



Health Care Reform: What is it all about?

A view from the front lines: Health practitioners, insurers, employers

Speakers:

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Reginald BULLOCK Jr., Esq.—Senior VP and General Counsel, Nassau Health Care Corp.
Stephen LYNCH—Former President of Health Plans for Health Net, Inc.

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**transcript not reviewed by the speakers*

Crossroads: Good evening, my name is Molly Poole. I am a medical doctor, and I would like to welcome all of you on behalf of the Crossroads Cultural Center. I would like to thank our co-sponsors: the Columbia Catholic Ministry and the MED Conference (we will tell you a bit about the MED Conference after our discussion).

We are very pleased to have with us tonight a distinguished panel of speakers who will help understand better what practical consequences we should expect from the new health care law and its implementation. To a large extent, the debate on health care reform has been shaped by "experts," both from the academic world and from various think-tanks and professional associations. The idea behind tonight's discussion is to ask a group of experienced professionals whose work is related to health care how the new law will concretely impact their work, and the health care system in their areas of professional expertise. As a general rule, experience is the best immunization against the temptations of ideology. In the case of health care reform, these temptations include both the utopian conviction that this huge social problem can be solved by technocratic means (i.e. government action) and the opposite prejudice, namely that nothing good can come from governmental intervention in the health care system as prescribed by the reform. Rather than joining this sterile ideological struggle, we want to listen to those who will deal every day with the effects of the reform, as the best way to learn what we should realistically expect.

It is now my pleasure to introduce our speakers.

Stephen Lynch spent 25 years working in the health insurance field. He was most recently President of Health Plans for Health Net, Inc., having retired in February 2009. In this position, he had full responsibility for Medicare, Medicaid, and employer-sponsored health plans in Oregon, Washington, California, Arizona, New York, New Jersey and Connecticut. At the time, these businesses provided health benefits for about 3 million individuals. Prior to that, he served as President of Health Net of California and President of Health Net of Oregon. He also held leadership positions at PacifiCare of Oregon. He has served on the Board of Directors for the Oregon Medical Insurance Pool (chairman), California Association of Health Plans, Los Angeles Free Clinic, Oregon Symphony, Foundation for Medical Excellence, and St. Vincent de Paul Society of Salem Oregon.

Dr. Alan Astrow has been Division Director, Hematology/Oncology at Maimonides Cancer Center since 2005. He treats patients with a wide variety of cancers, but has a special interest in the treatment of breast and gynecologic cancers. Dr. Astrow is widely published in the medical literature, has been a frequent participant in the popular Breast Cancer Update recorded audio conference series, and is a member of the New York Metropolitan Breast Group and the New York Gynecologic Oncology Group. Dr. Astrow has also conducted research and run seminars on ways to help physicians understand the values, needs, and wishes of patients, and

how to improve communication between physicians and patients. He is included in New York Magazine's list of Best Doctors in New York and the Castle-Connally Guide to Top Doctors New York Metro Region.

Reginald Bullock Jr. was appointed as the General Counsel and Senior Vice President for Legal Affairs for the Nassau Health Care Corporation as of June 2, 2008. Mr. Bullock is responsible for overseeing all legal matters that affect NHCC operations at the Nassau University Medical Center, the A. Holly Patterson Extended Care Facility, and the Community Health Centers. Prior to joining Nassau Health Care Corporation, Mr. Bullock was a Senior Associate General Counsel and Assistant Secretary at the North Shore-Long Island Jewish Health System from September 2000 until May 2008. While at North Shore, Mr. Bullock advised health system entities on general corporate law, real estate, corporate finance, corporate governance, healthcare regulation and exempt-organization issues under State and Federal law. Mr. Bullock was admitted to practice in the State of New York in March 1990 and in New Jersey in June 1991.

And now we'll begin with Mr. Lynch ...

Lynch: Thank you, Molly, and I'd also like to thank Crossroads for sponsoring a night like this. I think that health care reform has been managed by insiders. I'm not an insider anymore and I'm only representing myself, so I know a lot about how insurance works, but I want you to know that my perspective is personal.

I have a hard job because I'm supposed to describe this health care bill to you, this law that we have now in about five or ten minutes. It's 2,300 pages. We expect the rules to be 20,000 pages. It will take place over the next six or eight years in terms of implementation, but ten minutes ought to be enough! It's potentially boring, so I'm going to try to be provocative as well as informative, so if I provoke you, I'll be happy, which at considerable risk, if anyone's ever heard me speak before, I only have one story, but I have to tell it every time because it's appropriate every time.

I spent ten years living in Ireland before moving to Oregon. I was once lost on the back roads of County Kerry. If you've ever been to Ireland, County Kerry is a very distant place, and I was lost and I couldn't find my way back to Dublin, and I drove around looking and looking for the roads, and I could find nothing. Finally I found a farmer who was standing in a field, and he was across the field a little bit from where I was, so I got out of the car, I had to climb over the gate, I walked across the field, and of course he makes no move toward me whatsoever. When I get to him, I said, "You know, I'm lost. I'm looking for the road to Dublin." And he looked around and he looked at the sky and he looked at the trees, and he turned back and he said, "You know, if I were going to Dublin, I don't think I'd start here at all." And that's kind of the way I feel about life in general, but I certainly feel that way about health care. If I were going to reform health care, I wouldn't start with what we have. But that's what we're going to do; we're going to start with that.

March 23, 2010, an auspicious date, the President signs into law a bill. The bill was not read by all, not understood by very many, and passed with enough votes so the President signed it. A week later they discovered some things they'd like to change, and so they did a reconciliation of that. Over the next years, there will be guidance coming from a number of government agencies—Health and Human Services, Department of Labor, Treasury, the IRS, the Center of Medicaid and Medicare, and also some new offices that have been started up. One is the Office of Consumer Information and Insurance Oversight. It sounds like an exciting job. There'll be more that will be started up as we get on.

