SPECIAL PRESENTATION:

"PROGRESSIVE PRESCRIPTIONS FOR A HEALTHY AMERICA"

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MR. JOHN IGLEHART: Good afternoon and welcome. I am John Iglehart, editor of the journal *Health Affairs*, and it's a pleasure to have you here for this briefing. As you know, *Health Affairs* has published more than its share of health reform proposals over the years and we will undoubtedly continue to do that, not because it's going to happen tomorrow, but one of these days – one of these years – it will happen because any country as wealthy as ours that has fully 15 percent of its people without insurance will one day act.

The panel today will provide a variety of voices and viewpoints on this proposal, I am sure, but we will begin with John Podesta, the president and CEO of the Center for American Progress. And one sentence from its mission statement pretty well summarizes what the center is all about. "It is a nonpartisan research and educational institute dedicated to promoting a strong, just, and free America that ensures opportunity for all.

Each of the panelists will follow Mr. Podesta and speak for about five minutes. Following their formal presentations, we will give them an opportunity to react briefly to what their fellow panelists have said and then we will open it up for your questions and comments.

I am hoping that this proposal at last includes the remedy for the common cold, which I am suffering from at the moment, so I will probably try to limit my comments before my voice gives out, but with that I will turn it over to John Podesta. (Applause.)

MR. JOHN PODESTA: Well, John just set another higher bar for us to meet, so we thought we were aiming big to begin with, but now we have to cure the common cold. I want to thank John Iglehart at the front end, and I really want to thank *Health Affairs* for publishing our article, "Prescription for a Healthy America," in *Health Affairs*. It's tremendous that the article appears in such a prestigious journal.

I want to do a couple of others thank yous before I begin. Dr. Jeanne Lambrew, who is our senior fellow and a professor at George Washington University, has been tremendously instrumental in shaping this plan and I want to thank her and I want to thank Terry Shaw, who is standing in the back of the room, who is our Associate Director for Domestic Policy and worked over the past year to try to help pull this together and I am going to talk a little bit about where this all came from. And I want to thank this really tremendously distinguished group of panelists to comment on the plan and to give some competing views and to help us shape in and move this debate and dialogue forward.

I said that Terry and Jeanne and I had been working on this for probably a little over a year now and that actually dates back to something Jim Mongan and I were talking about, which is that the Institute of Medicine, a nonpartisan group of health experts, just

over a year ago presented our nation with a bold and unprecedented challenge. The institute called on our leaders to take decisive action to guarantee health coverage for all Americans by the year 2010. Jim was saying that maybe he was worried that it didn't get enough attention. I said, "Well, at least a few of us read it." And we sat down and said, "That's a real challenge that we ought to be able to give our best thinking about how we meet that." And that's what we are here to talk about today.

The institute understood something that unfortunately I think this Congress and maybe even this president have been willing to ignore. It is that today American families are confronted by an urgent healthcare crisis of immense proportions. As we meet here today, 45 million Americans lack the healthcare coverage they need. That's 5 million more than they were in 2000. And to put this in some perspective, that's 7 million more people than suffer from HIV/AIDS worldwide. That's 12 million more people than the total population of Canada.

The result is that here in America, the nation blessed with the most sophisticated medical care in the world, millions of families have no option but to depend on overcrowded emergency rooms and under-funded clinics, all because they lack the insurance it takes to provide for the basic care they need. But America's healthcare crisis isn't limited to the uninsured alone. Those who do have coverage are trapped in a downward spiral. If you look at the business page of the *New York Times* this morning, you see that being played out and over the course of the last couple of days as they are looking at what's happening to the auto industry and auto industry workers – and Wally, I am sure, is going to discuss that later. But they are trapped in downwards spiral; they are paying more for healthcare, but they are getting less in return.

Last year the cost of employer-based health benefits grew five times faster than workers' wages. Since 2000, the share paid by the workers and their families has climbed by 60 percent. These costs are bankrupting families. They are straining employers to the breaking point. They are undercutting our economic potential of our country.

Here in Washington, there are many who say that responding to America's healthcare crisis is just simply politically impossible; after all, change would affect billions of dollars, half-a-million doctors, and all of our lives. Even more cynically, I think some people would argue that America lacks the fundamental moral commitment to meet this challenge. Sure, Americans say they want affordable healthcare for all, but they are not willing to make the sacrifices required to achieve it. Well, we are here to say we think that's wrong. In fact we are convinced the opposite is true. We believe Americans are ready for a bold solution to the real problems they and their neighbors struggle with everyday. Such a solution, if designed to be practical, to be fair and responsible can overcome the political obstacles.

We also believe that Americans understand that a moral nation does not leave millions of men, women, and children on the outside of the healthcare system looking in. For most Americans, ensuring access to affordable care is not a political question of left

versus right, but a clear-cut moral question. Is it right or is it wrong? And doing what is right is what the Center for American Progress's "Prescription for a Healthy America" is all about.

Our plan is bold; it's achievable; it's grounded in fundamental American values and it will make a difference in the lives of American families. Our "Prescription for a Healthy America" has three major components and I am going to describe them briefly. First and foremost, it will guarantee affordable coverage for all of us and our families. Our plan offers the uninsured and the inadequately insured new options and assistance to create seamless universal coverage. It builds on both the existing employer-based system and Medicaid, preventing people from loosing the coverage that they now have. It maintains existing employer policies and makes such coverage more affordable, strengthening rather than undermining it.

It also creates the opportunity to enroll in a system just like the one used by federal workers and members of Congress. Individuals and employers can join the new purchasing pool to gain better, less costly coverage. Tax credits and federal reinsurance of the highest cost cases will reduce health premiums for families and employers alike. And our plan will simplify and extend Medicaid to insure all low income people. It will increase the federal share of Medicaid cost to prevent a cost shift to the states.

Lastly and most importantly, it gives people a choice, but it asks for responsibility in return. Either you sign up for a health option or you pay an income-related assessment for the cost of care that you will inevitably use. Such care will be paid for by Medicaid. Through this system, all Americans and their families can be quickly and effectively covered to meet that challenge that Jim and his colleagues laid out: covering everyone by 2010.

Second, our "Prescription for a Healthy America" will improve the quality and cost effectiveness of healthcare. Our goal goes beyond covering the uninsured; we also need to improve healthcare coverage for everyone, including those we have it today. We will do it in three ways. One, we are proposing a new emphasis on preventive care. Today we preach that an ounce of prevention is worth a pound of cure, but the way we pay for prevention actually discourages its use. We propose a new community-based prevention benefit that will lead to better health by ensuring financing, encouraging innovation and promoting personal responsibility.

Two, we believe that doctors, patients, and payers cannot make better healthcare decisions without better information. Our plan creates and funds a new public/private partnership that will research the relative effectiveness of different treatment options. It is a short-run investment, but one which will yield long-run gains, as we build a smarter more efficient and more cost effective health coverage system.

Three, we are convinced that we can't build the high performance healthcare system if it depends on obsolete information technology. The heath system's huge paperwork burden raises administrative costs and lowers quality. That means lost dollars,

but much worse than that it also means lost lives through medical errors and through poor quality care.

Investing in modern information technology does not come cheap, but its payoff is enormous. Taken together, these three policies addressing some of the root causes of soaring healthcare costs: preventable and expensive diseases, ill-informed health benefit policies, and administrative efficiencies. Responding to each will simultaneously improve the quality and care and the health of all Americans and it will save billions of dollars system-wide.

