.

[laughter 0:33:35]

**Man 1:**

Well one of the things that we hear about a lot is that this is going to save money over time. That was one of the big drivers, right? Was to reduce cost but you've explained how a lot more people are covered and you have to pay for preexisting conditions and all those things which should drive up cost. What are the major things in here that actually are going to drive down cost? I know there's 500 billion they say, that's supposed to be coming out of Medicare but I don't know where that comes from either so I'm just curious if there really is cost savings in here.

**Patricia:**

Sally, you want to take that?

**Sally:**

Sure, I'll be happy to start taking a stab.

[laughter]
There are a number of provisions in the law that are both meant to cut cost, increase revenue, and generally save money by some of the changes in reimbursement structures and medical practice. Specifically what you asked about Medicare, which is a question that doesn't come up when students ask. There are cuts in the Medicare advantage program. This is the program that was basically created when Medicare Part D, the drug benefits several years ago. And Medicare advantage programs are private insurance that provides managed care within the Medicare system. And originally the idea was that Medicare managed care would be less expensive than traditional Medicare, tradition fee for service Part A and Part B. And the reasoning was that when you're managing care, by definition it should be less expensive.

Partly to incentivize the creation of these Medicare advantage programs, when Part D was created, there were lots of financial benefits to Medicare advantage programs. So right now, Medicare spends 114 percent for people who are in Medicare advantage which is 25 percent of the Medicare population compared to 100 percent for someone in traditional Medicare. So this bill changes that. It brings the reimbursement to Medicare advantage programs back in line with traditional Medicare.

And that may mean some benefit cuts to Medicare advantage plans which right now can offer things like gym memberships and zero premium coverage, so that's one big chunk of savings. There also will be savings in Medicare in the Part D outpatient prescription drug program and partly that's from give backs from the pharmaceutical industry, particularly for non-generic medications. Some of the other savings have to do with taxes.

There are going to be taxes on, I mentioned the individual tax penalty if you don't get insurance when you're supposed to. There will also be taxes on Cadillac plans. Those are very generous plans provided by private companies. There will be taxes on those. There will be taxes on pharmaceutical companies and on medical device makers. There will also be some increase taxes on high income earners so those are some tax changes. There will be a variety of changes in how Medicare and Medicaid pay for services and Tam mentioned some of those, the accountable care.

Also, generally speaking, the idea of paying for not just per procedure or per event but the totality. Like, "Here's the payment to fix this knee and with this lump payment, figure how much to give to therapy, to medications, to this, to that." And the idea is that will help drive down costs. Probably some other things I'm missing. Those are some of the main ones.

Frederick:

Yeah. No those are exactly right and I think it remains to be seen whether or not things will actually balance out in the end because at the same time, you have this rate of rise that's driven by our aging population, not all of whom are law school alumni apparently.

[laughter 0:37:47]

I don't think they're all Medicare beneficiaries in here. I think that the taxes and penalties are definitely there. I think the real unknown question is whether all of these other pieces around accountable care organizations or these demonstrations whether or not they have enough behind them, or whether or not there are enough of them to actually do anything to bend the cost curve. It's really an open question. And just as an example, I think a lot
of people have pointed out that one of the primary offenders in cost is the way we pay for health care. So if we talk about things like capitation, or paying for episodic care, or paying for a patient's total care, that works in certain places.

And Group Health here in Seattle is a good example of a place where that seems to work. Of course, that's also an example of a place that both a cared delivery system and an insurance system combined. And so that their incentives are much better matched than a place where those incentives aren't matched that way.

And I just bring it up in terms of, I think it's absolutely critical to the whole cost saving piece, is rethinking how we pay for care, and yet that is also a huge lift, and not something you can do overnight.

It would be like going from billable hours to paying per case. Right? Or paying per client, a single flat fee. It would be that sort of big of a change. And I think while there are good examples of places where you can do that--Mayo and here in Seattle for example--there are just as many examples of places where you do something right, like at Boston Children's, and you end up losing.

I think there are fair opportunities in this legislation for us to start experimenting and to really try to encourage these kinds of things, but wholesale change is not in there.

