

Center for American Progress Action Fund

SPECIAL PRESENTATION
HEALTH REFORM: “NOW IS THE TIME FOR ACTION”

KEYNOTE SPEAKERS:

THE HONORABLE MAX BAUCUS (D-MT)

MODERATED BY:

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MS. JUDY FEDER: Good afternoon everybody. I'm Judy Feder, a senior fellow at the CAP Action Fund. And I am pleased to welcome you on behalf of the Center for American Progress Action Fund to a discussion of health reform this afternoon, "Now Is Time for the Action."

And it is my particular pleasure to welcome Senator Baucus to speak to us, to start off our event. Senator Baucus and I were just discussing that I'm aware that his interest and concern about health reform goes back a long way. And I know you know, Senator Baucus, that the Center for American Progress has affordable healthcare for all Americans at the top of our agenda. And we are very fortunate as is the nation that it is at the top of yours. And so, without further ado, we are delighted to have you speak with us this morning, and so, I'm happy to turn over the podium. (Applause.)

SEN. MAX BAUCUS (D-MT): Thank you very much, Judy. Thank you for CAP and other organizations who are focusing on what I think could be a banner year for the United States when we finally do get healthcare reform enacted. And of course, this is a common effort, a joined effort. I believe that nothing of consequence is ever accomplished when one acts alone. Rather it's teamwork, it's cooperation, it's partnership, and I very much appreciate all that you're doing in that regard.

So thank you so very much for inviting me here today to talk about the cause that frankly has become, for me, a calling, that is healthcare reform.

The title of this event, "Now Is the Time for Action" could not be better. I firmly believe that's true. We must act this year to reform our healthcare system because if we don't act, I think the costs are just going to be too high and the alternative just is not bearable.

To solve the problem, everyone will have to give and take. We're all in this together. We really don't have an American healthcare system. We have a hodgepodge. We have a collection of various different components. We're the United States. We're not other countries. It's through entrepreneurship, creativity, go West, young man is much more part of our culture than it is other countries, and various groups, doctors, hospitals, nursing homes, (current ?) manufacturers are providing care but they're also trying to make a buck, and that's why we have such a hodgepodge. And because everybody wants to be perfectly healthy if anyone can, and added to that, we have a system where most people just don't see the true cost of care.

But I believe that because we're so integrated that we should look at all the components, and nothing can be off the table. I also ask everyone to suspend judgment, suspend judgment until we can figure out how we can work this out together. By that I mean, if someone might hear about something that is, oh, gosh, I can't do that, I don't agree to that, my group doesn't like that, just don't (knee-jerk ?) automatically get

something, rather suspend judgment for maybe five minutes or hopefully a little longer because this is all so large, the enterprise here that's going to be a lot of give and take and where somebody might see something that might adversely affect him or his group or her group immediately if he doesn't massage it a little, think about it a little bit, thinking how to make it work and also recognizing that there are tradeoffs and further recognizing that nothing is agreed to until everything is agreed to.

I urge people therefore to keep an open mind about any of the various components that we're working on. It's all related. We cannot continue to address healthcare piecemeal. Rather, we need a comprehensive plan, a comprehensive healthcare reform for Americans, and that's, again, why all these parts have to fit together.

And it has to be an American solution, a uniquely American solution, private and public. We're not Canada, we're not Great Britain, we're not Scandinavians, Switzerland. We're not those other countries of different cultures. We're American. So therefore, our American solution has to reflect our country, and we are a country that probably therefore will want both a strong public and a strong private component. We have to craft our own American solution.

I've served in the Senate now for about 30 years, and I've got to tell you, this is the hardest legislative challenge of my life, but I relish it. It is so much fun. I'm trying to put all these pieces together. It's such a challenge and this is what I signed up for, frankly, when I ran for office a long time ago. It's kind of a culmination now to be able to be participating in, I think, one of the greatest solutions and efforts that country's faced in some time. I'm very enthusiastic about this.

I'm mostly enthusiastic because this is a moral obligation. Much of what we do in public service, even in private life is a moral obligation. That is we have a moral obligation when we leave this place to leave it as good a shape or better shape than we found it. I think that's true for every one of us. You know, we're not here forever. We have no proprietary right to everything that's on this globe. We're here temporarily. And it's our obligation to when we leave this place, leave it as good a shape or better shape than when we found it and that's especially true for our kids and our grandkids, and I think that's especially true for healthcare.

So we've got a job to do. We must move forward. Last week, Senator Grassley and I laid out a schedule, a schedule we think it's a good pathway toward legislation. And we're looking toward a markup in June. It's ambitious but I think it has to be ambitious. We have to seize the current momentum if we're going to be successful.

And last week, CBO released its estimate of the President's budget. Included in that estimate was a projection of future budget deficits that we face as a nation. You saw that released. The picture is a bit bleak. Deficits are higher and continue longer than we expected. That's a reality we have to face. The economic conditions facing our country are also severe: unemployment is rising, families struggling to make ends meet, many losing their homes. That's a reality.

But this economic uncertainty does not dampen the urgency of healthcare reform. Indeed, I believe and the president believes the economic downturn contributes to the urgency for healthcare reform. As Peter Orszag has also often said, the path to economic recovery is through healthcare reform. And it's clear that it is because of the costs of our current system, and if we don't act, those costs will continue to rise at unsustainable rates.

More than three out of five people believe that it is now more important than ever to take on health reform. And to those who think that we cannot afford to address health reform, I say, we can't afford to wait. We have two choices in life. Almost everything we do it's a choice, either try or do nothing. And my judgment is we have to try here because doing nothing will result in a much more costly result to our country than the initial startup and investment costs that are necessary that are needed for healthcare reform.

And I also believe we can't afford to wait because healthcare reform is not just a moral imperative. It's an economic imperative. The consequences of not enacting comprehensive health care would be dire. The costs would be unsustainable for individuals, families, employers, and state and federal governments alike.

Between the year 2000 and 2007, average premiums rose nearly 80 percent. In that seven-year period average health insurance premiums in our country rose 80 percent. At the same time, average wages rose just 15 percent. Eighty percent rise in premiums, 15 percent rise in wages. Clearly, a family can't keep up at those levels.

Last year, the average household spent more than a quarter of its income on health insurance, more than a quarter as our health insurance premiums. If we don't act to reduce that rate of health spending, in seven years, near the end of President Obama's second term, most American households will spend nearly half of their income on health insurance, from a quarter to a half in just seven years. If we don't act, increasing costs will result in more and more individuals and families without health insurance; just won't have it.

According to the Kaiser Family Foundation, 160 million Americans get their health benefits through their employer. That means that when people lose their jobs, they often lose their coverage. This month, the unemployment rate rose to 8.1 percent. Work done here at the Center for American Progress shows that, every day, 14,000 more people lose their health insurance coverage, every day, 14,000 people lose their health insurance coverage.

