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HEALTH REFORM ROUNDTABLE

HOSTED and presented by the Los Angeles Business Journal, the Health Reform Roundtable was a live, in-depth discussion, moderated by Los Angeles Business Journal Publisher and CEO, Matt Toledo, and featuring an esteemed panel of local health industry experts. What follows is an edited transcript of the discussion as it took place two weeks ago at the Regency Club in West Los Angeles. You'll read the hard questions – torn from the pages of the news today as the health care debate still rages — and the unique responses and perspectives from those in the trenches delivering health care services to the people of Los Angeles.

HEALTH REFORM ROUNDTABLE

THE PANEL

TERENCE CUNNINGHAM
Hospital Administrator for
Shriners Hospital for Children,
Los Angeles

Prior to joining Shriners, Cunningham served as the CEO of Ben Taub Hospital, an academic teaching hospital affiliated with Baylor College in Houston, Texas. He was Vice President for Administration at John Hopkins Hospital in Baltimore, Maryland, and he began his career in health care leadership in the United States Air Force Medical Service, where he was a hospital administrator for 27 years. Cunningham is a native of California and received his undergraduate degree in microbiology from Cal State Long Beach and his master's in hospital administration from George Washington University.

DR. DAVID FEINBERG
CEO of the
UCLA Hospital System and
Associate Vice Chancellor

Prior to assuming his leadership role with UCLA, Dr. Feinberg was the medical director of the Resnick Neuropsychiatric Hospital at UCLA. Dr. Feinberg is triple board certified in the specialties of child and adolescent psychiatry, adult psychiatry, and addiction psychiatry. He is a professor of clinical psychiatry at the David Geffen School of Medicine at UCLA. Dr. Feinberg graduated cum laude in Economics from UC Berkeley and graduated with distinction from the University of Health Science at the Chicago Medical School. He went on to earn his MBA at Pepperdine University in 2002.

MARK COSTA
Executive Director of
Kaiser Foundation Health Plan
and Hospitals, Los Angeles.

In his capacity, Costa has operational responsibility for all health plan and hospital functions at the Los Angeles Medical Center. Prior to his role at Kaiser, he provided over 25 years of leadership within several notable Southern California health care organizations, including Providence Health System, Little Company of Mary, Torrance Memorial, and California Medical Center. Costa is the past chairman of the Hospital Council for Southern California, a past member of the California Hospital Association board of directors, and past chairman and commissioner of the L.A. County Emergency Medical Services Commission. He received both his undergraduate education and master's of Public Health degrees at UCLA.

RICHARD JACOBS
Senior Vice President for Systems Development and Chief Strategic Officer for Cedars-Sinai Health Systems.

Jacobs began his career and 30 years of experience here with Southern California Health Care. He served as President of EHA West, executive positions with Brighton Consulting Group of Pasadena, and with the Presbyterian Intercommunity Hospital in Whittier. In his capacity at Cedars-Sinai, Jacobs is responsible for overall system development of the Cedars-Sinai Health System, directing strategic planning, system developments, major care and pair relations, marketing communications and client services, international health, telemedicine, community health education, and facilities planning and construction efforts. A native of Los Angeles, Jacobs holds his Bachelor of Science degree in Business Administration from USC and a master's in Public Health from UCLA.

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MATT TOLEDO: *Thanks to each of our panelists for making time to be here for this discussion today. Let's begin the discussion with me outlining health care reform as it is being proposed at this time. I'm going to attempt to characterize it to see if our panelists agree or disagree with the characterization.*

In a nutshell, with health care reform, a proposed system is being designed to assure affordable quality health coverage for all Americans. It's a matter of controlling costs by reducing long-term growth of the health care costs, both for businesses and for government, protecting families from bankruptcy and debt because of health care costs, maintaining coverage for people who change or lose their jobs, and ending barriers to coverage for people with pre-existing medical conditions. It's also about improving the patient's safety and quality of care, guaranteeing choice of doctors and health plans, and investing in prevention and wellness. This is how the Obama administration is characterizing the debate at this time.

So let me just go across the table here and see if we agree with this characterization and, if it needs to be bent, how you would bend it a little bit ... and if you are as confused about this whole thing as the rest of us are in this process.

MARK COSTA: I think none of us are going to disagree that access is an issue. Cost is an issue in the future, in terms of where we'll go if we do nothing. It's complex. I think we have to put reform in perspective, in that it isn't going to occur overnight. We don't believe it should.

We're based on an employer-based health insurance system that is going to be difficult to change. It probably isn't a good thing to change in terms of being the foundation in addition to the government's role.

To better understand the health care situation we need to take a closer look at the payment system. How do health care providers get paid for what they do? I think reform has to address that, has to provide the incentives, the motivations to do things differently, information technology, and information systems. How does reform motivate health care providers to invest in information systems so that we better understand the populations we're serving while it's to better use evidence-based medicine so that we can provide more cost-effective care and bring value?

