Health Care in the 2008 Elections:
Where Do the Candidates Stand on Promoting a High-Performance Health System?
Alliance for Health Reform and Commonwealth Fund
March 14, 2008

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ED HOWARD, J.D.: I'm Ed Howard at the Alliance for Health Reform. On behalf of Senator Rockefeller, Senator Collins and our board of directors I want to welcome you to this briefing on how the leading candidates for President would promote a high performance health system. We're pleased to have as our partner with us today the Commonwealth Fund, a century old philanthropy based in New York City that's probably done as much to promote a more effective and efficient health care system as anybody around. You'll be hearing from Sara Collins from the fund in just a moment.

A lot of you know that the Alliance's strongest interest in health policy is in broadening the number of Americans who have health coverage, but we never lose sight, I hope, of the question of coverage for what? Not just what benefits are in the package, but is the care you get the right care at the right time and can you or you and your employer afford it? That's what today's discussion is all about, getting better value for the $2 trillion or so that we spend on health care in this country every year.

Peter Orszag at a program we did a few weeks ago expressed his concern about getting better health care value showing a slide. You'll have to imagine it. I didn't bother to steal it from him. That compares the cost of care at

medical centers, really good ones, ones that were named to the U.S. News and World Report honor roll of academic health centers. And according to that slide the cost for this given block of treatment at a Mayo Clinic Hospital was just under half of the cost of that same care at UCLA Medical Center, which prompts Peter in turn to quote Elliott Fisher at Dartmouth and ask, "How can the best health care in the world cost twice as much as the best health care in the world?" And that question is at the center of trying to get at a high performing health system.

In the context of a presidential campaign each of the major remaining candidates has laid out a reform plan that aims in part at producing a more efficient, more effective delivery of care. It's an aspect of the debate I think that's gotten less attention than their respective plans to cover more Americans or to contain the growth in health care costs specifically. So we're very pleased to have with us not only very able individuals speaking in support of Senators Obama, McCain, and Clinton, but also as I mentioned, Sara Collins from the Commonwealth Fund, who's done some incredible useful analysis of the three plans and the extent to which they promote a high-performance system. Just a couple of notes before I introduce the panel. By Monday morning you can view a webcast of this briefing on KaiserNetwork.org, and we thank

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them for providing that service. You can also in a few days on that same website see a transcript. You can look at the materials that are in your packets on either that website or the Alliance website, which is allhealth.org. You can even download a podcast if you want. And you'll notice by the way there are blue evaluation forms in your packets that you want to fill out at the appropriate time. One of our panelists we managed to identify late enough in the game that you won't find her name on there, but we'll know who she is when you get to filling it out. And of course at the appropriate time you'll find a green card that you can use to write a question to address to one or all of our panelists following the presentation. So please, this is not just a pro forma request, turn your cell phones off or to vibrate so that you won't disturb the people around you. And let's get on with the discussion. Well, thank you very much. [Laughter]

We're going to start by hearing from Sara Collins, whom as I mentioned is with the Commonwealth Fund. She's Assistant Vice President in charge of the program on the future of health insurance at the fund. Sara is an economist. They're good at judging value, you know. She's directed a number of national surveys on health insurance. She's testified before many of you Congressional staffers in your subcommittees in Congress up here. She was an associate editor of the U.S. News. I don't

think you have anything to do with the honor roll of academic health centers. And of course she's graced a number of Alliance panels in the past. And I want to thank you, Sara, for coming and setting up for this discussion with the candidates.

SARA COLLINS: Thank you, Ed. It's a pleasure to be here today with the Alliance and this very distinguished panel of health policy experts. A report that the Commonwealth Fund commissioned on a high-performance health system released last fall, A Roadmap to Health Insurance for All, argues that our health insurance system is a major reason why the U.S. health care system overall performs poorly relative to other countries, and what we know are achievable benchmarks in access, quality and efficiency. According to the Institute of Medicine health insurance coverage is the most important determinant of access to care because so many people are uninsured or underinsured access to care is highly unequal. Poor access to care is linked to poor quality care. People who lack health insurance are much less likely to have a regular source of care to receive preventive services and to be able to manage their chronic health conditions. They have both poor health status and shorter life expectancies. People without coverage also create inefficiencies in the delivery of care, more duplicate tests, difficulty in tracking their health

records. A highly fragmented demand side makes it difficult for us to gain control of health care costs. Financing of care for uninsured and underinsured families is inefficient and characterized by cost shifting. There is a lack of positive incentives and benefit design in insurance markets.

The commission identified five key strategies for moving the health care system to a higher level of performance. They include: extending health insurance coverage to all, aligning incentives to reward high quality and efficient care, organizing the health system to achieve accountable, coordinated care, investing in public reporting evidence-based medicine and the infrastructure that we need to deliver the best care including health information technology and electronic medical records, exploring the creation of a national entity, a public— private organization, a quasi-governmental organization that would set goals for improving health system performance and recommend best practices and policies. Universal coverage is a necessary while clearly not sufficient condition for improving our performance. Moreover, the way in which we design health insurance reform will matter in terms of whether we can cover everyone and whether we can make sustained improvements in quality and efficiency. The commission has recommended several key principles of health insurance reform. It will be critical for example, that

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proposals cover everyone, that they provide benefits that cover essential services with appropriate financial protection, that premiums, deductibles and out-of-pocket costs are affordable relative to family incomes. Health risks would need to be broadly pooled. It should be simple to administer and coverage should be automatic and continuous. Dislocation at the outset should probably be kept to a minimum; people could stay in the coverage they have if they wanted to. Financing would have to be adequate, fair and shared across stakeholders.

The health care reform proposals in the election have fallen into two distinct categories throughout the campaign, and we will hear much more elaboration on the proposals from the candidate's advisors this afternoon. Senator McCain would expand coverage through the individual insurance market with tax credits, changes to the employer benefit tax exemption, and allowing people to buy health insurance across state lines. Senators Clinton and Obama have proposed plans for universal coverage that build on the current system, mix public— private group insurance with a shared responsibility for financing across individuals, government and employers. They include a new group insurance connector like that that has been implemented in Massachusetts with a choice of both private and public group plans with consumer protections and premium

subsidies. It would replace the individual insurance market and expansions in the Medicaid and SCHIP programs.

In our report in which we compare the candidate's health plans, which is available today, we make several key observations about the proposals. And the panelists will probably want to correct me and talk far more about this. Both the Republican and Democratic candidates envision a health insurance system that continues to be structured around private insurance markets with a supporting role played by public insurance programs. But they diverge significantly on how all of this would work. Senators Clinton and Obama appear to view the health insurance system as primarily on broad private and public group risk pools with regulations like community rating and guaranteed issues that prevent insurers from selecting against health risks. In contrast, Senator McCain appears to see a health insurance system that would rely increasingly on the individual insurance market, but would encourage less regulation of those markets than is even the case today by allowing people to buy health insurance across state lines.

There are some broad areas of agreement between the two parties. The candidates mostly agree on expanding coverage, or at least access to it, increasing the use of health information technology, requiring transparency of information on price and quality from providers and insurers, doing something to reform

malpractice, and emphasizing greater use of preventive services and better management of chronic health conditions, paying providers for performance, and pursuing comparative effectiveness research on treatment outcomes.

But the candidates differ markedly between the parties on the goal of universal coverage, requiring people to have coverage, an individual mandate which we've heard so much about so far. But what I think has received far less attention are the candidate's distinctly different views of the employer role in the health insurance system. Senators Clinton and Obama would keep employers in the system by requiring them to provide coverage or contribute to the cost of their employees' coverage. Senator McCain would effectively decrease the incentive for employers to offer coverage by changing the employer benefit tax exemption. This would imply a shift from the relatively greater security of employer group coverage with its broad risk pooling to the less protected individual insurance market where the people are mostly on their own. An employer mandate would also keep a substantial amount of financing from employers that are currently in the system, about $420 billion in 2005.