So the question is: What is the purpose of this law? The stated purpose is really pretty simple. It's to reform insurance and it's pretty noble in its aspirations first of all to improve access to insurance. Now this is not access to medical care, and it's really important that you understand this right through. This law is really mostly

about insurance and just a little bit about medical care, but because insurance pays for medical care, it'll have an enormous impact on medical care over time.

So the first thing—improve access for the uninsured. Who are the uninsured? There are 45 or so million uninsured in this country which is a large number of people, and it's a very shameful situation, but they're not all in dire straits. Some of them are college students finishing college, going on, not got a job yet. So any time you count the uninsured, you have to take a snapshot in time. Although the number may not change, the people do change. So it's not all the same people. Some of it is people in transition—from college into the work place, some people between jobs, and different things that make them uninsured at a given moment in time. There is not really a big problem with the very poor. The very poor have Medicaid and they have other programs like that that are available to them. It's the working poor whose employers don't cover them who are really the bulk of the uninsured who wish they were insured. There are also the people they call "uninsurable." So they have some condition which makes them less likely to get coverage because there is not a risk of care, there is a certainty of care needed. Those people are typically covered in state insurance pools. I was a chair of one in Oregon, and participated in one in California, and it's a state by state, and it varies significantly from state to state. Also a large number, between 10 and 13 million of this 45 million are the undocumented people in the country. And this law, you need to know right from the get go, is specifically excluding those people. So this law specifically excludes the undocumented, and it doesn't even address what will be done with that population should they seek medical care.

The second thing this law was going to go after was reducing costs. The way they talk about it, it seems to be about the cost of insurance policies. There's an important thing you need to recognize here—this isn't going to happen; it's just not going to happen. It's impossible to put on, you name the number—30 million, 40 million new people, and not have the existing people not pay more. It's not possible. There's pent up demand and there's medical inflation. And the medical inflation is what will keep things going. Last week Novartis announced that they have a new drug for multiple sclerosis which costs \$4,000.00 a month. You would not say "no" to somebody who had MS if they wanted that drug. I wouldn't say "no." It's a legitimate drug; it helps them; it gives them good quality of life; it's \$50,000.00 per year and they can't afford it. Someone else is going to have to pay for it, and that someone else is the pool of people who are insured. That's how insurance works; it's a pooling concept. So this notion that they're going to reduce costs is a complete and utter impossibility. It's not going to happen. The only thing they think they might be able to do, which is the way they started to talk about it as it was being passed, was what they call "bend the trend." So what they talked about doing was reducing the trend of the increase of insurance costs. So that's a less noble aspiration, but it's possible to do that, but you hear stories of people getting 20% increases in insurance right now, so they'll call success potentially 7% to 10%. But that's a lot of money every year on a high number to start with, so recognize it.

The last thing was really to protect patients from insurance companies. Most of the things that they've done, in my view, address the problems that most people were concerned about or are concerned about regarding perceived abuses by insurance companies. I would tell you though that for the most part if you looked at, which I used to do on a regular basis, what your customers are telling you about how they feel about you, anywhere from a low of 80% to a high of 90% are highly satisfied with their coverage. So people who are covered are generally okay, they're generally happy, and people who are not covered are generally not happy, and that makes sense.

So the question in terms of this is: Is it going to really fundamentally change? But like I imagine would happen if you pulled a thread off of a sweater, and you pulled it and pulled it and pulled it—the whole thing comes unraveled. When they looked at this, these are three very basic things. You don't need to change the world to fix these three things, or to deal with three things to the extent that they were dealt with. But they said, "While

we're at it, let's not waste the crisis." And they went after everything. They reformed existing rules. They created a new idea called "shared responsibility," which we worked on with Schwarzenegger's office in California. I worked on that personally. This notion got into the national legislation, and it means that every person has a responsibility to the rest of society to buy insurance for themselves. That's what this means. Starting in 2014 you must buy insurance or you will pay a penalty. And as it goes on that penalty will be up to 2.5% of your income. This is where most of the states' attorney generals who are suing the Obama administration, this is the issue. They don't believe that the government has the authority to demand that people buy things and then penalize them if they don't. This is a controversial part, but it's absolutely in there.

They also created new insurance models, new care models. It's like if you had a Honda from 1995 and you went and bought a Honda made in 2000. It's still a Honda. It's still essentially the same thing. It might have a couple different things. These new care models and new insurance models are essentially the same thing with new stuff on the edges.

There is the idea of subsidizing people for buying insurance. This all takes place in the form of tax credits. So for the lower income people that can't afford the insurance, they're offering tax credits. Well, a lot of times the lower income people who can't afford insurance aren't paying taxes, so they still get to pay the increased premium, but because they pay no taxes they can't get the subsidy. So there's a little bait and switch that's going on there. But it's available for those who qualify, but it's all in the form of tax credits.

There are new fees, new taxes and new penalties. I won't go into all of this, but there are, depending on who you are and what you do—all the stakeholders in health care will have new things to pay.

There are also fraud and abuse guidelines for providers. There is an estimation that Medicare spends between 10 and 15% (it depends who you talk to) of its total expenditure on fraudulent claims. So these would be physicians mostly, but providers who would bill Medicare for something that didn't really happen. In fact, in California they uncovered one where they were paying people to come from Connecticut to California. The whole family would get a paid trip out. They would harvest organs from one of the family members to sell for transplants, and the rest of the family would go to Disney Land, and then they would bill Medicare for a procedure. It got uncovered and got quite a lot of press in Los Angeles. But you didn't have to do much. They already have fraud and abuse guidelines. You don't have to create a new world in order to cover this stuff. You could just enforce the laws and go after it a little bit more strongly.

There's a ton of new data reporting and data collection requirements on both insurers and physicians and hospitals. I don't think the provider community has really seen these coming, but they're out there, mostly in 2014.

