



S A N A N T O N I O
MEDICAL FOUNDATION

**PANEL DISCUSSION
HEALTH CARE REFORM
JULY 28, 2009**

Panelists: Nancy Dickey, M.D., Texas Medical Association
Jennifer Banda, Texas Hospital Association
Cathy Starnes, Ph.D., SWBC
Guy Clumpner, HoltCAT

Moderator: Mike Kreager, Chairman, San Antonio Medical Foundation

Mike Kreager: Good morning. I think most of you know me. My name is Mike Kreager and I'm the chairman of the San Antonio Medical Foundation and I'd like to welcome you all for coming today. We want to tap today's panelists for insight information about the state of healthcare reform. Our ultimate goal is information and insight from which each of us may form our own conclusions. If that information provides a basis for further dialog and debate and causes any of us to reach out and contact our elected representatives, then we will have accomplished a great deal as a result of this meeting. This meeting had as its genesis a recent meeting of the Health Issues Committee of the Foundation that was held on June 11th. The meeting was chaired by Milton Lee who was assisted by his co-chair, Dr. Bryan Alsip. The initial purpose of the meeting was twofold; first to discuss the best uses of a grant from the Methodist Hospital Foundation in improving healthcare and second, to plan subject matter topics for the Foundation's Board meetings for next fall, winter and spring. The committee members soon began realizing that the Congressional Healthcare Reform initiative spending in Congress had been unaddressed by the Foundation. Many of us had the feeling that the legislative train was leaving the station without the passengers knowing the timetable, the stops along the way or the ultimate destination, much less the cost of the ticket. Frankly, while many studied members of the committee were well aware of the initiatives, far too many, including myself, did not know enough about the initiatives or the expected impact of them. As a result, the committee recommended that a special Board meeting be held as soon as possible to inform the Foundation about healthcare reform. It was decided that the meeting would be a working meeting with no business conducted. The committee felt that informed representatives of the four most important segments of the healthcare industry affected by healthcare reform be asked to serve as panelists. These segments are the physician community, the hospital community, insurance companies and employers. We are very delighted to have four panelists representing these four segments today. Our speakers are to my right; Dr. Nancy Dickey, to my left; Jennifer Banda, to my far left; Dr. Cathy Starnes, and to my far right; Guy Clumpner.

The Medical Foundation has been in existence for over 60 years. While its short-term objectives change as time dictates, its unwavering long-term mission has been to improve healthcare, advance biomedical science and enhance community wellbeing. This panel discussion is intended to continue to fulfill the foundation's mission by providing education. As a result of long-range and strategic planning by the Board of the Foundation, it has established three task forces; Access and Mobility, Wellness and Health Education, and Military Health Care. These task forces have been active over the last two years in monitoring and developing initiatives for the Medical Foundation. Most recently the Wellness task force has begun its rollout of an obesity pilot project. The task force has recognized that obesity is the most prevalent medical condition afflicting Americans with more than one-third of Americans being obese. Obesity has been linked to a number of medical conditions adversely affecting the obese person's wellbeing and health. The initiative involves a partnership of employers and nonprofits to instill awareness and achieve weight loss in the participants in the pilot program. That was a little political plug for the Foundation.

Here are today's ground rules and as all of you know me as Chair, I am a time czar. Each panelist will speak approximately 15 minutes on their industry's perspective on healthcare reform. Our friendly but firm timekeeper, Jim Reed, will be operating the lighting system to help and otherwise will give hand signals when we near the end of an allotted time segment. After the panelists are finished we'll open the discussion to questions from the audience and answers from the panelists. Keep in mind that our program is now going to be less than 120 minutes long, so we want everyone to have an opportunity to ask questions of the panelists, or if you have particular expertise to comment on a panelist discussion. When you ask a question, please state your name. If you have an affiliation, give your affiliation and if you will stand, it will be much appreciated by the panelists. I will ask that questions be confined to inquiries of fact. Please do not use the opportunity to express a political belief or express a conclusion without giving a concrete factual basis. For example, let's avoid statements like, "healthcare reform will turn the United States into a socialist society" or "a single-payer system won't work." Let's have an open mind, ask questions to elicit information. As a moderator and with an obligation to keep the discussion moving and providing an opportunity to all participants to ask questions, I will be your time czar and please do not be offended if I politely cut you off. Today's meeting is digitally recorded. We will have the comments transcribed in a couple of weeks. A copy of the transcription will be available at the Medical Foundation's offices. We'll arrange to post it on the Medical Foundation website; and if you would like a copy, please let Jim or Pam know and we will provide it to you.

From my limited reading on healthcare reform, it appears that there are three basic concerns. First, there are reportedly 46 million Americans who do not have health insurance and therefore do not have ready, affordable access to healthcare. This statistic alone can be debated as to whether it includes persons who can buy insurance but who fail to do so, but the belief is that there is an enormous number of our population who are not insured. Healthcare reform will attempt to provide insurance coverage to these individuals. While a laudable goal, there is concern over who will pay for the coverage. The current House bill which I find interestingly enough entitled America's Affordable Healthcare Choices Act proposes a surtax on the wealthy.

Other proposals look to cost savings. The added coverage is estimated at \$1 trillion over the next ten years. But keep in mind that current healthcare costs exceed \$2 trillion a year.

Second, the cost of healthcare and health insurance premiums for healthcare have far outpaced the rise in costs in other industries. In some, the belief is that healthcare is far too expensive. Fingers can be pointed to many sources for the skyrocketing costs but the consensus seems to be coalescing on diagnostic tests and therapies that have no proven beneficial improvement to a patient's health. Some would point out that the current system rewards testing rather than healthy outcomes. The administration believes that offering a public insurance plan as an alternate option to private insurance will curb increasing costs.

Third, despite spending more money per capita on healthcare in the world, the United States scores well down the chart of the world healthcare systems ranking 37th. France is rated No. 1. Notwithstanding this ranking by the World Health Organization, I dare say that not many, if any of us, would choose to go to another country than the United States for healthcare. This ranking is not to affront those of you who serve at the frontlines of patient care. It instead highlights the totality of the system and healthcare reform should look at fixing the defects in the system without engendering defensiveness from those parts who take good care of patients.

With this introduction, I will now turn the discussion to our panelists. First, I would like to introduce from our physician community, Dr. Nancy Dickey. Dr. Dickey is president of the Texas A&M University Health Science Center and is vice chancellor of health affairs. She's past president of the American Medical Association and has served in a number of leadership roles involving public health and medical education. She's also been elected to the prestigious organization, the Institute of Medicine. Dr. Nancy Dickey.

Dr. Nancy Dickey: Thanks so much. I appreciate it. I'll try to keep an eye on my time along with Jim so that I leave plenty of time for your questions. I come with a little bit of a challenge because I am a past president of the American Medical Association and I also happen to have the honor of chairing the Texas Medical Association's committee on system reform, and those two organizations have taken substantially different tactical responses to the legislation. So I'll try to clarify which side I'm representing a perspective from where those are divergent. I think that a great deal of the discussion is about the timing and the rapidity with which the changes are being proposed, and as I said to a group as we were getting ready to come up on the podium, I think to some degree, there will probably be this feeling of rush no matter when we do it. I finished medical school about 30 years ago and this has been the No. 1 topic ever since I finished training and got into practice. This is the third opportunity that I've had to participate as a young physician, a mature physician and a tired physician, I guess. And we haven't made any progress any time, so I think part of the reason for rushing is to suggest that the longer we leave it out there, the more opportunities there are to shoot holes in it and we aren't likely to get a great deal of reform. On the other hand, I'm delighted they're waiting until after the August break to vote because I have concerns that our elected representatives may not have even made it through the summary of the thousand pages let alone the thousand pages. The summaries are at least in English. I'm not sure what language they use in Congress but it's strange. So I happen to think we need to reform the system for almost all of the reasons that have just been pointed out. We have a substantial number of uninsured and I won't debate the number, but all of you who work

near a large medical center like University Hospital know the numbers of uninsured people who arrive for care. We know that the cost of care is going up and I'm sure we're going to hear from industry that it has an impact on industry and we know the data that says that we don't perform as well comparatively speaking in terms of quality of life or longevity of life despite spending more per person than anybody else. I personally don't think incremental is going to work. Again, I've watched for 30 years as we've said incremental, incremental, incremental and we seem to be going the wrong direction. That said, I will say that physicians have some very strong feelings about what the system reform might look like and the impact it will have on them. The bill as I have read it suggests that if you currently have insurance and like your insurance, you will be able to keep that insurance. And if you read a little closer, you'll be able to keep that insurance for at least five years. Along the way, they're going to be establishing standards for insurance and if either your company changes insurance options so you are forced to look at different options or if your current insurance five or six years out doesn't meet the criteria, it's possible that you would end up not being able to continue to grandfather what you've got. But at least for the time being, if you've got insurance and like both the cost and the coverage, you'll be able to keep that insurance. Medicare, Medicaid, SCHIP, TriCare will all continue to exist, again at least in the short term. One of the stumbling blocks is that this bill proposes there would be a public option; that is, that the government would then create another insurance plan that people could buy into, and there's a good deal of concern both that at the AMA and at the TMA that if there's a public option, that private insurance can't possibly compete cost-wise with a company that has a little more infrastructure than perhaps the federal government will actually assign to insurance coverage. It's also as cheap as Medicare is. Any of us who have to process insurance in our office would tell you that it's not quite as cheap on our end as it appears to be from the government's end. But, so the concern is, if there is a public option, that it will quickly become not an option but the only option because private insurers will find they just can't stay in business at a rate that causes enough people to choose to pay for United or Aetna or Scott and White or Blue Cross/Blue Shield. That's not addressed in the bill but the public option is certainly there as a choice. The plan talks about how much money people should have to spend for insurance and so it actually talks about percentages of income and public subsidies. Now this is a public subsidy to help people be able to buy private insurance and is in fact something that the American Medical Association and the Texas Medical Association have been in favor of for a long time. Keep the private insurance industry but if people can't afford to buy that insurance, give them some assistance so that they can go out and buy the insurance. In this bill, there's also a mandate. If you don't get your insurance from your employer and you haven't gone out to the bank of choices and selected insurance, then at date certain you will pay a tax penalty for not having insurance. Again, I'm reasonably in favor of having a mandate because there's a fair number of those 46 million who make a pretty good income and opt not to be insured because they know if they show up, you guys are going to take care of them. So if we're going to insist that we pay taxes for most people to have insurance, then those people who make enough money to buy insurance ought to have to buy their insurance. The problem I see is, the tax penalty is substantially less than what it'll cost you to buy insurance and so why won't most of us simply pay the tax penalty and not worry about it, and that'll be one of the issues I'll be taking to my elected Congressman, say, gee guys, you ought to at least make the penalty enough to force people to go to the insurance market to buy their insurance. The plan says that doctors can opt out, they don't have to participate in the public option plan. However, if you participate in Medicare and the public option, you'll get paid better, currently proposed to be a five percent