That leads me to my third and final component of our "Prescription for a Healthy America;" how do we propose to pay for it? How do we propose to finance it? We estimate that our plan would have a budget cost from $100 to $160 billion a year. These numbers do not include any of the savings resulting from the plan such as the reduced administrative costs, payments for uncompensated care, and preventable illnesses for example. We believe that our plan creates the platform for these long-run savings, but opt to be fiscally conservative at a time when healthcare cost estimates are suspect.

The only responsible choice given an investment of that size is quite frankly to raise revenue. We're convinced that the best option available is to enact a small dedicated value added tax or VAT. A VAT in the range of 3 percent to 4 percent with targeted exemptions for small business, food, education, religion, and medical care will fully finance our plan. Because the plan benefits all of us, we think it should be paid for by all of us. This approach – the VAT – is how most other nations finance their health and social systems. By enacting a VAT tailored to suit American needs, we not only will have the wherewithal to finance healthcare, we'll also be able to strengthen Americans' global competitiveness by taxing imports and reducing the cost of our exports. This will help to create a level playing field with our global competitors.

We think that Americans are willing to make this small sacrifice to pay for high quality, efficient, and dependable care. We believe this because our nation's history teaches us that we Americans have never shrunk from our responsibility to defend our core principles, our sense of compassion and justice, our commitment to fairness and community. For earlier generations of Americans that meant fighting to abolish slavery; it meant standing up for women suffrage; it meant joining the struggle for civil rights. Well today, improving the nation's healthcare system is the great moral challenge of our time.

America today is the most powerful nation in history and yet because we do not offer one simple protection, health coverage, our friends, our neighbors, our own families suffer unnecessarily. Cancer goes undetected, heart disease goes untreated, injuries are left to fester, and illness which could be cured easily instead is left to unconscionable pain and death. This is not the America Jefferson, Adams, Franklin envisioned when they risked their lives to write the Declaration of Independence in 1776. I submit that it is not the America we and our family should accept today.

We at the Center view this moment as the starting point of a broad-based campaign. We will work with the business and labor communities, with healthcare professionals, and with religious leaders and people of faith to impress upon the nation's leaders that the status quo today is simply unacceptable; that expanding coverage to all is essential to fulfilling America's promise.

Thank you. (Applause.)

MR. IGLEHART: Thank you, John.

Our next panelist is Dr. Jim Mongan, who is president and CEO of the Partners Health System in Boston, and in an earlier life he was on the professional staff of the Senate Finance Committee.

Jim?

DR. JAMES MONGAN: Thank you John, and thank you John Podesta for the work you are doing to bring attention to this important issue. I'll make two important points regarding health insurance in the next five minutes. First, this debate is not just about insurance, it's about people's health. Health insurance has an impact on people's health. Second, this is also about money. These proposals have always died in the past because Congress would not deal with the financing issue.

First, health. I was a member of the Institute of Medicine's Committee on the Consequences of Uninsurance in 2003. Its major finding was that there are serious health consequences to being uninsured. Although this may seem obvious, many people believe that the uninsured get healthcare when they need it. And, you know, in a sense they are right. After all, for an acute, traumatic health episode such as child birth or a broken leg, almost everybody does get treatment. We as a society are uncomfortable watching child birth in the street or ignoring those with an obviously broken bone. We are willing to pay the cost of moving that care indoors. But what's not well understood, is it the uninsured often do not receive care for less traumatic illnesses and in many instances defer care until their illnesses have reached an advance stage.

The IOM committee documented that the uninsured are far less likely to have seen a physician in the past year, far more likely to postpone or go without care, and far less likely to receive preventive care. They are twice as likely to be hospitalized for avoidable complications of diabetes or hypertension. The committee estimated that in addition to a known burden of sickness and disability, there were an estimated 18,000 premature deaths yearly as a result of uninsurance.

Everyone really interested in the right to life should be fighting for, and not opposing, universal coverage. It would be nice to see a special session of our Congress focused on the passage of health insurance legislation, which would be a real statement of support for tens of thousands of lives over the next decade. (Applause.) This is about people's health.

Now my second point: this is also about money, and for the past thirty years, money has always trumped people's healthcare as this issue has been considered on Capitol Hill. I served for seven years on the staff of the Senate Finance Committee 30 years ago. What I learned there was that the debate was all about financing. Opposition to employer mandates and other taxes killed the Nixon bill in 1974 and the Carter and Clinton proposals in 1979 and 1994. This proposal today steps up to the plate and proposes a financing mechanism to cover its costs, and starts an honest dialogue about alternate ways to finance health insurance coverage.

We live in a country, where federal taxes are at their lowest level since 1959. Tax levels in the 1990s, which drove one of the most productive economic eras we have ever seen, averaged 18.5 percent of GDP; significantly higher than today's 16.3 percent of GDP. This difference would yield over $200 billion of additional revenue annually. But make no mistake about it, increasing taxes to pay for health insurance will run into the teeth of the strongest political force of the last 40 years: the anti-tax movement. This movement is not incidentally largely responsible for the current governing party's control of the Congress and the presidency.

As I point out in a piece in tomorrow's *New England Journal of Medicine*, the anti-tax movement in this country is the biggest obstacle to expanded health insurance coverage. This obstacle will only be overcome when we as a nation answer the question, what happened to social justice as a moral value? We'll pass a health insurance bill when those whose major moral value is constant tax cuts are outnumbered by those who remember that our preeminent Judeo-Christian moral value is social justice.

Thank you very much. (Applause.)

MR. IGLEHART: Thank you, Jim.

Our next panelist is Reverend William Byron, who is the research professor at the Sellinger School of Business at Loyola College of Maryland, and former president of the Catholic University of America.

REVEREND WILLIAM BYRON: Thank you. I think in the interest of full disclosure I should say that I taught in the business school at Georgetown. I taught applied ethics; taught of course "social responsibilities of business." And in the academy, you know, it's publish or perish, but if you wear a Roman collar it's publish or parish. (Laughter.)

So I wound up moving a block down the street to Holy Trinity, where I was John Podesta's pastor and he knows that I'm interested in these things – have indeed done a bit of writing on it; come from a medical family; served on a joint commission as a public member, so I'm very interested.

I would like to do three things. One is set a context in the – picking up on that notion of social justice, but try to underscore and elaborate a bit the principle of the common good as an ethical principle.

Second, and this would be very close – toward the end – a minor editorial suggestion. And I will close with a disclosure of a bias, and I have to say the bias doesn't really influence anything I'm going to say in the front end, so you can be relaxed.

The notion of the common good is what I found in a study that I'm doing right now. I'm working on a book under the general rubric of old ethical principles for the new corporate culture. I'm interviewing CEOs who are either about to retire or have retired. For example Jim Burke, the famous – kind of the poster boy for corporate integrity when he pulled the Tylenol of the shelves. And I'm asking people like Burke to give me some of the ideas that they would pass along to a son or grandson now entering into business to help them to avoid the ethical quicksand that pulled down Enron, Arthur Anderson, and others. And this would not apply to Jim Burke, but it's very interesting. I have 10 old ethical principles; things like veracity and integrity, and the common good is one of them.

And where I find not resistance necessarily – to some extent disinterest and to a large extent agnosticism among people in American business right now is on the notion of the common good. It's a sense of an inability to appreciate and articulate any kind of an understanding of the common good. Well, pursuit of the common good is a basic principle of ethical behavior. It's a bedrock principle like the principle of human dignity, and with out it, social chaos would prevail. Yet this principle, of the 10 around which I'm organizing my present study, seems to be the most difficult for men and women in business to understand.