Taya:

I think the only thing I would mention that hasn't been mentioned yet is the luster and the progression of the health reform legislation of this idea of a public option. I think that if that had been included, the prospects for using governmental purchasing power to drive down costs would have been greater. And I think we are going to need to see the government come at it in different ways.

Patricia:

OK. Other questions? OK. We're going to go with you first because you kind of got up first, and then we'll go to this lady over here.

Woman 1:

The dean also has a question.

Patricia:

Oh, the dean also has a question. OK.

Man 2:

I've always been curious where we pay today, or how we pay today for the uninsured. If an uninsured person shows up in an emergency room, gets care, doesn't pay for it, how does that get paid for today, and how is that going to change?

Frederick:

We all pay for it.
Frederick:

That's one of the other intents of the law really is that by decreasing the number of uninsured, and putting them under an insured umbrella, that we can actually get a better handle on those costs. Have we just shifted the costs over? As I mentioned earlier, there are real health, and costs downsides to being uninsured. You come in much sicker. You're not likely to get preventive care.

So there is a potential for cost savings there in that, OK now we've insured this population, hopefully they'll be accessing care more regularly, and while that could drive up some costs, in the end the idea is that it will pan out because instead is subsidizing all that care with your commercially insured patients, or through state and federal grants, and other ways you actually have then put them all under an insurance umbrella.

Taya:

Just to get pretty specific about it, Washington State is one of the only states in the nation actually that has what's called a charity care law. And in our state people who are present in an emergency room and don't have insurance coverage right now up to the 100 percent of the federal poverty level are able to receive their care for free. And basically the hospital picks up the tab, and then it goes on from a sliding scale from there, and Washington state hospitals have actually all taken a pledge to provide financial assistance up to 300 percent of the federal poverty level.

I think one of the things that will be really interesting with the advent of this law, is how a much larger percentage of the population being insured plays into the amount of charity care that hospitals provide.

Sally:

I also want to point out Taya's right that Washington is very unusual in having that law. There is a federal law that requires that anybody, any individual, who comes to an emergency room be assessed to see if they're in an emergency condition, and if they are, they need to be stabilized. There is a bit of a myth. I think most people think that they have to treat you for free. They don't. Nothing in the law talks about payment. So you could end up with a very hefty bill, which sometimes goes unpaid.

That unpaid part can either be bad debt on the hospital's ledger or charity care depending on how they set it out from the onset. And how the hospital actually physically gets paid for that?

The short answer is partly they don't. Partly it's from charging more to insured patients. And partly there is federal reimbursement for disproportionate share hospitals.

And those are your hospitals that have a disproportionate share of uninsured or Medicaid patients. And part of this statue reduces what are called dish payments, reduces dish
payments on the theory that there won't be so many of these people. But there still will be some.

Patricia:

Of course it's going to be an interesting situation in the sense that currently our emergency department serve as primary care physicians for most of the population that doesn't have health care coverage. So we see not only patients coming in for significant emergency conditions who have let their condition deteriorate because they have no insurance, but we also see cold, sore throats, baby-care, coming through the E.D.

And the question is going to be whether or not this law will actually allow some of those patients to be off loaded from the emergency department to primary care physicians. Now where the rubber hits the road is in some cases these are not ideal patients.

Doctors may not want these patients. And so it may not save as much money as we would like it to save.

But that's the idea that if we had more of our population covered, they would access primary care physicians earlier in the course of their illness, and not present to the emergency department either with routine care issues.

Or a much worse medical profile that will costs a great deal of money to fix, and essentially usually be absorbed by the hospitals bad debt, and then passed on to all of us. OK. We had a lady over here.

Woman 2:

Mine is kind of a two pronged, and it's more a comment that I'd like you to comment on. From a worldwide perspective, other countries that do cover all of their populations, don't seem to have to get into all kinds of convoluted payment schemes to cover it. Most of them use fee-for-service and still provide adequate care for their populations at less than half the costs of what we're paying in our country.

And the second is comparative effectiveness research or CER. Now there are some pilot projects in this bill. But other countries make wonderful use of this.

The most notable example is the NICE committee in England which gets concessions from the pharmaceutical and device industry when they come in with something that's not all that effective, and costs a whole lot of money, and NICE says, "OK. We are not going to OK it for the National Health Service."

And then the companies come back with a lower offer, something which we don't have in our country.