To get a sense of the public's views on health care reform approaches, the Commonwealth Fund biannual health insurance survey of 2007 asked adults their thoughts on some of

the features of the candidate's proposals. Majorities of adults across political parties agreed that employers should either provide health insurance to their employees or contribute to the cost of that coverage. Majorities of adults across political parties also said they were somewhat or strongly in favor of a requirement that everyone have coverage, so an individual mandate. The support for this was not uniformly strong and it was less among registered Republicans. Majorities of adults across political parties thought that the financing of coverage for everyone should be shared among individuals, employers, and the government. On this critical issue of financing health reform a recent report by the commission, Bending the Curve, and this is available on our website, identified 15 policy options in four major strategic areas that could achieve cost savings in the health care system. They include options to produce and use better information, promotion of health and disease prevention, aligning incentives to improve quality and efficiency, and correcting price signals in health care markets to send positive signals for lower costs and better efficiency.

The Lewin Group estimated what the spending impact would be of these policy options on national health spending and on major stakeholders over a 10-year period. Savings to the health system ranged from $9 billion over 10 years to $368

billion. Most of the options include initial investments such as expanding the use of health information technology and over a four-year period you began to see some returns on that investment. The Lewin Group also modeled some of these savings options with a proposal to expand health insurance. The proposal is a mixed private— public approach similar to that in Massachusetts as well as that of Senators Clinton and Obama. The estimated federal costs in 2008 are just over $82 billion for that kind of proposal. If the new coverage expansion were implemented along with several of the savings options modeled in the report including the increased use of health information technology, new incentives for better health, payment reform, the net federal spending on the proposal would fall to about $31 billion in the first year. Savings from the initiatives increase over time and spending offsets would thus be larger in the out years. This really does demonstrate how pursuing universal coverage along with quality and efficiency reforms has the potential to improve the performance of the health system overall and has the potential to gain some measure of control over spending. So I'm going to turn this back over to Ed.

ED HOWARD, J.D.: Thank you very much, Sara. And let me just say a word in reinforcement of what Sara was just talking about, the Bending the Curve Report, was the subject of

probably the most spirited discussion that we had at the retreat for members of Congress that Commonwealth and the Alliance jointly sponsor every year. And this year in January that session was probably the liveliest conversation that members had. So much so that a couple of the people that were there arranged for a separate briefing, I think it was on the House side this week, where members and some staff people got together and talked further about some of those options. So I want to commend that document and the contents of it to you.

Before I introduce the first of our candidate representatives I should say none of them a staff member of these campaigns so they're here on their own time. But obviously we have consulted with the campaigns to make sure that there aren't any ringers snuck in there from a stray candidate who dropped out a few weeks ago. But we're very grateful that the candidates have recommended such wonderful representatives and grateful to all of those folks for being with us here today. A case in point, we're going to start with Gregg Bloche. Gregg is here on behalf of Senator Obama. He teaches law at Georgetown. He's on the adjunct faculty of the Johns Hopkins Bloomberg School of Public Health. He holds both medical and law degrees. He's one of the country's leading experts on racial and ethnic disparities in health care and

we're very pleased to have you start this discussion off for us today, Gregg?

GREGG BLOCHE, M.D.: Thanks, Ed. Thanks very much and thank you Sara both for your wonderful series of reports which I think are right on. And thanks to Ann Gauthier and everyone at the Alliance and the Commonwealth Fund for this opportunity to speak to you. Is this mike on by the way? Can you all hear me? No. I'm going to— it says it's on. Well, how about now? Is this— okay. I'm just going to kind of bend forward a little bit here. But I just wanted to thank Ed. I wanted to thank Sara for a superb set of reports on these hard issues. And I wanted to thank Ann Gauthier and everyone else at the Alliance and the Commonwealth Fund for this opportunity to speak with you.

I did an event last week on the Hill, in the capital actually in the Mansfield Room. And I discovered in advance of that event that the Mansfield Room is most famous as the place where Senators go to sleep during filibusters. And this was a daunting thing for a speaker to discover about a room and I hope I don't accomplish that mission of putting you to sleep today. It's a privilege to be here on behalf of Senator Barack Obama. As Ed mentioned, by way of clarification, I am not a campaign staff member and I am speaking in my own voice. I'm an enthusiastic supporter of Barack Obama and his candidacy.

I'm a legal academic but I've also cared for patients. And dare I admit that as an intern I'd gotten my share of 3:00 a.m. phone calls and I didn't like getting them, kudos to Sara and to Ann and to everyone else involved in producing Commonwealth's superb series of reports on how to get to a high-performance health system. There's so much in there to talk about. I'm not going to say a whole lot. I'm going to go where your questions take us in this conversation, but Commonwealth's recommendations are both visionary and pragmatic. I've used some of the Commonwealth materials in my own teaching and I agree in principle with just about every recommendation put forward in Bending the Curve, which I reviewed closely this week. And I really feel I can say that about anything I read. The academic in me says maybe they should have pushed the candidates a bit more on the challenge of making long-term cost benefit trade-offs, which will be inevitable, but I thought that the work was really, really impressive.

Now on to politics which is I guess part of why we're here. Well, things sometimes get a bit overheated in politics and they're a bit too overheated right now. So it's worth keeping in mind that each of the candidates represented at this briefing is a man or a woman of extraordinary and pioneering accomplishment and courage. But there are big differences

between the two Democrats in this race and Senator McCain. There's a common moral vision that animates the two Democratic candidate's proposals for health reform. And it's a moral vision that's the bedrock of the Commonwealth Fund's recent health reform reports. It's different than the vision that has driven past Democratic health reform plans, including the ill-fated Clinton proposal of 15 years ago.

It starts with the premise that Americans accept, indeed embrace, the principle that they should depend on themselves and that health is a matter of personal responsibility. But it provides a safety net when self-reliance falters because of larger economic and social forces or because of great personal misfortune. And this Senator McCain doesn't do. Hillary Clinton and Barack Obama are unified on this point and on the goal of making health care available and affordable to all. The Democratic moral vision calls for shielding the poor from the degrading and life-endangering consequences of going without basic health care because they can't afford to pay for it. And it calls for carefully tailored public efforts to provide public goods like research on the comparative effectiveness in treatment when market incentives fall short. The goal of these public efforts is to make markets work better, to empower patients and other stakeholders to make value-based choices about health care.

And to this end the Obama and Clinton plans have several common features. First an unprecedented call for all of us to take responsibility for our own health not just on medical care, but by making lifestyle changes to prevent or delay the onset of chronic and life-threatening illnesses. Senator Obama had to do this in order for his wife to let him go into this campaign. He committed himself to quit smoking. And there's also an understanding of health insurance as a shared duty, an individual obligation and a social responsibility.

Both plans give government a role in making coverage affordable to everyone in different ways. Both call upon individuals to acquire it once it's affordable. Senator Clinton proposes an individual mandate at the outset. Senator Obama is open to a mandate. Something that I think has been missed in some of the more polarized discussion of the mandates issue. Senator Obama is open to a mandate but would first explore enhanced enrollment strategies including opt-out at the workplace. Both plans expand Medicaid and SCHIP for the poor and near poor, both create insurance exchanges a.k.a. the connector model, to pool risk and to otherwise solve the problems of the individual and small group insurance markets. And both plans provide public subsidies to empower lower and middle income Americans to buy insurance either through the workplace or through an insurance exchange. Both build on our

current system of private, workplace-based insurance. They are not quote government-run health care as some Republican rhetoric would suggest. And both tackle the challenge of achieving cost control and value in health care by encouraging scientific and institutional innovation, investing in a large, broad program of comparative clinical effectiveness research and providing support for rapid introduction of electronic medical records. And both thereby take aim at the huge long-term challenge that's out there; the Dartmouth 30 percent, the nearly one third of American health care spending that we know is pure waste. The only thing is we don't have the outcomes data to know which of that one third of spending is pure waste, hence the challenge that Dr. Skinner has posed to all of us.

