ALLIANCE FOR HEALTH REFORM

Inside Deficit Reduction: What Now?

Alliance for Health Reform
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ED HOWARD: Hi, I'm Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller, our Board of Directors, to this final briefing in our four part series on the deficit and reduction work in Congress.

I'm really pleased to see so many of you today, it sort of belies the thought that in the wake of the super committee's inability to get to a big yes or a small yes, or any other kind of yes that we can forget about deficit reduction and its connection to the healthcare community. For one thing we need to understand what the impact of the Budget Control Act is on healthcare at this stage. It's not as straight forward as one might hope. And for reasons you're going to hear elaborated with eloquence from our speakers, the discussion about reducing the federal deficit and the role healthcare programs should play in that reduction is far from over. More is the date about reducing healthcare spending overall, whether by governments, or employers, or families.

Looking at the agenda, you'll see there are a couple of distinct divisions. First a factual look at where we stand today after the super committee failed to act, and before any automatic cuts take effect, and then secondly a broad discussion of the implications for healthcare of the upcoming

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steps in the process and a look at what's in store after that. And again have a chance to ask clarifying questions after the initial presentation, and then there will be a chance for a full discussion with your questions following the initial remarks from the rest of our panelists.

Let me just take a moment to note, as we reach the end of this series of briefings, that we couldn't have organized it without the support and involvement of all of our cosponsors, and as some of you have noted and if you look at the folders with all of the logos that you picked up on the way in, you'll realize that we have four cosponsors, have had for all four briefings, Robert Wood Johnson Foundation, The Commonwealth Fund, the Kaiser Family Foundation, and The Scan Foundation. There is background information, a little bit anyway, about each of them in your packets and I commend it to you to take a look at.

Before we get to the program, a couple of housekeeping items, a lot of background information in the kits that you have the logos on, including speaker bios, more elaborate than the introductions that I'll have time to give them. We've actually negotiated — it's the first in the history of the alliance, the speaker's asked for less time that we had originally allotted, so that we could get to a longer discussion, so I want you to be prepared to take an active part

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in the conversation at that point in the program. There will be a webcast and a podcast available of this briefing on Monday throughout colleagues at the Kaiser Family Foundation. You can reach it through our website, allhealth.org, and the kff.org website of the foundation. There will be a transcript on our website a few days after that. Our colleagues at The Commonwealth Fund will be doing a post on their blog tomorrow, which you can reach at commonwealth.org. So I will say only that you should take note of the green question cards that you can use and the blue evaluation forms in your kits, which I trust you will take advantage of and give us some feedback, so that we can do programs that better meet your needs.

So, we have a terrific group of folks to talk with us today. And in our first presentation, first part of the program, we're going to try to get all on the same page about where we are today after the super committee failed to reach agreement by the deadline set out in the statute. And as we did in the kick off briefing, in the series, we turned to Katherine Hayes. She's an associate research professor at GW's Health Policy Department. She brings to the task a quarter century of experience in health policy analysis, including stints on the staffs of both democrats and republicans on the Hill, so we're very, very pleased to have you back, Katherine, and look forward to your [inaudible].

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KATHERINE HAYES: Thank you very much, Ed. I appreciate the introduction and look forward to today's panel. And also thank you to the cosponsors for making this possible.

Now, if someone had said to me, Katherine you're going to be on a panel and it's going to be about the future of deficit reduction in healthcare, and you're going to talk about what is actually in the law. I never would have thought that, that would be the easy part of this discussion, but I find that, that is the case today.

So, starting off very quickly, talking about – this is sort of in background. Most of you know this, those of you who are familiar with the budget process, but I just want to talk about terms that I'm going to use today. One is discretionary spending and by discretionary I mean that spending that must be appropriated each year by Congress, as a part of the 12 regular appropriation bills, which of course I think we haven't done in almost a decade.

We've been working with CRs in the past, but for those of you who are a little bit older, you might be able to remember the day in which we actually did appropriations, but lately that has not been the case. And direct spending or mandatory spending, I'm referring to those programs that may continue without an annual appropriate program, such as Medicare, Medicaid, and Social Security also refer to, well

direct or mandatory spending. I'll probably use those interchangeably. The term in the statute itself is direct spending.

So, the Budget Control Act contained five separate titles. The only one going I'm going to talk about today is the part that is in red, Section 302, which is revised caps and sequestration. To put it simply, that is the section explaining what happens if the Super committee fails, so I won't touch on the other issues today. Generally the fallback enforcement requires 1.2 trillion and last time I was here I kept confusing billions and trillions, so I'll try to get it right this time. 1.2 trillion in spending reductions that began January 2, 2013, and of course that's with a caveat that unless Congress and the President step in and intervene and change the law. The statutory spending limits are those – they are discretionary caps that are placed in the statute, you know, for those of you who have had the misfortunate of actually sitting down and reading the legislation, there are two sets of statutory caps. One which saved $900 billion and then assumed that a super committee would save up to $1.5 trillion, of course that did happen, so during – and as part of the fallback, those caps have to be revised, and they are revised and extended.

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In the original legislation or not the original legislation, the first set of caps they were really broken down into two distinct sections that were referred to as security and non-security. And falling within the security category was not only Department of Defense, but also Homeland Security, State Department and a couple of other programs that are not as prominent. The National Nuclear something that I can't remember the name of, because I'm not an environmental person, but – or an energy person, but when you start talking about the split between security and non-security, it's important to understand that the definition is different when – in Section 302, so when Congress goes in and puts – or they did – and established and extended the new discretionary spending caps or statutory caps that will apply to the appropriations. It is divided, it is still called security and non-security, but security is Defense Department only, and the other programs, it looks like in the language would be included with non-defense programs, and of course non-defense being everything except defense. So, those are revised and extended, and in the original discretionary caps, they were – during the first two years there was an even split between security and non-security. As a part of the revised statutory caps, that split is extended and – well it was only two years in the first set of discretionary caps, but now as a part of the revised caps

that will be split. And when I say there's an even split between defense and non-defense that means in dollar amounts, not percentage amounts, in actual dollar amounts and it's extended through 2021.

And then once you are in these two separate categories, not that this is complicated, it's really straight forward when you think about it, but I would of drafted it that way I'm sure. When you think about it, you look at defense and non-defense, and you look at discretionary, once you are within the categories of defense and non-defense there's a proportional split among direct spending and discretionary spending, clear I don't know.

So, let's talk about sequestration and the new spending caps that are going in place. And you need to think about it a little differently, because the deadline or the date in which this enforcement will go into place, is already – it will be one quarter – the first quarter of FY 2013 will have already happened. If you recall the years begin – the federal fiscal year begins on October 1st of 2012 for FY 2013. Sequestration, in effect, will occur for both discretionary programs and for mandatory programs, because Congress has already set the spending cap for FY 2013 and I assume the agencies will have been spending according to that cap. Now if I were in an agency, you know, I might think about – I would have this date

looming and know that I was going to be hit come January 2nd, and so that may affect spending within the agency, but just know that for discretionary programs or appropriated programs only that sequestration will apply during FY 2013.

For 2014 through 2021 the statutory caps will guide domestic discretionary spending, so domestic discretionary spending will be set in effect by these statutory caps that are in place, and OMB will issue a sequestration order for mandatory spending or direct spending.

So, the other thing that I want to point out particularly with respect to FY 2013, and of course I want to mention that the Medicare reductions, there are a number of exempt programs, which I will get to in a minute, but Medicare reductions are limited to two percent. So, this may seem fairly straight forward, but again when you start thinking about FY 2013, recognizing that we're going to have sequestration beginning in the second quarter of the fiscal year, one would assume, because of the way the statute is drafted that the cuts will likely have to be higher in 2013 or not higher necessarily on a dollar basis, but higher than they would have otherwise been had the cuts been spread out over the entire fiscal year.

So, let's talk a little bit about the exempt programs, and you know, just for the sake of my fellow nerds in the

audience, I included both the section of the Balanced Budget and Emergency Deficit Control Act that we're discussing today, as well as the code citation and a link for those of you that actually want to pull it up and see the list of those programs that are exempted. There are really quite a few of them.

ED HOWARD: I was just going to say if you're worried about not being able to copy that, we'll put Katherine's slides on our websites and you can paste and have a little less chance of making an error. Sorry.

KATHERINE HAYES: You may want to make sure the link works.

ED HOWARD: Works, okay.

KATHERINE HAYES: Well, I couldn't get it to work. That's the correct link. I cut and pasted, but when I clicked on it – I just have to confess, I am technically challenged, but if you would have your, you know, folks check it.

ED HOWARD: We will do that.

KATHERINE HAYES: Thank you. So, exempt programs and activities, Social Security and tier I railroad, it's not really necessary for me to go through all of these, but there are a few that I'd to highlight. One, being refundable tax credits, so for those of you who are following implementation of the Affordable Care Act, the premium tax credits would be exempt from sequestration, that's a question I get a lot. And

a few other things, there's an option to either reduce the percentage cut in the military personnel account, and this is a decision that would be made by the President, but if they do — if he does the President needs to notify Congress. Other programs, there is a list actually under — I don't know, I think I saw Ruth come in, is that Paragraph G? Anyway, I always mess up the paragraphs and the subparagraphs and everything, so there is a list of 72 programs under 1(A), that include public health trust funds, that's another issue that comes up a lot, the impact of sequestration on some of the new trust funds that were established as part of the Affordable Care Act, and also federal retirement and disability accounts, and then prior legal obligations and low income programs, as well, including Medicaid, TANF, SSI, foster care, and child care.