Frederick:

Other countries don't have the profit motive in health care that we do. Other countries are un-American that way.

[laughter 0:46:24]
I think that really is, for me, the crux of the issue is sort of how much money is sloshing around. How many people are making money off of it, how many do—that's a huge driver. And it's part of the American way. We've created as system that works like that for well over 50 years. And it's about changing our expectations, and changing our culture, and changing our history which seems to me like a big lift.

Other countries do it absolutely differently. Other countries have a different social structure, a social mission. A different history and culture around it that allow this sort of sense of shared responsibility for the health care of their citizens.

And something like NICE works in the UK because you have a single payer, and you have a government backing you up in the exam room. And you can sit there with a straight face with that patient in front of you, and say that's not covered by the National Health Service.

Not, "I'm not going to give it to you." Or not, "You don't need that." But rather, "That's not covered by the National Health Service." And so when we talk about NICE here it becomes a death panel discussion.

Patricia:

OK, Kelly first and then this gentleman here.

Kellye:

When we did the program at the law school on the constitutionality of the bill, one of our students came to me and he actually was kind of upset that we were focusing on the constitutionality. He thought that was just clearly constitutional in his view. But he said, "You know, what I really wish the law school would focus on is the question of real poverty: the people in society, the least among us." And so I promised him that I would ask the panel. What do you think this bill is really doing in that sense of really addressing poverty? There are a lot of exclusions, as you all noted. What effect do you think it's going to have on those in society who are perhaps least able to fend for themselves in the marketplace?

Taya:

I can start. Well, sort of going back to the question that Dr. Chen was just answering. One of the things that was going around in my head is that we are still in this country having a very heated debate over whether we can agree that health care is a fundamental right of our population. We are not all on the same page on that question at all. From a very practical standpoint, the thing that I see this piece of legislation doing for those that are impoverished is this significant expansion of the Medicaid program. There are a lot of individuals who simply do not qualify. I think that this is less of an issue in Washington state with our state's Medicaid program and the basic health plan that we certainly do have uninsured folks. But in other areas of the country, it is so much worse. Don't know.
Woman 2:

Yeah. Yeah, I'll just add one concern about... But I think the bill goes, the law goes a long way in trying to bring into some kind of insurance coverage a lot of low income people who have simply been shut out for many years. I think that's a good thing. A concern that I have is a lot of them will be on Medicaid and our Medicaid program is already struggling. A lot of positions don't take Medicaid. It tends to be the lowest payer, so private insurance, then Medicare, then Medicaid. They also often are more challenging patients because they have more copy--you could speak to this more, Doctor Chen. But compared to non-Medicaid patients can have more complicated multi-medical conditions and also more complicated social circumstances that may lead to, for example, more canceled appointments that are just a hassle for a doctor. So there is a challenge with getting enough physicians for the Medicaid population now. The law does a couple of things to try to address this. One is it brings, for a couple of years anyway, the rate of Medicaid payment up to Medicare rates for primary care, which would be a significant financial increase for those who do Medicaid primary care. And also as various provisions to try to increase the supply of primary care physicians and nurse practitioners.

So increasing more residency spots, more loan forgiveness, a variety of things. Because you might know primary care positions under our current reimbursement structure end up with a lot less money than specialists. So while... My father's a physician and he's always said that when he was in medical school years ago, the brightest and it was the hardest sought residence positions were primary care. And now I think it's dermatology is the toughest to get into because it's both the most lucrative in terms of hours and maybe seen as the most stable. So there are some real increases, but some challenges.

Patricia:

OK. And I think one of the issues I think with the poverty issue is that there's a real question as to whether or not these, particularly the most poverty bound, are going to have a significant difference under this law. There will still be in that lower group a bunch of folks who are not going to be able to access any kind of coverage, the sort of remaining 12 million or so. And that's a challenge for another day. And I think as we look at the access issue, we will be revisiting this issue in future reform. And some of it will be around the poverty ridden who are not even able to access good health care despite the fact of this current iteration of health reform. OK. And we have this gentleman here.