So what's different about these candidates' approaches to health reform? Is there anything to choose between them with respect to pursuit of a high-performance health system? Well, their visions of leadership are profoundly different. Senator Clinton has spoken essentially of a COO model, of a Chief Operating Officer model involving close top-down control over government's moving parts. And Senator Obama has spoken of a model that emphasizes motivating the most able women and men in medicine and health policy and the competing stakeholders. And yes, we acknowledge they're competing, this is not about kumbaya, and the competing stakeholders to work

together. He's done this in health care beginning in his days as a state legislator, really beginning in his days as a community organizer before that. And he's assembled, dare I say this at the risk of seeming to praise myself since I'm in the group here, he's assembled an extraordinarily capable, I think wise and yes, experienced. Experienced in the ways of delivering health care and managing health care, not just the ways of Washington, yes, experienced health policy team to advise him and to get it done. Inspiring leadership has a central role in motivating Americans to come together to make sacrifices and to push stakeholders to collaborate on behalf of the common good.

These lessons are especially pertinent to the pursuit of quality and value in health care. The pursuit of quality and value isn't a top-down endeavor. It'll require cultural change and bottom-up commitment. It'll require collaboration among stakeholders. Indeed, that's already begun to happen on electronic medical record standards, benchmarks for clinical quality and many other issues. Presidential leadership that divides us, that proceeds by identifying and exploiting wedge issues, that sharpens conflict among the stakeholders undermines this kind of collaboration. That's what experience teaches us and frankly, the food fight over mandates illustrates this. The Clintons have chosen to use mandates as

a wedge issue even though the two Democratic candidates approaches, as I mentioned, the two candidate's approaches to enrollment are only trivially different. But the larger point going forward is that both Senator Obama and Senator Clinton are deeply committed to making health care available to all. That's unfortunately not the case for Senator McCain.

Senator McCain does deserve credit for offering more than any other Republican candidate did during his primary season on the affordability front, but it's still relatively paltry. He offers tax credits that aren't nearly enough to enable families of modest means to buy adequate insurance. And worse yet, he's proposing to end the tax deductibility of premiums to employment-based insurance while doing little about our dysfunctional market for individually purchased insurance. And he's proposing to put an end to most state insurance regulation without putting adequate federal consumer protection in its place. These radical steps could mean disaster for millions of Americans who now get coverage through the workplace, but who could, under Senator McCain's plan, lose this coverage. Government isn't and shouldn't be a guarantor of easy living irrespective of striving, but it ought to be an insurer of basic decency when self-reliance fails. And it ought to step up to the plate when market incentives are

insufficient to empower us to gain mastery over our common perils. Thank you.

ED HOWARD, J.D.: Thanks, Gregg. Representing Senator Clinton is Katherine Hayes, whom a lot of you know from her days on the Hill when she worked for both Republican and Democratic senators. Katherine's also practiced law at one of D.C.'s most prestigious firms and is now the vice president for health policy at Jennings Policy Strategies here in town. And Katherine, thank you very much for being with us.

KATHERINE HAYES: Thank you very much. First of all I'd like to echo Gregg's comments about the Commonwealth Fund and the Alliance for Health Care Reform. They have made such a tremendous contribution to the health policy debate and we really appreciate all of your efforts in this debate. So thank you very much. And thank you very much on behalf of Senator Clinton and thank you for allowing us to participate and to bring our thoughts forward here and thank you all for attending. I know a lot of you were up really late last night in the Senate with those budget votes, so probably a little sleep-deprived. And some of you who have come over from the House, having worked in the House and knowing that all meetings take place in the Senate and having to walk all the way across the Capitol every single time for a bi-cameral meeting, I feel your pain. Thank you all very much for attending.

First of all I'd like to say that I was really struck, and in reading Sara's report and in looking at the side-by-side, at the similarities among the candidate's plan, particularly in the areas of quality, health information technology, promoting value, and containing costs. I think regardless of the outcome of this race that we are destined to see some really good things in our health care system in the coming years. And I think there's a commitment and a consensus on a bipartisan basis to move forward with these things, and so I really— I find that to be very positive. I know for a lot of you the issues of quality and HIT is, I know as a health policy staffer on the Hill, you'd have folks come in and talk to you about that and my eyes would glaze over. It's just not very sexy. It's not very exciting. And it's just so encouraging that all of the candidates are talking about it.

There are also a number of differences, in part as Gregg has pointed out but what I want to say before we talk a little bit about the difference is that at the end of the day, although Gregg and I may have our differences and Senators Clinton and Obama may have their differences, at the end of the day Democrats will stand united. Whoever the nominee is we will be together and we will work very hard and then we can turn our focus on attacking Senator McCain's plan. [Laughter] So just a few quick things about Senator Clinton's plan, first

of all, as Sara mentioned that she's very much committed. She introduced her health care reform proposal in three phases. Only one of them is included in your packet today, that's the coverage phase, but she did one speech and released a proposal on controlling costs in our health care system and improving value, another on improving quality in our health care system. And I would suggest if you're interested in that that you take a look at them. They're on her website, HillaryClinton.com. And those are sort of the green eyeshades issues when it comes to accounting and quality, but the one that seems to get the most attention is generally the coverage issue.

With respect to containing costs and improving quality Senator Clinton's proposal, like many of the others, promotes the adoption of health information technology and e-prescribing. She provides funding for comparative effectiveness research and for the development and adoption of outcomes measures, and supports reforming our health care system reimbursement and federal programs such as FEHBP and Medicare to promote quality and to promote excellence, provider excellence. She is very much supportive of focusing on primary care and prevention and improving patient outcomes, promoting models of care that work, chronic care management, and successful models such as medical homes. And she's also very much supportive of promoting patient-centered care to make

patient friendly information available on treatment options, on provider outcomes, and on costs. In addition she very much supports getting patients more involved, getting them educated and more involved in their health care decision making process.

But I want it to be very clear. When people talk about patient-centered care sometimes that is a euphemism for cost shifting to patients, and Senator Clinton will be watching proposals as they come forward and evaluating them as well to make sure we're not, in our efforts to improve patient outcomes and put patients in control of their health care, to shift the burden of financing them solely to individuals. Senator Clinton has proposed initiatives across the board to address racial and cultural disparities. And I know Gregg, being an expert in that area, in the areas of research, education, quality in workforce, and also addressing workforce shortages to promote the use of primary care, to improve reimbursement for primary care physicians, to get more nurses in the field, and to get more teaching professionals into the nursing schools, and to improve the availability and quality of direct care workers for those who are receiving home care services.

In shifting from sort of the quality value piece over to affordability and providing affordable coverage for everyone, Senator Clinton believes that everyone should have a choice of health care plans. And first of all, I think she

learned very importantly from the last debate, the first thing that we've been told should come out of our mouths when we're talking about Senator Clinton's health reform plan in terms of coverage is if you like what you have you can keep it. So second, she also promotes purchasing through federal or regional purchasing pools like FEHBP and supports insurance market reform.

I'd like to highlight just for a second the tax credit, which is a little different from the tax credits proposed by Senators McCain and Obama. Hers is a premium affordability tax credit which limits premium costs to a percentage of family income as opposed to having a flat tax credit based on family income. And then finally Senator Clinton's proposal has a small business tax credit which helps small employers afford coverage for their workers.

And in putting this all together, one of the key principles was shared responsibility. She believes that providers should take responsibility and provide appropriate quality health care. That government should make sure that health care is affordable and should work to make sure that the insurance market reforms are in place and that pooling is available, that health care quality is improved, and that there are subsidies available for those who need assistance. I'd like to make a distinction. Large employers are required to

provide health insurance coverage for their employees, but one thing that wasn't reflected in the discussion earlier today is that there is no mandate to provide coverage on small businesses. There are incentives for small businesses to provide health care coverage through tax credits, but there is no requirement on small businesses. She recognizes that such a large percentage of our jobs in this country in recent years have been dependent on small businesses who are often just frankly unable in the current system to provide health insurance coverage for their employees. But she does provide assistance there.