So, I thought it would be good to put numbers in. I won't spend a lot of time on this, because I'm sure other panelists will talk about it, but I thought it would be good to put some numbers in here to just get a sense, more for illustrative purposes than anything else. And it's important to recognize that although CBO has done estimates, it will actually be OMB using their baseline, making the estimates, so and one thing that was really pointed out in the CBO report, and there's a link to that too and which hopefully will work.

Is that most of the funding, 71 percent of the funding has the caps revised and extended, comes from discretionary programs. And when you think about that in the context of federal spending and which programs are entitlements and which ones are discretionary spending, that is a pretty big chunk. And that doesn't include the original 900 billion, see I got it right that time, 900 billion that were in the original discretionary spending caps.

So to recap, effective January 2nd, 2013, automatic reductions of 1.2 trillion, assuming no intervening law, discretionary caps are revised and extended and they're split, and then Medicare is limited. And then additional resources, these are the resources that I have found incredibly helpful. Someone has kindly posted a CRS report on the web and there is the website for it, as well as two CBO documents, particularly the second one which has the estimates in it that I think are a really good resource. And with that I'll close.

ED HOWARD: That's terrific. Thank you. Let me give you a chance to ask clarifying questions. This is a lot of material, some of it's pretty granular, and there are microphones that you can use to ask those questions if you'd like. I'm going to ask one if I can. Just to make sure that I understand it, particularly in light of the fact that 71 percent of the savings come from the discretionary caps. How

are those caps enforced? You talked about OMB issuing the sequestration order, how about these caps and their enforcement?

KATHERINE HAYES: The domestic discretionary or I mean discretionary spending caps?

ED HOWARD: Yes.

KATHERINE HAYES: Those are actually set in the statute and so that would be left to Congress through the appropriations process to enact legislation to that meets that caps. Now of course under the Budget Act there are enforcement mechanisms. A point of order can be raised in either the house or the senate if legislation comes before either body that violates that, so it would sort of be self enforcing, but there are also provisions in the Budget Control Act that allows sequestration if Congress actually appropriates at a higher level.

Now, recognizing of course, I didn't mention here, I think I mentioned it in the last meeting that we had, that there are exceptions for emergencies and there is some statutory wiggle room that OMB will have there in making calculations.

ED HOWARD: One other point I wanted to clarify, you mentioned in your slides the fact that the Refundable Tax Credits for the premium subsidies in the Affordable Care Act

are exempt from these reductions. There's been some discussion about the subsidies for cost sharing that low income people who get their coverage through the exchange are eligible for under the ACA, are those protected or not?

KATHERINE HAYES: Well, you know, it's pretty clear. I think there's one section that says that unless something is explicitly exempt then it will be subject to sequestration. And unless someone can come up with a creative way to fit the cost sharing subsidies within one of those categories, they would be subject to sequestration and I understand that folks have made that interpretation.

ED HOWARD: Okay. I see no one – wait I see a hand up. If you would go to a microphone very quickly I'd appreciate it. There's one right behind you, yes. That'll make it easier for those watching the webcast to hear the question as well without my having to repeat it, and very good.

UNIDENTIFIED MALE: This relates to 2013, does Congress go first and enact the program by program funding, and then the question is whether that meets the cap, and if that meets the cap, it's okay. And what happens if Congress doesn't have full year appropriations in place for 2013 by January 1st.

KATHERINE HAYES: Well, yes, given that the federal fiscal year begins on October 1st of 2012, one would assume that Congress would have some sort of spending bill in place,

whether they are the 12 appropriation bills or whether it's a CR, either a long term or short term CR. If Congress doesn't have anything in place, I think that would result in a federal shut down and we'd have even bigger problems than sequestration.

UNIDENTIFIED MALE: But Congress has discretion in 2013 to vary the cuts in different programs, they don't have to – there's not an automatic uniform cut.

KATHERINE HAYES: Well, the cuts are divided equally between defense and non-defense.

UNIDENTIFIED MALE: Right.

KATHERINE HAYES: And then proportionally between direct and discretionary spending. And it would be left to the appropriations committee to make the decision as to whether those funds would go, you know, for which programs.

UNIDENTIFIED MALE: Thank you.

ED HOWARD: Yes, and I'd ask all our questioners to identify themselves if they would?

KATHY KUHMERKER: Great. Thank you. I'm Kathy Kuhmerker from the Association for Community Affiliated Plans. And I have a question that is related to the refundable tax credits, um, I certainly understand that he refundable tax credits themselves are not – are exempted from this sequestration, but one of the other, I'm going to say functions

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and quotes of their refundable tax credits, is that they can go to support basic health programs, if State decided that they want to do that for individuals between 133 and 200 percent of the federal poverty level. I've been trying to research this and looking at it – and I don't – wondering if you know whether or not – or have a good guess about whether or not those would be exempt or whether they would actually be affected by sequestration.

Well, I don't know for sure, but given that the funding source is the actual tax credit and the states would actually receive the tax credit, it would seem to me that they would be exempt from sequestration. Would that be your best guess, everyone else? I like that best guess. Thank you.

ED HOWARD: Well then, panelists have any questions they want to raise or points of clarification.

UNIDENTIFIED FEMALE: Katherine, there are, in addition to the tax credits there have been issues raised as to whether other elements that are critical to the ACA in terms of funding would be at risk, so in addition to the tax credits, what other issues have arisen and what do you imagine the risks might be.

KATHERINE HAYES: Well, can you give me examples of those that have come up. I mean we know Medicare is limited, we know Medicaid is exempt, other spending, you know, certainly anything that is subject to appropriations, it will be left to

the committees, the appropriations committees, and Congress to decide which parts of the ACA are funded within the spending caps. We understand that public health trust funds are exempt.

UNIDENTIFIED MALE: How about the innovation center money, a billion dollars a year.

KATHERINE HAYES: Well, is that through the Medicare program though? I think it's funded through Medicare, so it'd be subject to two percent.

UNIDENTIFIED FEMALE: It's appropriated.

KATHERINE HAYES: Oh, it's appropriated. Well, then it would depend upon whether Congress decides to fund it.

UNIDENTIFIED FEMALE: IPAB?

KATHERINE HAYES: IPAB.

UNIDENTIFIED FEMALE: The independent payment.

KATHERINE HAYES: Well, that is when – you think about it, when you think about both programs, you know, it applies to both programs and activities. And IPAB is funded through the secretary's discretionary funds, correct, therefore I think it would be subject to sequestration with a cap – well, I don't know if it falls within Medicare or not, it depends on whether it falls within Medicare, but again would be subject to appropriation.

ED HOWARD: And that actually raises a question that a couple people have brought up and some of the materials discuss

this as well. The two percent limit compares to estimates of what, five percent, 10 percent, 20 percent, that programs not protected under this law might be subject to and are there reliable estimates of what that percentage might be, so that if it's two percent, it's eight or nine.

KATHERINE HAYES: You mean if it were subject?

ED HOWARD: If it were subject, yes.

KATHERINE HAYES: Without the cap?

UNIDENTIFIED FEMALE: Yeah, what the estimate would be.

ED HOWARD: Without the cap.

KATHERINE HAYES: Yeah, I haven't seen that number, but maybe some of the other panelists who are much better budgeters and numbers experts than I am might be able to shed some light on it.

ED HOWARD: Okay.

UNIDENTIFIED FEMALE: It would be bigger, bigger.

ED HOWARD: That's an expert answer, absolutely.

UNIDENTIFIED FEMALE: Right.

ED HOWARD: Yes, go ahead.

LINDA BENNETT: Hi, Linda Bennett with Ask Me, could you – I guess it will involve a little bit of a crystal ball, some of the issues that will come up with if there's a doc fix pass before January, how that interplays with the two percent cut.

KATHERINE HAYES: I think I'll defer to our next group of speakers' on that, so thank you.

ED HOWARD: That's a queue I believe.

KATHERINE HAYES: I was promised I didn't have to predict anything.

ED HOWARD: Well, I predict your prediction will come up right. It's a good segue to our collection of four respected analysts, we were a little late getting here to the room, and it became clear as I was walking forward that they didn't really need any supervision. This panel could take over the program and answer questions, and raise questions at a level seldom seem at an Alliance briefing. So, we're very pleased to have four very distinguished analysts. And as promised I will not give them the introductions they deserve. We're going to start with Dan Mendelson, who's the CEO and founder of Avalere Health, a consulting and analytical firm with private and public sector clients, who has also served as associate director of Health for OMB. To his right, Stuart Butler, head of the Heritage Foundation’s Center for Policy and Innovation, so called think tank within a think tank, as he describes it, he's a key player, certified in healthcare by the National Journal, so you know it's true. Len Nichols, is an economist and director of the Center for Health Policy Research and Ethics at George Mason University. He's been at also the

New America Foundation, the Urban Institute, OMB during the Clinton health reform debate, he's been around, let's just put it that way. And to my immediate right is Sheila Burke, who's on the faculty of the Kennedy School at Harvard, she's the former chief of staff of Senator Bob Dole, and as the agenda notes, she is now the co-chair of the Health Project at the Bipartisan Health Policy Center. So, we've asked them to — actually they've asked us to allow them to be relatively brief in their presentations, so that we can get at and interchange in your conversation. And we're going to start with Dan.