Man 3:

Thanks. And this gets back to the international theme a little bit. Many of the most expensive sort of procedures done in the United States can be done at a fraction of the cost at an equivalent level of quality overseas. American trained doctors, brand new facilities. Does the broader adoption or more penetration of medical tourism, for want of a better term, hold any promise
at all for mitigating cost increases in the future? Or is that really kind of a just operating at the margins?

Patricia:

Who wants to take that? Sally?

Sally:

I can start taking a stab at that. I think medical tourism, which has come to be the phrase, it's an odd phrase, is a really interesting phenomena. And that's where people from developed countries go to developing countries for very high tech medical care. And the leaders in the developing world in this are India, Singapore...

Patricia:

Thailand.

Sally:

Thailand. And as you say, it's true. They often have very high tech hospitals with often US trained physicians, English speakers. With, you know, staff who provide the services at a fraction of what somebody might pay, certainly out of pocket. And even with co-insurance in this country. A couple years ago I went to a conference, it was a medical conference, in Canada and they were talking about medical tourism. And the person started speaking and saying, "Of course, many of our patients will be going because," and I was thinking ahead, because they don't have insurance. And the reason it was not that, it was in Canada you go to jump the queue to get hip replacements and knee replacements that you may have to wait for in Canada.

Here people who go tend to either not have insurance or they have very high out of pocket cost. And it is a growing field. It raises some interesting issues. One, if there's medical malpractice when it happens abroad, you really don't have recourse, realistically.

Two, there's some sort of global equity questions. If a lot of the really good Indian surgeons are being siphoned off to these hospitals that predominately serve foreigners, that's a little troubling. Well, maybe it's not our business. I don't know that this health reform bill will have an impact either way in this, given that there might be people who want to get service more quickly and avoid out of pockets, out of pocket costs. I'm also amazed that people will go for very major surgery. Fly to India, have a hip replacement. And then fly back.

[laughter 0:54:39]

Sally:

I don't know that I would do that.
Man 3:

Yeah, I don't think it's a big enough sort of volume right now to really know whether it's going to have any kind of impact on the bigger picture. I mean, it is less expensive to fly to Singapore and get a nice suit as well. So you can take advantage of sort of global economy that way in a number of different ways. But I think it will most likely be reserved for a very small group of folks who are interested in doing that. But the coverage issues are important, though, because we've seen cases of folks going to Mexico to get their lap band surgery or their obesity surgery. And that's not a covered--many times the complications from those operations are not covered by American insurance companies. And so they--anyway, so there's a number.

Sally:

Yeah. We might keep seeing that with Mexico, forgot about that. Mexico does a lot of US patients without obesity surgery and also dental surgery.

Man 3:

Yeah.

Sally:

That's not part of standard insurance coverage.

Man 3:

Yeah.

Patricia:

And of course one of the big medical issues is these patients come back to the US and if they get into trouble post-operatively, who's going to be able to take care of their post-operative complication when the guy who eventually ends up with them in the US. Doesn't really know exactly what went on over there and is in a poor position to really adequately address their post-operative complication. Other questions? Yes, two and let's start with the gentleman here at the second table and move onto our colleague in the back row there. Could you stand up, please?

Man 4:

I've heard that Washington Medicare payments are discriminatory low compared to other states. And that's why I pay my doctor an extra $50 a month just because she can still cover Medicare patients. I'm not one yet, but soon will be. Is that taken care of in this bill? Is there some mechanism to try to get equality between the states now? And is that a legal issue if in fact they don't do it?

Taya:
OK. So I can take that one. Actually, this issue of geographic variation is one thing that I was going to talk about and then ask, because I decided you didn't want to hear me talk quite that long. So, geographic variation is basically a fancy term that health policy folks use for meaning that some areas of the country use, or provide a lot more medical services than other areas of the country. And the federal government breaks it down, actually by county, but overall Washington State is one of the most efficient states in the country in terms of delivery of services. An interesting corollary to that is that the areas in the country that deliver a lot of services per capita are also those areas of the country that have some of the poorest quality outcomes. So if you're a consumer of health care, the idea that you're receiving more health care shouldn't make you too happy. What we have learned from this is that less care is actually better for your health.

So one of the ways that the legislation addresses this is it looks by county at those areas that are most efficiently providing health care services to its population and drives a portion of reimbursement to those areas. And then it also is setting up a couple of national studies to explore this scenario where you've got a high amount of services being used in poor health outcomes and what that might ultimately do for lowering costs nationally.