And finally she does include, as has come up the issue, she does include an individual mandate. And the individual requirement to provide coverage, the reason it's there is as all health policy people, I think it's indisputable, that it's impossible to eliminate medical underwriting in the insurance industry and still allow people to wait until they're sick to buy coverage. It's not that Senator Clinton just loves to require people to do things. It was a very tough decision. It's not easy to come out with a proposal that says that you would require, once health care is affordable or as health care becomes more affordable, to require people to buy coverage. And we can disagree over how many people will be left uninsured whether it's 15 million or less or more, but she really does

believe that as part of a core value as a Democrat, that it's important from the start to make sure that coverage is universal. And it's indisputable that coverage cannot be universal without an individual mandate. And that can be seen, there's historical bipartisan support for this, from Senators Chafee and Dole proposed this back in the 1990's. It was in the original Clinton health reform plan which was supported by Senators Mitchell and Kennedy and in the House by Congressmen Dingell and Rostenkowski. Senator Daschle has supported an individual mandate. Today legislation is pending in the Senate that has been co-sponsored by Senators Wyden and Bennett that includes an individual mandate. They too recognize this. We've seen it in the governors. And too Senator Obama has also supported it, an individual mandate for parents to cover their children. There's just a recognition that's there.

And before I close this is the second time that I've been on a panel with Gregg in which he has gone after Senator Clinton and called her a command and control executive. And I have to tell you that during the 1990's I worked for a Republican Senator, John Chaffee and he worked very closely with Senator Clinton. And she came to Congress. She met with Republican senators. She met with Democratic senators. She listened. She got their input. She got their opinion. She talked. She brought staff up to the Hill, although some joke

now about some of the meetings that went on in the White House to get input from everyone. And quite frankly the leadership were in the room when the bill was drafted. Senator Clinton did not propose a bill to Congress and say, "I'm going to put this bill forward," but she was asked by the Democratic leadership for those of us who were around then, she was asked to submit a bill to Congress so it could be scored. And the leadership in the House and the Senate very much played a part in that drafting of that legislation. So I think it's blatantly unfair to call her a command and control executive. One just needs to look at her record to understand how she's worked in the Senate on a bipartisan basis. Thank you very much.

ED HOWARD, J.D.: I think you've got one minute.

GREGG BLOCHE, M.D.: I did not use that term. I'm drawing upon what Senator Clinton herself said at the one debate where she talked about the COO model and managing the economy. And it was very much a top-down vision. I do think actually that Senator Clinton's been unfairly criticized for some aspects of her role in health reform. Ira Magaziner, not Senator Clinton, in fact oversaw that process and developed a plan in detail. Senator Clinton was really in many ways more of an external voice for that process. And Ira Magaziner's process was famously a top-down process with the famous 500-

person task force and the exclusion of lots of other people and public interest groups are still trying to get the records of that task force which have not been released. If we're going to assess Senator Clinton's leadership style let's look at those records and then we can make an assessment of Senator Clinton's experience.

ED HOWARD, J.D.: Okay. We can revisit some of this in the discussion period if it's necessary, but I figure it's time to let the other side try to destroy this consensus that we could attack Senator John McCain's plan with some impunity. I'm very pleased to have speaking on behalf of Senator McCain, Raissa Downs, who's now with the policy and lobbying firm of Tarplin, Downs and Young. She too has experience both here on the Hill where she worked for Senator Enzi of the health committee and in the executive branch as principal deputy assistant secretary for legislation at HHS. And despite our assertion to the contrary in her biographical sketch, Mike Enzi is not the chairman of the Senate health committee anymore. Maybe in the future, you never know. But Senator Kennedy's staff asked to clarify that just in case. And similarly on the blue evaluation we drafted Raissa so late in this game that we weren't able to fill her name in. So when you want to check that excellent box write her name in if you would. And needless to say we're very grateful for you to for having shown

up on such short notice but with such obvious credentials that we know you'll do a great job.

RAISSA DOWNS: Thank you very much, Ed, and I really appreciate having been invited. And again apologize in advance for it being a relatively last minute exercise. So if there are questions that I'm asked I'm very happy to take things back to the campaign that I don't feel comfortable answering, but just want you to know that this is about getting you information to the extent that we can in presenting the views of each of the campaigns, competing views in a lot of respects, but also shared views in many as well. And I'm just fortunate to be here. I'm flattered to be on a panel with impressive co-speakers and obviously Sara's work and the work of others who have really contributed and helped drive the debate about health care. And help provide detailed, reliable policy analysis about the state of the system right now and some of the implications for proposals that have been put on the table. It's invaluable. We all need to work off of data that we can rely on and so Sara's been a bit part of that process going forward.

It's, as Katherine said as well, we're both former Hill staffers and oddly enough this is my first surrogate experience for the McCain campaign, so in many respects I'd probably be more comfortable sitting in one of the chairs you're sitting in

right now than sitting up here. But again, I'm very happy to be here.

It is a debate that we all know, if you've been in town for five minutes or, quite frankly, 15 or 20 years, the debate about health care reform has been on the table and in a lot of people's minds throughout that period of time. And I think certainly it's a very ripe debate that's occurring right now and we'll see it play out with a lot more concrete detail next year once there is a new President elected. I agree with Katherine that whoever is elected it just seems inevitable that something is going to happen. The scope of that something and the extent of that something obviously remains to be seen. But I think that is an important thing to note, that this is a very good, healthy, lively debate as it relates to the need to make some changes in our health care system.

So what I'll really do is just provide a really brief explanation as to the motivation as I would call it behind Senator McCain's health care proposal. In your packets I believe you have a couple of speeches and I think a two-pager that really does outline the kind of paper that's available based on the campaign documents right now. So it's not a lot of new information I'll provide, but hopefully I'll talk to it in a way that makes it a little bit more understandable. As a candidate he's outlined a vision that I think provides a solid

roadmap to get us to improved affordability and quality, expanded access, and also to provide I think what has eroded and that is a meaningful role for the individual patients and families in the health care system. He's motivated by all three of these goals very passionately and I think he fundamentally believes that at the end of the day the winner is the patient, but that's also because the system improves based on some of the reforms that he would put into place. He believes that the health care system can be transformed to meet all of these goals that I've outlined. And he doesn't have to do so, however, at a price that is inordinately high to the taxpayer and nor does it have to be done at the expense of those currently insured Americans who want to maintain their existing access to coverage. It is true that he would propose changes that would essentially level the playing field in his mind for those individuals and families right now who seek coverage through the individual or small group market versus the larger employer market. But I think the goal of his proposal is not inherently to undermine employer-sponsored access to health care that exists right now.

He is really talking about creating something, I think, distinctively from the Democrat proposals that does not create a new government process. I mean, this is not a news flash to anybody, there are some philosophical differences between

Republicans and Democrats about how to move forward at least between these candidates about how to move forward with respect to health care reform. And is there a broader role, a more centralized role and not necessarily harkening back to the proposals of 10 or 12 years ago, but is there a broader role for government or is there a way to shore up and make more robust the existing private sector delivery system. And I think Senator McCain's position is that plan versus the former plan is the way to go. That has to do with a variety of things, his fundamental belief in the ability of the private sector and the competitive marketplace to deliver on higher quality, improved efficiency and maximize choice for individuals and consumers. But it also has to do with the fundamental issue of cost. I think that is probably something that he would argue is one of the major distinguishing factors between Republican and Democratic proposals on health care reform.