bonus in terms of the payments that would come to you and, there are concerns again that there is no overt language, something that Texas physicians are extraordinarily concerned about, no overt language about private contracting. Many of you may not be aware of the fact that if you have Medicare and you go to your physician and the physician says I'm just not willing to do that procedure, they pay me so little that frankly it costs me money to do it, you can't say to him, well, I'll tell you what. I want you to do the procedure, so why don't you and I just do that on the side, okay? I won't bill Medicare, you won't bill Medicare, and we'll just contract to do that. Can't do that. The doctor has to drop out of Medicare for two years if he wants to have a private agreement with one or a thousand patients outside of Medicare. Well, private contractor doesn't appear in this bill anywhere and it's one of the things the Texas Medical Association and reform committee wants to see. Fine. Have your public plan, have your Medicare plan, just trust patients enough to say to them, if you want to have a deal on the side, you can do that. One of the places you might know that exists is in Great Britain where everybody's covered by the government plan; but if you choose to, you can decide for a given illness or a given intervention that you're going to walk across the street and either pay with private insurance or pay cash out of pocket and it doesn't impact your participation in the government plan for the next three illnesses. We'd like to see that kind of freedom for patients who want to be able to go to a particular doctor or a particular hospital for a particular illness without being forced out of their insurance plan. It's called private contracting. The plan talks a great deal about evidence-based medicine and suggests that that's where a lot of the money to pay for expansion is going to come from. We're going to start basing the care we give on science and it's true factually that we don't have definitive evidence-blinded material about which treatment we should do for each thing for probably half of the things that we do. Now, that's not suggesting physicians are out there just blindly trying anything they want. It's the kind of data they have on which they base the decision-making. The government would suggest that we'll save enough money by doing only evidence-based treatments that we'll be able to pay for all these people who currently aren't getting insurance and are getting the care from the public dole. And again, there's a tremendous variety of physician response. The American Medical Association and TMA both embrace the concept of evidence-based decision-making and believe that we should then push insurance companies and the government to say now, you've got to pay us the money to do the studies to be able to come up with the evidence about what kind of interventions we should do. And failing that, then it's going to be difficult – you can't simply not provide care because we don't know exactly the right antibiotic to use for a particular kind of pneumonia. So evidence-based is going to create a lot of troubles. Who's going to pay for the research to be done? Does it mean you can't have anything paid for that doesn't have evidence? But perhaps the biggest sticking point is, who's going to collect the evidence? Who gets to decide what's good evidence? The medical profession believes that it ought to be the health professionals that decide that. The government is proposing there might well be a body of some kind, an FDIC or something, panel that would determine which things meet the criteria for evidence and therefore which things get paid for and which things might not get paid for. You're going to hear a lot more about evidence-based. I guess the last one that I'll talk about – I'm trying to keep an eye on the time up there – is liability insurance. Hopefully all of you here in San Antonio are aware as we are across the rest of the state about the tremendous improvement in the ability to practice medicine since Prop 12 passed. We have communities that have been able to recruit high-risk specialties that had not been able to recruit specialties in those areas for a decade or more. We've seen the number of cases go down, measurably down, and for all of us who pay liability insurance, we've seen those costs go

down almost every year across the state. There is nothing in this bill about liability reform, and so at the very least, those of us here in Texas want to be sure that language gets put in that says that we will not do anything in this bill to undo or reduce the liability protections in those states that have managed to do a good job. Personally, I'd like to see them go a little further than that and look at the impact that liability reform's had in Texas and other places and actually put liability reform in the bill, but recognize it's a democratic White House, a democratic Congress, they've not generally been highly supportive of liability reforms. There is the possibility that where there is good science and protocols that you could put in language that says if you're following a protocol, that's a positive defense. You followed the protocol, something goes wrong and the outcome is not good, you are defended by the very fact you followed the protocol. Now, we all know that not every patient falls into a protocol, but it would at least protect a fair amount of the care that physicians give if we could get that kind of language put into the plan. The plan does not address the issues of individuals who are here other than in some legal format and for those of us along the Mexico border, that still means a fair number of patients that won't be addressed by the plan. The plan does not address effectively in my opinion how we are going to impact the workforce. It does talk about medical homes, it talks about the need for more primary care so that more patients will access the system through a clinic or a primary care facility as opposed to shopping around to multiple different sub-specialists. But we are grossly underrepresented in terms of primary care providers and without substantial changes in the way that primary care is paid for, there is no reason to believe that we're going to be able to change that mix in short order. So the more they emphasize primary care, the bigger that shortage is going to be. One of the places they point to regularly is Massachusetts, that now reports to have 97 percent of its population covered, but you can't get in and see a physician because you're supposed to go through a primary care provider and they don't have enough primary care providers. There is the opportunity for significant administrative simplification. Again, I can tell you that every medical office and every hospital that currently bills would love to see meaningful simplification, but it's addressed much more in terms of a wide swap than specific language about how they would get that simplification. I think that pretty well sums up the biggest concerns. Let me address the controversy between TMA and AMA if I can. Remember the House Tri Committee, the three committees that had something to do with system reform, have now written their proposed bill. One of the two Senate committees has released their proposed bill; the other Senate committee has not and they'll have to come together and somehow write a Senate bill. That's as far as it's gotten. The House has to vote on a bill. The Senate has to vote on a bill. Then they'll come together to a conference committee where they'll have to agree on some kind of language, which may or may not come from one of the two bills. Then it'll go back to the two houses where they have to vote on it again, and then it has to get White House signature. So, AMA says, if you look at that whole arena we're way back here at the second inning. We want to stay at the table and so we, the AMA, continue to endorse the concepts even though we have some specific concerns. We the AMA, are basically saying yeah, you're headed down the right path more or less because we wanted a seat at the table and they have been at the table this time around which has not always been true. The TMA committee on the other hand got some fairly strict marching orders from the Texas Medical Association in May and they said there's way too many things that aren't in the bill or are 180 degrees from what we want in the bill – private contracting – liability reform – the public option and how long the public option would last before it suddenly became the only option and so TMA has sent a letter not saying we're opposed to the bill but saying you've got some holes here you're going to need to fix

before you can look to us to support the bill as it's currently being discussed. My guess is that most of the physicians here in this room are much closer to that TMA philosophy than they are to the AMA philosophy but interestingly enough the current president of the AMA is another Texan so we're sending mixed messages. I'll look forward to the other comments and then a chance to answer any questions you have. Thank you.

Mike Kreager: Thank you Dr. Dickey. Our next speaker is Jennifer Banda who represents the hospital industry. Jennifer is Senior Director of Government Relations of the Texas Hospital Association in a role at TMA or THA, I'm sorry. A little cross-pollination but in a role at THA. Ms. Banda focuses on a variety of hospital and health advocacy initiatives at the state level and in front of the Texas legislature. She manages HOSPAC, the political action committee for THA. She's held a number of positions in health policy serving as counsel to various legislators. She also has governmental experience at the state and national level. She's a graduate of UT Austin with a BA in the Plan 2 honors program and graduated from the University of Texas Law School. Ms. Banda.

Jennifer Banda: Thank you very much. I appreciate the opportunity to be here. It's always nice to be in San Antonio. My husband grew up here and I've already gotten a text message from him asking me to bring him a Chris Madrid's hamburger back for dinner tonight.