They want to reform the payment system for Medicare entirely, make it on a different basis. They will also expand eligibility for Medicaid. In some states you have to be at 100% of the federal poverty level. They're expanding that to 133% of the federal poverty level. Some states, the states I'm familiar with, are already beyond that, so this will be moot for them. And they're going to change the payment for Medicaid providers and make it into Medicare payment. My colleagues will speak to this, I presume, but Medicare or Medicaid, it doesn't matter; they don't pay the cost of care. Neither one pays the cost of care, so the way that providers have typically made it work is that they get a better payment from the commercial insurance population that is over and above the cost of care, and it nets out to paying for the cost of care. Also there are some new government bureaucracies to oversee health care.

So you can see how broad this is. I've really talked about market reforms for the most part, but it gets into just about everything. There are some quality provisions and so on, and there's quite a bit about the public programs that they intend to change.

The interesting part, the thing that I think is most interesting anyway, is that in terms of timing some things have already happened as of September 23, 2010, which was six months following the enactment of the law. So these things got a little bit of press, not too much. But now you can have no pre-existing conditions for children. You can't say to a child applying for insurance who is already sick that you wouldn't cover something for the first six months. That's kind of what that language "no pre-existing condition exclusions for children" means. You can add dependents to your coverage if you're a parent and you have a child age 26. When I was 26, I didn't think of myself as a child, but if you're a dependent age 26, you can be added to your parents' policy. I guess that's good for those just graduated from college who don't have work yet, to get coverage that way. Once issued, policies cannot be rescinded except for intentional fraud.

Health insurance companies have to spend a minimum of 85% of the premium they collect on medical care, and 80% for individual policies. This is kind of where it's at today. I think the health insurance lobby won this one. This is not a significant change and this is why I say to you that I don't believe they can reduce costs because the costs they're talking about are 15% of the dollar. So you can keep that 15% flat or reduced. If you don't do something about the 85%, nothing's going to change. The costs will continue to go up.

There are no lifetime dollar limits allowable, and patients would no longer have to pay for preventive procedures. Most of these recently enacted changes increase costs. They don't increase costs a great deal, but they increase costs because someone has to pay for all this stuff. And the way insurance works, just so you're clear, is that they get a cost and they pass it on to the consumer in the form of premium. Insurance companies don't make money; they don't print money. They take money in, and they send money out, and they keep a lot. And they keep a lot for two reasons: One is for profit, and that's the way it is. Even if they're not-for-profit, I've worked for not-for-profit companies, they keep it. It's just called "margin," not "profit." And the second reason is they keep it for reserves. So the way that these companies make their living is by taking risk, and if they take risk and they lose, in other words, they spend more than they took in, if they don't have some money in reserve, they're out of business and all that money is gone, and nobody has any coverage. So every state has regulations about how much you have to have in reserve, and it's substantial, it's a significant amount of money that you have to keep in reserve.

Here's what's going to happen in 2014. This is when it really happens, and I would at least make the point that 2014 is an interesting time—two years after the presidential election, and two years before the next presidential election. This is not an accidental date. It could've been 2013; it could've been 2012; it could've been 2015. This is a selected time and it's political in its base. Here's what's going to happen. This is where the big changes will happen. All applicants must be accepted. It's called "guaranteed acceptance by insurance companies." So there will never be anyone who is told, "You are not going to get coverage." There will be new premium rating rules. Now every state has rating rules for individual and small groups. Every state in the country has rating rules. They are going to standardize these across the country. Every time you standardize something, there are some improvements and some worsening in that in order to get to some average. And there will be improvements or worsening depending on what state you're in.

But insurance companies will be able to rate for four characteristics only: age, family size, geography, and whether you're a smoker. Now, the only reason they could do this anyway is because medical costs would be different depending on the circumstances. So they're basically saying age, because older people need more medical care. Fair enough. So older people will pay more than younger people. Family size—instead of saying a

single person should pay the same as a family of five, they're basically saying your family size can change. The amount of people means more cost. These are very logical things. Geography—much of medical costs in this country is an accident of geography. I've seen too many states—I've seen states where the hospital costs were very low on a per-day basis, but the length of stay was enormous. New York is like that. Los Angeles the cost per day is enormous, but the length of stay is very low. It comes out to almost the same number. It's interesting. But geography matters as well. And smokers, if you're a smoker presumably some day in the future you're going to have higher costs. You know it's interesting, they don't have gender on here, but a 20-year-old male and a 20-year-old female have totally different health care costs because the 20-year-old female could have a child and the child could require neonatology, and that's different because that 20-year-old male probably just has an accident. That's probably the only reason that 20-year-old male goes to get care. But those are blended and these are not. It's just interesting how some things survive and some things don't survive in the political process.

The next major reform starting in 2014 is risk adjustment, and this means that if insurance companies lose a lot of money, they are going to be repaid by the government. They are going to be reinsured by the government. And if they make money, they are going to have to pay the government. It's a very interesting concept. So there's no incentive to make money, but there's an incentive to lose money and get repaid, and in the meantime have a lot of money in the bank to get interest during that time. Do you see how that would work? It's very devious.

Insurance exchanges will be implemented. This is what Massachusetts has already done. It's a formalization of a marketplace. It creates everything in one place. I personally don't think it will change very much. You also have some new plan options and some required benefits. The last two are the ones that I think are meaningful: You have to play or pay. You have to purchase insurance if you're an individual, or you have to pay a penalty, and if you're a small group, you have to offer insurance or pay a penalty.