Because value is sort of the basis in this reform discussion. We could end up spending the most and maybe not providing the very best care.

DAVID FEINBERG: I think we're actually not talking about health care reform. I think we're actually having a discussion right now about health insurance reform and payment reform.

There's two parts to payment: Who is paying and then how that money gets divided. And that's really the discussion we're entering and, hopefully, that leads us forward around some important issues.

To steal from my friend, Tom Rosenthal, if you really look at health insurance reform, there are three things. There's cost, quality, and access. And we've never been successful in actually tackling all three of those at once. So you can get good quality and good access, but the cost will go up, for example.

Real health care reform can be done best, I think, though primary prevention. It's about people taking care of themselves. It's about eating right, ideal body weight, exercise, alcohol in moderation.

We would see a decrease in our costs of diabetes, cancers, cardiovascular disease, stroke by 50 percent — if we did what our moms told us. That doesn't seem to be part of the discussion.

What we are really discussing now is health insurance reform, which I think is necessary, but not sufficient.

TERENCE CUNNINGHAM: I have a lot of concerns about the rancor in the press, in the news media, about what these bills really mean. Of course, there's no final bill on the table that's passed. But I think there's a tremendous amount of misinformation and the public speaking is very polarized.

Even today I think we will find some things we will be on the opposite ends of the spectrum on. But I do think health care reform is coming. I think it is very important that the facts are put on the table in a sufficient time as demonstration projects before we go down the path of making changes that are irrevocable and damage the system.

A simple term like "access," for example. What does access really mean? Government will be glad to print a bunch of cards and say, "You have health insurance," but if you walk into a hospital, you may or may not get care on that day. That can be a real problem. Boutique medicine is becoming a phenomenon that's spreading very widely. But it's going to create a two-tiered capability of getting care in this country. Either you have money or you go to the emergency room. "Buy your way in," et cetera.

RICHARD JACOBS: I agree with some of my colleagues. The debate has shifted from access to costs, how to make health insurance more affordable, and, therefore, the discussion is around health insurance reform as much as anything.

And so the popular thing now is to talk about waste. So mostly, when we're talking about costs, we're not talking about the cost of an imaging procedure at Cedars-Sinai or UCLA. We're talking about the number of procedures that a patient and/or their doctors consume when taking care of a particular illness. And that's called waste. So a lot of people think there's a lot of waste in the system because we're doing too many procedures. Patients are experiencing too many specialists or other things that add up to the cost of care. If we can only manage that better, we can make health care more affordable.

And one way to manage it better is I think what Mark talked about in terms of payment reform. There's a lot of devices that are out there that people are talking about to make it more affordable. The problem is that on the political debate, the other side of waste, depending on your political views, is the word "rationing," and that's very scary and it's intended to scare you, because it suggests the notion that in order to be more efficient about how we manage care and how we deliver care to your patients, that rationing-type decisions will be made. Of course, that's going on every day today between you and your doctor and, unfortunately, increasingly, not at Kaiser, but at other health plans they're developing very robust systems to try and do what they can to intervene between the doctor and the patient and help manage the cost of care, all geared toward, I think, a worthy goal of making it more affordable.

Bottom line right now, the debate on affordability is between waste and rationing.

MATT TOLEDO: *Before we talk about reform and look forward to some clarity about how to improve this, I'd like to get a sense of what you individually believe is the biggest reason we're in the difficulty that we're in today.*

DAVID FEINBERG: I think the biggest reason is we don't take personal responsibility for our health; that there's clear evidence that taking care of yourself — you know, the way that I think about it, if you look at this health care reform that Pelosi is pushing, you're going to get your colonoscopy and your mammography free.

Well, we spend twice as much on entertainment in the United States as we do on health care out of our individual pockets. And there's the sense that you're entitled to this. Well, for those that can't afford it, I sure hope we're able to provide it. But for those of us that can afford it, this is something that is not as much fun as going to the movies, to get your colonoscopy, but it definitely has a payoff.

We have, any given night, 800 people that have entrusted their lives to us in one of our hospitals. And I can tell you, every single one of them would trade whatever they have to get their health back. And as far as that goes, if we walked around one of our hospitals, I could introduce you to a lot of people that now have cancer that spread to the brain because they were a smoker, now have multiple traumas because of a motorcycle accident, that had the ability to care for themselves and did not partner — and I take this as our responsibility, too, as health care providers — did not partner in a way that prevented illness or those with illnesses stopped or improved the progression.

So I think the biggest thing that's missing in this whole thing is the patient, the family, the social structure that allows people to care for themselves. When they start comparing us to other countries, you know, in other countries, the obesity is not the same as it is in the United States. We make up 5 percent of the world's population, and we consume 50 percent of the illegal drugs. That's not happening in other countries. So it's almost an unfair comparison.