I just wanted to let you know a little bit about the Texas Hospital Association. If you're not familiar with us, we represent almost 500 hospitals and health systems across Texas. We represent the public hospitals and for-profit hospitals and not-for-profit hospitals so we really have a wide array of hospitals and health systems and public policy that we work on on behalf of hospitals and we work at the Texas capitol and at the capitol in Washington, D.C. which of course since the legislature adjourned on June 1 we have spent a lot of our time in Washington and watching federal health care reform from the legislature to the Austin – I mean from legislature to Washington, D.C. we really went from the frying pan into the fire so it has been an interesting last few months. Today I wanted to talk about the hospital perspective and we talked a little about some of the statistics on the uninsured but I'm going to repeat them just because it gives you I think a little bit of background on where the hospitals are coming from when we're looking at federal health care reform. In Texas, we have 25 million Texans and 6 million of those Texans are uninsured. That's 25 percent of our population that's uninsured and in the urban areas it can be as high as 33 percent of the population that's uninsured. You think about that, that's more than the entire population of the Dallas/Fort Worth metroplex area. Seventy-nine percent of the uninsured in Texas – they work or they have a family member that works and I think that's a critical piece of information because it tells you that the problem is the affordability of health insurance. It's not necessarily always access to health insurance. And only 20 percent of the uninsured are illegal immigrants. So I think that's also something that sometimes gets mistakenly understood in Texas and that's an important statistic. At the Texas Hospital Association for the prior two years our number one priority has been to try to address the affordability and accessibility of health insurance and health care. And that has really been our priority as we have approached looking at federal health care reform. We would like to see federal health care reform affect the system because the current system is unsustainable on the trends and where we are headed. Just for you to think about the current insurance premiums you pay, more than \$1,500.00 of the premiums you're paying in your insurance policies are going to

support health care for the uninsured and the care that the uninsured are receiving. And when you look at our state budget and our federal budget the cost of health care is just absolutely eating away at the budget and it will continue to do so unless we do something to address that. Now when President Obama released his plan I think it certainly got everyone's attention. I know that it got ours. He originally proposed \$38 billion cuts to hospitals over ten years and as he has broadened and a little bit expounded on his proposal he's now looking at \$254 billion in cuts to hospitals over the next ten years and something that we are very concerned about is understanding that we need health care reform but that reform does not just mean cutting what we are providing the financial, that's going into the health care system. We can't just cut payments to hospitals and doctors and nursing homes and assume that we have reformed health care. It's bigger than that. It's a cultural change. It's a systematic change and that's what we would like to see. Of course the President's plan includes a public plan and he also – one of the other issues that we are watching at the hospital association is the disproportionate share of funds and that's, we call them DSH (pronounced “dish”) funds. But what those are, those are funds that help us make up from the losses that we get by taking Medicaid. I think everyone in this room would know that Medicaid does not pay cost to hospitals or doctors or anyone who receives Medicaid and DSH is a form of funding that Texas hospitals and some physicians receive to help make up for the losses that we take for seeing Medicaid patients and one of the things that we are seeing is some proposed substantial cuts to DSH in all of the plans and that's something that we're watching. I think that Dr. Dickey laid out a little bit of the two plans – of course we have the Tri-Care plan in the House and then there's two plans in the Senate that are both moving and so they do have similar characteristics. They propose covering 95 to 97 percent of all Americans with insurance. They both put a \$155 billion cap on the cuts to hospitals. They both maintain the graduate medical education which is critical to continue to educate and produce doctors all across the country and they both have reporting of hospitals for adverse events and hospital-acquired conditions. So those are some of the similarities that we're seeing but then of course the House version as they are debating it – and we thought that they would have a vote on the House version before they adjourn this Friday – in the House before they come home for August recess – and we found out last week and as the details were slow to emerge and as they're slow to work out the details –they are not going to have a vote in the House I don't think by Friday and so they are going to come home for August recess for 30 days and we'll be able to have a lot of dialog I think in those 30 days about what's going on. But the House version, the specific impact to hospitals – they are looking at cutting our cost-of-living increases by \$119 billion over ten years. They are looking at doing readmission policies so that if we treat a patient, release him and the patient comes back, the treatment of that patient when they come back would not be covered and the House is having a very, very stringent policy on that and one of the things that we're wanting to talk about is preventable versus unavoidable readmissions. If you're treated for a heart attack, we release you, you go home, you slice your finger with a knife and you come back for stitches or to get that cut repaired, under the House bill that's being treated as a readmission and is something that would not be paid for. And of course that is something and we don't think that that's a way to look at reforming the system. We need to look at the causes of readmission, not just the fact that a patient was readmitted and call that a blanket readmission and deny cost and care for that. The public plan that the House is proposing uses Medicare rates for three years and of course Medicare pays also less than cost and so that's something that we are watching very closely. If a public plan is being proposed to put into place, what payment system are we looking at putting in for the public plan? And then I

mentioned our DSH funds and in the House proposal they're looking at cutting \$20 billion in our DSH funds over a ten-year period. And then one of the things I think that was very interesting last week when President Obama met with the blue dog democrats who are the conservative democrats in the House, they came up with a new proposal that you may have read about or if you watched President Obama's speech last Wednesday night called the IMAC, the Independent Medicare Advisory Commission. What they have agreed to do is set up a commission that is basically an arm of the executive branch that would put all of the hospital payment, or all medical payment processes in the hands of the executive branch rather than in the congressional branch which is where they are now. And I think that that's a very interesting dynamic and is something that has a bigger issue I think than just health care policy. You're looking at taking something that has really been another branch of government and handing it over to the presidential branch of government and that's something that they're debating very heatedly in Washington as we move forward and we have concerns about that because turning something over to the executive branch who basically has blanket authority to set rates as we move forward takes a lot of the give and take out of the entire political system and then the way that we set rates and set our health care system right now. In the Senate what we are seeing – there's Senator Kennedy's committee who has voted out a bill and it's a much more liberal bill than what we are seeing trying to come out of the Senate Finance Committee. We believe that the Senate Finance Committee is going to be the ultimate leader in the Senate that will put out the bill that I think will be the primary piece of legislation. They are trying to have a more bipartisan approach on the Senate Finance Committee which is why we haven't seen a bill yet. It's much harder to do that when you have a bipartisan approach. In the Senate Finance Committee proposals that we have seen, our DSH cuts there would be \$50 billion over five years but they would be triggered upon increasing the amount of Americans that are insured. If you're going to cut funding to treat the uninsured it should have a consequential trigger that those cuts only take place when we do see an increase in the number of insured across the country and that is something that the Texas hospitals and THA would like to see; that those things are tied together because really that is the entire point of the entire proposal. They also have readmission penalties in the Senate Finance Committee but they look more at the unavoidable and, they do a better job of looking at readmission penalties in the Senate so we absolutely prefer their approach on the Senate Finance Committee to what would be our readmission policies. They also propose a public plan but rather than being run by a governmental entity it would be run more by a non-profit entity or local entities which is something that we think is worth pursuing and looking at. And they take our cost-of-living increases and cut those \$103 billion over ten years. Of course the question for all of this is how do you finance it. In the Senate, as of last week they were still \$320 billion short of financing their proposal and of course that's the more bipartisan approach and they're \$320 billion short. Specifically to Texas, we have some really strong concerns that we've been expressing to our congressional delegation. If you look at the proposals that are trying to get to 95 to 97 percent coverage of all Americans and looking at where we are in Texas – in Texas 6 to 7 percent of the population are illegal immigrants and are specifically excluded from this bill so right off the bat there's absolutely no way for Texas to get to 95 percent coverage when 7 percent of our population is excluded from the bill. I think that is a huge concern that we are trying to communicate to our Texas delegation. You know, getting to 95 percent coverage in Connecticut or Maine or New Hampshire and all of these other states – they have a completely different set of concerns when we all know that Texas is a whole other country. We see the bumper stickers the whole time. I see it all the time and that's what we're trying to communicate to our congressional

delegation. We're also watching very closely as I said the impact on what all of this will have on our Medicaid program in Texas and the DSH funds that we receive in Texas. We have a significant number of rural hospitals in Texas – of course more than you're going to see in any other state – and any cuts to the system that are going to impact and possibly close our rural hospitals are of great concern to us. A lot of our rural hospitals operate in a 1 and 2 and 3 percent margin if they have a positive margin at all and we are trying to look at how the reimbursement system would work for those rural hospitals. That's something critical that we're talking to our Texas delegation about. And Dr. Dickey certainly mentioned it – the work force shortages – the availability of family practice physicians. If we are going to try to strive for a goal where everyone has insurance that is a fantastic goal; it's something that we support, let's try to get there. But if you are insured and cannot go get in to see your family practice doctor, you're still going to come to the emergency room. So we aren't cutting out the problem we have now in Texas where we see patients coming to the most expensive place to get their health care – in the emergency room. They'll be insured in the emergency room rather than uninsured in the emergency room so that's better but it's still not the place that we need to have patients being seen. They need to have medical homes, they need to have the family doctors and that's something that we're watching very closely. And of course we agree absolutely with TMA and with Dr. Dickey about protecting Texas liability reforms. We want to make sure that we protect those because Texas is at the forefront of that in the nation and that is something that's critical to us. As far as the impact on the Senate Finance Committee – just to give you some numbers that are stark when you hear them – the Senate Finance Committee proposal, what that would do to Texas in our cost-of-living cuts it would be \$7.5 billion out of Texas hospitals. In our DSH reduction, it would be \$4.5 billion from Texas hospitals. In the readmission penalties and this is the less stringent readmission policy, \$137 million from Texas hospitals. So we're looking at one hundred or, \$12 billion over ten years from Texas hospitals. So that's of course, you know you can hear those numbers any time you start with a B – that's a significant amount of funding that we're looking at. And then of course if the public plan pays Medicare rates what we would be concerned about is that the currently insured patients, privately insured, over time if there's nothing that keeps people from migrating into the public plan we would move to a system where most of the patients in Texas would be insured in a plan that pays Medicare rates, which pay less than the cost of care, and so that is something that over time would have a significant impact to the sustainability of the entire health care system. As far as an impact on the Texas budget, what the Texas legislature sets every two years, if they mandate an extension of Medicaid which is something that they're looking at – expanding who's eligible for Medicaid – over time, the federal government will stop paying that and the cost will shift to the state. Under the Senate Finance Committee proposal we would be looking at \$3 billion more a year just from our Texas budget and that's a significant amount of money that the Texas legislature would have to produce in about five years when they start coming up with those plans. And I think just as far as the congressional schedule as we talked about, they're going to adjourn for the August recess – the House adjourns on Friday, the Senate will adjourn next Friday. They'll come back for about 30 days and then they'll hit the ground running when they come back in September and Dr. Dickey had a very good description of how they'll have to bring it together, pass those two bills and then go into the conference committee and for the political side of it what I find so fascinating as they're trying to work out – of course we know there's a democratic majority in the House and in the Senate and of course President Obama but in the House the interesting dynamic and the reason we have not seen a bill yet – there is a 40 seat democratic majority in the House

but 51 members of the democrats are so-called blue dog democrats who are the very conservative democrats, fiscally conservative democrats, and they are the ones that are really having the ability right now to help move the bill in certain directions and they're the reason that the leadership in the House has not been able to come to an agreement yet. It's those 51 members that really have the power in their hands. And I think just something else to think of politically and a lot of these guys are blue dogs when I talk about them but of the democrats in the U.S. House of Representatives 49 of those House members who are democrats, their constituents, their district voted for McCain in the last election. So don't forget that these guys, although they are working on health care policy, there's always the concern that you want to come back and reelect, they need to go home, explain the bill and then get reelected. So I think that's a little bit of the politics behind it and just not to mention the how to pay for it.