The common good is a catch-all phrase that describes an environment that is supportive of the development of human potential, while safeguarding the community against individual excesses. It looks to the general good; to the good of the many over against the interests of the one or very few. The notion of the common good is not to be confused with the utilitarian principle that would say the right action is whatever produces more good than evil for most of the community. Or, to put it in another way, the greatest amount of happiness for the greatest number of persons. Under this norm something inherently wrong and plainly damaging to the common good would be permissible if the decision went by majority rule. So in a world of ethical reflection large enough to move from personal and individual concerns to group and organizational issues and on out to global concerns, it's a matter of no small importance to have an appreciation of the notion of the common good.

I suggest that a way to picture the common good is to imagine an automobile tire, either the belted radials or the old fashioned inner-tube tires – many of you when you were kids were in an inner tube on a lake somewhere floating around and paddling and having a great time during the summer. If tire or tube viewed as a whole looks integral and strong, but it has a cut or a leak or other point of vulnerability at just one small point,

the whole thing will soon collapse. Think of this as the collapse of the common good. One small, unattended point of weakness or vulnerability can lead to a collapse of the whole – the whole – all of us go down if that point of vulnerability is unattended.

If the wheel needs alignment, that one point of imbalance can run the whole thing off the rim and the vehicle off the road. Patch the tube, plug the leak, repair the belt, balance the rim, or else it will all collapse. It is in the interest – it is in the interest of the rich and the powerful and those who resist any kind of tax hikes that were just referred to by Jim – it's in the interest of the rich and powerful to assist the poor and powerless. They are all part of the same tire.

It's in the interest of business to attend to the maintenance of the common good, to be socially responsible, to attend to the demands of corporate social responsibility because any business firm is part of that larger whole. The blind pursuit of individual rights threatens the common good. An effective, but widely ignored, social tool for meeting this threat is not only the principle of the common good, but another ethical principle that I call the principle of participation. If everyone votes, everyone volunteers, everyone speaks up, reaches out, and when necessity requires it doubles up, shares, and conserves, the common good will be served and the community will be preserved. So it's time for all of us to recommit ourselves to the repair and restoration of the common good.

What constitutes the common good in a particular set of circumstances and in a given historical context will always be debatable, and we are opening up part of that debate today. But if there is no debate – if there is an absence of concern for or sensitivity to the common good in public discourse, then you have a clear indication that society stands in need of help. As a sense of community is eroding, concern for the common good declines. This is an obvious danger in an age of individualism. A proper communitarian concern is the antidote to unbridled individualism, which like unrestrained selfishness in personal relations can destroy balance, harmony, and peace within and between groups, neighborhoods, regions, and nations.

There is a book, the *New Dictionary of Catholic Social Thought,* published 10 years ago, so not so new, and it contains an interesting article on the common good and it makes the point that recent teaching presents two complementary themes relative to this concept; namely, the obligation of the individual to contribute to the common good and the right of the individual to participate in the benefits of society.

Anyone who takes a moment to reflect on the fact that approximately 45 million Americans participate in no health insurance program today will be forgiven for expressing outrage at this obvious assault on the principle of the common good. For better or worse, all of us in the human community are in the same boat. All of us have to work to keep it afloat and pull our respective oars if progress is to be achieved. The communitarian character of human existence means that the good of each person is bound up with the good of the community. Thus, the obligations of justice and love will only be fulfilled when each person contributes to the common good in accord with his or her abilities and in light of needs of others.

Now my editorial suggestion. We are calling this as the Plan for a Healthy America, I would suggest that it be called a Plan for Healthcare Security in America. The vegetarians, joggers anonymous – a whole out of outfits could launch a Plan for a Healthy America, but we are right there at the heart of the issue of how this is going to be paid for and the issue – the stakes relate not just to well-being but to healthcare security.

And my bias. My bias is that I am not a big fan of Medicaid. I am a beneficiary of Medicare. I have to tell you that I would favor a single payer healthcare reform if everybody could have a Medicare-like guarantee of health insurance that would guarantee the adequate, you know, requirement – minimum decency requirement with access to supplementing it.

I spent a year last year down in Louisiana, and I have to tell you that in Louisiana the Medicaid program there has low physician-provider participation levels. Just a couple of years ago only 50 percent of enrolled physician providers were considered actively participating, meaning that they build the fiscal intermediary at least once during the year, but another 3,000 physicians licensed in Louisiana are even enrolled as Medicaid providers. On average, Medicaid continues to reimburse physician providers at approximately 69 percent of the Medicare allowable fee.

And my last comment: due to inadequate reimbursement structure that appears to be a statewide shortage of participating Medicaid inpatient psychiatric hospital providers across Louisiana. The point is, the poor have it tough enough and Medicaid in my view is not a strong enough fulcrum to swing them over into the kind of care that all of us would agree. I would say in closing that I agree with the ad that I saw on the Hill the other day – AARP and others put in there, in praise of Medicaid. Medicaid protects our most vulnerable system – citizens; children, pregnant women, the elderly, and the disabled, and is a safety net for all us. I think we could have stronger safety net. (Applause.)

MR. IGLEHART: Thank you, Reverend Byron.

Our next speaker is Wally Maher, the former vice president for public policy at DaimlerChrysler.

MR. WALTER MAHER: Thank you, John. I too want to commend John Podesta and the Center for developing this health reform proposal. I mean, as all too many of you know, achieving universal coverage, health promotion, spreading cost more equitably throughout the economy, and providing relief for business health cost are all desperately needed.

Let me at the outside just point out one little nit that always bothers me. Even in the Center's document today, and John Iglehart mentioned it and in his introduction talked about 15 percent of the public without health insurance. That mathematically is true, but I would urge all, you know, the researches and the people who cover this subject

to remember that we have got a significant number of Americans who are covered by national health insurance. The elderly, some of the key disabled; it can even include a lot of a categorically poor. I mean, we have got national health insurance for those. Those ought to be excluded from the base. And when you do that and look at the remainder of the American public that we're sort of looking for volunteers to pay for, you get a much staggeringly higher percentage of the public that are without health insurance.

I mean, it's incredible to me how little real attention is accorded to the plight of the uninsured and frankly the real danger opposed by our country's indefensibly high healthcare cost. The problems aren't new by a long shot. They grow worse every day. And reform proposals such as this will help shine more the light on these major problems.

I must say that at one time I really believed that health reformers should stress the moral imperative for reform, but I've got to say that I have some doubts today, which frankly might seem odd given that at least on the surface it appears that morality appears the rule the roost in the country. However, I would summit that if morality were the measuring stick, in the words of one formally highly placed public servant, it would be a slam dunk. But that – you know, that's just not the case. Today, a majority a voting Americans do have coverage thanks to the government and thanks to many employers. And enough of them can be convinced to be wary of what might happen to that coverage should the wealth to be spread. The result is apathy at best and opposition at worst.

And as Dr. Jim Mongan pointed out in a brilliant lecture that he gave last September, it's frankly tough to determine where rugged individualism stops and selfishness kicks in. In my judgment, morality will not be a compelling selling tool unless the U.S. is on the heels of a virtual economic collapse and true fear pervades the majority of American families.

Now back in the 80's at Chrysler when the company got significantly engaged in the subject of health reform, it really helped to have true believers in universal coverage involved. I mean, Lee Iacocca, who was the Chairman at that time; Doug Fraser, who was the President of the UAW; Joe Califano, a member of our board – they were key members of our board's healthcare committee and I was truly blessed to work with all three of them. However, I would be far less than candid if I did not point out that our board was also keenly aware of the fact that were the United States to develop universal coverage, and particularly with cost containment as part of the solution, it would help to moderate the company's healthcare cost and improve its global competitiveness.