Think how devastating that is for a mother with a sick child or how devastating it would be for someone fighting cancer, how devastating that is for someone with the misfortune to have an accident. As more people lose their jobs, more people will be forced to buy health insurance on their own. And they will have to buy that insurance in the dysfunctional and increasingly unaffordable individual insurance market.

Anthem Blue Cross in California just notified most of its individual policyholders they face double-digit premium increases, many more than 30 percent. Blue Cross of

Michigan is seeking approval for an increase in premiums of nearly 60 percent. That means that if we don't act, then workers who lose their jobs will not be able to afford coverage. It means that many of those purchasing coverage in the individual market will be forced to drop their coverage.

We need to make this market workable. We need to make it affordable. That will require action, I think, at the federal level. A few states have taken action to address this market. But in the vast majority of states, the individual market is like the Wild West. It's unacceptable.

We must see that insurers are competing on price and on quality, not on their ability to cherry-pick the healthiest. We need to eliminate the ability of insurers to discriminate against sick people, to discriminate based on gender, or to discriminate based on where you work.

Even the insurance industry has accepted that business as usual is no longer acceptable. They recently signed a letter – I'm sure most of you have seen it – supporting the changes that I'm proposing as if done with an individual obligation to purchase insurance. And once coverage is accessible, affordable, and meaningful, people should have a responsibility to get insurance.

An individual obligation to get health coverage is essential for several reasons. It is the only way to stop the cost-shifting related to uncompensated care. Today, the costs of care for 46 million Americans without health insurance are largely borne by those with insurance. Getting all Americans covered will also make insurance markets function properly. Insurance works because policyholders pay into their plans when they are healthy. And they get their medical bills paid when they are sick.

If a significant portion of Americans don't buy insurance until they get sick, then premiums will increase for all who do buy insurance. And the problem of unaffordable costs will only get worse.

As well, covering all Americans is essential to effective prevention and effective wellness efforts. And it's important to managing chronic illnesses. Efforts to guard against and better manage illness are an effective tool to contain costs. But without every American in the system, those efforts will fall far short of their potential.

And what about the costs to business? We also need to make healthcare more affordable for businesses. Americans are losing jobs because healthcare costs put American businesses at a competitive disadvantage. The manufacturing industry is facing stiff international competition. That's clear. American manufacturers pay \$2.38 an hour for health benefits. It's an average. Many more, much more in some other companies. What do you suppose America's major trading partners pay an hour on healthcare? Ninety-six cents. Two dollars and thirty-eight cents versus ninety-six cents. That's an uneven playing field for American companies.

American manufacturers spend nearly three times as much on health benefits as our major trading partners, three times. If we don't act, then that gap will continue to widen.

And what about the costs to taxpayers? And if we don't act, then the burden on taxpayers will continue to grow. In 2009, Medicare spending is projected to be nearly \$500 billion. Nine years later, 2018, it will be almost double that so close to a trillion. If we don't act, then in the next 10 years, spending for both Medicaid and Medicare will clearly be much more than double what we spend today. Meanwhile, our economy will grow by just 64 percent, that is half that rate.

What should action on health reform look like? At first, it has to be comprehensive. The time for incremental change has passed. It is increasingly harder to fix the system one step at a time. The Children's Health Insurance Program reauthorization bill that we enacted last month was a significant victory. After kids, however, it starts getting harder to expand health coverage for segments of the uninsured based on public sympathy.

Covering all Americans will come at a cost. But the cost of that coverage will be less if we also address rising health care costs. That means that comprehensive health reform has to be more than just universal coverage. It means that we must address rising costs. And it means that we must improve quality.

We cannot simply add 46 million uninsured people to a broken system. That would increase costs without addressing the underlying, fundamental problems in our system. And the projected costs of that path might well confirm the fears of those who believe that we cannot afford to tackle health reform.

Already, we spend twice as much on healthcare as any other industrialized nation, per capita. And yet, our outcomes are poorer. They're worse. They're much worse. They're worse by far. We're not twice as healthy by spending twice as much. We're almost twice as – less healthy, even more than that. International comparisons are 17 – we're 16th, 17th, 18th, you name it. We are not nearly as healthy as we sometimes like to think that we are.

In eight years, we will have more than 58 million uninsured Americans. And we will spend \$4.3 trillion a year on healthcare, 4.3 trillion a year on healthcare. We spend about 2.5 today. The \$787 billion economic recovery act that we just enacted just a short time ago was – yes, it was big. But compare the cost of that to \$4.3 trillion in health care spending each and every year.

Part of the reason that health care costs so much is that we do not have a health care system. There are a few exceptions and pockets of success. But generally, we don't have a health care system. We have a health care free-for-all.

Bending the growth curve of spending will be a challenge. We must change the way that care is delivered. The way that we pay providers contributes to higher health costs. Existing payment systems reward the use of specialty care and high tech

equipment, for example. We pay more to a hospital whose patients experience a readmission after being discharged. And we pay less the hospital that does the job right the first time and avoids a second hospital visit. That's just one example of many of the waste in our system.

Spending and utilization varies widely from one part of the country to another. It is amazing. It's based on practice patterns if nothing else. And those who are spending more are not getting more for their money. That too is clear. There's so much waste in our system, so much an opportunity to get rid of the cost tackling that, focusing on that waste. In many parts of the country, providers have answered the siren call of the payment systems. They therefore order more tests. They schedule more visits. They do more procedures. They perform more imaging services. And they prescribe more medications.

Due to a lack of electronic records, services are also duplicated. Due to a lack of comparative effectiveness research, providers lack information about what treatments work best. And due to a lack of transparency, we lack information about costs and quality.

We need to change that. We need to pay on the basis of higher quality and better outcomes. Where possible, we should create pathways to integrated, efficient systems of care delivery. We've made some progress in the economic recovery act. We made a significant investment in electronic health systems. We made changes in payment systems to reward providers that use these systems. And we made a down payment of more than \$1 billion toward comparative effectiveness research.

But we still have much of the heavy lifting ahead of us. Over the coming weeks, we will continue working on ways to improve quality through our payment systems. Rewarding quality will improve quality. And higher quality will also lower costs. We are on the path to reform. And I am doing everything that I can to keep pushing, along with my good friend and partner Ted Kennedy. Together, we have sketched out a path to get a bill through the Senate.

That path necessarily involves bipartisan support. Why? Because in the end, in the Senate, a bill needs 60 votes. Attempts to circumvent this requirement using the process called "reconciliation" would also require trade-offs, and, in my judgment, it would not be a good idea.

The barriers to getting a bill done are real. Our economic circumstances and the deficit present a considerable challenge. The pressure to offset new spending is greater than ever. The calendar also presents a problem, but we must act this year, and that means we have to act fast. To meet that deadline the House and the Senate need to pass legislation before the August recess. If we do not act this year, then we won't have another opportunity, in my judgment, for probably another decade.