Mike Kreager: Thank you. Thank you, Jennifer. Was it Senator Dirksen that said a billion here and a billion there and after awhile we're talking about some real money? Dr. Cathy Starnes is representing the insurance industry. She is CEO of Employee Benefits Consulting Division of SWBC headquartered in San Antonio. She has over 13 years of industry experience working for health insurance carriers. She obtained a Ph.D. in organizational leadership from Incarnate Word University in 2004. She has been a participant in the Greater Chamber's Leadership San Antonio program and was named in 2005 as one of San Antonio Business Journal's 40 under 40 rising stars of San Antonio. Dr. Starnes.

Cathy Starnes, Ph.D.: Thanks, Mike. And I'm honored to be with you here today and to be part of this panel so thanks for that. I wanted to share this (hold up a book), this was my life from 2000 to 2004, this was what I spent a great deal of my weekends, my after hours, my early mornings, this was my dissertation. And before Obama or the current administration had it on their agenda we had it on our agenda here in San Antonio. The title of my dissertation is In Search of a New Paradigm for Health Care, Consumer Perceptions of Provider Accessibility and Utilization and if you'll indulge me just a bit I just want to read two passages. Other than that it's good for late night dozing reading but two passages with you. Significance of the study: With a population exceeding one million San Antonio, Texas is a thriving medical community from which it is imperative to address health care accessibility issues for residents. As community leaders in academia and business, it is incumbent upon us to identify strengths and weaknesses in our local health care systems. This investigation included practitioners, clinicians, patients, health insurance carriers and community and academic leaders. The objective was to find ways to bridge identified gaps and create opportunities to work together to provide a better model for medical care access for the San Antonio population with possibilities of serving as a national model. Final reflections: As a Ph.D. candidate who also maintains a career in the health insurance industry, this study grew from a passion of more than nine years of experience and an observation of the health care delivery system.

I've personally met with providers, patients, business owners, corporate leaders, community leaders and politicians regarding dynamics in the industry and obstacles that are faced today along with upcoming challenges for which we need to proactively prepare. My objective is to provide research for a forum to initiate change in the system that would promote a more equitable approach, such that patients of every demographic characteristic, notwithstanding the type of health insurance plan maintained, could have the same perceived results of provider

services rendered. Healthcare is a vast and multifaceted issue with many constituents involved and endeavors to find solutions for success, an egalitarian approach to healthcare delivery systems for all Americans are vital to cohesively make viable change. So, this has been my passion since 2004 and it still is today. My role is vastly different. I've spent 13 years working in the health insurance carrier side and I now work for SWBC. For the last three years I've led their employee benefits consulting division where on the other side of the business we build employee benefit platforms and so we negotiate aggressively with the carriers and we look for opportunities to build fiscally responsible and sustainable employee benefit solutions for clients like HoltCAT and many others across the city and the nation. The scary thing for us, for SWBC, and I'm going to share with you some additional numbers later, but for SWBC is that the Obama Administration and the Congressional leaders are sending alarming signals by stating that the role of brokers may be minimized into new government programs to reduce administrative costs. So I think there's a lot of constituents here and we're all being faced with reducing administrative costs to pay for the new healthcare reform. The alternative solution is to use government run information and call centers similar to the IRS and Medicare help centers which are currently utilized. There are over 500,000 professional health insurance advisors, agents, brokers and consultants in the nation. Our role is to design and implement employee benefit plans, solve problems, develop health promotion and wellness programs, assist employers and employees in navigating the cumbersome healthcare arena to build effective and fiscally sustainable employee benefit platforms. Critically our role is to help employers forecast, evaluate funding options, negotiate short-term and long-term strategies through contribution strategy analysis, reserve funding analysis and benefit differential evaluations. So again, our role from the broker perspective is to put the carriers together, put the Humana and the Cigna and the United Healthcare and the Aetnas, we are kind of the accountability partners between you and them. To look at the financials, look at the numbers when we work with our employers to build those platforms and look at short-term premium rates and long-term premium rates.

I want to step back a little bit and share with you some numbers, I'm a numbers nerd a bit and so I want to share those with you. To kind of talk about the genesis of the issue and how we got to where we are and the predicament we are in today. Medical inflation rose 113 percent in an eight year period from 1998 to 2006; during that same time general inflation rose 28.8 percent. So if you look at those numbers 113 percent inflation for medical inflation, 28.8 percent for general inflation. Total healthcare spending was 2.4 trillion in 2007 or effectively \$7,900.00 per person, representing 17 percent of the GDP. Healthcare spending is expected to increase to 4.3 trillion by 2017 and that's not far away. So again, that's why we're here in this room today we've got to solve the problem and we're all accountable for being part of that solution. Annual premium for employer health plan covering a family of four averages \$12,700.00 and premium for single coverage is averaging \$4,700.00 across the nation. We all agree that our healthcare system has inefficiencies, excessive administrative expenses, inflated prices, waste and fraud which significantly increase the cost of care and health insurance for employees and plan members. So how can we impact the system effectively? How much can private insurance cost be effective? I'm going to give you a scenario that if you spend \$1.00 on health insurance premiums, how is that \$1.00 broken up from an insurance carrier perspective? Eighty-two to eighty-six percent of the \$1.00 that you put to your health insurance premiums goes back to the medical community to serve for the claims that are submitted from the provider, from the hospital, from the medical community, from the pharmacy and pharmacy is typically about 20 percent of the cost of an

employer's plan. So 82 to 86 percent of that \$1.00 are being spent on claims. Carriers work very, very hard to try to get that number down. Carriers would like to see that number 76 to 80 percent because that means the profit margin on the backside to the carriers is larger if they can contain the claim costs. So they do that by case management, coming to you to negotiate deeper discounts, disease management, wellness programs, preventative utilization activities. So those are the things that the carriers want to do to try to increase profit on the backside. But effectively right now we're seeing the trend 82 to 86 cents of that \$1.00 is spent on claims. Five cents is spent on taxes, assessments and state and federal mandates that the carriers are subjected to by doing business and then 9 percent is left for plan administration. The carriers would like to have 3 to 5 percent profit at the end of the year, so that's what their target is. You've seen national health insurance carriers dwindle over the last ten years. For example if we take a client or a company like SWBC where we have employees in 27 different states we have to use a health insurance carrier that has multi sight location, opportunities that can serve our clients, has network capabilities so that we all have accessibility for those employees in all of those states and there's great shrinkage in carriers because their profitability has dwindled so you've seen them merge and combine and that's been a difficult impact to the industry as well. I think one of the things that we can all probably ascribe to is that behavior modification is one of the quickest and best ways that we can change the cycle of the costs. An estimated 15 percent of the 82 to 86 percent of that \$1.00 that's spent in claim costs can be preempted by modifying behavior and here's just a quick example of that. If you take the determinance of health status 50 percent of what makes up your health status and your claim utilization is based on lifestyle choices; so 50 percent lifestyle choices. Two examples here are that \$75 billion per year is direct medical cost attributed to smoking. So that's \$75 billion in the United States. One hundred and forty seven billion is directly attributed to obesity and this is per the CDC. So 50 percent of what we're doing for our own health can be changed with lifestyle choices, 20 percent is genetics, 20 percent is the environment in which we live and 10 percent is access to care. The other big topic you've heard today, I think from all three panelists, well two panelists and Mike so far, all three of us is the uninsured situation. This has been a great platform for the administration and this is the problem we're trying to solve and I might take a step quite differently from that and say that's not the problem. We need to ensure equality in access and access and opportunities for everybody. But if we take that uninsured population and estimates are 46 million across the nation and you hear different numbers 42 million, 54 million, but the most touted number I think is 46 million across the nation. If you kind of peel back the layers and research what comprises those 46 million; 34 percent of those are eligible for government programs but they are not signed up so they're choosing not to engage in a conduit that can get them to you and get services paid for, 32 percent have annual incomes exceeding \$50,000.00, so they have the financial means but perhaps not the wherewithal to purchase the insurance, 14 percent are temporarily uninsured maybe they're moving from one employer to another and then 20 percent would be long-term uninsured so that can be the immigrants and other situations there. So the real impact of the uninsured across the nation that have no access is 9.2 million. So if you kind of peel those layers back a little bit I think it's meaningful to say that we have a problem but maybe that's not the basis of healthcare reform. Two additional scenarios to that; I think we spoke briefly about the Massachusetts Healthcare Reform Law and that was enacted in 2006 and I thought that was a good story so I wanted to share that with you as well. In Massachusetts they were trying to achieve 97 percent or they were trying to achieve full insured population and they've accomplished it they're at, I believe, 97.3 percent insured population. What it does, this