I think that as it relates to cost he has also argued very vehemently that the promise of fixing the health care system made by anybody, Republican or Democrat, is not a real promise, again, without really fundamentally addressing some of those cost issues that affect both the private sector and the public programs. He obviously, anyone who knows his record, understands that he is not a stranger to fiscal discipline. He

has demanded in a variety of different settings true value for the taxpayer dollar. So it's not a surprise to anybody that I think that's part of his guiding principle going forward with health care reform. So he does, again just to reinforce the point, fundamentally believe that costs can be lowered, quality and value can be improved, and new avenues for access to coverage can be created, but all in the context of a robust and competitive marketplace.

Specifically he has proposed the following reforms as it relates to affordability and value in the health care system, and again, there is a lot of overlap here. I think Sara pointed that out in her presentation. Katherine and Gregg had both mentioned some of the same things. There are some obvious things that can be done. I think the devil can be in the details, but there's some obvious things that I think anybody would do next year as it relates to improving affordability and improving value in the system, again both on the public and the private side. Pay per performance and quality of services is something that Congress has been talking about for several years now. Medicare has taken some baby steps towards heading in that direction, but I think something needs to be done aggressively in order to really see the value for those kinds of incentive changes to the system. A component of this which could include incentives for prevention

and early and accurate diagnosis again, are tools that are being experimented with in certain places right now but really are not broadly employed across the system to demonstrate a marked improvement in value and a marked improvement therefore in affordability.

The increased availability of reliable evidence-based information, I believe I'm correct in saying that the McCain campaign has not officially put out anything on comparative effectiveness, and I think believes pretty strongly that that should be a private sector-driven exercise. That being said, evidence-based medical information is the goal of some of these proposals and I think the congressional conversation that's taking place right now is largely a private sector-driven exercise on coming up with what is the best, most reliable evidence so that patients and physicians and payers can make really informed decisions about the right therapeutic treatment for a specific patient.

He would also increase the focus on federally-funded research both on cures, which is obviously a huge focus and a huge federal investment at the NIH right now, but most importantly, or I guess a new equally important focus, would be really on care for chronic illnesses. Chronic illness is a huge cost to the system. Obviously some of those diseases are not preventable and they need to be managed and patients need

to be appropriately treated with appropriate access to care. But there are also a number of conditions that cost in particular the Medicare program, an enormous amount of money, and a component of that should be figuring out prevention strategies for diseases that in fact are preventable.

He also supports the creation and expansion of patient-centered delivery models. I think this is something that Katherine referenced briefly, the use of clinics, the use of non-traditional venues to really open up access to the health care system to again make it a little bit more patient-centered as it relates to convenience, accessibility and affordability versus being such a structured systemic model that in particular in rural communities but also urban communities where it is simply hard to access care, that has presented a barrier.

The other thing which I think we all talk about, and I think health IT was mentioned, is obviously updating and bringing into this century the health information systems. There are examples of really efficient, error-reducing, quality-enhancing, patient satisfaction-enhancing, systems across the country, but it's still relatively siloed. There is not the broad based adoption or use of health information technology that clearly can relate to and directly result in

system cost reductions, but also huge improvements in quality. So that's something that he would aggressively pursue.

And then two other things just very quickly on this point, he would also work with states. Again, the states are to a certain extent a laboratory. I think what we've seen happen in Massachusetts is still, remains to be seen how that – whether it's going to be a successful model or not, but I think California is a little bit of a test case run for folks here in that that plan is not at this point able to move forward due to cost concerns fundamentally. So I think what he is thinking is an alternative view to continue to work with the states again where there is the opportunity for experimentation and exploration as to make improvements to the Medicaid program, potentially collaborating beyond payment and delivery model improvements, focused on quality and outcomes that really improve at the end of the day the program for Medicaid beneficiaries but also for the taxpayers who are sharing that burden at the federal and state level.

Quickly, this is all very publicly out there and we've discussed it a little bit here already today, in terms of reforming and expanding access to coverage itself, again Senator McCain does not view a heightened hand of federal government as the avenue to go there. I think he really believes strongly that to a certain degree, leveling the

playing field for those in individual small group market and allowing them to purchase across state lines, to purchase through pooling opportunities that don't currently exist, particularly for those small group employers, and to do so with actual financial support through the tax credit, whether it be the $2,500 for individuals or $5,000 for families, is a way to spur meaningful access for those who arguably are the most underinsured and uninsured right now in the country.

And the last thing that I would say is he, from a Republican perspective, talks a lot about personal responsibility. That is a phrase and I think a concept that everyone here believes in, that all of the candidates certainly would want to see as a fundamental component of any health insurance reform. It is really not lip service and it's not at the expense of patients and individuals who ultimately need additional assistance. I think he is not insensitive to that reality, but the fact of the matter is there is a role for the individual and the family in health insurance reform that doesn't really seem to exist in the system today. We talked about diabetes. I believe CDC, I got this in some of the materials actually that you have and it just struck me, there's a statistic that one in three five-year-old children will become diabetic as a result of either being overweight or having obesity. That's a staggering statistic and it's a

preventable statistic. The cost of the system today is $132 billion a year. And that's just one disease that doesn't count, tobacco that doesn't count, heart disease. In fact I remember working for Tommy Thompson and, I mean this was and I'm sure we heard it 800 times at this point, but God love him, he was passionate about prevention and dealing with these diseases that did involve personal responsibility but involved the public health system and a payer system that really focused on prevention and getting ahead of what are huge quality and cost issues. And so I think McCain feels very strongly about that and we would expect to see that kind of initiative expanded under his health reform proposal.

And with that I again apologize for not being particularly experienced at doing this or at surrogating for his campaign, but I'm very happy to take question.

ED HOWARD, J.D.: Terrific. Thanks, Raissa, and actually you did very well. Thank you very much. You mentioned, and a couple of the other speakers have mentioned, both chronic disease and comparative effectiveness and if I can insert a small commercial here. Our next two briefings at the Alliance involve those two very subjects. On March 28th we'll be doing a briefing that focuses on chronic care and what to do about it and on April 4th a briefing on the subject of

comparative effectiveness. So mark them down and we'll carry this discussion the next step in each of those topics.

Now it's time for you to come forward if you have questions. You have a microphone here; microphones at each of the back corners of the room. I would ask you to identify yourself and keep your questions as short as you possibly can to allow our panelists to respond. And let's start right off. Bob?

BOB GRIS: Bob Gris [misspelled?] with the Institute of Social Medicine and Community Health. My question has to do with the importance of fragmentation in the health care delivery system, as a constraint on getting real health care reform and the kinds of savings that the Commonwealth Foundation has identified. I don't see in the strategies of any of the candidates a way of confronting the fragmentation in the health care delivery system, fragmentation in regulations and fragmentation in funding. And since all of the candidates here ignore that issue I'm concerned that we are really not addressing the most important levers for public accountability. We all have nice ways of talking about cost effectiveness and improvements in quality, but if fragmentation is a constraint, how are the candidates going to address that?

ED HOWARD, J.D.: Katherine, do you want to start off, and then Gregg?

KATHERINE HAYES: Sure. If Senator Clinton did not propose, and I don't know if you're supportive of a single payer system, if that's sort of what you're getting at here, Senator Clinton did not provide or propose a single payer system and I think one of the reasons was a recognition that although a federal program like Medicare in many respects does a very good job in some ways, there are shortcomings in others, and I think it was really looking more at the issue of how people receive health care today. And how it's delivered and trying to deliver it in a way, or try to reform our health care system in a way that is the least disruptive.

And in terms of getting to the fragmentation I think one of the most important things is the fragmentation in care, of care delivered to patients. The number of doctors that they see, the prescriptions that they receive that other physicians don't know about, and one of the ways that she's tried to get at that is to really look at effective models of care such as, my mind has just gone blank on me, but coordinated care management and medical homes. I think particularly for some populations medical homes has proven effective. In fact, I believe the Commonwealth Fund did a report on that not too long ago and that there was a briefing on it and showing some of the success. So I think she's trying to really within the construct of our current system and coming up with something

that is least disruptive as possible to try to address the fragmentation in the system by looking at new models of care within the private sector.