Next year, we'll be in the midst of Congressional elections. The following year, we'll be in a presidential cycle. We have to act now. Fortunately, President Obama is

committed to reforming our health care system this year. The opportunity is before us. Stars, I think, are aligned. Now is the time for action. Let us work together to make it happen.

Thank you for the invitation to discuss the urgency of health reform. But before I yield for questions, let me just say I'm particularly pleased to share a stage with Judy Feder. Judy is one of the most capable and well-versed health policy experts in Washington. I've known Judy for a long time. I've felt that every year that I've known Judy, and a long history of working on ways to improve our healthcare system. In some respects, let's do this for Judy. (Laughter.) Thank you everybody very much. (Applause.)

Questions? Yes.

Q: (George Gould?) with Gould Associates. I realize that we within the last week the Insurance Trade Association and Blue Cross Blue Shield sent you and your colleague a letter drawing a line saying that they cannot support a government-established program. What does this translate into? How serious a blow is this to your effort?

SEN. BAUCUS: Well, we have to keep working together, keeping everything on the table realizing that there are tradeoffs here, realizing there are various ways to skin a cat. You know, there are ways of doing things. And let's look at the good news. The good news is and that letter said they're willing to no longer sell insurance based on medical history. That's a major step forward in getting rid of preexisting conditions, et cetera. So that's a major step forward.

And so, as we move then toward the rest of the plan, it includes the public option, my view is we can keep the public option also on the table. At first, it helps encourage insurance industry to move more forcefully toward market reform, insurance, health insurance market reform. And who knows, there are lots of ways to modify the public option. They've already seen two or three different examples.

And so, I just say to everybody, including the insurance industry, hey, let's just – we can't take it off the table because once I take that off the table, then other groups will want to take theirs off the table and this is going to fall apart. So let's just keep everything on the table as long as we possibly can, force us to start working on the easier parts first, and then we'll put some more difficult parts off a little later, and by then, some creative people would have, I think, more likely have figured out ways to deal with some of the more difficult parts and that would be one of them.

So I say, I hear them, but I'll take the good news first that they're willing to change the model, the business model for offering insurance, and let's take it from there.

Q: All right. They handed the mike while you weren't looking. Laura Meckler from the *Wall Street Journal*. Without necessarily committing to any particular option, could you tell me what you see as the range of potential pay-fors for health reform?

Obviously, the president put the tax change on the table. Could you just sort of list what you see as the potential options?

SEN. BAUCUS: This reminds me of a slight annoyance I had with the president's budget, because the president's budget does not assume a lot of cost within the system but rather in suggesting, I think it was, \$634 billion, said half of that should come from cuts in provider payments, the other half in raising revenue. And he suggested it was that 28 percent cap on deductions.

My view is, heck, let's first start looking at ways to save cost within the system, and there are tones – there's so much waste in the current system. For example, remember Mike Leavitt, Secretary Leavitt used to say for ever and ever, practically for ever and ever, that in the state of Utah, he ran a shop ground for – (inaudible) – we found that it was two or three times some hospitals than others, for no reason, for no reason. Why does it cost so much more at one hospital compared to another?

You know, most people in this room know that health economist Uwe Reinhart when he testified before our committee, he said he couldn't believe it. In the state of New Jersey we looked at the healthcare cost in the last six months of a person's life at three different hospitals. Again, I think the magnitude of three times in one hospital versus another. So we called them up. Why do you charge so much more than another hospital? Answer, that's just the way we do it. A lot of this is practice patterns. It's astounding. It's the kind of way it's done in certain communities. That's just what we do.

My view is that when we move much more toward compensating doctors, providers on the basis of quality, not quantity, but quality, and in much more comparative effectiveness with health IT, and you know, other concepts like medical home and – (inaudible) – and so forth, we're going to get rid of a lot of the waste that's in the current system, and a lot of that is transparency too, that is if people, consumers, insurance companies, docs see that hey, this device doesn't work any better than the other but the company is charging so much more, we're going to get a lot of waste out of the system.

Then, we can go to your question. And your question is what if that's not enough. I don't want to get to your question unless I have to. But I think I probably won't have to because we probably can't get enough savings out of the system but we should try there and that's where we should undertake our efforts, primarily.

Then we have to come up with other revenue. Again, there are lots of ways to raise revenue. And the president made one suggestion that there are others like looking at exclusion. That's an option. There're various ways to do that, a cap in perhaps income, or, some say, maybe insurance. But those are just – we're just in a talking stage right now and others will come up with lots of other ways to find revenue to the degree we have to have revenue.

But I say, first, let's get rid of the waste within the system. That's the real goal, get rid of the waste within the system because if we don't, we just start piling a revenue

on it that we're not getting to the underlying root of the problem here and that is a system with excessive costs.

Q: Do you think that the majority or the vast majority of the total bill can be paid through cost savings?

SEN. BAUCUS: I don't know how much, but boy, we're sure trying. We're talking to the CBO, we're trying to find out the answer to that question. We'll talk a little bit with OMB over at the White House. But the last iterations of what we're doing, if there's change in one component, find out what that score is, and another, and that score, and it's been difficult though because a lot of this, this is uncharted territory. This is new and so CBO doesn't have a lot of data. It's kind of hard for them. But that's a double-edged sword. It's an opportunity just to score some of these provisions in a way that's a little more helpful.

But let's focus on the cost. Don't forget the Jack Wenberg's study on geographic disparity. Nobody has disputed it, nobody. He basically pointed out that in the northern high plain states spending is about half it is in other states. And yet, the outcomes in those northern high plane states is twice as good. It's better. There's so much waste in our current system. You can't just cut the high-volume states. That is politically – (inaudible). But you can get there with reimbursement on quality, with better effectiveness, with IT, with transparency so docs and hospitals know what's being charged and this procedure against the next and that will, by definition, root out a lot of the waste that we have today.

Q: Yes. Stephen (sp) Lingo (ph) with *Congress Now*. I'm just wondering. You said earlier in your comments that there may be room to make adjustments to the public option if need be down the line. What kind of areas are there for adjustment, for negotiation with that plan? They seem to be against the idea of a plan in and of itself of public option for the insurance industry.

SEN. BAUCUS: People know that train is leaving the station. Insurance companies know that train's leaving the station. Large companies know the train's leaving the station. People know they can't beat something with nothing and as Russell Long once said, if there's any combine, he wants to be in on the combine.

So there's huge pressures for those that – initial concerns about public option to start to work, to try to find ways to make it work because otherwise they'll be left out in the cold. This is early. There are a lot of tradeoffs here. There are lots of different components to this system, and if people see that – and there're ways to try to make the public option a leveled playing field with connect-or-exchange approach too, so that those who are concerned about the public option might be less threatened.

On the other hand, there could well be a need for the public option because people are going to need to find some home to get good health insurance. It depends probably on the degree to which we can reform health insurance.