To make that point even more clear, business support, in my judgment, for any reform plan is highly unlikely unless it promises them cost relief. And even then, frankly, support isn't assured, particularly from those businesses whose business is healthcare and those businesses who have a track record of opposing any government-imposed increase in their cost regardless of the ultimate societal benefit.

The sadder fact is that really American business needs to get engaged. Our country continues to spend far more than other countries on healthcare and that excessive

cost not only burdens our economy, it is disproportionately and unfairly spread throughout our economy. I mean, if you look around the world, our leading trading partners without exception have some process to assure that all citizens have coverage, that the costs are equitably distributed throughout their economies, and that the costs remain affordable for the economies. We have none of the above.

Employers in the Unites States get to volunteer to pay, and one of the rewards they get for volunteering is the opportunity to get costs shifted to them from those employers who haven't taken up the offer to volunteer. Now, if you get tired of those costs or they become, you know, more and more burdensome, you always have the option to join the party and opt out; you can shift more and more production offshore; you can watch your business wither away; or, in extremis, you can simply turn to the bankruptcy courts and seek to start the whole cycle all over again.

Now, one key benefit of the Center's proposal is that it would distribute health costs more broadly throughout the economy by using a value-added tax. Ironically, where you see the incidence of most private sector, employer-provided coverage are in those businesses where the companies are engaged in global competition. And where you see the least are in those industries that face no global competition, such as much of the service sector, fast-food outlets, much of the hospitality industry. I mean, does anyone seriously think we would develop a balance-of-trade problem in pizza or hamburgers if their costs were increased slightly because they bore some share of the nation's healthcare costs?

I mean, an additional benefit of a VAT is that it is also assessed on all imported goods as well. U.S. manufactured goods exported abroad not only today incur U.S.-based costs including health cost, but they are also subject to foreign VAT taxes, thus contributing to the cost of supporting foreign social benefit programs as well. However, when goods are manufactured abroad and imported to the United States, the VAT tax that they incur in their native country is rebated to the manufacturer at the time the good is exported. The CAP – the Center's plan would help level that playing field.

The Center's plan would also help reduce the business health costs by providing federal support for both preventive and catastrophic health expenses. I regret, but can understand, why the plan defers action on serious cost containment. That ticking time bomb; however, must get on the table sooner or later. Congress and the administration ignored it when the Medicare prescription drug legislation was passed and we'll all regret that. As long as Americans are well insured and have no highly visible reminder of what it truly costs, neither healthcare utilization nor cost will reflect rational behavior.

Thank you. (Applause.)

MR. IGLEHART: Thank you, Wally.

Our next panelist is Dr. Ezekiel Emmanuel from the National Institutes of Health, where he chairs the Department of Clinical Ethics.

DR. EZEKIEL EMMANUEL: First, I want to thank John Podesta and Terry Shaw and the Center for allowing me to share the podium.

We have a healthcare proposal being published in the *New England Journal* tomorrow – it's embargoed till 5:00. On your chairs you should have this handout, which is a summary of our proposal as well as the article that will appear in the *New England Journal* tomorrow.

I also need to say, while I am the chair of the Department of Bioethics at the NIH, I am here not in that capacity because I am advocating public policy and so scratch that out of your minds, as they would say. I am here as a private citizen and head of something we call the Posterity Project.

Dr. Vic Fuchs and I – he is a professor of economics at Stanford; one of the original health economists; been working in this area since the 1960s – have developed this universal healthcare vouchers. We believe that, as you have heard, the system we now have is deeply and irreparably broken. It's got three main flaws: it's inequitable, and you've heard a lot about some of the inequities; it's inefficient, and you've heard some of that. We spend about $200 billion if not more on administrative costs and we can't even track quality of care delivered to most Americans.

In Medicaid and the state children's health insurance program, it takes two months of healthcare benefits to assess eligibility and people go in and out. And every time they go in and out you are spending two months to assess their eligibility. And as we all know it's increasingly unaffordable. Costs increased 4 percent above inflation in the medical care sector. Since the year 2000, 5 million employee – employer-based jobs lost health coverage. And the most important problem, of course, is not even being discussed in Washington and that's Medicare. Last year's trustees' report – I haven't seen this year's yet – tells you how bad the problem is by how much it would take to fix the system.

Just listen to this quote: "Medicare could be brought into actuarial balance over the next 75 years by one of two mechanisms: an immediate 108 percent increase in the program income – taxes – doubling taxes, or an immediate 48 percent reduction in the program outlays; cut benefits by half. That level of drastic action is what's needed to put the place in balance. No one's got a plan, as the *New York Times* said, even in fantasy to repair Medicare and that doesn't even talk about how unaffordable it is to employers, as you've just heard.

So Vic Fuchs and I have developed this universal healthcare vouchers plan and it shares a lot and common with the Center's plan. First, we share a lot in deep commitment to equity. We need to have universal coverage. We need to have a fair financing system where everyone pays – pays their fair share, and we don't – we can't relegate the poor to second-class healthcare. We need an equitable system.

We also need an efficient system. We need a system, that doesn't pay for a lot of unnecessary, worthless medical services and waste dollars. We need a system that uses the flexibility of the private market in delivering healthcare. We need a system that's efficient because it doesn't waste hundreds of billions of dollars on administrative costs. And we need a system that encourages individual freedom; that allows people to choose their health plan and to decide if they want to spend more.

Finally, we also need a system that, as John mentioned, is coherent with American values: coherent with equality of opportunity, coherent with the notion of individual responsibility – that there are no free riders; that we rely on the market-base systems. That's why Vic Fuchs and I have recommended this universal healthcare vouchers plan. It has ten points and six of our points overlap very closely with the Center's proposal.

First, every American should get a voucher to purchase healthcare: universal healthcare benefits. Second, they should freely be able to choose which health plan they want. Third, like the Center's plan it is financed through a value added tax. We have it earmarked only for healthcare, so people see a link between their tax and the benefit they get. Fourth, people have freedom to purchase more services. Maybe they want more choice of specialists. They want more mental health benefits; more dental benefits, with their own money after tax, no tax benefits for those additional purchases. Five, we rely on the private sector to deliver care just as it does now. We believe there will be some shakeout in the private sector. They can't continue with 1300 insurance and health plans in this country – doesn't make any sense – but we don't mandate that.

The differences are, now, we eliminate tax exemption for employment-based insurance and we expect employment-based insurance to go away. Businesses under the voucher system will not provide health insurance. We eliminate Medicaid. If everyone gets a voucher, there is no reason for Medicaid – no reason for SCHIPS (ph).

We phase out Medicare. We keep current beneficiaries in Medicare, but no one newly enrolls, so that ironically by 2020 when the trust fund disappears there will be no more need for Medicare. We administer the system through a national and regional health boards modeled on healthcare federal reserve system.

And finally, like the Center's plan, we use an Institute for Technology and Outcome Assessment to critically assess technologies and evaluate their cost effectiveness and how much benefit they are giving and we dedicate 0.5 percent of the value added of the total amount spent in the healthcare system to that.