I think it is our responsibility as individuals to care for ourselves. If we did, we would get a dramatic reduction in our health care facilities, we'd need less beds, and I think we could solve a lot of problems. That seems to be missing from the debate short of "you'll get a discount at a health club." To me, that's the issue.

MARK COSTA: I don't disagree with any of that. We know there's such differences in the risk of the populations. It can be by ethnic makeup of the population. That isn't right, so education and focus on wellness is certainly a priority.

Here's a different thought. We are some-

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what built around or very much built around a fragmented system. If you go to any one of our hospitals, the care is certainly coordinated for that admission. But the question is, is that care coordinated well once that patient goes home? Is the care coordinated on the preventive side, the primary care side? And much of the U.S. health system, I think we all have to say, is a very fragmented system and that's what leads to the inefficiencies, the waste, because the different parts of the system don't always know what the other is doing.

So what do we need to do about that? Why are we fragmented like we are today? Some would say it's because of how we get paid. We get paid primarily based on each unit of service that's provided. So each fragment of the system is out there to provide their services in a profitable way. There are payment system models that should and would incentivize the different parts of the health system to work differently if they are organized and then get more efficient care. We should see savings on the longer term.

RICHARD JACOBS: I think both those points are correct. I think it is also helpful to remind all of us that medicine has enjoyed an incredible track record of research and discovery. And I think a lot of the new costs that get borne and added up every year are because we are able to do new things through more people and people are living longer. And what was once an acute disease turns into a chronic disease, and adds to the cost. I very much agree with Mark and David, but I think there are other elements that kind of pile on when it comes to costs.

Hospitals are unique types of organizations, especially as you might think of them compared to your own business. We are labor intensive, we are capital intensive, and now we are technology intensive. You couldn't create a more costly model of an organization, I think, than a hospital, given that. We don't cut a break really in any dimension of care. And for those of us like UCLA and Cedars-Sinai that are involved in teaching and research, that has become very costly. But we hope that the yields that research and discovery bring about for the benefit of the community are very powerful.

MATT TOLEDO: *I want to focus now on the issue of the reform debate. It's surprising to me that there's a debate. The idea that we want to lower costs or create efficiencies, encourage preventive care, and improve the quality of the care would be items that everybody, regardless of political points of view, would say "that's a good thing — Let's figure out how to do that."*

So why are having this dialogue? Why isn't everybody together on it?

TERENCE CUNNINGHAM: Some of the very

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'To better understand the health care situation we need to take a closer look at the payment system. I think reform has to address that, has to provide the incentives, the motivations to do things differently.'

MARK COSTA

'If we don't get under control on the costs, jobs are going to disappear in California. The car companies pay more for the premiums in health insurance and pensions than they do for the cost of steel to build those cars.'

TERENCE CUNNINGHAM

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strong pet peeves I have about the entire debate are that we are giving a free pass to a lot of special interest groups that are making billions off of health care systems in this country with what I consider very minimal contributions. So I will give you an example of just two.

Today it's written into law that Medicare is prohibited from negotiating drug prices with drug companies or to ask for any rebates. In other words, they've gotten a free pass. Medicare pays the full drug prices charged to them. Then there is a new legislation that already bypassed — it's a special deal that's been worked out by the White House that the drug companies will give some money for Indigent Care, but they're going to charge full prices, plus they prohibit any importation of drugs from Canada. Why should we ask them not to share part of the responsibility and have a nice profit, but not billions and billions of excess profits?

The second area that I think is very egregious is tort reform and the lack of the ability to put a cap. California is one of the few states that has a cap on malpractice awards. There are proposals for trial courts where you would have a judge very well-trained in what happens in the medical arena to try to make decisions rather than to take cases before a jury, which may have very little understanding, I've found, on personalities and politics of the lawyers. But the lawyers will take up to 60 percent of the award. I don't see how that contributes to health care at all. We're talking, again, billions of dollars of costs.

Lots of special interest groups I think could make good efforts to help reduce the costs immediately, but so far they are getting a free ride because tort reform is off the table and negotiations with drug companies are off the table. We're all going to be paying for that.

MARK COSTA: Nobody is debating that the reform is going to be costly. Now it's anywhere from 900 billion to over a trillion. So that causes debate, especially in today's economy, obviously. So that would be one factor.

The other factor that we're seeing is that the general public, those of us that are insured, think we're getting really darn good care and we are. There's not too many dissatisfied patients that leave a hospital today with all the safety measures and kinds of technology available to them. Their illnesses are being addressed, and so that then creates debate. I think what we may be missing, because it is so hard to evaluate, is the quality of life issues. Those that have chronic diseases like diabetes, like asthma, like mental illness, that really are in the front end of our health care system, that's probably where we need to do much better as a country. It is difficult to evaluate, however.