DAN MENDELSON: Ed, thanks very much for the gracious introductions. I think the question for the panelists is, will we be more respected after or before we make these comments, but I guess we'll all find out. I think it's really useful to start with sequestration, to think about the impacts of sequestration, and we've done a lot of that in modeling and in, you know, figuring all that out. And as a presentation that's excerpted in your packet, it's on green sheet. If you look at that, you know, it's probably a good predictor for who's going to be banging on your door over the next year to complain. And I think it is worth thinking a little bit on the second page about why it is that pretty much the entire healthcare industry was united in its opposition to the super committee actually coming to an agreement and I think part of it is the fact that

it's going to be pushed off to 2013, that all of this is pushed off for more than a year. And part of it is because it's highly unlikely that any of this will actually happen, will actually come to fruition.

In our modeling of the discretionary side of things, there would have to be about a 7.5 percent reduction in NIH appropriation in the first year, not going to happen. And it's not going to happen because it would be deleterious and it would also, I think the appropriators will take their prerogative, these can be easily gained by bringing up the appropriations in different areas. And I think because of this it's useful to kind of keep this as a starting point, but then you quickly have to go to, well what is likely to happen and therefore what is it useful to focus on over the coming year. And I think that it's pretty much common viewpoint that we're going to be looking at 2013 as a year where there is likely to be some kind of a BBA like discussion, and that makes sense. And therefore it's worth taking the time to think about the BBA and how it was structured and what actually happened, and I'd like to make a couple of points there. The first is that it is not going to come slowly from the backs of the providers. The BBA, if you think about it was really – there was an allocation, think about a third, a third, a third between provider cuts, beneficiary payment reductions and increases in

revenue sources that would come either from tax, fees or other places. And you cannot get to a two trillion or a three trillion dollar number without doing that. It is just not feasible. And so I think that a realistic way of going at this will actually have to draw from all three of those buckets.

The second is that if you think about what is off the shelf now, at OMB there's this massive file cabinet and you open up the file cabinet and all the offsets are, you know, kind of lined up there. And of course when we started Avalere we brought the file cabinet over to Avalere and so we kind of maintain all of those offsets, and we've done a lot of scoring, but in point of fact I think that most of the offsets that are being rattled around right now are aged offsets. And there's a reason why they haven't been taken, they're all problematic, either politically or technically, and so it's kind of incumbent on the next generation of analysts to figure out, you know, kind of where we go from here. So, with that I thought maybe I would point in the direction of three areas that I think are particularly promising and, you know, they all kind of stem from a core concept, which is that there is a lot of expenditure right now in the Medicare and the Medicaid programs that is not managed. And you wouldn't do your own fiscal house that way and I don't think it's really appropriate to have any aspect of Medicare or Medicaid spending to not be managed, and

so the question is how do you get at management of the remaining parts. So, there are three areas that I think are potentially interesting to look at where more innovative policy could be crafted going forward into the next BBA type discussion, which I think is, you know, a year and a half away from now, so all of you are going to be a head long into it.

The first is that we need a new payment paradigm for long term and post acute care. Right now it makes no sense that those expenditures are not managed. When a patient is discharged from the hospital with a hip fracture, they might go to any number of different types of facilities, that same patient will cost more at one facility than another, because we have all these different payments, makes no sense, makes no sense that there is no PBM type activity to monitor what's going on in post acute care and that the decisions are not made by financially accountable people, so that's one.

A second is a focus on the eligible's and I think that, you know, it's fair to say that Melanie Bella and her colleagues at CMS are doing some very interesting work on the duals right now, that's very important, that's very good, but ultimately this is going to be a congressional prerogative, and one that I think the staffers in the room will want to play in and should want to play in. It should be managed, it should be managed consistently and whether it is managed by a managed

care company or by a state, I think is less relevant than the idea that the expenditures are thought about in a pool and that care is managed, in addition to the dollar resources.

And the last one that I'll mention is a new approach to physician payment, which I think is sorely needed. And the fact that we have what is essentially kind of a sham budgeting process in the physician payment area with SGR, and you know again, I think that pretty much everybody in the room has probably had to deal with the SGR reductions in one way or another. I think the most charitable thing that I can say about them is that they become kind of an annuity system for the campaign contributions for some of your bosses, but in any case I do think that coming up with a quality based system that is accountable and ultimately kind of resource accountable back to the federal government is absolutely critical. So, with that I will close and hopefully I've offended at least somebody in the room and give the microphone over to Stuart.

STUART BUTLER: Thank you very much and it's a great pleasure to be here. I'm sure everybody in the room remembers Winston Churchill's descriptions of Americans, that American's — you can always trust American's to do the right thing once they've tried everything else first. And one hopes that the Super committee and the sequestration is the last example of trying everything else, so actually going the right thing.

I agree with Dan that essentially this scenario we're looking at is not these sequestration actually going into place. The whole logic of sequestration is what I sometimes call the artificial Armageddon theory, that you actually set up a situation which is utterly unacceptable, so that in this case a Super committee will actually take the right action, well it didn't, and therefore now, do you do the things that were totally unacceptable, I think not. I think both history and common sense suggests that the Congress will move away from the main part of the sequestration over the next year or the next couple of years. So, when you think about that if Churchill is right then we're on the verge of actually thinking about doing the right thing.

Doing the right thing involves facing the original problem that these approaches were designed to deal with. The problem of the long term debt and deficits, the fact that almost 60 percent of federal spending now is on auto pilot, it is direct for its interest, it's not controlled, and we have large programs in the healthcare area that are defined benefit programs in the sense of giving people entitlements to specific things and saying we'll keep our fingers crossed that the actual costs will be acceptable. We have to have a serious discussion about restructuring these programs, so that we actually begin to get health spending on a reasonable track and

do so in a way that's efficient and actually achieves the objectives that we have. I think you've only really got, in this condition that we're in now, really two broad options about how you would try to do that. And I think both of these will be discussed and in play, and I think and I hope we make a decision over them.

The first is to sort of continuously kind of squeeze the balloon through various kinds of controls and regulations to try to sort of redesign bits of programs and squeeze them and set prices so that when you've done that somehow the number comes out right. That's obviously the logic of the IPAB in Medicare, it's the logic in a sense of the sequestration, but in my view it's not A) going to work and I don't think it's politically acceptable and will achieve the objective if we try to go down that road.

The second approach would be to say let's recognize that we actually do have to set a real budget for these currently autopilot direct spending programs, defined benefit programs. And we've got to do that and then decide how we're going to make that budget be allocated in some way. And I think you've really only got two approaches to that part of the problem. If you're going to have a budget and to reach the objective of dealing with the deficit and debt, you can either do it through some kind of defined contribution model, if you

like in some way. In other words, allocate certain resources to people or to institutions, and say, that's the money, now figure how to utilize it. That moves you in the direction of looking at things like the proposals for an allotment of Medicaid to the states with greater flexibility that people like Alice Rivlin and Paul Ryan and others, you know, have discussed. And then allow flexibility in terms of well how do you reach the objectives of the program. In the case of Medicare, it moves you to some form of premium support system. When you say to individuals this is the money you have, all kinds of protections and so on, but that is one way to go towards the idea of having a real budget and getting away from this idea of sequestration and so forth. The other way is to allocate the money in some way to those institutions that deliver healthcare and have a sort of what you might call some combination of a Canadian U.K. type of arrangement, where you allocate a fixed budget to institutions that deliver care and say, that's it, now you figure it out, we'll have all kinds of protections and so forth. But it seems to me that if you're going to solve this problem now in a serious real way, as opposed to trying something else first, that you've got to decide to go down one of those two broad groups, to put into place a real budget. I don't think we're going to see any action on this, this year. We talked about this a little bit

before we came up on the panel. This is an election year, I think there will be a lot of screaming and yelling, and so on, but I hope that serious people will take this year to think through what this real solution is and not get too entangled and wrapped around the axle on this idea that somehow this sequestration is going to start occurring in 2013, because like Dan, I believe it won't, and take this time to get it right. And maybe after the election we might have something approaching a consensus and a decision point about actually how to do it.

ED HOWARD: Alright, thank you, Stuart. Let's turn to Len.

LEN NICHOLS: What an optimistic note on which to conclude, I must say. I think we should give Stuart a round of applause. So, my happy task was to try to relate this to how states and healthcare stakeholders are thinking about this marvelous spectacle we call democracy here in Washington. And I want to start with four events that I think are highly relevant to the way they think about the world. The first was the rise of the tea party, and its rather direct focus on cutting spending no matter what. The second is PPACA itself. Whatever else may be true about the health reform law, it sent a very clear signal, business as usual is over, and business as usual is over, because we can't afford it. And if you don't

believe that just talk to your local hospitals which I'm sure have come to visit you about market basket update reduction.

I dare say four people in this room knew what market basket update reductions were until about two years ago and now every damn one of you do. So, the deal is when you tell hospitals you're going to cut their payment by something equal to economy wide productivity, which only economists can compute, thank God it's full employment for us, a number over which they have no control. And you tell them essentially they're going to have to get more productive each year than the economy as a whole in order to break even, you concentrate their minds.

The final thing that got them to think about this stuff is – well actually two more. Third the Ryan budget, the Ryan budget was a marvelous thing for lots of reasons. First it was an honest elocution of how you would do this without raising taxes. Second it took all of the savings in Medicare that were in the ACA, that when they were just in the ACA were, you know, killing grandma and included them, and therefore embraced them, and therefore I presume, spared grandma from the terrible fate. So, fundamentally what you've got here is proof that people like me have been saying for quite some time out there, it doesn't matter who wins these elections, we are going to cut

healthcare spending, and Ryan proved it for us, thank you very much.