So what does all this mean? Here's what's going to happen. Insurance costs will increase for those who are currently insured. Everybody knows this. Every politician who has worked on this, knows this too. And what they are afraid of is sticker shock. They're afraid that by putting so many new people in the system, the costs go up so much that there is a revolt which is seemingly happening by the people who already have insurance who have played by the rules, and now are not rewarded for that; in fact, they feel penalized. But the costs will definitely go up. There will be some subsidies in near term that will mitigate increases for some, not for all, and again it's in the form of tax credits. There will be access to insurance regardless of health condition, which is a good thing. There will be increased taxes or fees for certain different people in all categories, but for certain employers, certain individuals, certain providers, pharmaceuticals, and insurers, there will be reduced insurer risk and there will be reduced insurer profit. And so if people are against the notion of profit, that's probably not a bad thing, but that's the business that insurers are in. I'll talk about this in a minute, but this is going to make them more in the business of administration which is more like the utility, which means you do a lot so there'll be consolidation of companies, get a big volume of people, and you make a little bit of money on each person as opposed to the potential for a big gain or the potential for a big loss, which is the way insurance typically works. There will be increased access to Medicaid in some states as I mentioned before. I mentioned fraud and abuse. I think there could be some administrative efficiency gained by insurers, but if you're looking at this systemically, so the insurers save a little money on their efficiencies, the government adds new agencies—I think there's no change; it's just moved from one place to another, and I think that's also true about clinical quality and efficiency. I think there's the possibility of some clinical quality and efficiency gains, but the data collection and reporting will be a lot.

What won't change? The cost. Increasing the number of insured people will increase (not decrease) the cost. Insurance versus pre-paid health care. Insurance is taking the risk for unforeseen circumstances, unforeseen occurrences. That's what it is, right? You don't try to die to get your life insurance to pay off. You don't drive a car into a tree to get your car insurance to pay off. Health insurance used to be about catastrophic stuff. It used to be if you had some major thing you'd never be able to afford, you had this insurance thing that would cover it. It morphed over time and has become more of a pre-paid health care. That's what HMOs typically do. And the idea around pre-paid health care is that it's budget-based. So this is what countries who have socialized health care do—they create a budget and they fit within that budget. That's how they live. And this is where you start to move away from insurance. All the tools of insurance have essentially been taken away and you're now into this idea toward pre-paid health care. It's not that it's a bad idea; it's just a different way of doing it. But the costs are going to be essentially the same.

And the next point I feel strongly about—health care will continue to be rationed. It is rationed today and it will be rationed tomorrow. It's rationed today by insurance companies making choices about who is covered and who is not, by deductibles, by limits, by this, by that. It's rationed. It will be rationed in the future by “we need to have fewer MRIs...we need to have fewer this or that,” and what happens is you get into the notion of rationing by waiting lists, and rationing by this idea that has become a battle cry by those who oppose this of death panels. What they mean is care will be rationed. Care will not be allowed to somebody who does need it. It happens today; it will happen then. There is not a system in the world that does not ration care in some way. It's just how you choose to do it.

Managed care, which is a bad word in some places, and population health management, which is stuff like disease management of diabetes, these are population-based things; these will increase, and I think from the providers perspective they'll have more oversight by the governmental programs.

The last point, this whole reform did nothing about the tort system. So the malpractice lawsuits against providers will continue to be excessive under this system. It was not even brought up and discussed in a meaningful way, and it's certainly not part of the law.

So, in summary, I think the patient-physician relationship is really at the heart of health care. And for me, insurance companies will find some stuff, but I think we really need to reform the heart of the system. I don't think this is really about working the edges, which is my view of what they've done. Too often I think this system treats a patient as if he or she had no humanity at the moment of vulnerability. So at the moment, when a patient most needs to be cared for, we get into population health or systems or something like that. And I think right now we're piling new rules, new schemes on top of old ones. And I think there's a vain insistence that the original idea of insurance has merit. It's a questionable idea to me. It's possible it has no merit at all. Or perhaps it's in the category of “too big to fail.” But whatever, we are not fundamentally changing the system with this reform. It's not a fundamental change. And it's a lot of over-engineering that will create some new business opportunities in the crevices, so the stuff that falls down, they'll be new business opportunities, particularly for insurers, but in the end I think we need to ask ourselves if this reform, if this system provides sufficient comfort, sufficient healing to people who are sick when they're sick.

Thank you.

Poole: Now we have Dr. Allen Astrow.

Astrow: Thank you. You've heard the outline of the Health Care Reform Act, and I'll try and speak a little bit from my own personal perspective as a physician, and also try and fill in a few more details of the actual bill.

I am the chief of Hematology/Oncology at Maimonides Cancer Center in Brooklyn, but I speak only for myself. I don't speak for the institution. I would say that most physicians are skeptical of or even opposed to the current health care reform. Physicians tend to be fairly conservative. Most physicians were opposed to Medicare. Physicians have been opposed to national health insurance for decades, but this bill actually was supported by the AMA and was supported by the American College of Physicians. Most of the information I'm going to tell you about the bill I got from the American College of Physicians' summary of the bill.

I'm currently the chief of Hematology/Oncology at Maimonides, but before I was at Maimonides, I was at St. Vincent's Hospital in lower Manhattan. I spent almost twenty years at St. Vincent's. Something of my experience comes into play. St. Vincent's, as most of you know, closed this past year. St. Vincent's was a vital community facility, and it closed because it couldn't pay its bills; it went bankrupt. These issues are really crucial. There's now a section of lower Manhattan where there is no hospital. Yes, you can go to Beth Israel or you can go to St. Luke's Roosevelt, but St. Vincent's is no longer there. In my experience, St. Vincent's had a unique ethic of care, and that ethic of care is gone from the city now. So these issues are very important and they are life and death issues.

At Maimonides in Brooklyn, roughly 75% of our patients are insured by either Medicare or Medicaid. Medicare is health insurance for people over 65. Medicaid is health insurance for people who, in New York State, their income is less than 133% of the poverty limit. We are a private hospital but we're getting 75% of our money from public sources. In addition, we provide a lot of uncompensated care. We are in a part of the city where there are many people who are in the country illegally—however you want to refer to that group of people—undocumented, illegal. From the point of view of a hospital, there is no way of getting paid for the care of those patients, and we provide about 25 million dollars a year care that we don't get paid for. The reason why that's important is if you don't get paid for the services you provide, you can end up closing. That's why hospital administrators lose sleep. They have to figure out how they can pay the bills. They have to pay the doctors, nurses, the electric bills, and all the other issues that come up, and there is a lot of undocumented care that is provided.