I think as businesses, one of the things that Kaiser Permanente is starting to work with companies on is things like attendance. It's those chronic illnesses that affect productivity in the workplace. It's those chronic illnesses that really affect the workforce to be able to learn, be present, be attentive to their jobs. Yet, once again, it's hard to evaluate. We're not putting enough resources into that front end. So over the long term, what we're throwing the dice on is that we can take some of those funds at the illness end of our system and move it so that we get a higher quality of life hoping, really, because I don't believe it's been proven, that we're going to see big reductions in costs, but we're going to increase the overall health of our population, and there's a lot of myths to it.

DAVID FEINBERG: I think the best thing to comment about regarding somebody who is against reform is the guy who stands up in the town hall and says, "I don't want the government messing with my Medicare." To me, that kind of brought it home.

MATT TOLEDO: *You talked about some of what I'll call interest groups that potentially are trying to manage the debate or participate in the debate. One of the things I certainly concern myself with is the ultimate responsibility that businesses will have to bear regarding costs of participating in underwriting whatever reform is finalized.*

Do any of you feel that there is a business voice to take?

TERENCE CUNNINGHAM: Yes, if you're a drug company or you have some inside tracks in the political scene. But I think one of the things that businesses ought to understand is that there's a lot of predictions in the media, that if there is universal health, one-payer, etc., then most companies will probably drop their insurance plans because it would be in the best interest of the company to do that. So you have 100 percent control of all the health care that's given and the employers are out of it. Now, that doesn't mean you have to pay to play. But more and more this is being circled around one provider and everybody pays to some degree. So businesses are going to be impacted one way or the other.

I completely agree with the arguments about healthy lifestyles and wellness and so forth. It's not something so new. I think it's in the best interest of improving productivity, et cetera. Just a simple thing like obesity and unhealthy lifestyles cost our country an extra $150 billion. If people will stop smoking, get some exercise, take their medications as prescribed and so forth, we automatically significantly reduce the cost of health care. And we all pay for each other's care to some extent.

So businesses are a very important portion of this. And if we don't get under control on the costs, either voluntarily or otherwise, jobs are going to disappear in California. The car companies pay more for the premiums in health insurance and pensions than they do for the cost of steel to build those cars.

RICHARD JACOBS: I think one of the reasons this debate has been so significant is we're not hearing enough from businesses' perspective. I don't know if there is a way to turn this question around on the audience, but it's possible that, you know, those opinions are all over the place as well, in terms of those businesses, especially small ones that do want to continue to provide health care and others who would just as soon have some option that they could pay to play or get out of it entirely. The current situation, however, is that increasingly, every year, more and more businesses are dropping health insurance for their employees and it's one of the biggest reasons there is more and more underinsured or uninsured. I don't think we know, sitting here today, given the impact of the recession, how many uninsured we're dealing with.

And that's the second reason I think this debate has been a little bit awkward to have, because the uninsured tend to be the disenfranchised. And I've heard some reports say that they're not the ones that are voting, typically. So we are in this awkward situation in this country of those that are seen to be the voters as being the ones that have insurance. They're happy with their health care, they don't want to see a change, and so forth. But I have to say that I don't believe that – and I've watched this debate very closely – that we are hearing enough from business, especially small business.

MATT TOLEDO: *Once it's finalized, how do you believe reform as it is shaping up is going to affect smaller businesses? I'm talking about the businesses that are the economic muscle of the economy?*

RICHARD JACOBS: I think it's really hard to

predict in the following way: A big piece of the legislation right now is insurance reform and development of these health care exchanges where small employers and individuals might be able to go to purchase insurance. And, really, depending on what levers get pulled in putting that together will depend on what the impact is on business. So I know there's a scenario where this could be a good thing. It could be an opportunity to identify more affordable products for their employees or a pay-or-play mechanism that would allow them to lower their costs. So depending on how it shakes out, it could either be a more costly thing or a less costly thing.

But I would like to remind people in the audience that the cost of health care gets borne one way or the other. It's going to get borne through the tax system, which supports Medicare, Medicaid, the veterans health, and county health systems. Most care in this country is provided from some government mechanism.

On the private sector, obviously, that's supported through commercial insurance. And the premiums you pay for that are a hidden tax that covers the underpayment that is paid by those other government-funded programs.

So it's either going to come out of your pocket or the government's pocket. And we end up developing a lot of debates around what's a more efficient way to "tax the public," but the costs are going to be borne one way or the other.

MARK COSTA: I think one of the frightening elements is that we know this is going to take time. These ideas of exchanges in terms of how we might buy health insurance could take years to form to really create a competitive environment. With the economy, when I think of small businesses, what will they do? What will you do over a four-year period?

We already see, as Rick referenced, the dropping of health insurance. Within four years, if we had a major increase in terms of the number of people that were not insured, it could cause significant complications. Looking at our own industry of hospitals and half of the hospitals being unprofitable today, not having the capacity in our emergency rooms, not having enough beds … it's already an issue. If you look at our four facilities, I'll bet 90 – 95 percent of our beds are occupied today because of the closure of so many hospitals in Southern California. So within that four-year period, if we see more dropping of insurance and more uninsured, we truly will have a crisis and someone will end up paying for it. It will be government or it will be those that are providing health insurance that get the indirect tax.