GREGG BLOCHE, M.D.: This fragmentation issue is crucial. And we all know it from our experience. I daresay there's probably no one in this room who hasn't themselves or had a loved one with a serious scary and chronic illness who hasn't seen multiple doctors who don't talk to each other and we become the ones kind of desperately trying to get them to talk to each other. I've certainly had that experience myself with family members and friends. And that's one of the kind of 3:00 a.m. calls I get right now. This was central in the development of Senator Obama's health plan and absent the kinds of systems like the Mayo Clinic and systems like it, absent those kinds of systems throughout most of our health care delivery system we have to do this virtually. The idea of virtual networks has been put forth and that's one of the initiatives that we ought to go forward with. Episode-based payment is another. We need dramatic delivery system reform, but we need to get there in a kind of emergent fashion through incentives that push the market in that direction. Electronic medical records are an important component of this. Senator Obama actually puts 10 billion a year into this, more than the other candidates. And then the medical home concept can help.

It's going to be really, really hard because of the way our system is structured and because it is so enormous and so spread out. But if we get the incentives right centrally and if Medicare leads with these kind of incentives with episode-based payment and with incentives for virtual networks, et cetera, then we can get there. One of the lessons I think from the DRG experience, even thought there's lots of words there, one of the lessons there is that Medicare can lead and private payers and the delivery system respond to the incentives that Medicare creates.

ED HOWARD, J.D.: Weigh in?

RAISSA DOWNS: Yes, I mean not to beat the dead horse, I think there's probably a wide degree of agreement as it relates to the provision of care and reducing the degree of fragmentation as it relates to the provision of care, care coordination, the technology components, but also as you say, the incentives to push for payment for that kind of reduction in fragmentation improvement in overall outcomes. I think you—like the carrot and the stick are probably very critical.

ED HOWARD, J.D.: Go ahead.

SARA COLLINS: Yes, just one quick thing, just an observation across these plans, and you see these candidates struggling with ways to find out how to implement, for example, pay-for-performance. And you see in the McCain plan, for

example, the use of Medicare and Medicaid taking the lead. And then when you look at the Democratic plans they have the additional leverage point of the connectors, so requiring participating in plans to have coordination of care models, paying those plans on the basis of pay-per-performance. So you see their use of leverage points. The Medicare program, Federal Employees Health Benefits Program and its new insurance connectors as well.

ED HOWARD, J.D.: Yes.

MALE SPEAKER: Ed reporter, Men's Health Network. I came up with the question I was going to ask on behalf of the Men's Health Network but I just started thinking about my dad. And his private coverage covers his prostate screening every year and I think it's the only reason he ever gets his prostate screened because it's covered and it's, you know, cheap. So I'm looking at more government involvement in the health care system and the United States preventative task force does not recommend, or it just doesn't recommend for or against routine screening. So if this becomes not just a regular condition but policy and we're looking to work with the public and private fields will the private fields say, "Oh, let's get government recommendation that we don't have to include this in our plans?" And at that point my father will not, probably will not get screened for prostate cancer unless his wife pulls him

to the doctor like she normally does. So is there, any you guys accounting in any of these plans for some of these different little things that may occur when they're implemented?

RAISSA DOWNS: Well, essentially your question is does the government serve as the 800 pound gorilla in one respect in making determinations regardless maybe of the range or the scope of control that the government would have over any type of health care reform plan. If there are private plans doing things right now are they simply all going to move with the wave to whatever is set down by government? I think that would be a fear factor that the McCain campaign would have because it depends and I think we've had some positive experiences but also some other experiences less positive about government and government-driven policies being able to entirely keep pace with some of the innovations and the best standards of care. I think everybody, including the McCain proposal, would push not just through whether it's comparative effectiveness or evidence-based medicine models, but also the development and the dissemination of standards of care and best practices for physicians and providers to comply with. So I think, again from our perspective, we would believe that you could maintain those kinds of services and maintain the latest and greatest and the cutting edge innovation whether it's in screening

recommendations or actual treatment protocols by taking advantage of the more nimble private market.

ED HOWARD, J.D.: Gregg?

GREGG BLOCHE, M.D.: Yes. On this really important question that gets, as I think Raissa suggested, at a really broader issue. Congress isn't very good at practicing medicine. Dare I suggest that the good Dr. Frist proved that in the case of Terry Schiavo when he went to the video tape. But what Congress can do here and what has been proposed in different forms, and here's where I think we need to go, is set up a structure that is politically insular. Senator Daschle has proposed a national health board model on the Federal Reserve, there have been a variety of other proposals emanating elsewhere up on the Hill. You want to have leading figures in biomedical research looking at the best evidence and both channeling investment in comparative effectiveness research to learn what preventative and screening measures work, and making recommendations as to what ought to be covered. And some of these recommendations should become minimum requirements for listing on a health insurance exchange. Some of them will be discretionary. The key though is to have a process which is not going to be so vulnerable to interest group feeding frenzies that what you end up having on the list ends up being frankly like some of the state mandates for health insurance,

more the consequence of interest group feeding frenzies than smart clinical judgment. So some mechanism whereby we have leading figures in medical research making these kinds of judgments. And I think the example that you brought up is a nice example of where that should play out.

ED HOWARD, J.D.: Yes. Go ahead Katherine.

KATHERINE HAYES: Yes, and I think Senator Clinton would probably fall somewhere between leaving it to the plans to decide what to cover and having a national board decide what's covered, or a national entity decide what's covered. What her proposal does is provide federal funding for an agency like Actford [misspelled?] to contract with private sector organizations such as the Mayo Clinic to do comparative effectiveness research to find out what works and what doesn't and then reform the health care reimbursement system to reward health care providers who follow those outcomes and use the best practices and use those outcomes.

ED HOWARD, J.D.: Several of you have talked about affordability. This question leads to another question. One on a card talks about Medicare and Medicaid growing at unsustainable rates with respect to cost and asking when and how aggressively would your respective candidates do something about those costs? More generally I wonder if we could get you to talk a little more about costs based on something that is in

the packets, analyses if you will, a series of observations. I'm sure he wouldn't claim they were a real analysis of these plans, by Bob Leschewski [misspelled?], who used to run Liberty Mutual's health insurance plans and at the time was on the board of the Alliance for Health Reform in full disclosure. But here's how he described some of the cost containment plans in the various reforms. It happens to be in the post on Barack Obama, but it gets to everybody. "To really get at costs," Bob says, "you have to gore some very powerful political oxen among all the key stakeholders." McCain won't do it because he simply doesn't believe a direct assault on market players is the right thing to do. Put market incentives in place and it will encourage and reward efficient behavior. Obama and Clinton don't do it, not because they don't like government intervention, but because they don't want to offend key stakeholders who could derail any meaningful health care reform effort. So how do you get at costs? And I might add, in referring back to the Commonwealth Bending the Curve report which a lot of components of which are included in some of your plans, the Director of the Congressional Budget Office said most of these things fall outside the 10-year window that we're allowed by Congress to score. And so what do you do between now and 2018? Go ahead, Katherine.

KATHERINE HAYES: I'm glad to start. And this sort of dates back to my time on the Hill back in the 1990's. I remember sitting in a room in the basement of the Capitol, staffing John Chaffee on Ober 90 [misspelled?] and the two of them, John Chaffee and Pete Stark were going back and forth on some arcane reimbursement issue. And in the middle of this discussion Senator Chaffee turned to me and he said, "Don't you find it absolutely absurd that two members of Congress who know nothing about health care delivery and this particular provider, are sitting here arguing about how much is going to be paid for a certain procedure? Isn't that just crazy?" And I have to say I agree with him on that.