Another fact that people need to know is that roughly 10% of the population spends 65% of all the health care costs. So most health care costs are spent by a relatively small percentage of the population. Why is that? Fortunately, most of us are well. In fact, I see we have an audience here largely of students, so if you're a student and you're young, fortunately, for the most part, you're going to be well. And many young people go without insurance, and then it becomes a problem because you can get sick at any age, although the odds get greater as you get older. But you can get sick at any age, and many people who are younger take the chance, and it becomes a problem because people need care and have no means of paying for care.

As an oncologist, one of our issues is the cost of the care we provide is very, very expensive. So for example, there are new drugs becoming available every month that are potentially life-saving. The drug Herceptin, which is a drug for breast cancer, became available approximately ten years ago. One year of that drug costs at least \$50,000.00. Another drug, Avastin, also 50 to 100 thousand dollars per year, and if we want to improve cancer treatment, we need to come up with new and better medications. In order to come up with those medications, the companies that develop these medications want to have an incentive to develop them, so they want to make a profit. And any time they come up with a new drug, they charge a lot of money for the new drug. That's one reason why the cost of care keeps rising.

Just this past week, a patient of mine with ovarian cancer came in complaining of pain. I sent her for an x-ray; unfortunately the cancer had spread to her hip bone. It was a very troubling event for her. I had to tell her this. But she's in tremendous pain. I sent her down to our radiation oncologist for radiation to that area, and

discovered she had lost her insurance. So the care is going to be provided, but no one is going to get paid for this, and it creates a big problem. I've had patients who need PET scans, CAT scans for cancer, they've lost their insurance, and the radiologists don't want to do the scan. So the question about how you're going to cover people becomes vitally important for the health of the population, and it becomes a major problem for the doctor trying to take care of people who are sick when all of sudden he or she discovers that they have no insurance.

The reason why this bill was necessary are two reasons: One, roughly 50 million Americans have no health insurance. Now globally that's a scandal. Virtually no other country in the world has such a large percentage of the population with no means of paying for their care. The other problem, which has also been mentioned, is that the cost of care has been continually rising, so yes, I think as Mr. Lynch mentioned, the cost of care is going to rise under the Obama health plan. The cost of care is going to rise without the Obama health plan. The cost of health care keeps going up and up. There are a lot of different reasons for that, but it looks as if, if we don't do anything, within the next twenty or thirty years, health care would account for roughly 20% of the gross domestic product. Since the total federal budget is about 20% of the GDP... Maybe Mr. Lynch would know the exact number?

Lynch: 17%

Astrow: 17%. So basically the entire federal budget would be going for health care within the next twenty years. So that's one of the impetuses for this particular bill.

What do we do about covering all the uninsured and what do we do about the fact that the cost of care is becoming unsustainable? How do we keep vital health facilities open? How do we provide care for people who need care? So that's the nature of the bill.

From the standpoint of why the bill took the shape that it took, if you had to invent a health care system, you probably wouldn't invent the system that we have, but I think, as Rahm Emanuel is reported to have said—Rahm Emanuel was President Obama's key advisor, and he has recently stepped down and is running for mayor of Chicago. People complain to him that the bill didn't do enough and he said, "Well, I'm not trying to get a bill through the Brookings Institute; I'm trying to get a bill through the U.S. Congress." So this is the bill that could be passed. In order to get a bill passed, you needed to get sixty U.S. Senators to agree to it because otherwise it would've been filibuster.

So one idea that was proposed at one point, which to me seemed like a fairly good idea, perhaps Mr. Bullock could comment on this one, was to extend Medicare down to age 55. Medicare is basically single payer health insurance to the elderly. In the health insurance plans they take that 15 to 20 percent of costs now of health care, but they're not really providing any care. So from the doctors' standpoint, from the hospitals' standpoint, what the health insurance companies do is take money out of the system and they don't really provide care back. So Medicare doesn't take nearly as much out of the system. The administrative costs of Medicare is roughly only 3%, so for that reason some people thought that a single payer plan would make more sense. The problem is that the single payer plan doesn't deal with any of the other problems that we have—overuse of services, fragmented care, but the administrative costs of Medicare are lower, so one proposal had been to extend Medicare down to age 55. That almost got through, and then Senator Lieberman, who is from the State of Connecticut, a fine gentleman, but many of the major insurance companies are based in Connecticut and he decided he couldn't support that provision, and so that idea disappeared. There's a lot of horse trading that goes on. It's a 2,000-page bill because this is what it took to get it through Congress.

The other issue is why is it that you have mandates on coverage? A student, for example, might think, why do I need health insurance? The likelihood of my getting sick is low. There was an article in *The Wall Street Journal* by Betsy McCaughey saying that basically the Obama health care plan taxes the young at the expense of the old. Young people are now going to be forced to have health insurance. The reason for that is the only way that you can extend insurance to the entire population is if everyone participates in this system. If, for example, you had a system where you didn't have to have collision insurance on your car, but if you wreck your car, you are then entitled to get insurance coverage to replace your car, well, that wouldn't work. You have to have a system in which everyone participates, otherwise there's really no way to keep the costs down for people who are older and sicker. That's the nature of this particular bill. They want to get everyone into the system, they want to cover everyone, so that's why they have mandated coverage.

The other part of the bill that some people might question is: Why do you have employer-based coverage? That's unique in the United States. Your insurance tends to go with your job. That has caused a lot of problems because it's made it very difficult for people who are ill, who have a pre-existing condition, to change jobs. So one provision of the bill, which takes place in 2014, is that if you have insurance from one company, it will be portable. But it's really only in the United States that you have a connection between health insurance and your place of work. You could question that. You could say, why couldn't it just be state-based, geography-based? Again, it had to get through Congress. This is the system we have here and no one really wanted to change it very much, and so we still have employer-based care.