law requires every resident of Massachusetts to obtain health insurance coverage. Through the law Massachusetts provides subsidized healthcare for residents earning up to 100 percent of the federal poverty level and they partial subsidize healthcare for those earning up to 300 percent of the federal poverty level. So it depends on an income based sliding scale. The original projections were for the program to ultimately cover 215,000 people at a cost of \$725 million. However, the revised numbers are in and by 2011 enrollment is projected to grow to 342,000 people at an annual expense of \$1.35 billion. So economically and fiscally the Massachusetts system failed, it broke, it solved the uninsured problem but fiscally the state can't handle it. Additionally as was already presented, the influx of more than a quarter of a million newly insured residents has led to overcrowded waiting rooms and overworked primary care physicians who were already in short supply in Massachusetts, partially because the malpractice situation in the Northeast is so bad, so God bless Texas for that we're in a better position there. The other thing about the insurance population is the state risk pools. When you look at the uninsured situation, most states have guaranteed access to individual coverage. The costs vary by zip code, sometimes dramatically from one state to the next, based on additional state mandates. In Texas the Texas Health Insurance Risk Pool for the year 2008 had 26,908 members and the total claims paid for those members was \$265 million and that was on medical and pharmacy benefits. Where did that \$265 million come from? Remember premiums covered 70 percent of the total program expenses; 76 million came from assessments from insurance companies who chose to do business in Texas. What the Texas Department of Insurance is any health insurance carrier that's going to engage in business in Texas is subject to any assessments or risk pool support and they know that when they do business here. So I believe slightly over 100 companies were assessed that \$76 million and then \$3.5 million came in from federal grants. So the final audited net loss for the Texas Health Insurance Risk Pool for 2008 was \$76,000,471.00. How did that happen? The average monthly premium per member of that risk pool was \$593.00 but the cost per member was \$821.00. The pool is administered by Blue Cross/Blue Shield of Texas and Medco is the pharmaceutical component. The other two pieces I think that are important to share with you from that and why the costs were out of control were 68 percent of those members are age 50 to 64 and that's the aging demographic of our nation, that's what we're preparing for we're going to see those costs continue to increase and additionally the ICD 9, the top codes in the claim expenditures for that were neoplasms, circulatory and musculoskeletal disorders comprised 42 percent of that \$265 million. The political update, the size, the cost, the scope of the bill and the quick implementation of such impactful legislation is very scary to us. Scary to us at SWBC, scary to us for our insurance carriers, scary to me personally. The house bill is 1,018 pages, the House Ways and Means Committee, the Education and Labor and the Energy and Commerce Committee are working on that and then the Senate Health Committee theirs is 615 pages. So, we've all kind of worried about and addressed today can you all do that by the end of this year? So, I'm open to further discussion and questions and answers and I hope we can all help make a difference.

Mike Kreager: Our last panelist is Guy Clumpner. Guy is President of Holt Development Services, Inc. and Vice President of Human Resources at Holt CAT. He has worked with Holt for 28 years and has oversight responsibility for the Human Resource functions including employee benefits and Holt's group insurance plan. Mr. Clumpner:

Guy Clumpner: Thank you, good morning and good afternoon technically. Before I begin I'd make a couple of remarks: one it's scary to be asked to represent an entire business segment, so please don't hold me accountable for such a daunting task. I'll add that while I'm given to extraneous speaking the nature of this topic inspired me to avoid spontaneous combustion. So I will offer some prepared remarks and finally, Jim, I appreciate the time clock as well. I've tried for years and years to get Peter to sign up an aging, earthbound point guard, but he won't do it so that'll be my shot clock. In my capacity at Holt CAT I represent the interest of owners, employees and stakeholders who are charged with providing and managing effective healthcare coverage for over 15,000 employees at an annual cost of approximately \$14 million and to my estimate that's our third highest cost after payroll and inventory and by the way if anyone needs a tractor I can get you fixed up there. The concerns we have about pending healthcare legislation largely reflect the concerns we have about providing any benefit for our employees. Specifically providing valuable and comprehensive benefits which meet the needs of all employees and their dependents in a manner which is cost effective for all parties. In this forum I have been asked to share an employer's perspective regarding pending legislation and the changes in healthcare and not to offer specific alternatives. This is a good thing, for although my father was an OB/Gyn and my mother was an RN and brother graduated from Case Western Reserve Dental School I don't even play a doctor on TV. One perspective I can share is that from experience in business and as a leadership development expert is that more often than not finding the right solution is the result of effective analysis and that this audience well knows accurate diagnosis. Although we generally agree that the spiraling costs of healthcare is a significant issue for our country and that barriers for providing such care do exist, I strongly believe that the best way to improve it is through a focused and managed process approach. One which effectively dissects the confusing, contradictory and often all too bureaucratic nature of healthcare into its component parts. At Holt we celebrate and value diversity of opinion and perspective. When it comes to offering business solutions however we focus first and foremost on what's best for our customers without respect to individual agendas or political perspectives. It's a perspective born out of necessity and one which would serve our legislators as well. An effective and comprehensive effort to improve healthcare should reflect a willingness, and frankly obsession, on the part of providers and insurers to do what's in the best interest of end users where at the end of the day we all have to work with these entities or human beings with our own individual health concerns. In an ideal world the commitment to and achievement in improving our healthcare system would come with real consequences, positive or negative, for those who are responsible for affecting such change. That's the way it is in the business world. In the business world we typically don't pick calendar dates for project completion until we hear from all of the relevant stakeholders, determine strategies and tactics and gain upfront agreement on who owns the issue. The best businesses also clearly track and identify qualitative and quantitative metrics by which to determine their progress. Draft legislation with phrases like the following these features will ensure the public option as a leader in the efficient delivery of healthcare doesn't mean much unless I know what the words leader, ensure and efficient mean in real measurable terms. As for specific issues we believe must be addressed the following come to mind: first, carefully assessing, identifying and eliminating waste streams which exist in the current system. I won't win a Nobel Prize for observing that generally speaking when the federal government becomes involved in starting a program on the premise that it will be self funded, the self generally turns out to be myself and yourself. If we choose to implement a government based system, do it on a pilot basis and mandate that a certain percentage of current senators and congressman participate in the control

group. We have a saying at Holt that goes as follows “leaders go first”. Ensure that incentives for providers and stakeholders in the system are based on performance metrics with a focus on measuring healthcare system outcomes as well as specific targeted reductions in the exponential growth of providing them. Of particular interest to private employers is the proposal that we’ll be obligated to provide funding for employees who elect a government sponsored plan in lieu of any other coverage that we might offer them. In principle such a proposal is designed to make insurance providers mindful about cost containment, plan efficiency and design in order to offer a marketable and competitive product. In reality, employers such as Holt have long made efforts to ensure that the plan coverage they offer is comprehensive and that it attracts employees who have a choice about where they will work and build their careers. The notion of providing an opt-out public healthcare plan clearly creates an environment where adverse selection becomes more likely. The flight by young healthy employees to a public plan carries with it the risk of limiting the pool of candidates for otherwise desirable and comprehensive private healthcare options along with the risk of driving up the overall costs for employers and employees. Finally, while pending legislation’s proposals tout the notion of shared responsibility, in my humble opinion, much more weight needs to be given to shared accountability. That means that every player in the healthcare system game must come to the table and act collaboratively with identifiable risks and rewards in place. Perhaps most important is the notion that the American public gets involved. As painful as it is to admit I am technically speaking as a senior citizen. I’m also an employee and a family provider. I am currently dealing with the challenge of a thankfully healing knee injury, more insightful was a recent CT heart scan which I had, which revealed calcified blockage in my coronary arteries. This despite years of taking statins, riding a bike 50 to 70 miles on most weekends and going to the gym religiously. Through my own reflection, my own research and assistance from caring physicians I’ve come to this realization--the American healthcare system is not responsible for the plaque in my arteries or the fact that in broader terms I prefer to take my Lipitor as a condiment on my cheeseburger. Peter Holt who is willing to pay for over half my health insurance costs is not responsible for my health, I am. Any healthcare reform which cites wellness and preventive services as a cornerstone should do so in light of the overwhelming evidence that not many people are willing to make the changes that I have made with my personal health, to think otherwise is a risky proposition. Thank you for inviting me.

Mike Kreager: Alright at this time we’ll open it up for questions and answers. Pam and Barbara have portable microphones. If you have a question raise your hand, they’ll bring you a microphone and if you’ll state your name and any affiliation you have and remember that a question is an interrogatory and not a speech. Who’s our first taker? Dave has a question. What you want somebody to get hurt? No, we at least went to the tallest man in the room.

David Young, M.D.: Well thank you. I am Dave Young, I’m an internist and retired Air Force officer and we come at this I believe at a very interesting time in our history when we have to face up to the realities that we cannot give to all members of our society everything that they want. And this is going to be tough love. My earliest political memory was growing up in California. My dad was a general surgeon and we went up to the Steps of Sacramento to lobby against this horrible socialized medicine thing, Medicare. Several months later, because of over work, being unable to say no to people in the community he worked in, he suffered a devastating stroke and he was actually rehabilitated by the Veteran's Administration by exactly if you will,

the kind of socialized medicine that he had worked against. I spent my whole professional life worrying about this, thinking about this and the best explanation I can give you is to recommend you read Iococa's book about what brought Ford Motor Company almost to its knees. No disrespect to any fellow practitioners here but it was podiatry. At the end of the negotiating session Iococa says they said we were trying to get a little more and they said how about foot care. These poor guys and gals who are up there on the concrete all day. Podiatry services added on and added on and added on and brought Ford Motor to its knees. We saw that in General Motors. So actually let me stop the rant and perhaps address a question to Dr. Dickey and thank you, doctor, for your service over many, many years in working on this. We have to follow the money. It comes down to in the United States the money and we talked about problems in primary care. We talked about physicians' income being too high. Everybody says that's the problem. I've got a son in medical school now at Lake Forest. He won't be making a dollar on his own until his later 30s after he pays back his loans. He wanted to be a family practitioner. He says he can't afford to be a family practitioner. He's got to learn procedures to make it to payback. I believe that that will be the key feeling. You don't see that anywhere in the legislation about how do we actually force change by changing the perverse incentives and reimbursements that we have. Thank you.