You know, that is, in the private individual market, for example, if the result is that it's affordable because there's a subsidy and has high quality because there's a minimum benefits package either put together of Congress parameters or, heaven knows, what CMS or a board or something. We're not quite there yet. If it's good health insurance and keeping the public option on the table to get that good health insurance that might be a sufficient result.

So the goal here is for all Americans to have good health insurance and the public option is one component to make that happen. We're also going to expand Medicaid a little bit, Children's Health Insurance a little bit, again, it's public-private. We're trying to find a way to make this work.

Q: (Off mike.)

SEN. BAUCUS: Into what?

Q: (Off mike.)

SEN. BAUCUS: Well, you're asking pretty technical questions here. It depends on a lot of factors. It depends on the connector setup. It depends on how the so called public option is set up. There are lots of ways to set up a public option. It could be more like Medicare, it could be more like FEHBP. There's lots of ways to get at this.

So it's the goal – everybody keep the main goal in mind. The main goal in mind is to get health reform passed where all Americans are covered and we're all in this together and we're getting at so called bending the cost curve, getting cost down. That's the real goal here. And there're so many opportunity for tradeoffs here, for give and take.

And I'll do my very best to remind everybody that everything is on the table, nothing is agreed to until everything is agreed to. Let's just stick together. It's bipartisan. It's been a lot of – (inaudible) – Republican centers and they want healthcare reform too. In fact, it would be my expectation that President Obama would also want this to be very partisan, and he'll give Republicans a lot of credit for helping to come up with a bipartisan bill. It's good. It's a good bill. Sure, he'll still be president. (Inaudible) – ensure the credit for being president. That's great, because he's the president. At the same time, if he'll still push and making it clear that he wants a bipartisan bill too, but one that's good, not just for the sake of bipartisanship but one that's really (all ?) good, does and accomplishes what we're looking for that will help too.

MS. FEDER: We have time for one more. The last question.

Q: Matt Cover with CNSNews.com. Chairman Baucus, a lot of odd critics of this proposal say that any type of cost control method, even in places where it's done through things like what you've described which is reforms to payment options and looking at effectiveness, they say that inevitability, it leads to rationing on the part of doctors in things like long waiting lists for procedures or things that don't get done. It rationing

inevitable in any universal system? And if not, how are we going to prevent rationing in this country?

SEN. BAUCUS: Well, the goal is, again, payment for quality and evidence-based medicine. Now, that means the closer we get to our goal, when you go to a doctor and the goal is the ability to choose your own doctor too and the goal is you can keep your own health insurance plan, if you want to keep it. But the goal is that the payment system is reformed so it's on basic quality, and we have transparency, health IT, and the things we're talking about. Then, healthcare is going to be determined by the quality of the service performed much more than it is today.

I'm not criticizing docs. They want to do a good job, but docs today have to live with incentives that are given to them, and what are those incentives? Incentives are that you get paid more for more volume, more procedures you have, and so forth. And they're siloed. We have a very siloed system today. A lot of doctors don't like the current system. They don't like it at all. They're kind of frustrated themselves.

So again, if reimbursement on quality, all things I said, and that determines the care you get and we have a system where everybody can get health insurance, I don't see that that's going to be an issue.

Also with bundled payments, that's a goal in medical home. You're there with your doctors and there others who are involved with you and your particular healthcare issue, maybe an older person, maybe it's a senior, it's a nursing home setting too, or other care setting that you're getting quality care and you're going to get good care.

And what I like about this is not arbitrary. It's not like just cutting Medicare, whacking, say, 15 percent off of Medicare, or whacking this or whacking that. It's just more to get us all together and working together. I do believe the whole is better than some of the parts and get that synergy going here. And I think it will take a little while to get there. This could take a few years. We'll have to phase in some of this over a period of time, but I think the goal is very worthwhile. Judy. Thank you. (Applause.)

MS. FEDER: As the senator is going, I meant to do this at the beginning to call you attention. One of our – come right up so I can do this while everybody is getting seated.

One of our guests today, Karen Tumulty, the national political reporter for *Time* magazine had the prescience to have come out just today a piece on Senator Baucus, and the copies of the issue will be available for you after our session.

So in addition to Karen – I'm not going to give long introductions – but Karen Tumulty, you can pick her out. She's the woman.

We also are pleased to have Norm Ornstein who's a scholar in residence at the American Enterprise Institute.

And Paul Begala who is a known commentator, and I'm pleased to say, a professor at the Georgetown Public Policy Institute where I also am a professor.

And I would love to start our conversation by asking each of you to comment on – we've heard a lot of enthusiasm from Chairman Baucus this morning, a lot of excitement and commitment. I think that we all, you all, have been following this issue for a good long time, and why don't we start a conversation by each of us saying something about what you think the prospects are for achieving the senator's goals of getting health reform this year. Norm?

MR. NORM ORNSTEIN: Well, it's a lot different than 1993, '94. the idea that the chairman of the Senate Finance Committee says we're going to get this done by August, we're going to get bills in the House and Senate by August, is a striking change and it's a reason for hopefulness that we may move.

There are other reasons there including the fact that virtually all of the players in the process, like the insurers, are treating this in a very different fashion than they did in the '90s. They want to get something done and they're putting things on the table that were not on the table before.

Still, getting a bill done in both Houses, working it in the bipartisan fashion and having it enacted this year is a heavy lift. What I think we also have to remember though is we're already had through the expansion of S-CHIP and the stimulus package something on the order of \$223 billion in healthcare reform, expenses and the like. We've moved a step along the way. If it isn't done in one package, I think even so, by the end of this year, we're going to look back and see pretty profound changes in the nature of the healthcare system. And it may be that this will happen in a few chunks rather than in one fell swoop.

MS. KAREN TUMULTY: I agree with Norm that for those of us who covered this in '93 and '94, Max Baucus is the embodiment of much of the change that we've seen.

And I've been sitting through all those finance committee hearings back then and you know, the chairman then, Daniel Patrick Moynihan went so far as to declare there wasn't a healthcare crisis, that the Clinton numbers were fantasy. He was openly hostile to it and the political climate was different too. It was very scary for people to hear that your healthcare would be turned over to a bureaucrat. I think we've all lived since then 15 years of finding out that our healthcare has already been turned over to bureaucrats. They just happen to work for insurance companies.

So I do think there's a lot that's different about the political climate but I think too that once they get a bill that speed is really going to be of the essence because as much as you can say, well, corporate America wasn't there in '93 and '94 and they may be there this time, the insurance industry may be there this time, when you look at some of the things that they're talking about doing, for instance, taxing your health insurance

benefits, I mean, Paul, I could write the ads on those ones. So they are going to have to move very quickly I think.

MR. PAUL BEGALA: At the risk of repeating, it is so fundamentally different to hear the Senate Finance Committee chairman speak this way. I can't say enough about that. To hear him today talk about Senator Kennedy as his partner in this it's a sea change from 1993 and 1994 as Karen and Norm pointed out.

Second is Norman pointed out there's a very different attitude from industry so I won't belabor that.