The fourth thing and this is a little less funny was the observation that a rather large number of people who had been elected to serve the people of the United States, were willing to actually through the federal government into default in order to make a political point. That too has concentrated the minds out there in the real world where they think, holy cow they might actually do that, and that has had the effect of making people really pay attention to how we're going to get this healthcare thing under control.

Now let's talk about states, states are under — you might have heard this rumor, fiscal stress at a level not seen since the Great Depression. And let me just remind you about the Great Depression. Unemployment then was 25 percent. We're having a hissy fit over nine, okay, it was way worst. And by the way the states did weigh less back then, but they're under more stress now, so it is real. They very much in general would like to somehow cut Medicaid spending, but by in large the levers available to them are foreclosed by the Maintenance of Effort Requirement in the PPACA. They can't reduce eligibility, which they normal would. And they've already cut payment rates pretty close to the bone marrow. There's not a whole lot more they can really do, they're stuck. And they are

there for, I think there's a technical term, frustrated with the federal government reneging on its implicit promise to increase the FMAP as to federal share, which it did of course when the recession was most full blown. It hadn't gotten a whole lot better and we're taking that FMAP bump away. Why? Because we decided to be unbelievable riskily attached to cutting spending no matter how you do it.

It is really stupid to not separate long run and short run, but that is exactly what our current Congress is doing and therefore it's making the state's jobs even harder. Therefore they are not keen on what they're going to have to do to finance the Medicaid expansion come 2015 when they have to start paying. And I can tell you, you know, the reality is PPACA will require states to spend more on their poor than they are willing to do, than they would do voluntarily, and that's part of the struggle we're going to have to have going forward.

Now the private sector, you know, for reasons that make no sense to you or my wife, I get to talk about this stuff all over the country. I've actually done 27 hospital association keynotes since the law passed. It's amazing. Lots of frequent flyer miles. And you learn a lot, you learn a lot, that's why I do it, you learn a lot about what people really think. And here's what people really think out there who run the private sector of healthcare systems. We have got to pay the Chinese

back. We are going to have to get our fiscal house in order. The only way to do that is to get Medicare spending and Medicaid spending under some kind of control. The only way to do that is to get the healthcare spending under control. They know that, because Medicare and Medicaid just buy from the system. Therefore they know the gig is up. They know business as usual is over, they know they got to get more efficient, but how the hell are they going to do that all by themselves. Three quarters of them lose money on Medicare now, and just about all of them lose money on Medicaid. So, if all we do is public sector payment reform we will have failed, and we will have simply driven private sector prices up even higher. Therefore they know in Florida, in Oklahoma, and Arizona, where I have just been the last two weeks, they know we got to make this work, and the only way to make this work is to do exactly the kinds of walking toward payment reform that we're beginning to talk about. And here's the really good news, AHIP had a conference mid-October, had a little map up there of all the experiments going on and result of survey's they've done, 150 medical homes going on around the country, 30 ACO-like creatures already in place with health plans and provider groups, 16 bundling experiments, three full global cap, okay? That's all outside of what CMMI is doing, that is because everybody figures out we have got to make this healthcare

system more efficient. The only way to do that is to nail the private and public sectors initiatives and incentives, and that's how you get the restructuring that will make some of this possible.

But let me just tell you one more thing about the real world and private sector, they are capable of distinguishing between the short run and the long run, and they think Washington is stupid, stupid to be unable to balance those two concepts, and they think the idea of cutting spending now when they're facing the uninsured that they are facing, when they see what they've got, in order to make some number on a wall somewhere, when we should be expanding spending now and getting at the real long run, and the real long run involves incentive realignment, not whole cuts. Thank you very much.

ED HOWARD: Alright. Thank you, Len. Let's turn finally to Sheila Burke.

SHEILA BURKE: Thank you, Ed. I have been given the task, having heard from my colleagues all of whom are [inaudible] experts to talk about politics, which is often the case. And so what I want to do is spend a few moments reflecting on what the environment looks like, what the environment is likely to look like going forward given our past experiences with trying to see the kind of seismic change that was envisioned and in fact is in place as a result of ACAB

[ph], but because of the backdrop of the challenge on the budget.

I would encourage you in your packets that Ed and his troops have so thoughtfully put together, there are a tremendous number of very interesting pieces, and I would encourage you to utilize them. They in fact look at a variety of these issues in terms of the post-mortem and what the experience has suggested to us, and from a variety of standpoints. I would also encourage you to look at a piece that was in yesterday's New England Journal of Medicine by David Blumenthal. David has written a piece on sort of the Watershed Election and what we might expect going forward.

So, with that as backdrop, the – Billy Hoagland, who I think has spoken to this group a couple of times ago. Billy referred to the super committee of the 12 apostles. The 12 apostles were in fact given extraordinary authority, and for someone who spent a number of years on the Senate Finance Committee staff before going to the Leader's Office, I was offended with the authority that was given outside of the committees of jurisdiction. But not withstanding that, they in fact failed, as we all know, to be able to come to closure.

They failed for a variety of reasons, but I don't think any of us should understand or underestimate the extraordinary fundamental division that is deep and that is real around the

policies. This wasn't simply politics, it was really a fundamental difference of opinion over fairly fundamental questions in the direction that we are going both on the spending side, as well as on the revenue side. So, going forward I think we have to take into consideration what circumstances would allow those issues to be again addressed, either as Dan has suggested with a number of suggestions or as Stuart has suggested with some of the more major changes, but I think going forward you can not underestimate that there is a real fundamental difference. And part of its reflected by what Len suggested in terms of the freshman, the rise of the tea party, but it really more fundamental within the parties in terms of their views, of the role of government, and the role of these programs. So, going forward if we think about the timeframe, we are in fact in the midst of an election. We have a timeframe that essentially takes us between now and the end of this coming year at the election point, but we have a laying duck session potentially, if in fact there's something that occurs in the course of the spring that would lead us to essentially have to stay in session if in fact they aren't able to complete the minimum business necessary, and there is the period of time that will occur after the election. So, if we think of each of those in terms of timing, it is always difficult. If you think back to the kinds of reforms we've

seen in recent years, and I went back to serve all of the efforts at least that I was involved in and it was ERDA, DEFRA, TEFRA, COBRA, DEFRA, all of those efforts to try and drive policy. With rare exception none of them occurred in the year leading up to an election, almost all of them occurred subsequent to an election. ERDA for example was the first year after Ronald Regan was election. DEFRA was in '82 or TEFRA was in '82, but if you look at each of those, the one exception interestingly enough in our world was welfare reform, which occurred in the summer of '96, leading up to the '96 election, and it came about for a variety of reasons, not the least of which was a president who was essentially triangulating and trying to move to the middle to essentially bring along the independence, so the timing of these issues is extraordinarily important. It is unlikely those circumstances will repeat themselves between now and this coming election, so you're likely to see in the course of the spring, an attempt to try and continue to frame these issues. The only chance at real reform would be at the passage of a budget resolution, which we have not seen success with in recent years, which would lead to a reconciliation process, which would lead to instructions to committees of jurisdiction to achieve the kind of results that are envisioned by the committee, not likely to happen in an election year.

Who the people are at the table, there have been a lot of comments made about who made up the committee. You did have some major players in the Chairman of Finance and Ways and Means and Freddie Upton from Commerce, but you didn't have the necessarily leadership to essentially compel the action forward, so who comes to the table, and where those decisions are made will be quite critical. The momentum, Len has suggested correctly, I believe, that the momentum on the federal side and the state side will continue to grow, there is growing understanding of the challenge that are being faced, and I think that kind of momentum will continue to push for the public to essentially acknowledge that these are issues that need to be moved forward. The governors, because of the challenges they're facing on the Medicaid side will continue to keep pressure on those programs, again with a view to the long term in terms of getting some of these things done.

Around the momentum on taxes, nobody's happy, neither the left, nor the right, there's a fundamental disagreement of what the structure ought to look like, but an agreement that it is far too complex and far too involved, and that we need to begin to address some of those fundamentals, but it will be up against the momentum on the spending programs and whether you can see the two sides acknowledge and be willing to trade off against those differences. We did not see that trade off, but

it was fundamental to the breakdown of the Super committee, the differences between spending commitments on the entitlement side and taxes.

The status of the ACA, there are a great many who are going to be looking to see what happens in the courts this summer, and whether or not the ACA and its commitments, whether on the states or the federal side are essentially going to be put aside, which will change the game again in terms of the nature of the debate. The worst case scenario, whether it's a crisis, we inevitably respond in a crisis scenario, if in fact in January you saw Moody's or a whole series of the rating agencies downgrade us, as a result of what's occurring in Europe or what's occurring here, that could in fact lead to action on a part of the Congress. In the absence of that it is unlikely that we will do anything more than simply get through the spring and the things that have to be done.

And then of course there is the great unknown, that is the thing that occurs that none of us anticipate, whether it's an environmental change, whether it is a security related matter, something that essentially gathers the country together and puts aside at least temporarily those differences and focuses on those issues, but essentially the ground work for post election is, I think the environment in which we are. That has occurred before where essentially you begin to look at

those elements where there is at least consensus, where there seems to be agreement there were a number of things put on the table in the context of this reform. As Dan suggested, many of them are ones that we've seen before, but further understanding some of the options that Stuart has mentioned, whether it's restructuring of the Medicare program, whether it's looking at the trade off with the states and the feds, in terms of the structure of Medicaid, the populations or the services that are provided. Again, the momentum on the part of the states to begin to look at that. I don't think it's the last chance for reform. One of the papers in your packet says, is this in fact the last chance for reform, having passed I think the answer is no. I think it is the lead up essentially, and we can spend the next six or eight months preparing for what will really be the debate that will occur following the elections. And as David suggests in his piece in the journal, the outcome of those elections will make a fundamental difference in terms of what those responses are likely to be.