Dr. Nancy Dickey: Thank you. Well-stated question. You're absolutely right and we tell state legislators and federal legislators you can create all the training spots you want. You can even do loan forgiveness if you want to which will encourage a few more to go into it but the reality is we don't let stupid people into medical school and so when they get to medical school and they say now, let's see, at the end of the day I spend virtually the same amount of training to be a family doc or a pediatrician or one of the interventional specialties and they're going to make three times more than I am. Gee, you know, I think I could learn to love to be an orthopedist or pick the one you want. No, again no insult intended towards anybody; it's just the way things have worked out. So we are going to have to pay primary care providers more or perhaps we'll stop looking at physicians as primary care providers and we will instead use nurse practitioners, physician's assistants and others and simply tier it in a different fashion and I don't think we have the data to tell you whether that will get the same kind of primary care providers. All of the different bills have something in them about attempting to improve primary care. None of them, frankly, address the issue of incomes in a reasonable fashion and, in my opinion having been part of the AMA during the RBRBS discussions, the problem is, and I think you heard that from hospitals when they talk about they're going to take away the DSH money in exchange for the fact you'll have more insured patients coming in the door, at least that's the theory, and I think the place it's going to come from is from high-paid specialties into lower-paid specialties and that automatically sets up conflict between physicians and creates a group of nay-sayers who are going to say whoa, we don't want to go down this path. It's one of the reasons that I think that we may end up having a very fast timeline because the more people that read the bill, the more people who identify their particular ox is going to get gored by this and therefore, it was years ago with the Hilary Clinton debates, when people said everybody has a plan they think they could endorse. The problem is if you can't get society to endorse your plan, everybody's second choice is the status quo and so by putting off voting on this until the end of the August recess when people have time to look at it, it may well be that we not only identify interventional specialists who say forget it, I'm not interested in going there and I can't blame you because frankly, I wouldn't want to give up my income when I've already based my lifestyle on what I'm

doing. We'll find hospitals who are against it because they can't afford to think that their entire clientele is going to be paid at Medicare rates. We'll find employers who are hesitant because they're going to have their health benefits taxed in order to pay for people that they've actually, technically aren't even pay for through their taxes. We're going to find ... So the litany of people who are going to find some reason to say don't go there is simply going to grow. On the other hand, I think it's imperative, and I think you implied the same with your comments, what we're currently doing is not sustainable. We cannot continue to see 10, 15, 20 percent inflation when the economy's inflation is 3 percent. We cannot continue to see the explosion in interventions without some evidence that it's making a difference in terms of the health outcome at the end of the day. And my fear is that if we don't put a solution on the table, that we will end up with an unworkable solution imposed upon us because the economy will force us in directions that don't necessarily make good sense for healthcare.

Mike Kreager: You know, Dr. Young referred to Lee Iococa and last night I heard the governor of Michigan refer to her state's automakers as basically insurance companies who happen to make automobiles. Next question. Harriet?

Harriet Helmle: I may not need a mic. Actually, this is going to tag in a little bit with Dr. Young, and I don't know how to pose it as a question but we currently have Blue Cross/Blue Shield and I know that when I had a broken femur and had a lot of complicated issues my doctor, my orthopedic surgeon, billed almost \$12,000.00 and they paid him \$1,500.00 and that's pathetic. I mean that's absolutely pathetic. We're going to find such a shortage of doctors in this country because why would you want to do that for \$1,500.00 for you know a five, six-hour procedure. So and especially when Blue Cross/Blue Shield's CEO makes \$1 million. I don't know any of my doctors that make \$1 million. So it seems like it's a little bit lopsided with the insurance companies where they can come in and basically force hospitals and doctors to accept Medicare rates when that doesn't cover the cost of medicine. And I'm not sure that they're really addressing this. We've got to somehow or another quit naming the doctors and hospitals as the bad guys and figure out a way to compensate them adequately, especially if you put the insurance companies in, and all of their execs, on the same level. If you look at it that way, I don't know if that's even addressed in the bill.

Mike Kreager: Jennifer, you want to take a close stab and comment on that?

Jennifer Banda: I noticed that there was a quick study that I noticed in preparation for this as well, that the Washington State hospital systems in 2006 did a study to evaluate private pay insurance versus Medicare and Medicaid and what they found was that the profit margin for the private pay and the private insured was 14.5 percent, the Medicare and Medicaid reimbursement model was 18 percent below the operating cost for the hospital. So, again it's the employers and it's the private pay that are subsidizing the Medicare and the Medicaid, the RBRVS reimbursement level. So, I agree completely with you. We can't sway to that side of the house. We've got to make it a more equal pay.

Dr. Nancy Dickey: Let me say though that the problem today is, and I consider myself a relatively educated consumer, that we talk about costs and we talk about charges and, the reality is that this bizarre system we have put together means that the two, bear little relationship to each

other. So, physicians for example know that Medicare's only going to pay us a percentage of what we charge and so in order to see a 3 percent increase of what they pay you may actually increase the charge by 10 percent and then after they get done doing all of their machinations to it you actually get a 1½ or 2 percent increase. And then private insurance does different machinations to the same thing, so the reality is that I think it's very difficult to know where between the \$1,500.00 your doctor actually got paid and the \$12,000.00 that was charged, what's the cost. I can tell you that it's less than the \$12,000.00 that it was charged okay. It may well have been more than the \$1,500.00 that was collected but I think one of the things we need, they keep talking about transparency and I have to tell you that if you can look at your bill and have any earthly idea what you're going to end up paying before you get at least four sets of explanations and then ultimately I simply pay whatever the one on the fourth or fifth that threatens me to the, to the collection agency and I still haven't got any good idea of whether I paid the right amount or not. It's almost as bad as dealing with the IRS, so I don't think the insurance companies created that problem, I don't think doctors created that problem, I'm not sure whether the government created the problem but I can tell you we'd be better off to simply put the whole thing down the garbage disposal and start over again and say now, what's a reasonable income for a physician working this specialty with these risks and how many procedures does he or she do and we'll do some kind of a division that comes back and says here's a reasonable charge. My bet is it would be somewhere in between those two numbers you gave us. So the system today is almost impossible for those of us who understand it. So imagine your poor patient who walks in the door and gets a number, there's just no way for them to know what that means.

Guy Clumpner: And I would add from a business perspective you know the parent, the learning from me here is that what you hear in the public domain is the provision of healthcare services to the public of what's available and what's not available. You know the reality too is you also have to have providers. We have a family friend who's in the same situation at medical school. My father regrettably died at the age of 42 in the '60s and everyone thought we were "rich" and as my mother liked to let me know when she was alive, we were mostly just in debt at that point, which I have now come to appreciate. But you know the other outcome is you want people to choose these provisions. But people you know in the leadership realm, the thing we share with people who want to be good leaders is there's nothing better you can give people than the gift of clarity because that's what people want in their lives, period, end, some sense of clarity. And you have a system which by its very nature, brings out discussion and so how can we trust it and how can we know what the real charges are and to the points that I think were made, we have somewhat of a parallel in our world right now. We're in a declining world market, Caterpillar for whatever reason and we are their partner, don't get me wrong, and continues to increase the cost of their products. And it's what makes people choose other products frankly. So there are some similarities there.

Mike Kreager: Got some questions in the back, Barbara, this gentleman?

Dr. Steve Davis: Oh hi, I'm Steve Davis. I'm a dermatologist and I'm also on the BioMed SA Executive Committee. I think that one thing that we need to be mindful of is that the current debate seems to be over how to provide healthcare insurance to the American public, and I think that it's important not to lose the idea that what we really want is how to increase the availability

of affordable and efficient healthcare for the public. And this goes to what Dr. Dickey had to say is that the system got broken way back, to where we haven't developed a system that encourages efficiency and affordability in the delivery of healthcare. Instead we seem to be spending all our time talking about how to give people insurance and, in the current climate health insurance is different than every other form of insurance. Our home insurance is insurance. If your home burns down, if you get broken into that's insurance. If you wreck your car, that's insurance. Putting in a new yard, fixing your plumbing, repairing your carburetor if cars have them anymore, those are maintenance costs. So one could argue that, going to the doctor to have a wellness physical, to have your tonsils looked at, to have your moles checked, to have your prostate examined, those are costs just like going to the mechanic or going to the attorney. You know there's no legal insurance, you go to someone, you negotiate a rate, you get a fair product at a fair price and that's the cost of living. So pursuant to the idea that we have lost a little bit of the concept of free market medicine which incidentally is not a radically conservative idea, it's just an efficient idea that can benefit people from every party of the political spectrum. Does the new healthcare legislation provide for additional availability of providers? Certainly we're trying to incentivize people to go into general practice, but for example, I'm a big advocate of the use of physician assistants and some nurse practitioners as you alluded to Dr. Dickey. They're capable of providing very high quality healthcare but might not be able to do the cardio bypass surgery but they can probably handle 70, 80, 90 percent of the things that walk in the door. And to train a nurse practitioner or a physician assistant is a lot less costly and a lot less time consuming than to train a physician. And speaking for myself and others who employ physician assistants and nurse practitioners, these are very often highly intelligent, highly motivated, very competent and very careful individuals. So I guess the question is to you, or anyone on the panel, is what is the provision for increasing the number of providers around the country and in general the attention to trying to increase the availability and affordability of healthcare and not just coverage?