DAVID FEINBERG: I would like to say that I think business has a huge opportunity, if we look over the last few years with Pacific Business Group on Health, with the Leap Frog Group. I mean, unfortunately or fortunately, you get your insurance these days through your employer. So the employer is the purchaser. There's this move making it closer to the actual user and eliminating the moral hazard of the user not being the purchaser. But Leap Frog Group had gotten intensive care doctors in the intensive care unit, which improves the quality and decrease the costs. That was driven by business.

So I think business has an opportunity as the purchaser to say, the same way General Motors said, "We want just-in-time steel that is cheap and high quality and low cost," to say the same about health care. That's how we saw managed care to start with. Businesses finally said, "We can't afford the increased premiums." And for a period of time we actually had a leveling off of premiums. That was business as a purchaser driving some fundamental changes.

So as providers, I think our partnering with business on these issues are absolutely crucial and really could drive a lot more change than you probably see coming out of Washington.

TERENCE CUNNINGHAM: I agree completely and I would challenge each one of you to talk about these issues and try to champion ideas with your business associations, your business roundtables, and other groups that I think should represent a strong voice of America about how business is to survive and how health care reform is going to help preserve business in this country.

MATT TOLEDO: *Dr. Feinberg and Mr. Costa both talked about the increasing number of people that are uninsured given the economy. Mark, as you indicated, that number is likely to go up. Statistically, that would be the case. I understand last year there was $5.1 billion of bad debt, essentially, that providers charged people that are paying for health care to offset that cost. That number is going to become larger.*

The question becomes, is that going to be a burden on businesses and current payers or is it going to be government debt going forward?

DAVID FEINBERG: It's a burden on us.

MATT TOLEDO: *But is it a burden to you or is it a burden to the health insurance providers or is it being laid off against the insurance payers, or is everybody taking their piece?*

MARK COSTA: In the short-term, if someone can't pay for their care and they're in a hospital, the health care provider is going to absorb that. But we need to stay in business. The public wants us to stay in business. So the pricing in terms of our relationships with insurers, which then gets passed on to you, then needs to be altered. That's for sure.

I think the other thing we know is that government does pay over half the bill. The changes in terms of what they pay us also comes back to how we can run our businesses in terms of supporting the capital investments that we want and the public wants. So it really all is together. Getting to your question, if we don't do something to bend the curve in costs, we see more uninsured, the costs will go up, and either government or businesses will pay for it. Or the flip side is we will have massive closure in capacity, which would probably be the

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scariest scenario because then we have people that have no way to get the care at all.

MATT TOLEDO: *Isn't that strain already occurring? Aren't we already getting to that crunch point?*

MARK COSTA: We are. Our emergency rooms, you know, are very full. The LA Times has educated us all on that. So that's the situation today. But the doors are open and they always will be in terms of emergency rooms and hospitals.

Again, we've got to not just bend the curve.

We've got to get the population to get the front end of the health care that they need, get themselves well, get themselves on medication so that they're better managing the chronic illness. If they don't have health insurance, it's harder to access that front end of the health system. That's why they end up in the emergency rooms.

RICHARD JACOBS: On what Mark just said and others have been saying, there are two major ways to deal with the health care cost problem: One is what David talked about in terms of personal responsibility. The percentages of our health care costs that can be impacted by improving personal behavior is just enormous. It out distances anything else. And the second thing is what I referred to earlier, waste. Waste, meaning doing more for patients collectively that maybe isn't necessary or appropriate. We must try to get our arms around that. Of course, that leads you into the rationing debate. But let's put that aside. So you need those two things. And as Mark suggested, the only way you will be effective on making progress on those two huge aspects of getting a handle on health care costs is by bringing everybody in the tent. As long as you have 50 million, maybe eventually 60 million people that are outside the tent, it's going to be very hard to provide the care or systems that are going to be needed. That's why it is so crucial to provide incentives to hospitals and doctors and others to be more efficient and effective about their use of resources.

To the extent that health care reform doesn't pass, we don't bring people in the tent, we are not going to have a shot at improving those two big buckets of opportunity.

MATT TOLEDO: *We have a question from the audience. How do we achieve the lifestyle changes that you've been talking about to produce better quality health for Americans when some people have strong reactions against controlling people's lives?*

DAVID FEINBERG: I often say to people that if I had a winning Lotto ticket in my pocket, worth $50 million, but you've got to exercise three times this week, take alcohol in moderation, get some sleep, and don't get too stressed out. Can you do it? Everyone says "Absolutely, yes." And then I say, "If I make it $100 million, will you do it for a month? Let's make it $500 million, but you've got to exercise all year. You've really got to do it." You lose a few people, but most people will do it.