ED HOWARD: Thanks very much, Sheila. You've heard a lot insight. I've been taking furious notes, I can tell you for the last period of time. I also want to congratulate the panel on keeping within their self imposed shortened periods of time to allow us to launch what we're now doing, which is I would hope a lively interaction among folks who are at the

table, and at the microphones, and with the green cards if you have questions.

Let me just start off asking each of you – there are so many entry points to this conversation, but one of the things that seemed to be common when it was mentioned was the real difficulty of achieving anything substantial legislatively anyway, in the period between now and next January, absent some unforeseen event or great unknown. What should we be doing in this period? Holding candidates accountable, holding forums in which experts can lay out alternatives or just holding our breath?

UNIDENTIFIED FEMALE: Len, you want to start?

LEN NICHOLS: Well, I would start just by saying, I think what Stuart and I, and I'm sure others, I know Sheila and Dan too, basically during our spare time and that is try to formulate options for people when they get ready to have an adult conversation later, that's kind of what we do for a living. And I think that's really where we are. I think where we are is what are the things on the table. In some ways all those commissions, the Bowles-Simpson, Domenici-Rivlin, etcetera, you know there's a lot of options there, obviously none of them leaped up and were immediately embraced by the current leaders, but you know what, like Dan was saying about the OMB slide drawer, it's all kind of been worked out one way

or another. We can calibrate this or that, but I think it really does come down upon the intellectual apparatus underneath the political parties to come up with concrete options between now and '13, so we'll have something to go with.

DAN MENDELSON: You know, I would add that there are the large conceptual concepts Stuart was talking about, you know, premiums for example, a lot of us have worked on those for a very long time. When I was at OMB between '97 and 2000 we were playing with a lot of that stuff as well, and you know, a lot of that stuff is there, and then you've got the little ones that are all, I think very well explicated by the Super committee and by other committees that are in the file drawer. And where I would love to see all of us focus our time, effort and attention are things that sit somewhere in between, that I think are much more likely to actually get us out of the short term mess, because I don't think it's feasible or realistic to think that we're going to move to global budgeting of the Medicare program in 2013 or 2014 even. I don't think we're at crisis point at this point that would force us into that place, but I do believe that doing something substantial on dual eligible's or doing something substantial on long-term post acute care or really kind of getting into some of these lesser managed aspects of the system can happen, and when these issues

have come up, like for example when post acute care was taken up under the Reform Act it wasn't ready for prime time. I don't know how many of you remember, but there was an early proposal that would have bundled all the costs of post acute care into the hospital payment, and that was actually interesting policy, because it would have created an accountable party for all of those costs, but it wasn't, you know, the hospitals weren't ready, the long-term post acute care providers were not ready, nobody was ready, so if there is a major focus on some of those other elements, I do think that we'll be better prepared to actually move the ball forward a little bit come 2013.

SHEILA BURKE: One of the things that concerns me – one, I think we have to be alert and aware of, and concerned about, in the course of the political debate, people taking absolutes and absolute positions, which subsequent to an election they then are essentially compelled, so that, you know, taking things off the table scenarily, and so whether or not you raise that in the context of a debate, whether or not you try and continue to raise those issues. I think that's one of the concerns, but my other concern is, I think we instinctively, and perhaps it's because all of us have perhaps spent too much time here, and that is presume that the answer will be federal. And I think we underestimate, and I think

you've just pointed out a couple of examples. We underestimate the capacity of the states to being to help identify in the course of their work, in the course of some of the efforts that Len's pointed out, to begin to look at, experiment with, and test different systems, and I think a concentrated and focused effort to begin to gain information from the states to understand what they in fact are testing, what kind of flexibility you give them. There is inevitably a concern that arrays to the bottom, which is a real concern, but in fact the states have shown tremendous resourcefulness in many respects. And I think we ought to as we look at options and prepare them for post 2012, make sure that we are in fact engaging them in this conversation, not simply assuming that the feds can define the answer.

STUART BUTLER: Yeah, and I could just add, if we were a parliamentary democracy, we might be imagining that we could have an election over this issue with clearly defined positions and so on. The Spanish just did this and voted in a different government, that's not going to happen. America doesn't do things that way, it's too fuzzy in terms of the political debate and so forth. That said, I think what Sheila said is absolutely right and I would sort of add an item to that. One is we've got to have a conversation, starting now and it may last for two or three years before we really see action, about

what is the process of actually getting this decision met. Is it going to be some, you know, a Super committee in Washington making a decision, no I don't think that's – if people want that, it's not going to happen, but I think this idea of bubbling up, the idea that the answer's going to come from somewhere other than Washington, and therefore encourage a process to make that happen is something that sits well with the American people, it makes sense to them.

I think the other part is some underlying kind of values and themes that have just got to be – the discussion has got to be crystallized over there. Should Medicare be something that people can get irrespective of their income, some huge range of benefits, and no matter what it costs they'll get them, and if their kids and grandkids suffer the cost so much, so be it, or is it going to be something different. Those kinds of underlying, what you might call soft, sort of values themes have got to get into the conversation more, because if they don't you're going to see just a debate where people are just not even on the same song sheet. They don't even understand how a particular proposal links to things that they really value as fundamental values of themselves, and so on, and that's going, so those sort of – the process conversation and the sort of themes and values conversation has got to be triggered, and is going to go beyond

this election before we're actually going to see, I think, this problem solved.

ED HOWARD: Thank you, Stuart. I'd like to try to do something a little different. I want to try to concentrate this conversation for the next few minutes on the kind of responses to the period before we can do the kind of long-term manipulation that some of the panelists have described. We've got a couple of questions here that are technical in nature and fit into that category. Mike, I have a hunch you have a broader gauged question that you want to ask and if so, I would like you to hold it for just a minute.

MIKE MILLER: Sure.

ED HOWARD: Okay, you're a great man. This one goes to Katherine actually or others on the panel if they care to. Can you clarify if there's a difference between how sequestration works for 2013 versus the other years? Is the 2013 process uniform and automatic in its cuts on discretionary spending and afterwards you have more congressional discretions through appropriations, or is it the OMB process. In other words, what's different between 2013 and '14 through '21.

KATHERINE HAYES: Sure, 2013 is very different, you know, as I mentioned we're going to be into the second quarter of the fiscal year when sequestration actually hits, so with respect to mandatory spending programs, OMB is going to, in

theory if this happens, if Congress fails to intervene will have to make across the board cuts in all programs, with a 2% limit on Medicare, all non-exempt programs. With respect and for 2014 through 2021, discretionary spending will be subject to spending caps that will be done through the regular congressional appropriations process or lack thereof, as we've seen recently. For 2013 specifically, it will be left to OMB, as I understand it, of course I'm certainly open to those of you who were around when the first sequestration took place under Gramm-Rudman-Hollings, as I understand it what will have to happen is that there will have to be a sequestration for discretionary spending as well in that case, because we will be into the fiscal year, but I guess, of course it will depend on what Congress has enacted through the appropriations process that year.

DAN MENDELSON: I think, you know, we have some very detailed modeling on a year-over-year basis, and I think what Katherine said is exactly right in the sense that because it's a short year there are much higher cuts in the first year that get forced into the system, which is why I think it blows a gasket in the first year and never makes it out of the box, but you know, the global limits on spending are kind of spending caps, I think are potentially a more durable solution, and it forces some level of prioritization within the OMB. I don't,

you know, for having spent time at OMB, OMB does not take kindly to, you know, meat axe type budgeting where you are forced to make a certain reduction across the board, it just doesn't. And the Congress takes even less kindly to that, so you know, that's really I think the process that we have initiated here.

UNIDENTIFIED MALE: And how much discretion does OMB have in this process?

DAN MENDELSON: I think OMB would have a tremendous amount of discretion to make proposals, but ultimately it's going to be up the congress to actually make the decisions about how the appropriations get done.

UNIDENTIFIED MALE: One last really short-term question, I guess or I guess it's not short term until 2013. Will GME and IME, direct and indirect graduate medical education funding be subject to sequestration? Katherine, you want to?

KATHERINE HAYES: My guess, you know, I don't see a reason why it would not be, you know, if you look at those programs that are exempt from sequestration, Medicare is not exempt from sequestration, it is however subject to a 2% cap, and so I would assume that it would be subject to 2% reduction within the discretion of OMB to do it however they want, but I don't see why not.

ED HOWARD: Mike?

MIKE MILLER: Thanks, Ed. Mike Miller. I do have sort of a broad question, maybe a little heretical, cause really what we're talking about here is legislative or administrative actions that cut projected spending, and as Len pointed out, you know, the providers of the community know that it's not business as usual. Medicare's moving into a mode through the ACA provisions and others, where they're really changing how they're doing things in working with private sector, and not just saying we're going to cut this dollar amount by 2% or 5%. As Sheila said, there's a lot of state action going on, actually I've been working sort of the local level, and Ed, on your Web site there's a great map that shows the arch and Robert Johnson, and the Beacon programs. There's a lot of things going on at the sub-state level, where they're enacting things not business as usual. And CBO doesn't really, I think and I think at OMB to some extent too doesn't know how to score that, so I think there's a lot of things going on that are going to change actual spending, but that aren't really very score-able, and I want to know what you guys think about that and if there's a way to change the business as usual scoring. I know this is an ongoing debate, but also how you think that the provisions that might get scored to achieve the projected savings, is there a concern that those actions might get in the

way of these actual local level and real world implementations that will change our health spending in the long term.