Dr. Nancy Dickey: Anybody? There is some language there that talks about increasing the number of primary care training programs. It talks about moving some of that training out of hospitals and into ambulatory care centers which makes sense. Trained pediatricians in the hospital for three years and then they go out and see ambulatory pediatrics. There's a great deal of difference between what they train to do and what they spend their time doing. There is some language in I believe the House bill that talks about looking at certified nurse midwives, health nurse practitioners and physician's assistants but I don't think there's a great deal of language about that anywhere in any of the bills. It does talk about primary care homes, it does talk about trying to have more primary care access and more linkage of wherever that primary care home is, that medical home, so that patients end up with all of their information hopefully residing with one practitioner. One of the areas of waste that's talked about, and there's just not a good deal of data about whether this is nice rhetoric or whether it's true, but the number of patients who get repeat lab test because they saw one doctor, they ended up seeing another physician and when they get there that physician doesn't have the lab work so they repeat the lab work. Doesn't have access to the X-rays so they repeat the X-ray. So there's a great deal more attention paid to how you're going to use electronic records and connectivity to try to get rid of the waste that's in the current system. But most of what they say about primary care and increasing the number of practitioners is frankly, kind of a tip of the hat. Is that fair?

Jennifer Banda: Mm hmm. And I think I would just add onto that and say you make an excellent point. What we do need to be talking about is accessibility to affordable healthcare. Everyone right now in the United States has the ability to go to an emergency room and get care if there's something wrong with you, but it's not the place to go when you have pink eye. We need to work on medical homes and accessibility of healthcare, affordability of healthcare and I think you make a good point with that.

Mike Kreager: Dr. Hinchey?

Dr. Bill Hinchey: I have also been a past president of the Texas Medical Association. Really two questions, is there anything about first dollar coverage where the consumer has to be more responsible for their healthcare costs and the bills? And second, Nancy, you mentioned about the standards for private insurance along the way to be developed and we all know the government takes a long time to write regulations. Is there anything to protect private insurance if the regulations aren't written?

Dr. Nancy Dickey: I don't recall anything about increasing responsibility with first dollar coverage. There is language in, I think, all three bills that talk about covering preventive care, removing co-pays as a barrier to preventive coverage. So your colonoscopies, your mammography, your annual physicals. In fact I think at least one of the bills references the recommendations in healthy people so it's age-specific preventive measures that are based on evidence would be paid for upfront without a co-pay. Otherwise, I don't remember anything about, but most of the affordability language is then accountability language that basically says we're all going to be much more transparent about what it is we do and what you, what the patient's benefit comes from hoping they, the patients will then opt to see their primary care provider instead of the subspecialist or forego a particular intervention because there's no science to suggest it's helpful. In terms of, I'm sorry the second piece?

Dr. Bill Hinchey: Regarding insurance and if those regulations aren't written are the private institutes going to be penalized for not being able to follow regulations that aren't written which now happens as we know all along?

Dr. Nancy Dickey: Let me give you my interpretation, because I don't recall anything that says if they're not written by, I know that there is a specific five-year, this is in the House Bill, a specific five-year period of time before any criteria would be applied to private insurance. And my assumption is that if those definitions aren't written then there's no way for you to penalize private insurance because the penalty would come if they write criteria that private insurance isn't meeting then that's how they would be able to say I'm sorry you can no longer have your insurance because it doesn't meet the criteria. If they haven't written the criteria, it would be difficult for them to eliminate your private insurance. So in some ways, we might be better off if they didn't get around to writing criteria. That's my interpretation.

Cathy Starnes, Ph.D.: I think that the bills those are overwhelmingly silent on personal responsibility in fact, all three of them.

Dr. Nancy Dickey: Other than the fact they mandate you have insurance and they'll tax you if you don't. And they do dictate the percentage of income which is a sliding percentage. If you're down at 120 percent of poverty it's like 2 percent of your income, and if you're north of 400 or 500 percent of poverty it's 8 to 10 percent of your income. Once you get above 400 percent of poverty I think they'll be willing to take your entire income if necessary.

Mike Kreager: Alright, Dr. Pridgen you've had your hand up for a while.

Guy Clumpner: I just want to add real quick with relative to the comments that were made earlier about maintenance costs. I think there's a huge opportunity and obligation there and that comes from personal experience because we've had change in plans where deductibles go up and what not and even as a well-educated person I find myself going geez you know, when does insurance kick in and the parallel is I don't look at my wife and say sweetie you know, the auto policy's due, we need to wreck the car you know, so we can get our money's worth this year. I mean, to some extent some of the things that I do pay for, because my doctor doesn't file for insurance frankly, he's a pretty non-traditional guy and I'm thankful for that. I have to pay for it but I look at it as an investment in my well being and I think there's an opportunity for somehow to have that articulated. When we acquired the dealership in Dallas in '02 they were covered 90/10. Peter's always had a philosophy since I've been there for three decades of 50/50. It's now somewhere around 55/45.

But the question I ask our new employees upon having to deliver the news about their new premium was, to what extent are you going to be motivated to control your utilization of medical care if Peter Holt is paying for 90 percent of your premiums. And guess what the answer was. We're not. And I said good, we're going to help you avoid that reality. From now on you get to pay for half of it because this is called a partnership. But I think the government would be best served to include some of that accountability language in whatever legislation they pass.

Mike Kreager: Jim.

Dr. James Pridgen: I'm Jim Pridgen, San Antonio Medical Foundation. I'd just like to ask Dr. Dickey and the others, would it not be advantageous to place some representatives some of the very large clinics here in this country on this panel for evidence based medicine. The Mayo Clinic for example has been in business for over a hundred years. Dr. Mayo, one of the first things that he did was place Harry Hardwick in charge of the medical administration of the clinic and there are many people that feel that the medical administration of the clinic is as important as the medical care so we have a lot of information from them. They've metastasized these little clinics that are spread out throughout Minnesota, Wisconsin and Iowa in addition to the one in Florida and one in Arizona. I just think that they have a lot of statistics that they could bring to the table that might be helpful in putting some of these things together that we're talking about today.

Dr. Nancy Dickey: I know much of Congress has looked at the Mayo Clinic type groups that are out there and in fact I think that's probably the source of what they call in the House bill accountable care systems. In fact, they would like to consider talking about paying a lump sum for care. Let's say you have to go in and have a coronary artery bypass then for a Mayo Clinic or

a Scott and White where the physicians and the hospital are all one economic entity they would pay a given amount of money and let the hospital and the doctors figure out how they were going to divvy that up. The problem is that the vast majority of physicians in this country don't work for a medical system and they certainly don't necessarily work for the same system that owns the hospital and so we physicians and I think I can say this pretty globally, we physicians would be more than happy for you to give us a lump sum and we'll decide how much to pay the hospitals but we're not real happy about the fantasy that you're going to pay the hospitals and expect them to be fair about what they pay us. So, there are in fact a lot of conversations about how to create these accountable systems for the 80 percent of physicians and hospitals that have a very loose relationship and I'm on the staff of a couple of hospitals but I consider my relationship pretty arms length. I put my patients in the hospital, I hold them to some standards in terms of the care they provide but what they get paid and what I get paid are very different things. So, they have looked at those. Whether the Mayo and Geisinger and so forth have more data on evidence base I'm not aware of the fact that they do. Now remember what we're talking about here is the variations of care and the variety of choices for what you do. If you break your hip it doesn't matter whether you break your hip in Rochester or in San Antonio or in Tiny Town, orthopedic surgeons basically treat it the same way no matter which hospital you go to but if you have a mildly elevated cholesterol or you have chest pain then the way that you get that worked up, evaluated and treated varies all over the place depending on where you happen to be. One of the surgical examples might be hysterectomies so for 20 years we've known the data that says depending on the town you live in you can have 100 percent higher likelihood of having a hysterectomy in Town A than Town B with exactly the same medical history when you walk in the door. Now, one of those is bound to be somewhat off in terms of the response. What drives it? Well, we can't seem to figure that out except that a community begins to define its standard of what's done. If in fact 30 or 40 percent of the surgeries that are done are not driven by great science that says as a result of the surgery you're going to live longer, live better then we'd save a lot of money if we didn't do that 40 percent if we can figure out which 40 percent it is. I can't help but think of the comment on the cheeseburger you know, I have a ton of patients that are on cholesterol medications and most of them wash it down with Blue Bell ice cream. So you know, should we not give them their cholesterol medication? We'd save a lot of money until they promise us they're going to only have one cheeseburger every six months and no Blue Bell ice cream. I don't know. But those are the kinds of things that we don't have the data and frankly how Mayo treats it in Rochester and how Mayo treats it in Scottsdale are going to have variations and certainly how Mayo treats it versus how Kaiser treats it are going to have variations. That's where they're saying we need to put the data together and figure out what the best possible answer is.

Mike Kreager: You want the physicians paying the hospital?

Jennifer Banda: Actually that could turn out well in some cases. I think one of the things that they're - all of the bills are looking at some sort of what they're calling bundled payments where they are trying to get the hospitals and the physicians as incentives aligned to do the same you know, it's all the evidence based care, bundled payments, it's the same buzz words we're hearing over and over. Part of the problem that we have at the federal level is right now hospitals and doctors can't necessarily get in a room and collaborate and say okay, we're going to do this, you guys do that. The Stark law at the federal level and then we'll share the savings. If we all

use the same titanium hips or if we all use the same Product X, Y and Z, we'll share those savings and that's prohibited in the United States right now because of gain sharing. So I think that that is something that they're going to have to look at the federal level as they're taking us down this road of all the buzz words, bundled payments and gain sharing and all the things that they're trying to look at and I think President Obama was actually at the Mayo Clinic last Wednesday so we are hearing a lot about what they're doing you know, and I think that that's something that they're going to be looking at.