We have had so many— you look at the current Medicare program and you as staff, many of you and former staff, understand how arbitrary all of this is. You look at the growth in the system and the budget committee tells you how much money you have to cut out of the Medicare or Medicaid program or how much you have to spend in Medicare in Medicaid so you play, as my husband likes to say, you play Battleship with CBO. If I do this how much savings will I get? If I do that how much savings will I get? And it's just a crazy system all the way around and I think one of the ways that Senator Clinton is trying to get away from all of this is, again,

looking at those treatments and those outcomes that work and those that don't.

Beth McGlynnis [misspelled?] has done some great work that shows not only are patients not getting care that they deserve, but there are a lot of patients that are getting care that is just flatly not effective and not useful. And by looking at outcomes and looking at using comparative effectiveness to find out what treatments work and what treatments don't work, I think we're really going to be able to stop paying for some of the care that is inappropriate and thus find savings in our health care system and start paying for some of the things, primarily prevention services, that we don't pay for now.

And so to say that, I don't think it's fair to say we're not goring any oxen here. We're not going to say across the board Senator Clinton doesn't propose for example, cutting hospital services across the board, but that's sort of using an axe for something that you should use a scalpel for. And by looking at what treatments work, what treatments don't work, reimbursing providers based on those treatments, then I think we can really achieve savings in our health care system.

GREGG BLOCHE, M.D.: Well, I'm in agreement with Katherine on this. I mean, one of the observations I'd make about the Commonwealth Fund report, Bending the Curve, is that

it really does a beautiful of marshaling everything that we can do in that period of time without engaging in the kind of cost benefit trade offs that for instance my colleague at Brookings, Henry Aaron, has said will inevitably be necessary. And at the end of what's the outcome, do you take it 10 years? I forget the period.

At the end of that the curve has been, I think about three eighths of the way from Peter's now famous projections on behalf of CBO down to where we'd be at if health care stayed steady as a percentage of GDP. In other words we keep rising as a percentage of GDP. Over the longer haul, the much longer haul, the country will have to make some really hard trade offs between the benefits of health care and the benefits of other kinds of private and public spending. But right now there's that Dartmouth 30 percent that stands there beckoning. Thirty percent of our spending that is available to be trimmed without foregoing benefits.

So, let's go after the Dartmouth 30 percent first, along with the administrative waste and the other low performance dimensions of our system and let's also build up the foundation of comparative effectiveness research so that if and when we need to face those kind of harder trade offs decades out beyond the 10-year window, we'll be much better prepared than we are today to do so.

RAISSA DOWNS: Yes, I mean I think there's, again, on issues like this, a relative degree of agreement. I mean I hate to use buzz words but there's this value-driven proposition that people in the health care sector are using on both sides of the aisle, but I think this is exactly that issue in terms of goring oxen. The idea the right point or the right path forward is to hit this issue in such a way that it doesn't, as Gregg said, invite sort of the political feasting on the process. So it really has to be done in a way, information has to be developed, information has to be used in such a way that it doesn't create such a fear factor among the whole variety of stakeholders, that it doesn't get off the ground before it's started.

SARA COLLINS: Just having looked at the proposals from four years ago compared to the proposals this year, there is a substantial piece on quality and efficiency improvement in all of these proposals. And I just, the chart in your chart pack from my presentation, if you go to chart 11, I don't think we have it on the screen anymore, you can see some of the proposals that are currently in this group of candidate's proposals. Paying hospitals for better performance in the Medicare program, that's certainly a shared idea across all these proposals, a savings of $34 billion over 10 years. Paying for episodes of care and that's also in all of these

plans, a savings of $229 billion over a 10-year period. So there is a lot of cost savings in these plans, in the proposals, embedded in these proposals, and I think that the candidates do need to talk about and highlight that as potential savings to the health care system.

ED HOWARD, J.D.: We've got a couple of questions, actually more than a couple about mandates. And this one's phrased pretty felicitously. Obama says get insurance affordable then consider mandate. Clinton proposes a mandate but surely assumes a threshold of affordability in the individual market before enforcing a mandate. How long would it take for the Clinton plan to get the individual market ready enough to enforce a mandate?

KATHERINE HAYES: I have to say I can't answer that question. We have, there have been a number of estimates as to how much savings would be achieved by a lot of the reforms so I don't know the answer to that question, when it would go into effect. I will say, however, that the unique design of this subsidy really helps address that issue. Instead, as I mentioned, instead of being a flat subsidy based on income the amount of the subsidy would limit your payments, your insurance or your share of the premium to a percentage of your income. And she really hasn't gotten into or given a level of detail and analysis. And of course if she had she would be called

command and control if she put too much detail in that proposal at this point. But, so I think that there is a basic understanding there that as health care reform becomes affordable that the mandate would go in place, but I think that there's a sense that as the President of the United States, a Democratic President of the United States talks about health care, it's important not to concede universal coverage from the outset. And clearly there'll have to be compromises made. A President doesn't write the legislation Congress does and she is very much committed to working with Congress as President of the United States to come up with a proposal that does guarantee universal coverage and does have everyone in the system but in a way that makes it affordable for American families.

GREGG BLOCHE, M.D.: Well, Katherine, you go again. [Laughter] The 15 million left behind claim is pure invention. And it doesn't make it any less invention to say that it might be less or even more. The question I think underscores that this is really not much more than a matter of semantics when it comes to the policy. It may be a little bit of a different perspective on the risk of imposing a burden that's unaffordable, but it's pretty clear that what these two candidates are actually saying down in the wonkish weeds is pretty similar. That affordability is going to be a serious

challenge, that we need subsidies that are both going to work within our political process, particularly as this economy appears to go into what appears to be within the last few weeks, a recession perhaps a deep recession, there's going to be serious challenges on the affordability front. And beyond the issue of setting the subsidies right there's big differences in approaches you can take on enrollment.

I would point for instance to work that's been done, empirical work that's been done on enrollment in 401K plans. And it turns out that if you do opt in the enrollment can often be less than 50 percent, but if you set it up as an opt-out then it's 90 percent. And there are a whole lot of other technical things that those who develop enrollment strategies pursue that make huge differences. So all of that is worth doing and frankly the use of this mandates thing as a wedge issue, talking about a Democratic president, the main thing that the use of mandates as a wedge issue on behalf of a candidate that really wants to win is to increase the chance that there will be a Republican president in January of 2009 through this divisiveness. And in real life this is going to be, negotiating these details, will be a challenge for the new president if there's a Democratic president, with Congress. And to say that we can prescribe this electorally now and to say that by demanding more on the stump, you're going to get

more from a Congress, those are notions that are disconnected from reality.

ED HOWARD, J.D.: Katherine, you want to take 30 seconds?

KATHERINE HAYES: Yes, Ed. First of all I just find it ironic that the Obama campaign, who put out a Harry and Louise mailer saying that Senator Clinton will make you buy health insurance coverage even if you can't afford it, I find it ironic that we're being accused of using this as a wedge issue. But really I think this is more a question of leadership and a question of where you come down first of all on the policy perspective. No credible person will tell you you can do guarantee issue in the insurance market.

GREGG BLOCHE, M.D.: And who decides what's credible?

KATHERINE HAYES: Without making everyone...

GREGG BLOCHE, M.D.: You're the arbiter of credibility?

KATHERINE HAYES: So at any rate and then secondly those of us who have worked with Congress and have observed Congress for the last 20 years, recognize too that if you don't have an administration that is willing to make the tough decisions then Congress is not going to run up and say, "Oh, you didn't make the tough decision. Please let me enact legislation that is even tougher than you proposed." I mean you just don't see that happen. And so in point I would just

like to say that I think it, again, it's ironic that we're being accused of making it a wedge issue because you're embarrassed that people still are uninsured under your plan. But finally at the end of the day, those of us who have worked on the Hill know how hard it is to come back in a few years. When we did health care reform in '94 no one was ready to look at it again in '95 or '96 and do something significant. So to say that we're going to enact comprehensive health care reform and then come back in a couple of years and then we'll do the individual mandate when there's nothing to give individuals when it's all already been given away is just not politically practical. But ultimately at the end of the day there will be compromise and we'll see how it works out.