Third, there's a larger and strong (amen ?) chorus in support of the healthcare reform including the Center for American Progress Action Fund which did not exist then and a whole larger progressive movement that is supporting this cause.

And I think supporters are more savvy. As someone who helped ruin healthcare reform as political adviser to the president – I was one of the people who thought it was such a neat idea for the president of the United States to get that pen out, stand there in front of all of you and say, if you send me a healthcare bill that does not cover everyone, I will take this pen, veto that bill and send it back and we'll start again.

We let the perfect be the enemy of the good. Supporters don't see it that way. I think Senator Baucus is endlessly pragmatic at the same time that he's saying, you heard him, it's just an appeal. Let's get something done with a very, very last resort avenue which was not open to Clinton of reconciliation. The senator poured some cold water on that justifiably. I don't think any senator wants to see that process used but it's at least in the discussion.

And I think the least commented upon but maybe the very biggest difference is a president who is capable at the push of a button of raising hundreds of millions of dollars pristinely, ethically. He raised something in the order of \$600 million. In this last election cycle, the average donation was \$86. When somebody gives you \$86, you're not going to be ambassador to Luxembourg.

But it used to be \$86 were not very useful to politicians. He has found a way to use technology that did not exist 15 years ago to completely revolutionize fund raising on a progressive side, and I think may have something to do with the different attitude from industry which outspent us 100 million to 15 last time. It is not going to happen this time with this president and his capacity to make money.

MS. FEDER: Talk a little bit more about what you think – that we all share the sense of the differences. What do you think about the differences in the way the administration is proceeding?

MR. ORNSTEIN: Well, there are differences, of course, with '93, '94 as well, and the fundamental one is you do not have an administration plan going to Capitol Hill

and basically being told this is the plan. If you're going to tinker with it, you're going to tinker at the margins of the margins.

In this case, you have principles. You have a lot of things that candidate Obama said but where he's now indicating as Senator Baucus has said, just pull something together and then we'll talk about it later.

There's a deference to Congress and the role of Congress in writing legislation that simply wasn't there in Bill Clinton's first two years. Some of it comes from coming out of the Senate. A lot of it comes from having a vice president and a chief of staff who understand this process, but some of it is you learn from past mistakes.

But let me say there's one thing that isn't different, Judy, and that is the level of dysfunction in the political process has probably grown since '93. And it is not clear, despite the professions of desire in both parties to come together and make this work, despite the fact that you've got a number of senators from Bob Bennett to Chuck Grassley who say they want to be at the table, the experience of the stimulus package or the omnibus appropriation of the way the budget's been received would suggest that we're not a point yet where the Republican Party wants to be a partner in major legislation.

And that's where the reconciliation issue comes back. Whether the administration can artfully use a club over people's heads, not to use it, but to say, if you're not genuine about coming together with this, and of course, it's also got to be give and take where you really do see serious give on the part of Democrats, which may mean a public plan ultimately being off the table, and it may mean the inducement of having some tax on health insurance benefits despite the way that Obama ripped McCain on that during the campaign.

But basically saying to Republicans, we've got an option here where we can freeze you out and do it with 50 votes. And if you don't use it and don't threaten it in a way that alienates everybody, it's another reason to be a little hopeful that we can actually get this done.

MS. TUMULTY: That is, you know, it's like that way is so dangerous because assuming you have a bill that gets passed this year that way with 55, 54 votes in the Senate with no Republican buy-in, it's not going to be implemented right away. It's going to take four, five, six, seven years to really get it implemented. That takes you through a whole bunch of election cycles. And we've seen so often before that when Congress does something drastic on healthcare, it can be undone, it can be pulled apart.

So I can certainly – on the one hand, I understand the need to have this option to sort of shove it through, as I've said, they've got to this fast. But on the other hand, it does seem like there's a lot of danger in that approach too.

MR. ORNSTEIN: But it's not that you would use it. I would hope you wouldn't use it. What you want to avoid is this notion of sitting around the table endlessly where

the other side is basically saying, well, of course we want to work with you, but then we can't do that, and dragging it out to a point where then it loses all of its momentum. You want to have the ability to say to them, you come to the table, we're going to cut a deal, but if it's clear there's not good faith negotiations to get to a deal, then we're going to stop this at a certain point and we have an option to use. That's the way you want to employ it.

MR. BEGALA: Maybe I'm reading too much into the senator's comment. It would sound like August is that point. And I think you're right. I think right now, even as a professional Democrat, it looks like a lot of Republicans are negotiating in good faith and really want to see something done, and then we'll see when we get to it, will they find a way to do it.

If I can – now that I've assumed responsibility for the failure of healthcare last time around – defend President Clinton on this. Congress came to him then and said, you cook something up, and we'll pass it. They ceded that authority to him. It was, I think, foolish. But the president crafted his package because the congressional leaders, some, who, like the one who we mentioned who was chairing the finance committee, had not desire to write a healthcare bill, but others who did still wanted to see what the president had first.

And I think this process is more sensible. It's probably more what the founders intended. But in that case, it was President Clinton responding to what Congress asked of him then.

MS. TUMULTY: Can I echo that this public option – I mean, to me, and tell me if I'm not hearing this right here, it seems like Senator Baucus and even the president, earlier this month, was saying as loudly as they could, this is a bargaining chip. This is something that they are likely to give up at the end, to get other things that they want. And you hear some compromise versions of a public option, for instance, a public option that would not be able to allow government subsidies. It would essentially have to be on the same financial footing as the private insurance companies.

But then, when you see that, it's hard to figure out how you get the kind of cost savings you're going to need and make the numbers add up. But I do think that that ultimately is going to be what either this public option debate and how much they're willing to compromise on this is going to be what keeps people at the table or drives them away.

MR. BEGALA: That's right. That will be a good sign of the good faith of both sides. But again, we've talked about how President Obama has learned from the mistakes of President Clinton. I think he's learned from his own mistakes. I think he negotiated with himself far too much in the stimulus package and I think he presupposed a Republican Party that he didn't – I'm not inside his head, but no reasonable person thought a majority of Republicans would support this.

But you know, during public opinion polling, 32 percent of Americans supported President Obama's stimulus package. One point four percent of Republicans in Washington supported it. That's a disconnect that's too great to be sustainable, I think, right?

So I think the president made a lot of preemptory compromises in his stimulus package and got nothing for it. And I suspect this time around, he's not going to make any compromises until he's getting a vote for those compromises.

MR. ORNSTEIN: But it is a bargaining chip with two different constituencies. It's a bargaining chip with Republicans who fear that any public plan is the inevitable movement towards a single-payer system. And the same with insurance companies.

So you can make one set of deals with Republicans so that you take that option away and provide the assurance that this is not the camel's nose under the tent phenomenon, but another with insurance companies to make sure that you've got the kind of plan that has the elements in it for everybody where you don't need a public option as an inducement or as a fallback.