Mike Kreager: As you know, what went through the New Yorker Magazine and has incensed McAllen is the article that showed that the average Medicare per patient payments were around \$13,000.00 compared to the Cleveland Clinic and Mayo which were around \$3,000.00 or \$4,000.00. Marvin you have the next question and then Barbara bring the microphone up to Louise Beldon. Marvin you have the next question.

Dr. J. Marvin Smith, III: Okay. Well, we've talked around the problem and the problem is that the patient thinks they're spending somebody else's money. The doctor thinks they're spending somebody else's money. The hospital doesn't know where they're getting theirs and the employer is willing to give a benefit but he'd like for it to be 50/50. He'd like for it to be partners, so how do all of you and when we think about our country it's the individual making responsible choices that have personal and economic implications. So how do all of you get together? On the business side, HoltCAT is already doing something. You're telling them you're giving them 50 percent of their benefit, they've got to make choices. The insurance company's got to tell them we're going to provide a certain benefit but you've got to make wise choices and what doctor and what hospital you choose depends on it. The hospital has got to tell them that you're going to go broke if you don't have it. So how do all of you from each of your aspects change what is presently before us which is ultimately doomed for failure? Ultimately doomed for failure because it's based on false premises.

Guy Clumpner: Well, I'd make one comment, in terms of parallels to the world I live in and I keep harping on leadership because that's kind of the environment I work in is getting the voice of the customer engaged in all of this and then part of the challenge from my opinion is that by and large many of the customers in this arena are largely uneducated and that's not meant to be a criticism. In this country we don't seem to want to expend the intellectual energy to learn about these things that impact us. We watch Fox News or whatever it might be or we hear from our irate neighbor or whoever has a heart condition about how cruel the world is but I think before we go anywhere we should do exactly what you're talking about. Getting the voice of the key stakeholder groups involved in this. Getting the people in Washington, DC exposed to the real world. I don't have a lot of compassion for the work they have to do because I can't comprehend doing what they do legislatively but a lot of it seems to be occurring on an uninformed basis and to the point that was made earlier, predicated on an interest in getting re-elected. That is the nature of the game. I don't think that's in the best interest of all the stakeholders that are involved so I think you have to get all the players involved and mostly the providers because without them we don't have a system, oh by the way. Because in some ways we all are customers in this relationship and users and I don't know that that's the effect in Washington. I know that's not an answer but that would be my solution, to try to do a better job at doing that.

Cathy Starnes, Ph.D.: And I'll add to that from the insurance side of the business. It's been about five years since the whole consumer driven health care initiative has been launched. The initiation of HSAs which were government approved and mandated in some areas, HRAs, transparency, high deductible health plans so that the member of the health plan has to pay the first \$1,000.00, \$1,500.00, \$2,000.00 of their health care cost and then everything exceeding that would revert to the health insurance company. I think that was the health insurance side of the business that was trying to address exactly what you're saying. Comments like Guy says, folks did not engage. It's not working. Folks are not educating themselves on where the best providers to utilize if it costs \$60.00 for a treatment here and \$80.00 for a treatment here. It doesn't matter because my plan at HoltCAT or my plan at SWBC is going to pay for that so I think about five years into this when the insurance carriers had the consumer driven approach and trying to engage the member for accountability and responsibility in those health and medical decisions. It's not getting the results that we were hoping so I don't have the solution for you yet either. I think that was the intent from the health insurance side to engage the population.

Jennifer Banda: And I think part of that is honestly we need to look at a culture change. Guy addressed it a little bit, you have no idea what your health care costs are, you have no idea what you are paying for when you pay your deductibles and your co-pays and what we are looking at is we have gotten to the point where the consumer is so uneducated because we let it get that far. So we have to get to a point where really we're looking at a culture change for people to understand this debate and I think our CEO at THA always says you know, culture will eat strategy for lunch every single day if you let it. And that's something I think that we may see as we go down the road on this debate on health care reform.

Guy Clumpner: I think one thing that went unaddressed and this is really the result of my own little experience with my CT scan because while I don't think I'm on the verge of imminent demise they say only the good die young. But in my own exploration in discussions with the cardiologist around what I should be taking. My general practitioner who's a guy I dearly love but he's also a friend you know, had prescribed this Lovazan or whatever it is, the pharmaceutical triple filtered Omega 3, which I later learned through a little analysis that the real cost of that prescription medicine is about \$3,300.00 a year and when I get to the cardiologist he says you might want to do what I do and go down to Costco and get some fish oil you know, it gives the same affect. So bless my GP's heart you know, I go back and say Mike, here's reality. He says well you know, I'm not a cardiologist and I said that's true you know. But I'm going to Costco and that's a whole other piece of it that has to be addressed around the power of marketing and creating value for things and what the real true cost of what we pay for in medicine is and once again there's absolutely no agreement on standards and what people require. But my numbers that I get every three months were showing me that I was taking all these expensive pills and it wasn't all that good. And for me to say that's okay, it's mostly covered by insurance is just merely thanking you guys for paying for some of it and I can't get there. I don't think this is the way the system needs to be designed.

Dr. Nancy Dickey: I'm just trying to figure out how you answer the crowd - I mean truly the best way to do that is to erase the entire whiteboard and start over again and that's virtually

impossible when you recognize that 17 percent of the gross national product in this country is driven by health care. One out of every three new jobs that's being created is in health care. In fact it's the only sector that didn't lose jobs during the last two years of economic downturn and so be glad your son is in the medical school. And so it impacts absolutely everybody and the ability to start with the whiteboard may be impossible. So perhaps one of the messages I would like to see you deliver during the next 30 days when your representatives are at home is perhaps let's not try to rewrite the entire book because it's based on false assumptions. Let's do three things. Pick three things. I have to go back to what Dr. Young said to start with because there's several dirty little secrets that somehow never get put on the table. He said it and we let it slip right by and that is I don't think we can pay for everything we know how to do for everybody in the United States. And I spent the first eight years of my life in houses that didn't have indoor plumbing and so I've come a long way baby. And I'm not willing to pay for everything that I want access to. I'm willing to pay for it for me and mine and I believe there's a bucket of things because I'm sure the press is here. I believe there's a bucket of things that is immoral for us not to provide to every American, legal or illegal for that matter, and so those two are some distance apart and I think one place to start is let's define what that bucket of morality is. I feel sure it's scraping people up from gunshot wounds and car accidents. I'm reasonably sure it's delivering babies and because it's all of our pocketbooks it's also taking care of their diabetes and their heart failure and their hypertension because it's just really stupid to not take care of their diabetes but we're willing to take care of the amputation or the renal dialysis when they get there. So let's define that bucket and then let's say one of the things about America has always been that if you have worked hard and done well there are certain things you can buy that other people can't buy. You can buy Jaguars and Mercedes and you can buy a second house and you can buy a jet airplane vacation someplace if you want to. But as long as we continue to at least imply that everything we know how to do is going to be covered in these bills, the answer is we aren't going to be able to afford it. I think the second thing that we have to talk about is that it doesn't matter how much prevention you do, to the best of my knowledge, none of us are going to get off this planet alive. And so if you in fact live healthier we won't spend as much on you during that 50 to 65 segment so we'll spend it when you're 85. Okay? Remember when they passed Medicare and Social Security very close to the same time, right? You were supposed to work until you were 65, die at 66 and we were going to pay for your retirement and your health care for one year. Right? So any of you who are over 66 you're digging in our pockets unintentionally. We wouldn't have these problems if you guys hadn't insisted on living what they predicted for you. So while it's true that obesity and smoking and it's easier for me to talk about smoking because I should lose some weight, right? But those kinds of behaviors create health care costs but we're not going to get the cost of health care down to zip just because we all start eating better, walking two miles a day and not smoking. It means that we'll pay for a different illness somewhere down the road a little bit. That doesn't mean we shouldn't encourage healthy behavior but I'm always concerned because it's just too easy to say we'll all do this health prevention stuff, the cost of health care will go down. No, we'll spend it on octogenarians or centenarians because these bodies wear out eventually. Okay? And I think the last part is that there does have to be some responsibility. Now whether we as health care providers are providing care that happens to be good for our pocketbook but not necessarily good for patients or whether it's we as patients who are consuming medications that perhaps we don't really need to have, there's some responsibility for all of us there and none of those things get put on the table.

Guy Clumpner: Well, and I think too at the risk of you know, and avoid a discourse on ethics and leadership that it's what we work with every day, that's been left out of this discourse. I mean, when you try to take an issue like this and break it down to an issue of moral turpitude that it is either right or wrong that confuses the issue in a lot of ways but when you're looking at ethical paradigms you're looking at long term versus short term, you're looking at self versus others, you're looking at honesty versus loyalty and you're looking at justice versus mercy. And those are all right versus right choices. They're not right versus wrong choices and to cast this whole dialogue in anything different than that and fail to honestly address that those are some of the issues we have to resolve, in my opinion is irresponsible.

Mike Kreager: Okay, gang. We've been at it for 120 minutes. I know that the panelists will be here for a little bit longer if you have a question. I mentioned at the outset that this program had a start on June 11 and it doesn't happen because someone just thinks of it. Jim Reed who is the president of the Medical Foundation and Pam Leissner who is the director went to a lot of effort and trouble to put this all together to get all of you to come to arrange for our panelists to be here. Take a minute with me and give them a round of applause. Our panelists generously gave of their time. Several of them traveled to be here with us. We as a foundation are giving them this as a token of our appreciation. This is a book entitled *Physics for Future Presidents, Science Behind the Headlines*. The author is a physicist and a winner of the McArthur Fellowship and he in this book I'm told tackles the most troublesome problems of our day. On behalf of the Medical Foundation and all of our guests I want to thank our panelists for being here. Thank you all for joining us and I think this was a productive and useful event. Thank you all.