SHEILA BURKE: Dan's probably the best person to answer this question, but you are correct, Mike, it is not a new issue. We have battled for years with OMB and with CBO over their estimates of what the likely outcome would be as the result of an action. And it is a difficult task in the absence of evidence to convince them they're certainly examples of where we presumed that something would result in the savings, where in fact it resulted in increased utilization or I mean, their whole variety on the Medicare and Medicaid side, but I think that continues to be an issue and they, I suspect come at it with some skepticism appropriately placed, but I know, you know, the budget committees go back and forth, certainly the committees of jurisdiction, finance certainly did go back in forth over trying to argue the case, you know, if we do this then this will occur, and it will result in, you know, less hospitalization, you know, whatever it happened to be. But I think that – again I think that's not a new issue, but Dan was on the other side of that.

DAN MENDELSON: Yeah, I would only add that the scoring methodologies are not only well thought out, but also well policed by the budget committees and by CBO, it's pretty tight. And having fought a lot of those battles, some successfully,

some unsuccessfully, I will say that I think it's very, very difficult and I don't think there's a way out of this problem through scoring. I mean I will be the first to say that there are big problems with scoring. I think the way that the class act scored for example shows the problem with scoring, and the problem with scoring again is that you have this ten year budget window and that it's an artificial window, and so there are a bunch of things that you could change, but we are facing a deficit right now that, you know, goes, that's unrivaled since World War II. And I don't think the solution is going to get beamed in from Mars or Kansas, or anywhere exotic. I think that it's going to come from right here in Washington D.C. from the people sitting around this room. Because, you know, that's really where things will have to happen, so anyway, my view.

LEN NICHOLS: If I could just –

ED HOWARD: Go ahead, Len.

LEN NICHOLS: If I could just add, uh, 30 seconds as a way long time ago, OMB person. As Ed said, Stuart's key and I've been around. So, I'll just say, you don't really want to change the way CBO does its business, what you want to do is produce evidence that they can accredibly actually account for. And I would say the most important thing about those things that are going on that you and I just worship, is let's get the

evaluation done right, so we can actually prove it, then we'll be fine.

ED HOWARD: And – but how long is that going to take, I mean you talked about the map, the AHIP map that [interposing] –

LEN NICHOLS: Well, Mike's fundamental point is the baseline is going to change from the behavior and we're going to watch it and that will be the proof in the pudding, so we'll go from there.

ED HOWARD: Yes, go ahead.

STUART GORDON: Stuart Gordon with Amerigroup, and this is in fact the alliance for healthcare reform, so let me pose a scenario, and that is, the visionary with a capital V is gone officially as of today from CMS. And I think in part because we all knew the visionary was going to be a short term visionary. A number of programs, a number of innovations sort of flowed out of CMS in a fairly rapid manner, also because of ACA, that was that one conference earlier this week where they referred to it as turmoil, and they were all people that believed in these things. The providers participating in all those innovations, all those healthcare reforms are basically, for the most part, conservative. I work for an organization where we're still struggling with whether or not we're going to do exchange plans, so with the visionary gone and the drive

that the visionary provided gone, these providers are about to, I believe, see a Congress that is holding a budget axe over every innovation that has been proposed.

Now in the next year or so we're not going to see a lot of — I don't think we're going to see a lot of quantifiable results from those innovations, at least not immediately, so what happens to healthcare reform in this environment?

SHEILA BURKE: Well, I guess it depends on what you define as healthcare reform. If you look to a number of the changes on the financing and delivery side, separate them out from the broader politics of healthcare reform, but recognize that there is, I think a growing understanding across the board that we need to do things differently, both for the people that we serve, for patients, as well as for the provider groups and others. I think you're right, that there will be this overwhelming sort of threat of the use of the budget to prevent certain kinds of things from going forward, but I think a lot of those innovations are occurring in both red and blue states. You've got provider groups organizing some of the groups that Len suggested, and others who are because of the compelling market issues within their own community are beginning to look differently at whether they vertically or horizontally integrate, whether they look at the continuing of care, so that essentially you're looking at patient not only at the point of

service, but at the continuum of the point of entry to the point of discharge and that includes both the preadmission, as well as post admission services. I mean we are finally recognizing that patients don't come in silos, they come as a whole package and you've got to figure out how to manage them. And so I think the pressure for us to rethink the way things are delivered, I think isn't essentially going to be lessened over time, I think it will only grow. I think the hospitals are struggling to understand how to deal with it, certainly the academic teaching hospitals and others are struggling to figure out how to manage those issues. So, I am not at all of the view that all of that will stop, either because Don left, nor because of the other battles that are taking place. I mean there are issues around IPAB, there are issues around elements of this that are more political in nature, but I think the fundamental desire to sort of rethink the way we finance and deliver services is pretty broadly spread. Now whether you go to a market strategy in terms of how you structure Medicare, you know what you do in terms in of the state/federal compact on Medicaid and whether or not you rethink that strategy, because of pressure out of the states. But I think the fundamentals, I sit on the AAMC Board and I sit at these board meetings and listen to all the, sort of teaching hospitals and the deans, and some of these other folks, and I mean they got

it, I mean they understand that the way they've done business before isn't going to work going forward, because the patients are demanding something different, the payers are demanding something different, so I am not discouraged in that context. I think things will move forward. The backdrop will be challenging, the financing will be a challenge, just the politics around some of the other elements, but I think we are understanding increasingly that the systems isn't working well. I mean we're not getting the kind of outcomes, the kind of quality that we want and I think people are of a common mind to try and make that better, I think, now maybe I'm not rosy colored glasses with that, but that's certainly how I view it.

ED HOWARD: Stuart, actually that reminds me, you were talking about trying to get into a conversation about where we're going connected to the distinction that Len raised about short-term versus long-term approaches to dealing with this. Is the conversation we need to have how to get federal health spending under control or is it how do you get these innovations that are occurring in the private sector, and the state, and community level in place in ways that might take advantage of the efficiencies that they generate?

STUART BUTLER: Well, I actually think it's both of course, and I think that one of the things and [inaudible] offline for a moment, that this whole 10 year window in terms

of the way CBO is a horrendous problem. Not only does it give you the wrong sign in something like the class act which, you know, was suggested it was sort of a money makeover the long haul, but it gives you know way of gaining the benefits from making decisions now in either a budget sense or a political sense that really will have huge effects in the future. So, I think redesigning the way we measure and portray federal spending is critical. I think it is an issue of looking at the public sector in the sense of when you're looking at the deficit and debt issue that's government spending we're talking about there and that is the heart of it. And then as you also said, I think that a process for allowing this bubbling up of innovation that's going on, I mean reform is happening all the time in the sense of people trying to find better ways, and it isn't necessarily all market, it can be governmental institutions and so on, but we should be capitalizing on that rather than either ignoring it or trying to drive it down one way from here in Washington. So, I do think that engaging the governors, engaging some of the more creative, private plans, sort of in this conversation to say, you know, there's hope here, there are ways of moving forward, and use that in a sense to try to move the federal government to start to allow or encourage the kinds of on the ground activity, even more of that, that will ultimately be the key to solving our spending

design challenge, that at the moment we just seem to be incapable of dealing with.

DAN MENDELSON: I think that's very well said, to be, you know, to maybe reduce it to some practicalities, interaction between the innovation center and the Hill is going to be very important, because there are a lot of very interesting demonstrations that are coming through the innovation center in post acute care. Related to health information technology, for example in other places where congressional action could actually facilitate more rapid evolution in the private sector, and I think that, you know, the limitation of these demos is that they're demos, and that there are so many that are going along, and so you can't just rely on that process and expect that that's going to solve things. There has to be payment system changes that are made to facilitate a lot of the changes that are being experimented with, and so really beginning to kind of pick some of those items and bringing them into the legislative process I think is going to be very important over the next year.

ED HOWARD: And how much of what's in the Affordable Care Act now and that presumably will survive at some level despite the sequestrations is going to foster that kind of activity, or is it going to have to happen, you know, absent

governmental or at least federal governmental encouragement, or supervision, or channeling?

STUART BUTLER: Well, I think the federal government's role is to facilitate things. I don't think it's going to come in the sense of the federal government figuring out, sort of, what the magic bullet is, having gone around the country, you know, with Len or somebody else, and say, oh, this one is the right way to go. I just don't think that's the way to even think about how the federal government can make this happen. It's got to be a more structured process to give the green light. By the green light, I mean things like both regulatory, both administrative waivers and legislative waivers to allow some very interesting things to start to really happen at the state level, that's a facilitation function, that's not, in my view, the thinking behind the ACA in general, it isn't, so I think it takes a very rather different view from as to how the center works and that's how the center in sense of the political center here in Washington of the federal government actually operates. It's got much more of a facilitation role, allowing things to happen, not trying to lead it.

LEN NICHOLS: Yeah, if I could I would just jump in and agree with Stuart, that one of the things that we probably need more of is essentially ask the question, what can the federal government do to allow people to do stuff that's a good idea,

but they're prevented from doing it now by existing rules, but I will point out that while perhaps some parts of the ACA might take that old traditional, you know, you got to ask for permission instead of forgiveness approach. The Center for Medicaid [inaudible] is completely different, and that is indeed obviously the child of the visionary, and there is $10 billion there, and if you take two-percent we've got enough left, hell we can't give it away that fast.