Several changes have taken place already. We've heard about some of them. As of 2010, insurance companies cannot exclude children who have health conditions. I think that's a good thing. You can't deny children coverage. You no longer have lifetime caps on your health insurance. A lot of plans will say, "We'll only cover you up to, say, \$100,000.00." Well, I'll tell you, if you have any serious illness, let's say if you have a serious malignancy, \$100,000.00 is not going to get you very far. So as of 2010, the lifetime caps are gone.

In 2010 you now have tax credits for businesses that have fewer than twenty-five employees. So it's trying to encourage small businesses to cover their employees.

In 2010 was set up something called a high-risk pool. So what happens if you're an individual, and you're not employed, and you want to buy insurance, but you've got some illness; let's say you have diabetes. So it's very hard to purchase insurance if you've got diabetes because no insurance wants to sell to someone who has diabetes. The government, as of 2010, is helping to subsidize state-wide high-risk pools. Mr. Bullock, you probably know more about these terms than I do, so if I'm getting any of these facts wrong, please correct me.

It extends dependent coverage up to age 26. You've already heard that. Up to age 26 you can be covered by your parents' plan.

In 2011, there's going to be a decrease in the so-called "donut hole." This is part of the Medicare plan. Under Medicare, Part B, you have pharmaceutical coverage, coverage for your drugs, but you get coverage up to the first \$2,000.00, then between \$2,000.00 and \$6,000.00, you've got to pay all of it yourself. But over \$6,000.00 you get coverage again. So between 2011 and 2014, that so-called donut hole is going to shrink. There's going to be more and more of a subsidy provided for the elderly to pay for their pharmaceuticals. That's going to begin in 2011.

There's going to be a benefit for an annual wellness visit. Insurance traditionally covers you only if you're sick. So if you want to go for just a check up, you're not sick, generally that's not a covered service, but there's going to be a mandated annual wellness visit, and they're going to be eliminating co-pays and deductibles for

approved preventive services like vaccines; anything that's been proven to be effective, it's a preventive service, there will be no co-pays or deductibles.

The issue of medical liability reform was brought up. I think Mr. Lynch was correct; this bill does very little to address medical liability, and just to give you an idea how this has an impact on hospitals, the main liability cost for hospitals in New York State is on deliveries. There's an enormous liability to deliveries, and hospitals actually do not want to deliver babies anymore. Hospitals are trying to get out of the "business" of delivering babies, and many hospitals have stopped delivering babies. At Maimonides, we have a commitment to deliver babies. We deliver 8,000 babies per year. You walk into the front door of Maimonides Hospital, there will almost always be someone walking out with a baby. On each delivery, the hospital loses over \$1,000.00. Every time a baby is delivered, the hospital loses over \$1,000.00. So that's 8 million dollars per year, and I'm probably being conservative here. So if the hospital were working like a business, what would it do? It would shut its OB floor without question. And most hospitals would like to shut their OB units because they lose enormous amounts of money on this mainly because of the liability that's associated with delivering babies.

So part of this bill is going to be a demonstration grant—50 million dollars for demonstration projects. Well, that's a drop in the bucket. Trial lawyers have a big impact on health care legislation, but there are going to be some experiments with other forms of malpractice coverage.

In 2013 they are going to raise the Medicaid payments for primary care physicians. It's true that neither Medicaid nor Medicare really cover the cost of health care, but if you have regular Medicaid and you go to a private doctor, Medicaid will pay \$7.00 for a visit. That's why no private doctor will take patients who have Medicaid. In 2013, Medicaid payments for primary care physicians (so oncologists will not be affected by this, but an internist, a pediatrician): the rates of payment will go up to the same as Medicare. So Medicare for a routine office visit might pay \$60 or \$70, so that's what we'll be paid for a Medicaid patient.

Finally, in 2014, as we've heard before that's when the main provisions of this bill will take place, coverage will be expanded to 32 million Americans. 32 million Americans who are not currently covered will be covered. 16 million of that 32 million will be covered by Medicaid, and the other 16 million will have some form of private insurance. Medicaid is fairly inadequate coverage, so just from a cancer standpoint, if you look at survival statistics, patients who have no insurance with breast cancer have much worse survival than patients who have private insurance. In addition, patients with Medicaid have worse survival. Now it's unclear if it's their insurance or some socio-economic factor, but Medicaid is substandard coverage, but that's the best the government can do right now.

What's of interest to New York State, New York State has been very generous with its Medicaid coverage. In New York State you're eligible for Medicaid coverage if your income is 133% of the federally defined poverty level. If you live in a state like Mississippi, Louisiana, Alabama, you're eligible for Medicaid only if your income is 25 or 50% of the federally defined poverty level. So far fewer people in those states are eligible for Medicaid. You wonder how poor people get medical care in those states. I can't really answer that question, but we are much more generous in this state. And for children in this state, you're eligible for Medicaid if you have 400% of the federally defined poverty limit. So there's virtually no excuse for any child in New York State not to have health insurance. So what this bill has done is it has nationalized the standard. It has raised all the other states to the New York State standard of 133% of the poverty level. So how does that affect New York? Well, the Federal Government is going to heavily subsidize those states to insure those patients, but we're already at that standard in New York, so we aren't going to get that money. Senator Schumer, at the last minute, got a little bit of extra money thrown into the bill to help New York State, but the hospitals in New York State are very concerned about the implications of this bill for the financial health of hospitals.

Personally, as a physician, I think this bill is a good thing overall. I think having 50 million Americans not covered with insurance is a national scandal. I think it was the best we could do at this time. There are problems that will have to be worked out. The cost of this bill is going to be roughly 100 billion dollars a year. So over ten years that's a trillion dollars. So that has to be paid for some way. One way that they're going to be paying for the cost of this bill is by eliminating certain things like the Medicare trend factor. Maybe Mr. Bullock can talk a little bit about that. What that is, is that every hospital gets an inflation update every year. They are going to eliminate that from hospitals. And they are going to eliminate some other pool of money for uninsured patients. A lot of pools of money that have been helping the hospitals of New York State are going to be reduced and so one concern we have in New York State is that in order to help cover patients in other states where there have been very conservative limits on coverage, the hospitals in New York State are going to take a big hit. Our hospital right now is looking at roughly 3% per year loss in revenue which would come out to roughly 30 million dollars a year. 30 million dollars is a lot of money to try and figure out how to make up. So there are some concerns about how this bill is going to affect all the hospitals in New York State. These things are going to have to be worked out over the next five years as the bill begins to take shape.