Patricia:

OK. Next question? Yes.

Woman 3:

Quick question. I know it was part of the debate early on but I didn't know if it actually made it into the bill, if there was anything on changes to the physician referral law, Stark. Did they do anything with that? It's one of the things I'm looking for buried in the 2,400 pages...

[laughter 0:58:49]

...that I haven't gotten through yet but it affects my practice quite a lot.

Patricia:

It would be highly unusual if there weren't some changes to Stark in this thing.

[laughter 0:58:54]

Taya:

For those of you who don't do Stark, count your blessings. It's a very complicated law that has changed every single year, and it has to do with relationships between physicians and hospitals, which is obviously significant to any kind of business arrangement. There must be some changes in there because all of the accountable care and payment for taking care of a condition, those all have Stark implications. So there are a lot of little bits and pieces in there. And I know the American Health Lawyers
Association Conference is actually in Seattle this year in June. And I'm speaking at it so I get all these emails about it, and they just sent out one saying, "OK, can you incorporate health reform into your thing?" And the Stark people are like, "Of course."

So there's going to be Stark after reform, advanced Stark after reform. I don't know the exact changes but there are a variety of bits of pieces, and there have to be or else a lot of these demonstration ideas won't work.

**Patricia:**

OK. Other questions? Yes, one there in the back.

**Woman 4:**

Professor Chen, can you comment on what changes the University of Washington medical school is contemplating in terms of either the types of students that are admitted or the curriculum and training as a result of this?

**Frederick:**

I don't know of a lot that's directly a consequence of the legislation passing, although the fact that the debate was going on certainly had an impact. The School of Medicine is the only medical school for the five state WWAMI region, and so as a result primary care and especially rural care has been a real priority for the School of Medicine throughout its history really. We have recently started a number of programs. There's a program called TRUST which is a pipeline program which really aims to get out to rural communities, help both high schools students and college students from those communities think about medical profession for their careers, encourage them. There's some loan repayment and scholarship provisions to that and a separate admissions process for students committed to rural and under served care. It's just gotten started. It's really in its first, second year with some federal grant funding to get that started.

The WWAMI program itself has always been committed to that. I think we've recognized in the School of Medicine that it's a priority and continues to be a priority even though we have this big research mission and this also heavy patient care mission too. So the School of Medicine is well aware of that.

The other piece of it which fits in with similar discussions around the care organizations is that the School of Medicine and Harborview specifically and some of the UW clinics have engaged in the patient-centered medical home project. It's actually a collaborative project run by the state's Department of Health. The medical home is an idea that not do you need to fix reimbursement and insurance access, but we actually need to fix some of our processes in our health care delivery system, and especially in primary care.

It's no good to tell folks not to go to the emergency department when their primary care office is closed at four o'clock in the afternoon. How do you reach somebody after hours? Why do you have to wait for an hour and a half
in the waiting room? Who's actually helping you take care of your diabetes when you only have 15 minutes every two months to see your doctor? And are there other folks in that clinic who can contact you in between and make sure that you're eating right or checking your blood sugar? Those kinds of things.

That's really on the service delivery side. There actually is a lot of language in the law around medical home and demonstration project like this, some tied to reimbursement and some just tied to the quality pieces. So UW is well aware of that, as are the other health care systems here in town. So there's actually a good bit of activity that's happening around that practice redesign piece.

But it goes without saying that all of these pieces in health care are quite interconnected and it's very hard to do a practice redesign if you're not at least addressing some of the payment inequities and reimbursement inequities, which we're starting to do in the bill a little bit. So they all go together and it's very hard to move one piece without recognizing that it's attached to the other pieces.

**Patricia:**

And this points at one of the questions I think that's floated around a little bit is the issue of reimbursement. There is a difference between coverage and reimbursement. Just because a service is covered doesn't necessarily mean the reimbursement level is going to be high enough to make it easy to find a doctor who will see you. And that's of course what happen with our Medicaid program and increasingly with our Medicare program where there is a fairly comprehensive level of coverage but the reimbursement level is so low that many doctors are deciding that they don't want to take care of those patients.