So, fundamentally there is a lot of creativity that's going on right now, and in fact the most recent request for ideas, which is essentially tell us what you think would work is a damn good example of what we're talking about here, and that is take some of those ideas that are out there and try to make them multi-payer and try to make them move faster, and try to spread and breakdown the barriers, so I do think that the federal government's role is catalytic in this regard, but it also, frankly, they're going to have to pay for some infrastructure here and there and yond, to make it work and that's really what that money's for.

SHEILA BURKE: I also think that I wouldn't disagree with either Stuart or Len, but I also think there seems to be some willingness to make course corrections, I mean we know that the initial regs on the ACO were not, shall we say, well received, and so there has been a course correction to rethink

what in fact led to people saying, no, you know, the structures are not the right structures, then we did pioneers. I mean there seems to be a willingness at least to think and to respond to legitimate issues that are being raised, but I also think that there is work going on that certainly is not necessarily the result directly of federal activities, but is going on for a variety of other reasons. And the question is how do you make sure that occurs and not put impediments in the way rather than anything else, but some funding, whether it's on the IT side, you continue to hear that sort of those IT infrastructure, the ability to share data, the ability to essentially access information I critically important, and so the question is how one responds with an infrastructure, as well as a response to divining a new system.

ED HOWARD: Very good. Yes, sir.

BOB ROEHR: I'm Bob Roehr, British Medical Journal. For about 15 minutes during the healthcare debate there was the phrase, bending the curve in terms of costs and expenditures there, and my sense was the best we could hope for was, you know, just bring down the average rate of growth and the spending to that of the rest of society, instead of having healthcare become an increasing percentage of GNP or GDP. And even under that most optimistic scenario we would see a plateauing of health spending at about 20 percent or even more

of the total economy. Is it possible to not simply just stabilize at that type of level, but actually control costs of healthcare, so that they do shrink a little bit in terms of GDP?

ED HOWARD: We've got a lot of economists up here, I'm sure they have an answer to that.

LEN NICHOLS: Sure, it's possible, but it would take the kind of will that Stuart wishes was in the backbone of the people who are elected to serve the people of the United States. You talk to really smart people out there who run hospitals, or they run big systems, they run physician groups, they run health plans, and they kind of know where the bodies are buried, and the estimates are pretty uniformly, roughly a third of what we spend is not increasing health. So, yeah, it's possible, but it will require folks to do what – for example the American College of Cardiology has begun to do by putting out, based on real data, their own data, their own registry data, they're way ahead of most specialties in this. What they call appropriate use criterion for various high utilization imaging and some procedures, and roughly I think the scientific evidence is something between 11 and 30 percent is probably not indicated and wouldn't happen if you were in a different place in a different part of the country, and so 11 to 30 percent of cardiology is, I don't know, a big pile of

money. I think it's the single largest expense in the Medicare program. It's about 40 percent of the total Medicare spending, so it's a lot of money. So, yeah, it's possible, but don't forget, and I'm sure you know this, one person's cost is somebody else's income, so we have to have a glide path.

I mean fundamentally this whole thing is hinged on no one's worked out the transition matrix's math, maybe Dan has, somehow I think we might have a few footnotes to go, and so fundamentally that's the deal, we've got to work out how to get from here to there. If you work out how to get from here to there, in my opinion, it's going to be possible for Washington to do it, Stuart and I agree. But those guys out there in the real world can if we give them the right incentives. You're going to have to share the savings with them, you're going to have to share the savings with them. You have got to give them some kind of, if you will, interest in the social interest of reducing cost growth. If you do that you can damn well do it, but it's going to require a rather different approach to incentives than we've had yet so far.

DAN MENDELSON: Len's answer is really interesting, because he says it's possible, then he gave you all the reasons why it's not going to happen, so I'd like to just say that I don't think that's going to happen, and I don't also think that it's either a feasible, realistic, or a helpful goal to try to

think that we're going to, you know, freeze costs or bring them down. I think that the right level will equilibrate in a lot of ways, but I do think that in the short term, what we – what everybody in this room should be focused on, are finding the places where there are heavy inefficiencies, because there's a lack of management in the system, and to go after those areas aggressively, to try to get those efficiencies.

I'll also point out that one of the most important provisions in the Reform Act, the change in the Medicare Advantage payment system, where the Congress had – we have this star rating quality program, and we're going to start using this quality program as a basis of payment. It is a radical reform in a lot of ways, and you basically take between five and ten percent of a health plans revenue and put it at risk for quality, and what do you think is happening, well, you know, the plans are running out as aggressively as they possibly can to try to bring their star ratings up, so they're immunizing more people, and they're making sure that beta blockers are prescribed post-MRI, and they're really responding to this payment system.

And to me the answer in the next couple of years, really sits at that nexus point, which is that if we take – if we mind the places where there are inefficiencies and try to take it out, like in post acute care and the dual eligible's,

and if we continue to push the payment systems towards quality based payment systems that also, you know, achieve strong public health goals, then I think we're moving in the right direction. But I don't think that either of those things is going to bring me – bend the curve necessarily or bring things under control.

STUART BUTLER: I mean, I think Len is exactly right in the way he described the 20 percent or the macro situation that all spending is somewhat his income. And the only way we're going to see this cost grip actually coming down is for some combination of few people to be in the healthcare system, and not learning the salaries that they thought they were going to earn in the future. That's true in other countries, and it has to be true for that cost number to come down. And the issue is, how do you do it? I'm skeptical that simply saying, let's look at efficiencies as a way to make that happen, because I have this feeling that if a physician, for example, finds that one particular source of income from a particular procedure can be done more efficiently with less revenue coming in. They'll find other ways or create new things they can do to you, all very good that will bring their revenue up, because they have a sense, an image if you like, of what their appropriate remuneration should be as a physician. That has to change in some way, it can change through budget, pressing it down,

that's what some of countries do, it can come in a variety of ways, but that's got to happen. When you start doing that to physicians they start complaining with some justice, that it cost me so much to go through medical school, how am I going to cover that. Well, then that's – you've got a trickledown effect, in the sense of once you start challenging those numbers of people and how much they earn, that starts to put pressure down the chain, and that's a process that's going to happen here.

What you can't do is say, we're going to somehow get the cost curve to come down, but somehow we're going to have the same number of hospitals doing sort of the same things, and the same number of people having roughly the same incomes, it just cannot possibly happen, so something has to change in this equation, and it may be that physicians have an income status in the United States in the future, somewhat more like physicians do in other countries. And the same with people who run hospitals and so on. Ultimately, maybe that's what's got to happen.

DAN MENDELSON: Alright, you're supposed to be a Republican.

STUART BUTLER: I'm not a Republican. I don't – I don't take insults like that.

DAN MENDELSON: I'm sorry, it's not an insult, you know —

STUART BUTLER: Especially if what is logically the only way through, you cannot possible have — everybody would be the same in the healthcare sector, the same number of people and somehow the total number girls.

DAN MENDELSON: I'll give you — I'll give you a different — I want to give you a different example, I want to give you a different example, because physician income, I think, you know, I have a slide that basically shows a continuum of different — of how payment systems evolve and if you have kind of an under fettered payment system where, you know, kind of there' no management. Moving to quality based payment I think is a useful next step, and then, you know, you can evolve it from there, but put physician income aside, let's talk about re-hospitalization. And this was actually one of the more interesting and creative proposals that was in the President's budget, where he said, look, let's think about a penalty for re-hospitalization, and that we will not pay for the cost of a re-hospitalization, which forces more care management down — downstream, and that's the kind of thing that I think Is possible, and important and can be done, so you know?

STUART BUTLER: I don’t disagree with that. I just think that if you do that, it will be better, and then hospitals will find some other way of recouping the revenue. And unless you tackle that head on hospitals have got to get less total revenue coming in, and physicians have got less totally. If you're going to see total cost as a percentage of GDP go down, its' the only way it can happen. I'll give you an example where it doesn't happen, you know?

SHEILA BURKE: I think Stuart's presumption is correct. I mean we have seen this time and time in the Medicare program where MedPAC points this out repeatedly that if in fact you press down one part of the balloon, another part of the balloon essentially curves as they move within income opportunities. But the other scenario, I think, in addition to the two that both of you have raised, is that it's not only a question of the income of physicians or sort of how we deliver services today. It is also looking differently at what the workforce looks like. And in fact I think a rethinking of what the responsibilities and authorities are within the workforce, are there things in fact that are occurring today that are done either by physicians or others that could be done by advanced nurse practitioners. Are there community health workers, are there folks within the institutional system to manage those transitions, so I think it's not only a question of looking at

our distribution between specialties and primary care, which is radically different than every other country. But it's also how you utilize the entire healthcare work force in a very different way. And we have historically not done that and the payment systems have failed to acknowledge that. And I think there's a real desire to think today, what is the right allocation of work, what's the right allocation of services, and how best do we manage payments. So, I think that's the other piece that has to be considered.

ED HOWARD: Great.

UNIDENTIFIED FEMALE: Could I make a suggestion, over here.

ED HOWARD: No, I – hang on just a second. I thought Len was –

LEN NICHOLS: I was just going to add one little point, I'll be really quick, and that is while I love to watch Sheila and Stuart to take my side against Dan, what I would – to shift completely and to defend Dan, there is one thing we haven't mentioned, and that is administrative simplification, and how that could help on the provider side. Let us not forget, again smarter people than me think hospitals spend about $0.20 on the dollar getting paid, doc's – small practices, $0.30 on the dollar. Okay, that's because we have something approximating

1,300 insurers in this country, and they all have different claims judication algorithms.