But things are happening already. Regulations are being written. It's not as if all of a sudden in 2014 this bill is just going to magically be enforced. Already the bill is having an impact, and more and more aspects of the bill will be taking shape over the next five years.

Thank you.

Poole: Now Mr. Bullock.

Bullock: Good Evening. Today I'm going to talk about the impact of health care reform on my hospital as a way of illustrating the challenges facing public safety in hospitals in the wake of health reform.

In spite of the worries that Dr. Astrow has pointed out for many hospitals in New York, health reform is generally a good thing for most voluntary hospitals in the State of New York. By voluntary hospitals I mean in New York you can only be a hospital if you are not-for-profit, so generally not-for-profit hospitals that are privately run institutions. My hospital is a quasi-publicly run institution which means that our employees are government employees. I'm a public officer of the State of New York and we have nurses and doctors who are also public employees, so effectively we're delivering health care with government employees which I'll revisit at a later point to illustrate some of the other challenges that we have in terms of our cost structure.

What I'm going to do is tell you a little bit about the basic background of my hospital, and what sort of patients it has, the sources of revenue and the general population that it serves. We are a 550-bed hospital; that's a level 1 trauma hospital located in the East Meadow/Uniondale/Hempstead areas of Long Island. What's significant about these areas is that they are large pockets of that geographical location that's designated by the government as medically underserved. You get a medically underserved designation generally based on the income of your population and the amount of health care facilities that are available. Now, as you can imagine, the poorer the neighborhoods, the less likely that health care institutions are going to be rushing to provide services in that area because they are more likely to find patients who are either uninsured, under-insured, uninsurable or primarily on Medicaid or Medicare. So that sort of describes the universe of our patients that we see on a daily basis.

Probably close to 70% of our patients are on Medicaid or Medicaid-eligible, or they are uninsured. We probably get maybe another 15% who are on some form of commercial insurance and those patients I refer to as our "involuntary" patient population. Because we're a level 1 trauma center, what that means is that if there's an accident on the highway or there's a major medical emergency this refers to our emergency room traffic where

the ambulances will take you to the closest hospital depending on what condition you're in. And so those are our involuntary patients. Most of our commercial patients come there against their will.

Our primary sources of revenue are mostly from Medicaid, to a small extent Medicare, and to a smaller extent commercial, and the balance is what we would call "self-pay," or in the hospital we jokingly refer to it as "no-pay." Our hospital has an annual budget of approximately 550 million dollars. So we're a large institution and apart from the hospital we have a nursing home and we have four community health centers or family health clinics that are also in medically underserved areas within Nassau County. It provides primary care to a vast, largely minority population and a largely undocumented population. But of that 550-million-dollar budget, approximately 20% we get revenue from that from something called "Disproportionate Share (DSH) Payments." Now this is a special program that the Federal Government has to compensate hospitals like us that see a disproportionate amount of Medicaid patients or uninsured patients. In terms of patient profile, there are a lot of similarities between patients we see and the patients St. Vincent's used to see, and some of the patients Maimonides sees.

Astrow: We get a lot of Disproportionate Share patients. That pool of money, the Disproportionate Share, we get a lot of that money also. We see a lot of patients who are undocumented.

Bullock: And really that's how some hospitals like ours survive. In a survey done by the National Association of Public Hospitals, it was shown that the difference between surviving and not surviving in terms of profit margins for public hospitals that receive DSH versus public hospitals that don't, is pretty significant. In the negative 10.5 category (NAPH members without DSH or UPL payments) would be St. Vincent's because St. Vincent's provide significant service to the Medicaid and uninsured population, but they were not DSH beneficiaries, which was one of the contributing factors to their declining finances. Even with the DSH payments, we as a hospital still struggle to break even and a lot of times we run on a deficit.

One of the ways in which the new health care bill has been paid for is through a reduction of DSH payments, and DSH payments also apply to Medicare because there are some hospitals that tend to get a disproportionate amount of Medicare patients. As Dr. Astrow pointed out, neither Medicaid or Medicare really covers the cost of actually providing care, and that's why you have to get those extra payments from the government.

In 2014, the bill will reduce Medicaid DSH payments and add for Medicaid to the tune of 14 billion dollars. The way they are going to stage it is, in the first year, there is going to be about a 600 million reduction, and the next year another 600 million, so it's going to be roughly 5% per year. What that translates into for us as a hospital on our budget is roughly 5 to 6 million dollars a year of payment reductions from our own budget. So within the first four years of health reform, we are pretty much going to be down to about 30 million dollars in lost revenue from the DSH program.

What's interesting about the fact that we're compensated for DSH is that when health care reform fully takes effect, a significant portion of the patients that we see will now have insurance. Unfortunately, we've done an informal study of our uninsured patient population, and we estimate that about 70 to 80% of our uninsured population is undocumented. So we're still going to have the bulk of the uninsured that we've normally been getting compensated for from Medicare to take care of, but less of it. And so the question is really at a certain point, what do we do with the undocumented? For the most part, the undocumented are still going to come to hospitals like mine and Dr. Astrow's, but we're just going to get less money for it.

Now the other issue for us with respect to health care reform, and the reason why I've said it's a great thing for voluntary hospitals, is that it's possibly not a great thing for public hospitals. The reason is that basically the

perception of public hospitals within most communities is that “give me your tired, your poor, your undocumented...” and nobody else who has a Cadillac insurance plan actually wants to voluntarily go to a public hospital for service. So in 2014 we’re going to be in the awkward situation of competing with voluntary hospitals for former patients who now have insurance. And in certain ways most public hospitals are unprepared for that upcoming competition and I’ll tell you why in a little bit more.