Now, as I mentioned, we have a lot of agreement with the Center's proposal. The main disagreement is that we don't think we can build on the current system – that the current system is irreparably broke. Most of the people who believe you should build on the current system believe that it's too big a leap to move to another system. Our view is quite the opposite. If you move in the current system to include the 45 million uninsured, it will cost you a $100 billion; and as Jim Mongan said, a $100 billion is the thing that sticks in Congress' throat and prevents you from instituting universal healthcare

coverage. If you look at a voucher system, we get tremendous savings by eliminating the administrative costs of Medicaid, by eliminating the administrative cost of the employer-base system, and it would cost no extra money by our calculations to switch over to a voucher system. That makes it a lot more politically feasible than if you have to spend a $100 billion using the current system and its tremendous inefficiencies.

We don't think healthcare reform is going to pass today and Vic Fuchs, for those of you who don't know him, is 82 years old. We wrote this in the belief that healthcare reform is going to come. It is going to be a major agenda item in the next presidential election and we are planning, like the Center, to try to change public attitudes and to think critically about where the country is going and how we can implement healthcare reform in the near future. It's not going to happen tomorrow, but we need to develop the best plan we can, with the widest support we can, for the very short-term future, where it will be on the agenda and where we will get it passed.

Thank you very much. (Applause.)

MR. IGLEHART: Our final panelist is Jeanne Lambrew, a senior fellow at the Center for American Progress and the lead author on this paper.

Jeanne?

MS. JEANNE LAMBREW: Thank you, John. I am actually going to, in the interest of time and my voice because I also need the cure for the common cold, keep my remarks brief. But I would like to characterize our plan. We set out to answer a very specific question, which is how do you get from the current system to a sound system which covers all Americans as quickly as possible? That's a different question than what is the ideal system. It's a different question than what is the most efficient or cost effective system? We have elements of all of that in our plan, but we really have one very laser-like goal, which is how do we get from here to there. Because the reality is that any change in a health system faces enormous obstacles. History is littered with elegant, ideal, and failed policies.

We think the time for action is now, so we have designed a plan that covers all and aligns healthcare incentives, but we believe can be embraced and enacted quickly. This is for several reasons. First, it adds to, rather than replaces, existing coverage. We learned in 1994 that people can easily be scared by people like Harry and Louise to think that they are going to lose what they have today, and even though, you know, you can argue that a more ideal system would be more seamless with one source of coverage, talking to seniors about losing their Medicare I think might even scare them more.

In addition, it aids the uninsured, but also assists those who are struggling to pay for care today. We can't forget that many people spend the large proportion of their income on premiums. We help them as well as the uninsured. We help employers who now offer coverage, as Wally said, by lowering their catastrophic costs and lowering their preventive costs. We also give some new voluntary options for those who don't offer

coverage today. We do not have an employer mandate. We rely on a mix of public and private insurance, avoiding the ideological wars that have marked previous debates.

We do lay the ground work for what we consider meaningful, rather than arbitrary, cost containment. Until you have the information and the information technology tools in place, it's very hard to have competitively oriented, good cost containment. And we offer a way to pay for this investment; no small contribution at a time of budget deficits.

I'll add that we think that Jim is right, money is the issue, but we do think that this Congress and the public are willing to come to the table with money and money doesn't just solve the uninsured problem. It does address some of those Medicaid problems that were mentioned. I am on the governor's taskforce in Louisiana, so I spent a lot of time down there this last year and the answer – the problem is not Medicaid as the program. The problem is money.

Lastly, we suggest that the rationale for change cannot rely only on dry statistics about health in the economy. Bold changes only ever happen when people believe that it is the right thing to do, so this article is just the beginning. We at the Center for American Progress look forward to working with leaders at the local, state, and national level to flesh out this plan in a way that it can gain the kind of bipartisan support that it needs to pass. We also will work with people of faith to make health reform a moral imperative that public policy-makers can no longer ignore it.

Thank you. (Applause.)

(Audio break.)

MR. IGLEHART: – that would help the panelists understand from where you come. First, I would like to take question or questions from the media. If there are any reporters here that have a question, I will take that first. If not, we'll just move right on.

Okay, there was a question in the back. Yes, Bridgette?

Q: Hi. Yes, I'm Bridgette Taylor. I work for the Energy and Commerce Committee on the Hill, but I'm speaking on behalf of myself. I have a question for Mr. Emmanuel. You talk about your voucher plan and getting rid of Medicare and Medicaid and allowing people to have choices in order to be able to purchase more mental health services and things like that. Last time I checked, mental health services you don't buy like you buy extra service for like a Cadillac or a Ford. So I wanted to ask what you would do for people who were low-income or elderly seniors who don't have the extra money to purchase these services who actually do them if you give them a voucher to go buy it.

DR. EMMANUEL: That's not – the voucher is for a universal benefit package, okay? That includes mental – some mental health benefits, and actually what we've

priced is on the average employer-based system now, okay? So most employer-based systems now have some pretty good mental health coverage, but they don't have everything you might want. You might want to add more coverage, first. And everyone gets the same voucher.

Second, I want to emphasis – I think I was pretty careful in my words: we are not getting rid of Medicare; we are phasing it out, and the phase out is very important. No current beneficiary loses anything, all right? People who are in the voucher system simply continue in the voucher system as they go past 65, and Medicaid people – they would now suddenly not get Medicaid. They would get basically the same kind of insurance coverage that most employees get at big companies.

Q: The only thing I would say is that for a low-income person who needs those extra mental health services, it's not like purchasing something that is just something that's a luxury item. If you need extra mental health services it's usually because you have a very serious problem. And I'm just proposing this; that you consider as you move down this path some way to help those people because they are going to find themselves in state institutions and a lot of them are able to stay out of state institutions if they have the ability to get the services that they need.

DR. EMMANUEL: Thank you.

MR. IGLEHART: Yes, sir?

Q: I'm – (off mike). I'm Morton Manz (ph). I'm a freelance writer.

I heard nothing about controlling drug prices. Under single-payer in Canada drug prices are low. That's why Americans buy there. What would you do about controlling drug prices?

MR. PODESTA: Well, let me start maybe Jeanne and Zeke will want to comment on it as well. I think we have separately written on the control of drug prices, particularly in the Medicare program, and the most important element of that is giving the government the capacity to negotiate for lower prices through bulk purchase but with – this has been – I think the focus of this paper is not been primarily in that zone, and maybe Jeanne wants to add to that.

MS. LAMBREW: I'll just add that, you know, one of – we think one of the long-run most effective ways to control costs is to do this comparative effectiveness research. If we have two drugs in the same drug class and we find out that one costs more and one cost less – the one that costs less is as equally affective – then we can make smarter decisions about what we cover, what we charge co-pays for, and how we begin to design a smarter system. You know, Zeke's plan has a same sort of investment as we do. This is something that Congress is considering and frankly has been mildly opposed by some in the drug industry because they are concerned that that is exactly what might happen.

But the smart way to do this is to begin to get the information so we can then design good policy to make those kinds of changes.

DR. EMMANUEL: You need to have that kind of technology assessment because if you don't have the technology assessment, you don't know whether the investment in the drug, even if its price is high, is good because you've got another trade off. And we are in heated agreement: the best way to control drug prices is to shift the purchase so that you are using what's affective.

MR. MAHER: Let me just – if I could.

MR. IGLEHART: Sure.

MR. MAHER: As you know, back in 1965 when Medicare was passed, the price for getting the support of the medical community was usual, customary, and reasonable fee reimbursement. The cost for getting the hospital support was cost-plus reimbursement, and ironically it took until the conservative Reagan years of 1980, when the cost that for that 25-year luxury got totally unbearable before you started using some government-impose regulatory tools on Medicare costs.