ED HOWARD, J.D.: Well, let's compromise by taking a couple of questions from the microphones, the people standing at the microphones patiently at the back of the room. Let's start here on my left and I should say to those folks who aren't asking questions right now, we only have about 10 minutes left if you'd like to pull out those blue evaluation forms and fill them out as you listen to these last couple of questions that would be much appreciated. Yes, sir.

JOE GUARINO: My name's Joe Guarino I'm with the Alliance of Health Care Sharing Ministries. We are a community of Christians who share each other's medical bills without

insurance. And that's what distinguishes us from most everything else out there. First of all I'd like to know whether or not you've ever actually heard of us and if you haven't I'd be more than happy to talk to you about it later; if you have then my question goes to tax parity. We hear a lot of discussion about the evening of the playing field, the leveling of the playing field between employer-sponsored insurance with pre-tax dollars and private insurance with after-tax dollars, but you're also talking about insurance where would folks like us fit into that picture? How would we too, get an exemption deduction or credit?

RAISSA DOWNS: That's very, very good question. Honestly I would want to make sure that we give you the right answer so I would love to connect with you after the session and make sure that we get you connected with folks. I just don't want to mis-answer than question.

GREGG BLOCHE, M.D.: It sounds like a really interesting model and I'd love to learn more about it. I think you point to the real challenge here which is to make sure that we pool risk. And it sounds like, although and this is maybe here I am the academic speaking, but if you have a large enough— how many folks in your organization? How many folks are participating in this risk pooling?

JOE GUEARINO: In this medical payment arrangement we have approximately 40,000 households across the country. We're in all 50 states.

GREGG BLOCHE, M.D.: Wow. That's awesome. So now an academic would say what you have is insurance because you're pooling risk. Not only do you have insurance but over a much broader risk pool it's much smarter insurance than many health insurance policies, especially self insurance programs are. And the challenge here is to make sure that risk is pooled. A big worry with respect to Senator McCain's proposal is that what's presented as leveling the playing field is taking out the incentives to keep employers in the risk pooling business without doing enough to create alternative risk pooling. And to the extent that we lose risk pooling we're going to have higher loading charges for individuals, people being driven out through classic adverse selection and risk selection from the insurance pool. And we're also going to have diminished ability to negotiate rates between, or diminished ability of payers to negotiate rates with providers. So we're going to actually see costs increasing from the higher loading charges, the higher prices that providers will pay as well. But the larger challenge here is to keep the risk pooling that we have and to enhance risk pooling. That is what the connector model

that the Edwards, Obama, and Clinton health plans embrace is meant to do.

ED HOWARD, J.D.: Yes, sir?

FRANK MCARDLE: Thank you, Ed. I'm Frank McArdle with Hewitt Associates and I just have a question about the provision or proposal by Senator Obama and Senator Clinton that would create a publicly-sponsored plan option competing alongside private sector options. I was wondering if you could explain how that would work, what kind of inherent favoritism or bias would there be in one direction or the other, and also if Senator McCain has any perspectives on the success of that kind of competition? Thank you.

KATHERINE HAYES: Yes. Both Senator Clinton and Senator Obama have proposed allowing individuals to choose from a variety of private health insurance plans as well as a public option through a purchasing pool. There is not a lot of detail, at least in Senator Clinton's proposal on this. The concept would be that, or the thought is that it would be a program similar to Medicare or somehow piggybacking on Medicare to allow folks to— the chief criticism I've heard about this and the chief concern I've heard about this is it's impossible for private insurance plans to compete with the public program. And I just sort of sit there and scratch my head over that. Why would a private insurance company want to say that they

can't, and they're trying to promote private health insurance, why would they want to say they can't compete with a public program? We see this going on right now in effect in the Medicare program. There is the public fee-for-service Medicare program and there is also the Medicare Advantage plans out there that are competing with public programs. So I envision it would be very similar although we can disagree over the payment rates that are being proposed right now or the cuts that are being proposed right now.

RAISSA DOWNS: Yes, just to answer your question very quickly, obviously as you point out it has not been proposed as a component of the McCain plan. And again, there's just that fundamental distinction and disagreement about the right path forward in terms of expanding the number of options, affordable and varied options for consumers. And it is just simply not structured through creating another government option.

GREGG BLOCHE, M.D.: Yes. And I think what this is meant to do, the public and private options, is to let consumers make the choice. It strikes me it's almost more of a Republican concept than a traditionally Democratic concept. We have a debate about who should deliver both the financing of health care rather than trying to decide this centrally, let's set up a competition and give consumers an opportunity to make the call and may the best plan win.

ED HOWARD, J.D.: It has a nice ring to it. Yes. I think you have the opportunity for the last question.

ANDREA BIRKA: Hi, my name is Andrea Birka [misspelled?] and I am currently a nursing student at Georgetown University. I think this is a great conversation on how we're going to provide care, but what I'm curious about is how each of the candidates plan on addressing the health care working shortage and particularly the nursing care shortage. If we're not able to provide the care then this discussion really carries no weight.

ED HOWARD, J.D.: Okay. Good question. Katherine, go ahead. Do you want to start?

KATHERINE HAYES: Yes. Senator Clinton's plan would address the issue in two ways. One there is a workforce provision that is— there is a provision in her proposal and I think it's in the quality piece which is the second piece that was released, and I'd urge you to go to her website and take a look at it. But it has a series of strategies, grants that would be made available to states and to universities to help increase the number of nursing faculty on the short-term basis. Second would encourage public— private collaborations at the state level to bring more people into the workforce and to help them stay there. One of the problems clearly has been retention. And then third, really fundamentally looking at a

restructuring of reimbursement to encourage a team-based approach to health care that would give nursing professionals and other health care professionals more of a role in the delivery of health care, more of a team-based approach to improve job satisfaction and the reimbursement hopefully would increase wages as well.

GREGG BLOCHE, M.D.: I would be in agreement with that. The incentives are key and episode-based payment is going to give hospitals the capability not just to pay fair and attractive wages, but also to create working conditions that diminish the problem of burn out. I remember rather painfully, the experiences that I saw nurses going through at Columbia Presbyterian. People had all sorts of jokes, most of them not repeatable in this setting or in a family setting, to talk about these conditions. The burnout was terrible. People would leave the field after a few or several years and I think dealing with the decency of working conditions is really central to the workforce dimension of this and that's part of Senator Obama's plan.

ED HOWARD, J.D.: Okay, Raissa?

RAISSA DOWNS: It's an excellent question, I agree. And you're doing a very laudable thing to be pursuing this as a career path. I mean, I think as everyone has said, you create the right incentives, you reimburse for care both preventive

and acute in a wider variety of settings that hopefully creates a better work environment but also a better economic model for drawing people into the field. And I think it's a conversation that I hope that you and your colleagues in the organizations that represent you here in Washington really engage in, as more meat is put on the bones for all of these candidate's plans, I mean it's a critical component especially as you look at the rural and urban and underserved areas, not just in what we think of as the more traditional health care debate venues.

ED HOWARD, J.D.: All right. Well, thank you all very much. We are going to hear more on these topics and related ones over the next six months or so. And I would urge you to, well as a matter of fact, let me just say, we will make sure that all three pieces of the Clinton plan are on our website. If other candidate's representatives would like to have us put additional material in that bundle of materials posted on our website we'd be happy to do that. Let me just ask you, if you would, to fill out those blue evaluation forms as you go and thanks to the Commonwealth Fund for its support. And thanks to Sara and the candidate representatives for a very rich discussion, and I'd ask you to join me in thanking them.

[Applause]

[END RECORDING]