And one of the areas where we see this health reform bill stand back and not do too much is on the issue of the reimbursement level. There has been a lot of focus on coverage, not so much on reimbursement, and that is unfortunately something that's going to come home to roost. As this plan is implemented, doctors will either decide that reimbursement is sufficient or that it's insufficient. And if it's insufficient, we'll know pretty quickly that the patients may have coverage but they can't get care. And so that remains to be seen.

As we heard health reform talked about on TV a lot they kept highlighting some of the really efficient systems - the Cleveland Clinic, the Mayo Clinic, Marshfield Clinic in Wisconsin. And almost nobody focused on the fact that there's one thing all those centers have in common: their doctors are on salary. And that's not the way that most of medicine works.

**Woman 5:**
I have one comment and one question just on that last issue about the Medicaid program. There actually is a change in the bill that expands how medical assistance is defined under Medicaid and it includes the provision of services. So I think there are some nuggets in the legislation increasing reimbursement because the state Medicaid agencies will have the obligation not only to pay for the service but actually to ensure that it is provided. But my question is, in terms of these consumer assistance programs and ombudsman programs, what are you hearing about how they're going to be set up both here and nationally, and will they do more for people than just, here are your rights? Will they actually provide advocacy and representation?

Sally:

That's a great question. I just saw on the news today that Kathleen Sebelius said that her agency will be the national helpline. Are we going to be calling her, asking what to do? There is in the law requirements that these health exchanges have ombudsmen, and have Internet presences, and have various technical means to help consumers who are not conversant in health reform language figure out what they should be doing. So the requirements are there.

How it's mechanically, physically instituted will be interesting, although we do have the Massachusetts model, which has been up and running for a couple of years with an ombudsman, and Internet presence, and flyers, and all those sorts of materials.

In terms of advocacy, some of it's left to the states. The insurance commissioner's offices, and there is a variation in how activist insurance commissioners are. Some of it's delegated to the Federal government. So, it will be an interesting interchange of balance.

Patricia:

OK, other questions? Yes.

Man 4:

Should opponents of federal reform worry about [indecipherable 1:07:28]. Is there justification to take action [indecipherable 1:07:35]?

Patricia:

I'm going to turn this over to Sally, because this is one of her areas of expertise.

Sally:

This has to do with pending lawsuits challenging the Constitutionality of provisions of the law, although arguably, if those provisions are out, the whole law's out. The challenges come from--now, there are three main sources. There's the Florida Attorney General lawsuit, to which 13 others
have joined in, and two governors now say they want to. And then, the Virginia Attorney General lawsuit. And then also one by private individuals.

The Thomas More Society has filed a lawsuit on behalf of several individuals. These challenge the Constitutionality, mostly on the individual mandate, arguing that it exceeds Congress' authority, either under the commerce clause or the tax and spend authority.

There are two other challenges to the Medicaid expansion and the health insurance exchanges. Those, I really don't think--some states can opt out. I think the weaker potential argument. The individual mandate challenge is not frivolous, but it's an uphill battle.

In terms of what people who disagree with the filing of the lawsuits and the premise can do, or ought to do, that's, I know, currently being debated by a lot of attorney generals and governors who disagree with their counterpart in the state. Do you support amici who are going to be filing briefs arguing that it is Constitutional?

The Oregon governor said he was going to file a lawsuit saying it is Constitutional. I'm not sure what that looks like.

[laughter 1:09:18]

And then, certainly, the Federal government will be defending it. Some governors and/or attorney generals, if the governors want to be part of the lawsuit and the AGs don't, have wondered if they can be parties. So, could you have, for example, the US government, CAP and Sebelius--the US government, and Governor Gregoire versus Attorney General McKenna and the others as the named parties? That would be very odd.

I don't know. It will be interesting. It is going to be a great, great law school exam for all sorts of law school professors. You have procedure, Federal courts, Constitutional law, all sorts of issues.

**Man 4:**

Just a follow up. What I want to--if you can answer this, maybe [indecipherable 1:10:06. What does McKenna's participation in the lawsuit add to the opponent's case? Is there a practical reason, from a legal standpoint, to try and nullify [indecipherable 1:10:19] ? That's my question.