The reality is that at UCLA we treat two million patients here in our outpatient facility. We get five by helicopter every day. We do more organ transplants than any hospital in the United States and likely in the world. We have 800 patients in our hospital every night. And every single one of those, if they had the lottery ticket — and thank God some of them do because they helped us build the building — but if they had the lottery ticket, they would trade it for their health. And it's very clear that that prize is better than anything you can get and there's really clear evidence on that.

Now, I don't want to simplify it to the fact that everybody should walk and eat vegetables and eat fruit because if you go to certain communities, walking and getting fresh fruit and getting drinkable water is a very, very difficult socioeconomic problem. But to me, when we start saying that everybody has the right to health care, I see a lot of people who seem not to have the right to a home and seem not to have the right to a safe neighborhood and seem not to have the right to not be worried that there's bullets flying. If we go to South Central – I mean, we are a hospital, by and large, down Wilshire Boulevard. You can find all of our hospitals. If you go to South Central, the beds per thousand almost don't exist. And we don't even need to start talking about putting a hospital there. We need to talk about the basics of making sure that there's a sense of community and people connected.

This health care issue is not going to be solved overnight. It's not going to be solved with legislation. It's going to be with getting Bert and everybody else like him doing it. It is hard work and there are incentives that we can do that. So how many of us don't speed because you don't want your insurance to go up? You don't not speed when you're driving because you think it's unsafe. Going 80 is fine. I just don't want to get caught because then I've got to pay. And when I do get caught, I'll go to traffic school because that'll keep my insurance down. None of us think twice about eating some terrible fried potato thing. Yet, there's a huge cost associated with that.

We now have at our UCLA wireless health institute technology where we can tell whether you took a pill or not by how many times you opened the cap, etc. We can measure what your weight is at home for congestive heart failure patients through a scale that then tells us this person is not eating right and can potentially lead to another hospital admission. Or what about if we actually told those people, If you do the right things, there is a decrease in your share of cost. And if you don't do the right things, there's going to be a longer wait, a longer line, and you're not going to get the same type of treatment. But, as it stands, there is almost the assumption here that you can do whatever you want. You can drink as much as you want. And if you come to UCLA and you have Blue Cross, we get you another liver. Now, I would love to put our hospital out of business because people took care of themselves.

To me, your good health is the greatest prize you can get. There is nothing better than your health. We've lost a sense of that as a country. Now we are a country of excess. This is a country where we don't care that kids are homeless. We don't care that people are shooting each other. And to me, those things have a dramatic affect on our health care costs. We know that low socioeconomic status associates with increased health care costs. That's the reason we get beat up that Mayo Clinic is cheaper than us. If you exclude the people in South Central and East Los Angeles that are below the Federal poverty line, our health care costs are the same.

So to me, those are the issues that have to be addressed that are not being discussed at all. I think it starts at home. I think it starts with each individual. I'm disappointed that the President smokes cigarettes, that he solved racial issues drinking beers, and that his surgeon general is obese. To me, what are we doing?

MARK COSTA: At Kaiser Permanente, we do have great data in terms of understanding the health of the 3.3 million members that we take care of. And here's some things you might find interesting: Sixty-eight percent of all the costs spent at Kaiser Permanente are with a very small population. This 68 percent have chronic, bi-chronic diseases. Many of those members have multiple chronic diseases. So we talked about how everybody needs to come to the table in terms of payment, in terms of supporting a reform process. What I want to pose is how do we work differently — employers, brokers, health insurance companies, and health providers — to take care of this much smaller population that is chronically ill and that leads to the very highest costs because they will eventually need acute care in one of our hospitals? We really aren't talking today much about how we can work differently together. Part of what that would require is information. Do you know as businesses the general makeup of your populations? Do you know what chronic illnesses your employees have that are leading to a higher risk? What are you doing in terms of who you're working with, the employee, their families, the providers, the insurance companies, to try to figure out how you can turn that trend?

Because it is a trend.

Just like the cost trend is going up, the chronic illness trend is going up in extreme measures. It's scary because it's

affecting our children. When we talk about obesity, it's not of the elderly or the middle aged, it's of our children. Those are going to be costs we are going to be bearing for decades.

So, again, reform, yes. The way it's being discussed as payment reform, it's really the work relationships, the relationships we have with each other to try to change those trends.

MATT TOLEDO: *What advice would each of you have for business owners — both in terms of participating in the dialogue, participating in this debate, but more importantly, in terms of how to manage their costs?*

MARK COSTA: Ask yourself, "What role do I want as an employer with health insurance? Do I want to be active?" Okay. Meaning, do I want to understand the options of the insurance plans? Of course you do. Do I want to understand them from a cost standpoint? Of course you do. Do I want to understand how I can get engaged with my employees in terms of health education and health prevention? Maybe you do. Maybe you don't. I think it's going to be key to understand what role you want beyond simply trying to control the costs themselves because the costs are just a residual of all the underlying pieces of the health care system and the health or illness makeup that we work with.