So if you do this well, and a lot of this presupposes that we have not just negotiations in good faith but good negotiators who are able to make a lot of tradeoffs simultaneously – it's going to be like juggling 30 chainsaws at the same time – you may be able to work your way through this one and end up with the outcome that you would hope would be there that a public plan would give you without necessarily having a plan.

MS. FEDER: Although, as a bridge to take you to another conversation and then we'll open it up, when you think about, as Senator Baucus said, when you think about the things that a public health insurance option do, it is essentially to – it's not a substitute for have a connector with good rules for insurance but it's got the potential to model good behavior in all of the changes in the delivery system and in the ways in which insurers interact with the insured, with us.

So I think there's a tremendous amount of potential there and we wouldn't want to lose that as we go forward.

And it leads me, since I know I want to leave you to talk about, or ask you about your sense of the way the public are understanding this issue these days, in part because of their experience with insurance companies, and Karen, as you said, that they're having bureaucrats make these decisions right now.

Do you think – we all remember and probably many in the room do, in '93, '94, "Harry and Louise" being able to scary the hell out of everybody saying that we're going to be worse off not better off with reform. My own view is that people now understand that it's what we've got right now that's pretty scary and that we do need change.

MR. TUMULTY: Well, one big difference between '93 and '94 now is that nobody is proposing that anybody who likes their health insurance would have to give it up, would have to move into any other system.

But I was also struck when I was traveling on the campaign last year, at every single event that Hillary Clinton did, she would describe the various options for health reform and she would always say, then there's the option of a sort of Medicare like system for everyone, single-payer essentially. And never once did I see anything but a majority of the hands go up in the room. And I asked her at one point, I said, would you have seen that in '93 and '94? And she said, absolutely not.

MS. FEDER: Interesting.

MR. ORNSTEIN: You know, back in '94, when the plan first emerged, I wrote a piece in the Post saying this is not going to work very well and here's the reason. There is a universal public definition of healthcare reform. Healthcare reform is where I pay less.

And the plan was framed so that the message to 250 million Americans was here's the plan: 37 million will pay less and you'll pay more. And it was very difficult to get around it when you frame a plan in terms of the uninsured.

But now it's a different world. It's not just that we've gone from 37 million to 36 or 38, or whatever it is. You've got 50 million who have been uninsured sometime within the last few years and found it a distinctly unpleasant experience. And then you've got an awful lot of others who have been pushed off on the part time or consultant status keeping their jobs but no longer having the benefit.

And then you've got most of the rest us. Every year now, my human resources person comes to me and all the rest of us and a very great plan with a benevolent employer saying, you know, it's gotten too expensive. We have to change. New insurer perhaps, if not, new pharmacy benefits manager, higher copays, higher deductibles, different doctors.

The wrenching experience that people have now every year I think leaves a receptivity, a willingness to take a leap for change that is just far different than what we had in '94.

MR. BEGALA: If you have not, you need to read the article Karen wrote about her brother. It is a spectacular first person account of sophisticated insured people going through this Kafkaesque system. That's what so many of us have experienced first hand. And I think Norm is right.

But at the same time, I think that Senator Baucus, the president, very attuned to the fact that we're not going to recreate the entire world. This is not year zero, this is not storming the best deal. This is incremental. The senator said, we are the United States.

We are not other countries. And he came back to it. We have to have a uniquely American solution. And I think that, first, it's right, and it's reassuring.

To plug another person's article, Atul Gawande who back in the day was a Clinton adviser on healthcare is now a doc and a writer. He wrote a piece in the *New Yorker* that suggested that culture matters most. And so, the American health system will be American. It won't be British or French or Canadian and it will grow like a coral reef, off of what we already have in now. And I think Barack Obama especially is really attuned to that. I think he – he just got elected president. He understands this country and its culture really well.

MS. FEDER: Just a comment before we open it up. Using incremental in that sense it is an evolution. Where we are I think is consistent with what the president is talking, what Senator Baucus is talking about. I just would –

MR. BEGALA: If you believe in evolution because it's just a theory. (Laughter.)

MS. FEDER: But I wanted to distinguish that. I thought that the chairman was very strong in terms of making clear that piecemeal solutions, and some of you have kind of allowed is how maybe that's all we'll get, and I want to push a little bit more on that, that that won't solve the problem. And so, there's two different uses of the term. But why don't we open the floor to questions? Press?

Q: I guess if – I said name and affiliation, but you didn't hear the first time. Matt Cover with CNS News. I think one of the criticism's levels at the first go around and I think everybody has just kind of touched on it here, is that it was almost too much, too soon, or viewed – it was able to be portrayed that way. I guess, what, in your opinions – this is for the whole panel – is the risk that that's going to come back again given the economy, given Senator Baucus touched on the CBO's deficit projections for just Obama's first budget much less the next three. Is he running even a greater risk now of failing because it's too much too soon?

MR. BEGALA: I think that the 15-year period after the failure of that, I think most people would say our healthcare system has not gotten better. It's gotten worse. So, in other words, I think that rather than too much too soon, people might say not a moment too soon that we really need to move on this.

And success breeds success. The president succeeded with his economic recovery package. He succeeded with his omnibus budget. My guess is he's going to have other successes leading up to this.

And I think, at least Democrats learned another thing from '94, at least in my own view is the biggest single reason that Democrats lost the Congress in 1994 is not because we succeeded at so many things that we tried but then we failed on one very big thing. If you look at the first two years of Clinton with the Democratic Congress, he passed and enormous amount of legislation, for crime to the budget, to national service in AmeriCorps, huge change.

But my own view is we lost the Congress because voters looked at them and said, okay. We gave you the keys of the kingdom buddy, House, Senate, White House, and you couldn't deliver on healthcare.

I think the Democrats today understand that that they're going to rise or fall together and that they have to succeed on this, and I think that that's why they're giving this president so many successes.

MR. ORNSTEIN: I think the pitfalls are more on the financing side in a couple of ways. The first is trying to make something like this happen and in and of itself over say, a two or three-year period, finding the money to pay for it. And if you can't find the money to pay for it, then you're going to find Democrats split right down the middle. You're going to have a lot of liberal Democrats who will say, you know, it's an economic crisis, never mind the PAYGO stuff. Let's just move forward. And then you're going to get this corps of fiscal conservatives who are going to rebel against that. And that's where you may then find an excuse for Republicans to peel off and join them. That's a big problem.

The second part of it is also a fiscal one and it is the longer term fiscal challenge where we have a president having an entitlement summit and talking about doing something about the long-term growth of what is really far more Medicare and Medicaid than Social Security.

How do you pull this public-private package together, even as you simultaneously are trying to restrain the future growth of Medicare and Medicaid, even as as a part of this package, as he said, you're going to expand even more children's health insurance and Medicaid. That's enough to make your head hurt when you try to think about pulling those pieces together.

But if you're going to do this as a comprehensive package, you almost have to pull all of that into one piece. And that's not even considering the different tradeoffs you've got here to try and pull your political forces together. That's the biting off too much at this point, not, I think, a public that will get scared that this just too much too soon.