I expect that the cost control is such a lightning rod to attract all kinds of opposition that that is perhaps one of the reasons that you don't see it in this proposal, not to mention I don't think for a moment that the Center does not believe that costs are a huge problem; it's just a lightning rod for opposition.

MR. IGLEHART: Len?

Q: Len Nichols from the Center for Studying Health System Change. I'd like to first applaud Jeanne and John for putting together this proposal and trying to advance the debate.

I was curious, for those of us who do wear battle scars from decades ago, sort of what happened to the employer mandate? In particular in the discussion of shared values and the common good – I support that completely, but can you give us some thinking, about why you don't have an employer mandate as part of plan?

MS. LAMBREW: I will say a few reasons. One is that we don't, like Zeke's plan, eliminate or cap the employer exclusion in the tax code. In the other words, we keep in place the policies that there today that sustain employer coverage. We don't think we need it to maintain employer coverage. We create this new pool that small employers, large employers, any employer can come into to purchase coverage through, and in fact if they do so they qualify for some reinsurance or federal subsidy for their high-cost cases. So we kind of give a new option with some choices, so we actually hope that there may be some employers who are not offering today that will do so.

And lastly, we think that – so the first part of the answer is we think we maintain employer coverage, so people who have it today can keep it. Employers who offer it today can offer it for less money.

But the second part is when we are thinking about financing, we decided that – we think that the cost of this improved health system, which both helps lower-income people, which is primarily where our assistance goes to and makes these critical investments, should be borne by everybody. The broadest way to finance this plan is, we think, the value-added tax. It spreads it very thin – excuse me, very widely, but in a very small way across all goods and services; everybody pays for this benefit, versus an employer mandate which really is concentrating the financing among low-wage firms who aren't offering today. So we made the choice to both keep in place incentives, to keep employer coverage intact and strong, but also to finance this more broadly.

MR. EMMANUEL: Can I just say one thing? If you are interested in political feasibility, it seems to be an employer mandate kills your plan. Business wants out of healthcare. They don't want to be locked into it. And if you put an employer mandate, you can be sure that they are going to oppose you. That's why we completely get rid of business because we believe change in healthcare is going to be driven mainly by business and the states. The states trying to get out from under Medicaid and business trying to get out from under healthcare costs. And I think if you have an employer mandate it's politically dead on arrival.

MR. PODESTA: Can I –

(Cross talk.)

MR. PODESTA: John, could I just add –

MR. IGLEHART: Sure. Go ahead, John.

MR. PODESTA: – one point of not really clarification, but expansion of what Jeanne said. It's not only just the question of placing the burden on low-wage firms; it ends up placing the burden on low-wage workers as well by competing against wages if – we felt that this means of financing ended up spreading the cost against a broader group of – really the whole country, as opposed the putting the burden on the firm which would then be passed along the low-wage workers.

MR. IGLEHART: Okay. In the back there, please.

Q: Collin Pitts (sp) with the Service Employees International Union.

Both for the Center's plan and for Ezekiel's idea – I mean, Ezekiel, you talked about maybe perhaps phasing out Medicare in about 20 years. You didn't speak to Medicaid, but for both plans you'd look at the – you are addressing the cost of care. Have you looked at it – considering what just happened in Congress over the budget and

Medicaid, have looked at issues about – let's not use the certain term, reform, but at least a new blueprint, particularly for Medicaid, and how you can restructure it, but to get the cost, actually, of care down to some degree. Particularly, there was a question about prescription drugs in mental healthcare, but prescription drugs in general.

DR. EMMANUEL: Well, I mean, we just get rid of Medicaid. We have a voucher system and everyone in Medicaid is folded into the voucher system. we simply get rid of it. I mean, we did address it very specifically. We get rid of employment-based coverage, we get rid Medicaid coverage because we don't think those systems are viable. We think we can change the system in four years.

MS. LAMBREW: And, I guess, our plan we did not phase out Medicaid. We keep Medicaid intact and build on it. But let's diagnose Medicaid's problems. If you look at recent articles, they have suggested that the reason why Medicaid cost growth is going up is, number one, enrollment increases. Right? This is because since 2000, as John Podesta mentioned, the uninsured have gone up 5 million. Since 2000, the number of people on Medicaid has gone up by 6 million. So think about the math there.

Medicaid has been protecting our nation from having an uninsured problem that could be twice as high. So it's being driven by enrollment. If we have a universal coverage system, that pressure goes away. We actually would finance more people coming into Medicaid through federal financing, but we wouldn't really kind of shift this cost to States.

Second main reason why Medicaid cost growth is high is dual-eligible, so as Medicare, low-income people who need nursing home care and other services that are not provided for by Medicaid. In other words, Medicaid's problems are not really Medicaid's problems. They are the health insurance system's problems; they are dumping people into Medicaid and it's Medicare's shortcomings which is leaving Medicaid to fill in the gaps.

MR. IGLEHART: Jim?

DR. MONGAN: One other comment about Medicaid. I served for number of years on the Kaiser Medicaid commission and it is an extraordinarily complex and important problem. One thing to keep in mind is that the vast majority of Medicaid expenditures go to the aged and the disabled, and a very large proportion of those go for nursing home care. Most private health insurance policies don't include nursing home care and consequently presumably that would not be averaged into a voucher cost.

So I think there is always going to have to be some kind of supplemental focus on the kind of services that Medicaid provides or a great deal will be left behind.

MR. IGLEHART: Let's go over here. Yes, sir?

Q: My name is Bruce Walman (ph) and I've just returned from 25 years of receiving healthcare in Sweden and Norway, and I would say that we have better health than both of those countries at about half the GNP. So I would say that the trouble is that this system here does reflect American values and that's maybe where – one of the roots of the problem. (Laughter.)

A number of people pointed out that costs are overwhelming the system, and that problem is only going to get greater, so I think you need to look at the institutions that are providing it, and especially the market mechanism been put into effect and really needs some drastic action, which I don't think that – you know, the program you are presenting now is going to able to solve in time.

Just one example, the technology – you're talking about technology efficiencies and I also have thought that would be a great answer because I have seen a lot of that in Norway. But I have a friend who works in an emergency room and I can assure you that since they put in an electronic journals it's only increased the amount of bills going out from that emergency room because it's much more efficient to do diagnostic tests that meet insurance standards. So with that – the change in the way things are measured just by having new technology, it might make the problem worse (nonetheless?).

But, Mr. Maher, I was interested in what you had to say and I was wondering what would it take to get business to realize they need a drastic change in the system before they will be able to compete with other places in the world?

MR. MAHER: Well, business is not monolithic in the United States. There are – make no mistake about it, there are certain businesses for whom this problem is highly acute. They are very much aware of it. That being said, today some of them are still reluctant to stick their head above the fray for fear of irritating the regulator. In other words, if you are a business doing business in the Unites States today and the current administration and Congress are opposed to universal coverage, do you, you know, run into that fray and risk irritating the regulator? A lot of them, they have opted not to do that.

As I mentioned, you have got businesses whose business is healthcare. They feel – you know, my cost is their revenue. They feel totally different. And there are businesses who have been successful in totally taking a pass on this subject and, therefore, they are reluctant to incur any added cost – zero – 0.1 percent – zero. I mean, they opt for zero. So –

MR. IGLEHART: Ezekiel, you have a comment?

DR. EMMANUEL: (Off mike.)

MR. IGLEHART: Yes, ma'am? We'll get your next.

Q: Thank you. My name is Annabelle Fischer (sp). I'm a mental health therapist. I first want to tell you that most folks who do get mental health treatment from mental health professionals whether it's psychiatrists, psychologists, or social workers are paying on their own. Those folks who have insurance, the coverage is very minimal and most mental health therapists are not getting a high enough reimbursement rate to send in any insurance forms so they are charging per hour for fee.