RICHARD JACOBS: I think Mark's advice is

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'What businesses can do best is really demand value, which is to get low cost care that is of the highest quality, the same way you buy steel, and it should be delivered conveniently, it should be patient-centered.'

DAVID FEINBERG

'If the answer to reform is not dealing with the health of the population or not dealing with the waste, but just lowering the prices that health care providers receive, then for doctors and hospitals, it could be disastrous.'

RICHARD JACOBS

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the best. I would just add that this is a rare opportunity around the health care reform debate or health insurance reform debate, whatever you want to call it, and I would like to hear more from you as to what you think will work for you and to be engaged in the debate. There is so much misinformation out there. It is really distressing. But I think whatever side of the political spectrum you may be on, if you're interested in trying to help solve this problem, try and get engaged and try and work through all the misinformation that's out there about what's going on.

And that misinformation is coming from both sides of the aisle. Please don't infer that I'm suggesting otherwise. But I really appreciate everybody in the room taking this issue as seriously as you possibly can and participating in the political process.

MATT TOLEDO: *Terry, what are your thoughts relative to your advice for business owners on how to deal with the cost issue?*

TERENCE CUNNINGHAM: I don't want to be repetitious, but one topic I do want to bring up is that I think there will be an extremely serious tacit problem to take care of the people that need care that are not getting care now. We talked a little bit about bed closures, etc. I run a pediatric hospital. In the past ten years in Southern California, 840 beds closed. You have hospitals now that are near 100 percent capacity on taking care of kids. And it's going to grow worse because there's so little money in health care. The reimbursement rate for kids, Medi-Cal, is second worst in the nation here. Therefore, people are leaving, beds are closing.

In the next couple of years, the pediatric population in California will be 30 percent. So we're talking about huge portions of society. The primary care physicians are on the low end of the reimbursement spectrum and many of them are not interested in getting further reductions in the Medicare payments as they go forward.

So these other factors are important, but I hope health care reform is not setting up false expectations of "I've got an insurance card, I can get anything I want." It's not going to happen. It's got to be part of the formula that is worked out so that we have balance.

MATT TOLEDO: *Dr. Feinberg, your advice for business owners as it relates to controlling costs?*

DAVID FEINBERG: Part of me says that businesses should run their business and do their best to stay out of health care. We are the health care providers. And what businesses, I think, can do best is really demand value, which is to get low cost care that is of the highest quality, the same way you buy steel, and it should be delivered conveniently, it should be patient-centered, it should be such that it gets people back to work. But you don't want to get into our business. It's a crazy business. I do think you really want to push the value question. And I think when businesses have pushed that value question in the past, we've seen some great steps forward.

MATT TOLEDO: *Are you concerned about how the reform will impact your ability, your business as a business, or is it just a case of "I'm going to wait and see what happens and I'll deal with it when it gets here?" What is your biggest concern about this whole thing?*

RICHARD JACOBS: I think we are concerned as an industry because right now it's hard to predict which way it is going. Under the guise of payment reform, which is so importantly needed, as Mark described so well earlier, I think it can also mean something else. It could mean substantially reduced payments to the hospitals and physicians. The system is at capacity right now. And the potential for enfranchising so many more insured, the fact that we're getting older as a society – I think we have a significant capacity problem. And if the answer to reform is not dealing with the health of the population or not dealing with the waste, but just lowering the prices that health care providers receive, then for doctors and hospitals, it could be disastrous. That's one of the things we're trying to be mindful of.

Thankfully, there is a lot of innovation going on around ideas for payment reform that Mark talked about that I think can provide the right incentives. But it is very tempting, especially in the Medicare program, to solve their budget problems just by lowering the fees that go to doctors and hospitals. That's not reform at all.

MARK COSTA: A big part of what we have to watch — and we are at Kaiser Permanente — is that there will be a new population that could have access, just like all of us in this room. They'll be able to have a primary care physician, they'll be able to have a front end of the health care system. There's over two million people that don't have that today in Los Angeles. So within Kaiser, we need to look at what our capacity is.

What we would hope is that there will be less demand in our emergency rooms, but we're going to need more capacity at the front end. So how we're expecting upwards of half a million people that, with health care reform, can suddenly access Kaiser Permanente, we need to plan for that so that we can deliver on the promise that people are going to be in the front end and we'll be able to avoid the back end.

DAVID FEINBERG: The biggest issue that is facing us, and I think it is a local issue and that it's really important that we're here at the table having this discussion, is the issue of health care cost variation. There's a thing called the Government Dartmouth Atlas that President Obama walks around holding. This Atlas shows that if you die and you're a Medicare beneficiary in the last two years of life, it costs you about $50 million at the Mayo and $93 million at UCLA, and I'm sure at Cedars it is another one of those very highly expensive places. So that's what they're saying. That if we took that money — that wasted money at UCLA and Cedars — and put it to care, we could take that money and now we could insure all those uninsured people.