**Sally:**

I know that state legislators--the state legislature is still in session, and there has been discussion amongst them on should the legislature do anything--The Democratic leadership--to prevent his participation. For example, cutting off funding, or changing the statute that arguably authorizes him to do this. That, I think, some people say is a two edged sword, because having an attorney general with some independent power theoretically has some value. But, I know there are discussions going on amongst the Democratic leadership in the state legislature about what, if anything, ought to be done
by the state legislature about disagreement with his participation in this. Certainly, they legally could do some things. I don't know what will happen, if anything.

**Taya:**

I think several states are struggling with this. There's a number of states where you have a Democratic governor, Republican AG, a Republican governor, a Democratic AG, and you have one party or the other deciding to sign on to the Florida lawsuit and their compliment saying, "No, no, no. We're not going to allow that," or "We're going to sign on the other side." I think it remains to be seen exactly how this dynamic between governors and AGs is dealt with, because most states do have a fairly independent AG. I just was in Minnesota for the Easter holiday, and they have that exact same situation: A Republican governor, a Democratic AG, and they way they settled it out was there was independent power for the AG to at least file an amicus brief. It was less clear that they could actually bring the entire state into the suit. And, there was independent power for the governor to do an amicus brief without the AG's consent, but it was less clear whether they could actually sign on to the entire suit.

So, the upshot in the Minneapolis papers was that the AG said, "Hey, look. You want to file an amicus brief, Governor Pawlenty? Go ahead. I'm planning to file one on the other side. Neither of us can actually join the suit, because we can't agree." Now, that may be a figment of Minnesota law.

**Frederick:**

When is the next election?

[laughter 1:12:35]

**Taya:**

And, of course, the wheels of justice move slowly. The next election may make a difference.

**Frederick:**

That's right.

**Sally:**

One other thing I would just add into the whole lawsuit mix that was brought up at the law school panel on this that I thought was really interesting is that there are actually questions about standing and rightness that could suggest that maybe all of these lawsuits are premature. No one has been injured yet. And, questions about are the attorney generals the right people to be bringing these lawsuits on behalf of states generally, or should it more properly be individuals. I thought those were a couple of interesting things.

**Patricia:**
We have time for one more question.

**Man 5:**

This might be a simple one. Will this have any impact on the Uniform Medical Plan?

[laughter 1:13:32]

**Patricia:**

We'll give that to Freddy.

**Frederick:**

A very good question. On the face of it, and from my understanding--not really. We're not a Cadillac plan. We have already--there are no preexisting condition exclusions for the Uniform Medical Plan that's offered to all state employees. We've done away with lifetime benefits limits for the Uniform Medical Plan several years ago. There are always pieces of medical that we will look at, and need to consider some of these things, like patients on medical home stuff, accountable care organization, and how we pay organizations if they fall into a demonstration, for example, I think may have some implications for us.

But, in terms of coverages and benefits, I don't think there will be, certainly, the Uniform Medical Plan, like many other insurers in this state, have been in the thick of this, and really from the perspective of insurers, they're really dealing with that cost slope, both for their beneficiaries, as well as for their customers, the payers, the state or large employers. That slope is going up quite significantly, and that's why you saw some crazy things like premiums going up significantly.

I think plans are going to be looking at this in a number of different ways. Certainly from a coverage standpoint, I don't think there's going to be any major changes for Uniform.

**Patricia:**

OK, let me thank all of our presenters. I'm sure they'll be here for a few minutes afterwards for taking any more of your questions. Thank you all for your attention.

[applause 1:15:13]

**Kellye:**

Let me join in thanking you for being here today. Pat, thank you for your great leadership of the panel. Panelists, really terrific job. What a great example of real interdisciplinary questions, you know? So many questions of law, policy, public health, medicine, et cetera. It's just wonderful to be able to bring people together to really get into this issue.
I also want to let you know that some of you may want to learn more from the panel. We did a whole that was specifically on the Constitutional issue, and you can watch that program. The link is available from the law school's home page on the website. So, it's just www.law.washington.edu, and you can find a link to that earlier program that we held on the Constitutionality issue, if you care to watch that, and learn a little bit more about it.

If you would, please join me again in thanking our moderator Pat Kuszler and also all the panelists, I'd appreciate it.

[applause 1:16:20]