MS. FEDER: Interesting in that regard, Norm, as the senator said in calling Peter Orszag is that the path to economic stability – I don't have the words exactly correct – the path to essentially getting Medicare and Medicaid spending under control is to essentially make sense out of our whole health system. And so, it actually, it is unavoidable, and it seems to me that that's what you have to persuade people. Is that fair?

MR. ORNSTEIN: I think it's fair but just getting some of those pieces together doesn't mean that magically, given the demographics and some of the other phenomena that you're going to bring programs that otherwise are growing very dramatically as a share of GDP under some control.

Now, maybe that you can pull some of those pieces together and that includes some elements of means testing which we've tried before on the Medicare front and failed to do, but it may be that we're going to have to put some of the burdens, mix them around differently here. And maybe if you do that as part of a large package, you can make it work.

MS. FEDER: And I think that when you look at it, the large part of it is getting the slowing, as he said, bending the curve. It's slowing the rate of growth and cost more than it is what people are contributing, but I hear the challenge. Did you want to comment, Karen?

MS. TUMULTY: It's just – if you start talking about that kind of stuff and then you get into the territory of making people give up what they've got and that's where "Harry and Louise" can come riding in again with a vengeance.

MR. ORNSTEIN: I wanted to make one other point, Judy, that has not been much on the table and I think it ought to be. So much of this focus is on the insurance front and it's getting people insurance. To me, at least as much focus ought to be on delivering care to people.

MS. FEDER: Absolutely. Absolutely.

MR. ORNSTEIN: And just having insurance doesn't mean that you get care. If you are a single mom and you don't have insurance, and you're working as a waitress, and your kid gets an ear infection, give that person insurance. She's still going to have to take a half a day off from work to go wait around the pediatrician's office, lose the income and maybe lose the job.

So if you can't find a better and more efficient way of delivering care, including preventive care to people, and that means dealing with the nursing shortage, maybe having mobile clinics that can go into areas where people don't otherwise have doctors, that all ought to be a part of this package or we're really going to be missing something major here.

MS. FEDER: And I think you heard that in some of the senator's remarks when he talked about those issues that you really have to change delivery. It's got to work for people who have health insurance. And I think that that is a focus that makes it a challenge. Yes, sir.

Q: Thanks. Matt Singer, Forward Montana. I'm curious because even if this bill gets 100 votes in the Senate, I think we can probably all agree without significant cost controls in five years, it's not going to be sustainable and it's going to need more changes. If we don't have a public health insurance options to model good behavior, to negotiate better prices, how either short of very, very heavy-handed regulation or throwing people to wolves do we ever control costs?

MR. ORNSTEIN: You've got the wolves at least to throw them at. (Laughter.)

MR. BEGALA: That's more a Judy question.

MS. FEDER: And the senator said everything is on the table there. What you're raising is that it actually is a continuation of what we're talking about in the public health insurance option is part of that in terms of having an insurance company whose commitment is to getting better delivery of care which is exactly, I think, what Norm is talking about.

So I think we need to use many of the tools whether through a public health insurance plan or through all insurance plans including Medicare and Medicaid to focus more on prevention and primary care and to manage the chronic illnesses which are a big, big piece of what we're seeing going forward. And so I think that that's the broad objective is that we have to change the delivery system as well. Oh, I'm so sorry.

Q: Hi. Thank you. Dr. Margaret Flowers. I'm a physician. I've left practice to work fulltime on healthcare reform. And so many of my colleagues are leaving practice because what we have right now is really quite unworkable for both physicians and patients.

And I was glad to hear your comment about Hillary Clinton's campaign because it's very clear that the public wants a publicly funded privately delivered health system. Physicians want a publicly-funded privately-delivered system. The only people that don't seem to want it are the people in Congress. And we have tried private health insurance in this country. It's a market failure and there are very good reasons for that. You can't treat health like a commodity.

The private insurers are on their way down because of the economic crisis, employer-based insurance is eroding. Why do we continue to prop it up? Why don't we allow it to go and actually create a health system which is publicly accountable and transparent and serves health? That's my comment.

MS. FEDER: Is that a comment or a –

MR. BEGALA: I think some of it is – because the point Dr. Gawande makes in his article that it is an accident of history that we have an employer-based healthcare system. It's because we had to get around World War II restrictions on wages.

MS. TUMULTY: But he points out it's an accident in the history that England has single payer.

MR. BEGALA: Exactly. That was I was going to say. Yes. And so, and yet, we live with that. And so, I think that reformers are – they want reform but they cannot afford to fail again. And so, at least speaking as one person who supports reform, I don't want to let the perfect be the enemy of the good. And if your idea is perfection – but there's not – I'm certain on Capitol Hill the political will for single payer at all, and I don't think Senator Baucus what – (inaudible) – at all.

MS. FEDER: Was going there either. But let me ask you all another question. I think that when you're talking about frustration with insurance companies, there's a tremendous frustration with the rules under which, or the behavior that they are able to engage in which is to make life impossible and paying bills, and paying claims, and also to exclude people based on their health status. So what do you think the stomach is on Capitol Hill for writing real rules?

MR. BEGALA: I wrote it down. You heard Senator Baucus, not radical – he said, we need to eliminate insurance companies' ability to discriminate against patients based on age, region, preexisting condition, and so forth. It is pretty strong.

MS. TUMULTY: It is, but you know, when you look at the regulation that's out there, for instance, Henry Waxman last summer had a hearing on a practice that was not unlike what happened to my brother which was the insurance company when they found out that you're sick, they go back digging through your medical records to find something that they can use to – it's post-claims underwriting, after the fact.

Well, it turns out there is – it's 50 state insurance commissioners who really haven't done a lot about it, but there's actually a federal regulation that has been on the books against this since 1998 and it has never once had an enforcement action under it.

MS. FEDER: You're absolutely right. What you're raising is that we need new rules but we need with those rules and with existing rules, we need government that's willing to enforce them.

MR. ORNSTEIN: That is, I think, or should be a tradeoff if you do not end up with a public plan option. And you do have the insurance industry really come in a very great distance from where they were, with the condition that you have the universal coverage, to accept a different set of conditions in terms of who they will ensure and how we'll handle it. If you don't do this with a specified set of what would be in a minimum plan and some –

MS. FEDER: Specified benefits, you mean. A specified benefit package.

MR. ORNSTEIN: A specified benefit package and some cost limits, and you compete within that and you can add on in different ways and then you subsidize for people who can't afford it.

And then I think you've got to have some of the ideas that Tom Daschle and his colleagues have come up with. You've got to have a broader way of making sure that companies don't evade basic standards. You've got to have some regulatory apparatus.

That's what we're going to end up doing. If you could snap your fingers, we just don't do radical reform in this country where we take existing actors and throw them out and bring in others. Even if it were desirable, it's not practical and you're not going to get votes for that.