Problem is that that data is very, very flawed. What they tell you is, first of all, the only outcome is death. We've engaged with the other five UCs and with Cedars and are just publishing a study now and we're looking at things other than that – because there are other outcomes in health care other than death. We're looking at congestive heart failure patients, how they came in. One of our hospitals that's held out of UC Davis has a very, very low-cost provider. When you put us all, the six of us, five UCs and Cedars, in the health care variation — and you're not just looking at death, the cost numbers become much, much, much smaller and it actually shows that in terms of expense, Cedars and UCLA had even better outcomes. So maybe spending more is actually associated with better outcome, which is then an interesting question that society has to answer: Do we want to spend more?

But talking about waste and redistributing money to places like Minnesota – to me, this is the one that keeps me up at night. It's a very different market here. To build a hospital in California, it costs 35 percent more than it does in Arizona because of the seismic standards. We have a higher percentage of people that are living below the poverty line than anything we've seen in northern Minnesota. We have nurse ratios — we have legislation that requires us to run at certain levels. So it artificially drives our costs up. And then

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HEALTH REFORM ROUNDTABLE

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if you look at things like commercial insurance where we have great penetration from managed care in Southern California, our commercial costs are less than they are in places like rural Minnesota.

So the notion of taking money from UCLA and Cedars and New York Presbyterian and giving it to Geisinger and to Mayo Clinic, is very short-sighted because, really, most of that money is going to care for those uninsured people that are coming to us that are more expensive to care for that aren't showing up in Rochester, Minnesota. That's the issue, to me, that is very frightening. I think the best thing that we have is the American Hospital Association — headed by the chief executive officer of Cedars. He's in the tent and really understands this point. Otherwise, what we will end up seeing is these expensive urban areas getting beaten up on – and having their costs required to be dropped to help cover others. So to me, it's more complicated than the Newsweek article that says, "if we just shifted the money, everything will be okay."

MATT TOLEDO: *We're starting to run short on time, so I'm going to ask the panel one more question. I'm going to make it a "twofer," but if you could answer these two questions, I think it would be very helpful in terms of getting our minds around this health care reform debate.*

There is a lot of confusion about health care reform and some misinformation. What would each of you say is the most reliable source of information regarding this discussion and this debate? And the bundled question is, do you believe we'll have reform legislation signed this year?

MARK COSTA: It's tough to answer the first part of your question — in terms of "most reliable." I think it's about listening to everything because there are so many stakeholders and everybody has accurate information, has timely information regarding where they are coming from. I think it is important to get involved and stay involved. Talk to as many of the different stakeholders as part of the health system as you can. Talk to your brokers, talk to your insureds, talk to health care providers, talk to physicians. It is their livelihood and it is safe to assume they are staying on top of it.

Will there be health care reform? I personally think there will be some form of reform. Will the magnitude of it change the way everything looks today? I don't think so at all. I think we have to have some kind of payment reform to change the way that health care is paid for. I also think the portability issue is a very frightening one for patients — that you could lose your health care either through a job loss or just simply having an illness and being totally exposed. I think that part of health care reform has a good chance of passing, though, yes.

DAVID FEINBERG: I'll pass on the first part of the question because these days it is hard to even know what "reliable information" is.

Will there be reform? I think we'll see some reform around the edges. I think we'll see where people won't get dropped with pre-existing conditions. I think we will see that there will be portability, and they'll probably beat up the Medicare structure. That's my guess of what will happen in this round.

TERENCE CUNNINGHAM: I think we will find some degree of health care reform take place this year. I would say at least an 80 percent chance. Hopefully it is a very small step. Hopefully there's some demonstration projects rather than an "all-or-nothing" situation. But it is coming and I think we will all be impacted.

For accurate information, read a variety of publications, journals, your own associations, business associations, et cetera. There's a lot of voodoo economics that comes out. There's a lot of rancor, too. There's a lot of untruths, etc., that are taking place, and you've got to try to read between the lines. Ask those that are in the health profession, whether physicians, administrators, nurses, etc. They have some insights that politicians don't have and vice versa. It's unfortunately a very complex subject we cannot cover in one hour, or one year even, but it's going to impact us all. So the better informed you are and the better your business is informed about the impact, the more prepared you will be for the future.

RICHARD JACOBS: There are, unfortunately, very few places that you can get good, balanced information about health care reform, and I'm not sure I can suggest any, but I did learn of one new one last night. I was watching Sports Center and the reporter was recapping some of the NFL games and he said, "That quarterback's play had more holes in it than Obama's health plan." So everybody is into the act. What can I tell you?

We will have some form of health reform though, I'm convinced of that. In some form.

MATT TOLEDO: *Thank you for investing your time with us this morning. Please join me in giving a round of applause to our terrific panel!*