I want to say, yes, I think this is a very complex problem and I understand more clearly now why since healthcare is voluntary for businesses why you are not mandating this kind of change for healthcare providers. My question is to both – to, I guess, Mr. Podesta, Dr. Emmanuel – well, anyone. I don't hear any discussion about how to begin to address, not necessarily resolve, the amount of provider reimbursement either one of your plans will do, because we are a society that believes in making money. There is nothing wrong with that – free enterprise. We are not Sweden, we're not England, we're not Canada. We're the United States, so we are free enterprise system. So I don't hear any discussion about reimbursement to providers and how this would work or how you all would work with the insurance company since there are so many of them now that really dictate what I believe are the high healthcare costs.

Thank you.

MR. PODESTA: Well, I would, I think, start by saying that what we have done is to some extent left in place the structure of private insurance. We also – as both Jeanne and I said, we have leave Medicare and Medicaid in place as a – and I think where Zeke and we all disagree is sort of on the financing side. We are so like how do you put – you know, what the structure of the provision of healthcare looks a little bit the same. We're leaving in place an insurance-based system. He's moved to a voucher system. We think ours is more politically feasible. He thinks his is more politically feasible. And we sort of – you know, that's a kind of an interesting debate.

With regard, though, to the provision of reimbursement, I think we both agree that we've got to move to a more cost-effective system; that the cost – that if you look at comparative costs and comparative outcomes in the UK or in the Scandinavian countries or in Canada, we cannot stay on the path we're on. We've got to move towards more cost-effectiveness in this system and I think we – actually, that's a place of common ground where we think that more information and the application of information in – I think in both plans, actually, we use a public/private partnership to kind of get that information pushed through the system – will lead to better choices and better outcomes, both at the individual level and at the system-wide level.

MR. : I think I'll pass. Let's just move on.

MR. IGLEHART: Okay. Yes, ma'am?

Q: I am Deborah Bass (ph) and work with Andrew Weil – Dr. Andrew Weil from the University of Arizona – as well as a lot of (integrated?) physicians. And my question

is, I think we need to define or do you think we need to define what we are paying for? Because what I hear is that we're paying for disease care, not well-care. And I think the system needs to start moving toward health and wellness because we can't afford disease. We have to get people before they become ill.

Thank you.

DR. EMMANUEL: Well, to some degree I think you're right, but you have to remember it is a healthcare system and you invoke the system when you get sick. I do think we can do more on the prevention side, but the fact is that most of the rise in cost – that some of it's due to the aging of the population, some of it's due to the underlying inflation rate, but the big thing which is killing healthcare, which is sucking more dollars in from the rest of the economy is growth in technology, and we need a more rational use in that growth in technology, and that won't happen overnight. It's only going to happen when we can figure out which technologies work and which don't.

But remember, under the current system things like Medicare and the insurance industry cover things like Erbitux. You know Erbitux from ImClone? All of you have heard of ImClone, right? That great drug that ended Martha Stewart in prison. You know, it was statistically significant. It cost about $20,000 for two cycles of therapy. Most patients will get six cycles of therapy and it raises average lifespan 1.7 months – six or seven weeks. Now, Medicare covers it. Most private insurance covers it. Is it a reasonable thing to cover? Would a cost-effective system cover it? If you evaluated it in outcomes and technology, would we cover it? I submit that when we have that kind of assessments, we'll have a system that says, you want Erbitux? You pay for it. The comprehensive system that we provide as a society to people doesn't cover that kind of stuff.

MR. IGLEHART: Zeke, could you envision the day when NIH would get into the business of assessing technology?

DR. EMMANUEL: Thank you, John. That's why we create in our plan the National Institute of Technology and Outcome Assessment, first. Second, we don't have its financing dependent upon the vagaries of Congress so that if they rule against a particular provider or, say, ImClone, they come back to Congress and lobby them to cancel it. We have a dedicated 0.5 percent of the healthcare budget going to it, so it has the finances and the amount of money to actually rigorously evaluate.

Once that, I think, happens, we get a different change in culture. We get more – medicine begins to look more like the computer industry. You get industries or technology companies that are looking how can we reduce costs – do the same for less? That is the key. Right now, all medical technology companies do one thing: what can I do, assuming the system will pay for it? They don't look at how can I do it for less. Once we get the how can I do it for less, we're going to have a very, very different situation and that's where we've got to get to.

MR. IGLEHART: Yes, sir?

MR. PODESTA: I think – I know Jeanne is champing to come back to the original question because I think our plan does actually prioritize wellness over illness. Maybe you want to do a little of the detail, because I see you jumping out of your –

MS. LAMBREW: I do feel that is one of the, I would say, truly innovative parts of our plan, and you can read about this in our article. In recognition of the fact that we don't do that well at making sure that people get what is the recommended set of screening and diagnoses and preventive care services, we propose to actually carve prevention out of insurance, recognizing that the incentives in the system don't quite work.

I mean, if somebody's going to be in an insurance plan for a year or two, why would that insurance plan really want to pay for all the kind of screening for mammography, et cetera? So we would carve it out of insurance, create a national program to fund prevention, not just in physicians and clinical settings, but in community-based organizations. We know that schools should get involved in obesity prevention. We know that tobacco cessation programs don't necessarily work best coming from medical practitioners. So we actually prioritize this in a very serious way: pulling it out of an insurance system, directly funding it, relying on experts like the U.S. Preventive Services Taskforce to figure out what we should cover and really trying to make this more of a true public health benefit than a medical care benefit.

MR. IGLEHART: Jim, go ahead.

DR. MONGAN: John, if I could make a comment that speaks to what I sense to be the tenor of a couple of the questions of recent minutes, which is talking to the proponents of both plans and asking the question of, gee, are you doing enough about cost? You're focused on coverage, but what are you doing about cost?

I want to say just a word of perspective about this because in a way I'm pleased that both of these plans have focused on coverage. If you look back and what's happened over the past 30 years, we as a country have slipped into a mentality that says we've got to deal with costs before we can expand coverage. Well, think about that for a minute. What we're doing is we're holding hostage the uncovered while we try and decide what to do about cost. That's not right. They shouldn't pay the price. We should cover everybody and then together as a nation we should decide what we want to do about cost.

There are some people, like Dr. David Cutler up at Harvard, who are beginning to argue that maybe 15 percent of the GNP is not bad. Maybe we're getting value received for that healthcare. But on the other hand if we think, you know, we just don't buy that, then as a society let's decide together what we do about Claritin or MRIs, but let's not force all these people who are proposing plans to hold the poor hostage to our inability to solve the cost problem. (Applause.)

MR. IGLEHART: Yes, sir?

Q: I'm Merrill Goozner with the Center for Science and the Public Interest, but this question really flows out of the book that I wrote about the drug industry. And I want to return to the question, John, that you raised about political feasibility – our plan versus the voucher plan that Dr. Emmanuel is talking about. Why not a plan that simply says Medicare for all? And why not get rid of employers by finding it with a VAT? Why not get special interests out of the Medicare payment determinations by setting up the institute that will evaluate technology?

MR. IGLEHART: Jeanne?

MS. LAMBREW: I'll just say that in terms of political feasibility I have the – I'm not sure if it's a fortune or a misfortune to work on the Medicare buy-in proposal that you all might remember that Clinton proposed in 1998. Let me be clear: the buy-in proposal for a very limited number of people, ages 55 to 64, fully financed by those individuals – there were no government subsidies really associated with that program. We couldn't get anywhere with it. I mean, that's the reality.