The other factor that is supposed to help us is the expansion of Medicaid. For most New York hospitals who serve a lot of the Medicaid population, that’s no help because as Dr. Astrow pointed out before, there’s already sufficient saturation with Medicaid. There is probably only about 4% of the New York population left that is eligible but hasn’t reached us yet, and so effectively there’s no additional revenue source for a public hospital from that actual expansion.

We’ve already covered DSH reduction; we’ve already covered the Medicaid expansion and we’ve covered the insurance reform and why neither of those particular prongs is useful to a public hospital because of how we are, so we go to the actual implementation of health reform and what health reform actually means for hospitals and physicians. The way the plan is set up is that there’s going to be an increased demand for primary care physicians (PCP), and there’s an increased emphasis away from in-patient, hospital-based care to out-patient, primary care, and much more of an emphasis on physician practices as well as what we’ve already seen in the last nine months, and I have friends, former colleagues who practice in private firms as well as in other hospitals, and the merger activity or the acquisition activity for hospitals with respect to physician practices and private physician practice has been at a maddening pace over the past nine months. Most hospitals with any reserve cash are going out and buying a lot of physician practices. Why? Because the structure of health care reform is going to reward providers who are in more of an accountable care setting, and they are going to reward providers who are much more networked and can have a wider continuum of care and share risk within a wider spectrum so as to reduce costs. I can’t speak for Dr. Astrow’s institution in that regard, but unfortunately, our institution is woefully unprepared for that. The main reason is because we’ve been a hospital that has been geared primarily to governmental payments or subsidies to provide care to patients that we didn’t have to chase after. These are patients who came to us because they didn’t have anywhere else to go, so we didn’t have the financial incentive to build up a network of physicians who would be feeders of patients to us, to the hospital, because every hospital survives on being able to get patients from physicians who refer the patients to them for procedures. We never needed that because we had our community health centers that would take a certain population, refer them to us, or they came walking into the emergency room, and we took care of them. 99% of our doctors are employed by the hospital and work within the hospital in an in-patient setting, and the same with our clinics. There isn’t the traditional physician office arrangement within our health clinics because nobody really had to go out in that customer service franchise way and attract patients.

Astrow: Who are your competing hospitals?

Bullock: Winthrop, Mercy, the Catholic health system, Good Samaritan...

Astrow: That’s where all the private patients will go.

Bullock: It’s already happening. In fact, even on the OB/GYN side, I would have to say that you are fortunate that you can walk down your hall and see nothing but pregnant ladies and babies because even on that side as a public hospital we’re losing out. We will have a significant number of maternity cases walking our hallways, but we never see the deliveries because invariably by the time they’re close to term, somebody else in the community has managed to convince them, and “Wouldn’t you rather come to the safer environment of Mercy or Winthrop to deliver your baby? It’s much nicer over here. And you have insurance.” Right now managed

Medicaid actually pays a nice sum for delivery whereas for other sorts of primary care they don't, but they actually pay, so it's very attractive for some of the hospitals to actually get these Medicaid patients.

That also has a reverse multiplier effect for us in terms of patient demand because you know the old saying, you treat the mother, you treat the children, and then maybe you'll even treat the husband. We don't get any of that downstream benefit once the mother goes to deliver someplace else. And so these are the competitive forces that are already in operation against us which raises a question of what role is there for a public hospital under health care reform if our sources of revenue and our ability to compete is diminished? But those are the challenges that are ahead for us as a safety net hospital, to be able to now start building physician networks, working with community physicians.

One of the things that we've started to do as a result of health care reform is that we've now gotten involved in an extensive outreach with providers within our area that actually serve a lot of Medicaid patients. We've left the doctors who deal with commercial patients because we know they'll never come to us, so we now focus on the Medicaid providers in the neighborhood. We've worked on and transformed our community health centers into federally qualified health centers and what this does for us is it gives us a bit of a leg up in terms of rates because the FQHC status actually gives you a slightly greater rate than you'd get on your Medicare for primary care, and that will help us in our bottom line, and as a result of that we've actually now gotten the interest of some community physicians who want to get in on the FQHC bandwagon. And so that's helped us in the attractiveness factor.

The other thing that we're trying to do is what our competitors are doing—buy physician practices. But again, we're targeting it with respect to a certain population, and trying to find new and innovative ways to keep the existing population, including the uninsured. One of the more interesting things we've done with the uninsured in order to compete with their affections post health reform is to increase our charity care outreach, but do it in a way that it doesn't feel like charity for them. We have a program called "New Care" where essentially we give the uninsured a health card. It encourages them to use our primary care services or any other services, but it's a branded thing. Although it's meaningless because we're not insurers, it's meaningful in the sense that it gives them instant access. They're already in our system; we already have a history on them, and we treat them as we would treat any other patient with insurance by virtue of them presenting the card. So we're doing different, innovative things like that to hopefully retain some of these uninsured once health care reform comes in.

But it will be interesting to see how we fare after 2014. That's the sum and substance of my talk.

Q&A

Poole: Just to briefly end our discussion, I want to make two very quick observations. My first is a quote from T.S. Eliot who cautioned us that "It is impossible to design a system so perfect that no one needs to be good." That's for another discussion. And the second is that I am really floored by the fact that I know so little about this health care bill and yet I've had no shortage of opinions on the subject for the last several months, and it's really a judgment on me. I had forgotten the simple fact that a reasonable judgment starts from a thirst for facts, and it is reminiscent of my days as a medical resident when I knew nothing and I still had to take care of patients and so I was always going to the textbook looking for more information and asking my friends, "What do you think I should do with this guy with hypertension?" It's that original position where we are hungry for facts that I had forgotten. And this is why I am so grateful to our speakers for offering us what we need most to make a more reasonable judgment on the subject, and that is the facts. So I thank you very much.