MS. FEDER: And some argue having the new rules and the private plans and the public health insurance option gets us a long way there. Other questions? Leslie (sp).

Q: Leslie Scallot (ph), I'm an independent advocate and consultant on mental health and health. I'm concerned about the prevention question. We've sort of take it the reform community as an article of faith that prevention is going to help save money overtime. But CBO seems to regard this as simply a cost. Any kind of preventive services are a cost in the system. They don't recognize savings. And from what I've heard, it's on the grounds that people will live longer and therefore cost more money to the system overtime. How do we deal with that in this debate?

MS. FEDER: Well, let me frame it a little bit differently for this political panel which is to ask you all, one is that I think you're raising not only the importance of prevention and how people understand prevention and the need to invest in it, but you've also raised with your question, Leslie, the issue of the Congressional Budget Office and what gets scored and what doesn't, what is identified as savings, and when it's identified as a savings, it is now, is it years out, whatever.

And I actually would turn to the panel and ask them about what they think about what people understand in terms of what value we're going to get from the system and what we can do by investing and how you cope with the fact that you've got a score keeper.

MR. ORNSTEIN: It's difficult. It's a good question and some in the CBO have suggested we just give free cigarettes and lots of red meat to older people.

MR. BEGALA: Take the seatbelts out of their car.

MR. ORNSTEIN: Look, a good part of the dilemma when we talk about entitlements, Medicaid is long-term care for the elderly. It's another backdoor way in which we financed a system.

MS. FEDER: And people with disabilities.

MR. ORNSTEIN: And people with disabilities. But the long-term care, you get people living into their 80s and 90s and even beyond, and figuring out how you're going to pay for all of those things is difficult. The success you have at a preventive level does have long-term budget costs, if you want to look at it in those terms.

And yet, what I would say to those people is, why is it that insurance companies now are giving people incentives to do all kinds of things to keep them from getting obese, to make them healthy? It's because it's still better and much less costly to prevent serious illnesses, or chronic illnesses, or health disasters. But we're going to have to worry about people living longer. That's a part of it.

MS. TUMULTY: They hate it when that happens. (Laughter.) It's true too, the insurance companies, they have a short-term reason to do this because by the time people get to be 65, they become the government's financial issue. But there is so much that could be done especially in chronic illness, when you see the – what is the percentage of federal healthcare money that goes to treating diabetes? It's some huge ridiculously large. If you could just deal with obesity in children, you wouldn't have to be spending that.

MS. FEDER: It's common sense is what you're saying as well as evidence. Yes.

MR. ORNSTEIN: When you talk about waste, you've got to be a little skeptical in a sense because this is all money going to people. And what I would do is waste somebody else's income and you've got an awful lot of people who are very smart who are going to find ways to make sure they don't lose their income. And if they lose it in one area, they'll pick it up in some other place. But there are places where there could be savings, clearly. There are areas including managing chronic diseases that are extraordinarily important.

And one example that I use, and I've asked around and there are clearly a lot of them, somebody who – a young person who had kidney failure, his mother donated a kidney, gets a new kidney, has no job. Medicare is paying for all of this. Three years they pay for all the drugs which are something like \$12,000 a year and then they say after three years, we don't pay for that anymore.

So he loses the kidney, he goes on dialysis. They pay for dialysis for a lifetime. It's about \$75,000 a year. His quality of life, much, much worse. It's an insane regulation. And I thought, this can't be, but it's there. And the system is riddled with regulations in a (stone ?) and a stove-piped way for reasons that may have made sense for short-term cost savings but that are extraordinarily expensive. And clearly scrubbing these rules even as we go along, you actually can find ways that will save money.

MS. FEDER: And get us better care.

MR. ORNSTEIN: Yes, and get better care.

MS. FEDER: I think we've got time for one last question. Yes, sir.

Q: I'm a retired surgeon and I work in the field of research on healthcare quality. I raised this issue on 31st of October, 2008, when CAP released its "Blueprint for Reform." And I want to revisit this same question again, particularly now given this political climate and the issue which is about passing the reform.

And I want to ask the panelists the question that, yes, when these political solutions are implemented, they are triggers to changing the mindset of a civilization, and since the issue of accident of history was raised and in systems we can talk about the initial conditions where something triggers a process that has an effect over a period of decades.

So what kind of thinking is going on to change a few things that have come to our healthcare system as a legacy of last, I would say, 70, 80 years, even that precedes the two big wars? Has there been any talk about addressing the premises of our healthcare system? Just to give one extremely politically volatile example is malpractice litigation. Just to give one example.

MS. FEDER: This is mine and that's yours.

MR. BEGALA: Well, to the malpractice, that's generally, there have been a lot of proposals in Washington. That's generally a state-based issue. And some states – Karen and I are both from Texas originally – have passed pretty aggressive sweeping changes in their malpractice laws. And you'd have to ask the docs there whether insurance rates went down or up or things are better as a result of that. I'm very skeptical that things got any better, frankly just by taking away the patients' right to protect themselves in court. But my state did that. I don't think things got very much better for docs because of that.

MS. FEDER: No. And I think that actually, it's generally regarded that that's a small piece of the problem, but I think in the terms of your bigger question is exactly we're talking about a whole pattern of medical practice that grew up, and of insurance practices that grew up. And I think that that's exactly what reform is about changing is shifting away from the focus on specialized services more into prevention on better health and designing an overall system in which everybody participates and everybody is covered and has access to a delivery system that works.

So let me just – so thank you. And let me turn back to the panel for some closing words. I'm going to take a gamble here. I think it's a little risky and I know it's always safer in Washington to bet on no change rather than some change. But looking at where we are now, looking at the seriousness of the problems on which there's a lot of agreement and looking at the energy that we seen from the chair of the finance committee, and the president of the United States, and many others, you think we've got a shot?

MR. ORNSTEIN: Yes, and I was not one who joined in the skepticism about President Obama taking on too much in his first year. This is the time to move ahead on a host of fronts. The crisis is an opportunity, but all of these things coming together give us a very, very strong shot of getting some done.

MS. TUMULTY: I think so too, especially, I think the window here is very short and I think, in some ways, that may kind of clarify everyone's thinking and their effort.

MR. BEGALA: Right. And to come back to our speaker, Senator Baucus had it exactly right. Next year will be the congressional election year, then we'll start gearing up for the presidential election and it's now or never and I'm ready to bet on that one.

MS. FEDER: So you heard it, everybody's bet. We haven't asked people to put money on the line, but I don't have to go that far.

MR. BEGALA: I bet on Texas to beat Duke last week, so you can try.
(Laughter.)

MR. ORNSTEIN: I hope you didn't bet on Duke last night.

MR. BEGALA: No. I was glad to see them go down last night.

MS. FEDER: So it's clear that from this panel and from the Chairman of the Senate Finance Committee Senator Baucus that now is the time for action. So thank you all, thank you everybody.

(Applause.)

(END)