It was at a time when we weren't quite so polarized and yet we still couldn't make progress on it. Medicare's a fine program. There's many good things about it. It actually is doing well. The trustees' report today actually says it's doing a little bit better than people thought it was doing. So I would argue that it does what it's supposed to do, and if you look at the assessment commission's reports on it, it is providing access and meeting its mission in a fairly efficient way. That said, we're so single-mindedly focused on getting everybody into the system, we're looking for the ways to do that the best.

The HPP idea that we've talked about is something that has support from people like Stuart Butler at the Heritage Foundation as well as some groups on the other side of the political spectrum. Building on Medicaid to cover all low-income people is something that both sides of the aisle can agree to. Medicaid is not necessarily a program that everybody would agree to cover middle-income people, but if you really focus on low-income people you get a lot of bipartisan support for that.

We really – we use tax credits. We are not just doing a public program extension. We're using tax credits to get to the middle-income (audio break).

MR. PODESTA: – we did. Jeanne said she was a veteran of the '98 bill. We're also both veterans of the '93 and '94 exercise, and so I think what our assessment was was that we wanted to be bold in our goal. We wanted to meet the IOM challenge and we wanted to be far-reaching in getting there, but we thought the most practical way to do that was to build on existing structures. Zeke had a different political perspective on that and, Merrill, you have a different perspective on what gets you the farthest down this track.

We thought that – and, again, I think perhaps reflecting on our experience in – you know, you can always fight the last war, and I'm sensitive to that, but I think that we think that taking people out of the system that they're in was one of the – and creating a kind of a bureaucratic structure at the national government level were two of the things – the major thing that were the impediments to moving forward in 1994, so we built on existing structures. We've done it, in our minds, in a way that produces more cost-effective medicine, that will bring down the overall costs of the system over a period of time, and we've challenged ourselves to go ahead and pay for it. You know, and other people have different ideas. We're willing to sit and both debate the substance – how much wellness, how much reflection on illness, but we're also obviously prepared to debate the political feasibility. We think this a plan that kind of hits the sweet spot of trying to be, as I said, bold in its vision, practical in its application, and capable of producing bipartisan support.

DR. EMMANUEL: Far be it from me to question John. He's a politician and I only have a Ph.D. in political science, but it seems to me Medicare for all is a dead letter. You've got half the country who is not going to go for it and you can only get change by being bipartisan, and if half the country wants to dismantle it or views it with hostility and certainly won't expand it, it seems to me a very bad place to start.

Q: (Off mike.)

DR. EMMANUEL: Look, we understand that. We understand that, but they're not the only people who have to buy in. There are 280 million Americans.

Q: (Off mike.)

Q: My name is William Neil (sp). I'm an author of a long essay called the "Great Moral Inversion: How the Republican Right Disabled the Democratic Compass." I came with a question today about medical – the situation on medicine in this country, and it was, why have none of the proposals gotten political traction? And would what I hear today get political traction?

And I guess I've heard from a number of the panelists and I've come up with an answer that we can't get it at this ideological moment – the dominance of the Republican Right – and I think we have to continue to put models on the table, and John is going right into the headwind in terms of putting a – linking it to taxes and pick up on Dr. James's comment that it is a moral question and the way public morality and which issues become moral issues is defined in this country is a reflection of the ideological times and is so relevant to what we've put on the table.

So I'll leave myself open for comments. We won't get it, Mr. Maher, until we get a crisis. That's the way it happens. The redefinition of what becomes a moral issue – and what a week we've had about that – is a good lead in. Also, that ground must be cultivated and changed. Jerry Falwell says entitlements are immoral in his eyes. And I think, you know, no matter how careful you try to position the proposals on the table,

that's the way it's going to be portrayed. And the tax is right there. I don't know that we make social progress in this country when taxes are viewed as the devil's work. This is a terrible situation to be in.

So I'll leave it with that. We have a big fight.

MR. PODESTA: If I could just comment. I thought that both Father Byron and Wally have just been hanging around in boardrooms too much when Father Byron said that – and he wasn't associating himself with this, but he said that most business leaders today are agnostic on the common good. And Wally said that the way to sell something is not through kind of the moral valence here or the moral prism.

It seems to me that that's wrong. I'm not that cynical. I believe that the American people can be called to do great things, and we offer this plan in that spirit.

MR. IGLEHART: We'll take one final question.

REVEREND BYRON: Could I –

MR. IGLEHART: Sure, Father, go ahead.

REVEREND BYRON: Let me pick up on that. As you asked your question, and, John, you can back me up on the history of this thing. I remember when Harris Wofford ran for election in Pennsylvania and he went to see his ophthalmologist to get his eyes examined just as he was starting out on this thing. And you know how it is; it's all dark and, you know, "Is it better this way or that way?" And the doctor said to him, you know, it strikes me as strange that a criminal in this country has a right to a lawyer, but a person who is sick doesn't have a right to a doctor.

And driving home, Wofford kept thinking about that and then put it into a television ad for the campaign. It ran consistently through the campaign and he wound up with an upset landslide. You know, he was like – I don't know, John – 10 points down going in and he came out 20 or 30 points ahead. That was before the effort that John alluded to in the early days of the Clinton administration to try to get healthcare reform.

Wofford ran on that and I think he struck a responsive tune and I wouldn't be surprised if that didn't have some influence on the president's agenda to put it up high. He figured it was time.

I don't know whether it was a failure of communication. I thought they got close, but didn't make it. And then you could say, well, there were technical things that maybe did it in. I do think – you know, I disclosed my bias at the end and I said I'd rather see this go on the wheels of Medicare and I'd rather see something where a Medicare-like coverage was available on a universal basis for the minimum, and that would throw it back to a fee-for-service arrangement with physicians and I think you'd get physician

support on that. And those who could afford it could still buy insurance to supplement so that they could get more.

I believe you could get political traction for that, but I don't claim any expertise (inaudible).

MR. IGLEHART: Yes, ma'am? You get the last question.

Q: Yes, my name is Judy Serrano (sp) and I'm a legislative fellow in Debbie Stabenow's office. And this is actually a personal question for both proposals. I have a daughter with very severe cerebral palsy who at this point is receiving her services through a Medicaid waiver – home and community-based waiver. And just wanted to make sure that both of your proposals allow for those types of services. My daughter receives 24-hour supports in her apartment so she can have the life that she wishes. So just wanted to make sure that your proposals include that kind of service.

MR. IGLEHART: Jeanne?

MS. LAMBREW: Yes, absolutely. We maintain Medicaid recognizing that it doesn't just serve a low-income population, but it serves a special needs population. There are individuals who can't get and can't survive without the extra nontraditional medical services that Medicaid offers. We would maintain that and in fact it would be easier for states to provide that to a broader group than just the waiver group if we came in and fully federally funded coverage for low-income populations.

DR. EMMANUEL: Yeah, what we have argued is that we would carve out the long-term care and other special cares for disabled individuals; that you can't have it as part of the regular system. That would have to be carved out and handled separately. And actually our financial calculations excludes that amount. It's not anywhere near half of the Medicaid and needs-tested programs at the moment. It's about $100 billion of it, which is about a third of it. And so that would be carved out separate, and again our calculations don't – for economic feasibility don't include that at all.

MR. IGLEHART: Thank you. I'd like to thank the authors for their work, the panelists for their reactions, and you for attending. We're adjourned. (Applause.)

(END)