Now it'll take a while, but in the law there is a process and the process is already started to move to standardization of those claims judication algorithms, and I can tell you, you will get a whole lot of money back and that money can be used to compensate for the empty beds and the lack of procedures that the docs and the hospitals are going to suffer, so anyway there is that little found money there.

ED HOWARD: Okay, now we have time for just a couple more questions. I ask you to listen to the questions and answers while you are multitasking by filling out your blue evaluation form. And I believe this gentlemen was at the microphone first.

STUART GUTTERMAN: Hi, I'm Stu Gutterman at The Commonwealth Fund, and I'd like to put some perspective in light of the conversation the last couple of minutes, on bending the curve. The latest projections by the Office of the Actuary at CMS have health spending in 2011 at 2.6 trillion, 2010 at $2.6 trillion, projected to go up to $4.6 trillion by 2020. That means that there's a total of about $36 trillion in healthcare spending that's scheduled to be – that's on the table for the next 10 years. If health spending were kept at the growth rate of GDP according to those figures and they're

outdated, unfortunately GDP's not growing as fast as they had originally projected, but using their projections health spending would be $4.1 trillion by 2020. That would be about a 60 percent increase over 10 years if we held health spending to the same growth rate as GDP. We're not talking about a decrease in spending.

We're talking about a decrease in the growth of spending from something like 80 percent over the next 10 years to something like 60 percent over the next 10 years. So, let's keep this in perspective when we're starting – when we're talking about empty beds, I don't think we're talking about empty beds. I think we're talking about building a new hospital wing in seven years, instead of building a new hospital wing in five years. That may not be good news for hospital administrators, but it's not quite the same thing as having half empty hospitals. So, I think when we talk about all of these strategies, we need to talk about them in the context of the fact that we're looking at, unless we do something quick, 80 percent increase in health spending, and we're talking about an ideal situation that nobody believes we can really do that would reduce the growth in health spending to only 60 percent over the next 10 years.

ED HOWARD: Challenging figures, any reactions? He's right, there is a consensus, he's right. Yes, go right ahead.

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CAROLINE POPLIN: I'm Doctor Caroline Poplin, I'm a primary care physician. If I could just inject into this question of physician incomes and other costs, something that's not mentioned, and that is we're talking about the situation, what we can do to the people who exist now. If you look forward and say, well orthopedic surgeons now make half a million dollars a year, but in the future for new people coming out, you will only make 40 or 50 percent more than a primary care physician, as in Europe, then people can plan accordingly. It's much easier to say that, than to go back and say, well you've already put in eight post graduate years of residency, and now we're telling you, we can't pay you. If you tell them in advance, like they do in industry, the people coming into industry now, the people going into public employment. They know they're unnoticed, they will not have the same pensions, they will not have the same salary increases, you could do that for drugs too. Germany is doing it. They're saying if your new drug comes in and it doesn't have a substantial benefit over what's on the market now than you will get the price of the market now. You can't just set your own price at whatever the market will bear.

UNIDENTIFIED MALE: And let me just add to that series of observations. Our earlier conversation about short term versus long term, because what the doctor is talking about will

not yield short term budgetary savings that are going to help states or the federal government hit that 1.2 trillion.

STUART BUTLER: Maybe I could just respond quickly though to that. I think I would sort of half or three quarters agree with you, that certainly you always have this predicament, what about people who in good faith have planned or incurred cost [inaudible] and that's true in any field. And therefore you want to have a long glide path to use, so Len's terms, to make this happen, all the more reason I think in the policy debate then to have a conversation with the kind of numbers we just heard and also a true long term picture where we're going. This issue about the 10 year period where we measure everything just underscores how that skews the whole discussion and prevents the kind of long term. But I would say just let's realize that there are people in all kinds of other sectors, particularly in the last two or three years who've seen plans that they made and things they thought were iron clad forever having to change. I don't think that physicians should be exempt from that if everybody else has to. If teachers and firefighters, and people in the private sector and so on, so I think there's got to be a reasonable kind of balance here. I think some people in the medical field are going to have a situation where things they planned, and they may be in their mature years and so on, are going to be a

little different. I don't think there's a way around that, as at least part of this solution.

DAN MENDELSON: I think it's a thoughtful comment though, and I think that if you look at the disparity between specialist income and primary care physician income, that the fault of that really does sit with the Congress in my view. That the Congress has advocated responsibility for the allocation of that to the RUC, and the RUC makes decisions, but the Congress is ultimately the body that is responsible for Medicare payment, and that there could be an equilibrating mechanism that would be put into that system that could be phased in over a number of years to address the disparity and, you know, again this is one of these things where I've been doing this 20 years and it's been a source of complaint for 20 years, but nobody has done anything about it, and to begin – to phase in certain adjustments like that, I think is appropriate. And I think that, that's the kind of thing that could be addressed in the context of a broader reconsideration of how we do physician income in this country, but it would have to be, you know, part of a bigger solution where there's a put in take back and forth between the specialists and the generalists.

SHEILA BURKE: I agree with you and I think there's been attempts at that. I mean as a result of MedPACs work, but also congressionally. I mean we've looked at different update

factors for primary care versus we used to call them the cognitive versus non-cognitive services, not really a fair description, but I think Congress has attempted around the margins, but I think you're right, it's a more fundamental question, but I think they've attempted to try and look at that, but it is an issue that's been around for a very long time.

ED HOWARD: Alright, the honor of the last question goes to you.

MARY WOOLLEY: Great, thank you. Mary Woolley with Research America, and let me first say, thank you for really provocative, interesting conversation. I want to ask the panel and particularly, Sheila, perhaps you to react to a couple of things that I've really been struck by, just in terms of general population data. In terms of the demand for change, and the level of concern among the public for things including the cost of healthcare, and access, and many other things. So, I've really been struck by some data, just a couple of pieces here.

So, in 2005 70 percent of the population said that they felt that the healthcare they received was based on the best and most up to date evidence. That's now dropped to 45 percent, so less than half of people feel they're getting high quality care if they get care at all. And secondly it's now

over 50 percent of the population will say that the United States doesn't have the best healthcare system in the world. And if the trends are going in this really negative direction and there's more and more public recognition and i.e. demand for change, how do you think that'll play out in the election that's coming up and given what you said earlier, Sheila, about how Congress is historically unlikely to make a change in the year right before a presidential election.

SHEILA BURKE: Those are compelling numbers, but if you were to talk to Bob Blendon or the folks that do a lot of polling around this area. Bob would tell you that as a general matter, who's one of my colleagues at Harvard, the pulling over the years with respect to healthcare has remained relatively stable, it ebbs and flows. It never hits the top of the list of things about which people care nor that they vote about. If you ask, within healthcare what are the things they concern most about. Bob's data, state cost, and is the thing people care about. If you ask is it in your top issues upon which you will base your vote, the answer is no. And if you ask within the context of healthcare, what are you prepared to do to deal with this issue.

The absence of consensus and the lack of understanding of what the key elements are is really quite stunning, you know, are you worried about the uninsured, will you cover the

uninsured, yes. Are you prepared to pay higher premiums or taxes to deal with that, no. Are you worried about cost, yes. You know, is your personal physician — sort of like the view about Congress, I hate Congress, but I love my Congress person. You know, I, you know, I think the whole healthcare system, you know, sucks, but I like my doc. So, you have a — members have a very difficult time drawing from that data any sense of consensus about what it is people would want to do. Are you prepared to have fewer choices, no. So, all of the triggers, all of the levers that we arguably have in the financing system politically are enormously difficult. And so one of the challenges has been how you drive that consensus.

There is this increasingly overwhelming fear, but for the majority, the large majority of people in this country who have coverage, the concerns are radically different from the people who do not. And so how you build a consensus around are you prepared for revolutionary change, are you prepared for seismic changes in the choices that you have, do you understand the implications of those changes, is what challenges members to essentially take these positions that would pick them out of the mainstream in terms of what interventions, so it is a process of education.

I think Len's point that people ought to be out there talking about what these options are, what they mean, a growing

sense of understanding on the part of the public about what the options look like and what it means to them, but we have essentially encouraged people to think they can have what they have, when they want it, you know, when they choose to need it, rather than that there will be decisions made. Everything's put in the context of rationing, which exists today, but it's just not, you know, in a category clearly defined. So, your data's exactly right, people are concerned about quality, people are concerned about this system, but it's an abstract rather than a specific, and so it is difficult to get people prepared to stand up in support of members who take those positions. Often, even in town hall meetings, in 20 years that I spent on the staff up here, you know, I don't know how many town hall meetings I went to Osawatomie, Kansas, it rarely came up except in the context of a very personal, this is my problem with my insurance company, but rarely in the context of the broader system. And so I think that's one of the challenges we have is helping convert it into a conversation the American public engages in. That's my own view.

ED HOWARD: And I would say a very apt conclusion to the conversation, which I have found exceedingly rich and helpful, and I want to thank you for your contribution to the questions, and the observations coming from the audience were, I think, some of the best we've had in this series.

I want to take a moment just to thank, once again, our friends at the Kaiser Family Foundation, The Scan Foundation, The Commonwealth Fund, and The Robert Wood Johnson Foundation for allowing us to put this series together. Put it together very quickly, but plan it over a period of time that allowed it over a period of time that allowed it to span the period during which Congress was really working on this problem. And finally I'd — reminding you to hand in those filled out blue forms as you go, but before you do that join me in thanking the panel for an incredibly useful conversation. [Applause].

[END RECORDING]

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