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WELCOME:

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Harvard University

ACADEMIC DISCUSSION:

AMY FINKELSTEIN
John & Jennie S. MacDonald Professor of Economics
Massachusetts Institute of Technology

MODERATOR:
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ROUNDTABLE DISCUSSION - ADDRESSING GAPS IN COVERAGE:

ESTHER KROFAH
Executive Vice President of Health
Milken Institute

KYU RHEE
President and CEO
National Association of Community Health Centers

HENRY WAXMAN
Former Chairman, Energy & Commerce Committee
U.S. House of Representatives

MODERATOR:
WENDY EDELBERG
Director, The Hamilton Project, Senior Fellow
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FURMAN: Hello everyone, and welcome to this event for the-- organized by the Hamilton Project on health care. I am Jason Furman. I think I'm a senior counselor or something for the Hamilton Project. I was the director of it about, well, more than 15 years ago, when we did eight different papers on health care — half of them on different models for health coverage, half of them on different models for cost. In that intervening time, there have been a lot of other proposals on health care, and many of them have actually gotten in the bloodstream and helped shape things, including shaping things that had been in the Affordable Care Act. So, we were so excited when we had two great new proposals and things to discuss on health care. And I'll be-- I'm doing the first one now, and don't want to waste any more time, and get straight to it with Professor Amy Finkelstein. So, Amy is an enormously distinguished scholar who won something called the John Bates Clark Medal — that is a little bit harder to win than the Nobel Prize— track record of lots and lots of papers on positive economics, explaining things and trying to understand the world. Not a lot of time on policy proposals. Why did you jump from almost nothing to a whole book and then to a Hamilton brief?

FINKELSTEIN: Oh, you know, it's a great question. And you were completely accurate in describing the 'almost nothing' part. My coauthor on the book, Liran Einav, and I have been — he's an economics professor as well, at Stanford — and we have somewhat deliberately stayed out of policy discussions. We've been working on health economics together for 20 years because, basically, I always said I work on things that I don't know the answer to. If I knew the answer, then I would work on something else. And the impetus for writing this book was that that was always the response I gave when people would say to me, "So what should we do to fix our health care system?" I would say truthfully, "I don't know. That's why I work on it." And at some point, my father-in-law asked me this question, and I gave that stock answer. And he said, "Seriously, Amy, you know, you've been working on this problem for 20 years. You must be one of the world's experts' best places to answer this question." He is, you know, overly generous to a fault — something I will, as an aside, say his son did not inherit, but separate matter — and I'm in favor of being overly generous. But anyways, you know. "You have nothing to tell me really about how to improve U.S. health insurance?" And I thought, "Okay, that's-- when you put it that way, it sounds pretty bad."

And when I talked to my coauthor, he was like, "Yeah, we should have something to say, at least to lay out the key issues and the inevitable tradeoffs." And then once we started engaging in that, which was a very different type of exercise for us, after a lot of thought and discussion and a lot of arguments, we thought we actually had figured out the answer and we wanted to tell more people than just my father-in-law, which is why we wrote the book. And I will say, related to that and true to my word, I don't plan to do more research on health insurance because I feel at least I've solved the intellectual problem and I want to work on health

care delivery and more efficient delivery of medical care where I feel like there's still a lot of unanswered questions.

FURMAN: That's the way I feel about carbon tax research, and I haven't even done any of it.

FINKELSTEIN: That's, that's always the example I give of this. It's a really important problem, but I don't think it's the barriers are intellectual.

FURMAN: And I should have said, by the way, the Hamilton Project version of it is short, readable, and free. The book is a really, really great read, so I'd encourage people to pick that up after you've read the Hamilton Project version. Now, tell us what this proposal actually is — the solution, the answer to this question.

FINKELSTEIN: It's two parts. It's universal, automatic, basic coverage that's free for all patients. And then the option for those who want and can afford it, to be able to supplement that with their own money in a well-designed and well-functioning supplemental market. So it doesn't quite fit on a bumper sticker, but that's as close as an academic can get to a slogan.

FURMAN: And so it's fair to describe this as a plan that looks a lot like Medicaid, except, unlike Medicaid, you can buy something on top of it if you want more.

FINKELSTEIN: I think that's fair. The one thing I'd add is that for people who are currently on Medicaid, for whom presumably they wouldn't-- most of them probably would not top up, it would still be better for one very important reason, which is something I didn't appreciate until we started working on this, which is while attention tends to focus on the one in ten Americans under 65 who are uninsured at a point in time, a far greater number one in four Americans under 65 will spend some period of time without health insurance over a two year period. And when they do, they're often uninsured for a long time. So 50% are uninsured for six months or more. So that's both people with employer-provided health insurance and people with Medicaid who risk losing that coverage if their eligibility changes. Or, as we were just talking about at lunch, they just fail to file the paperwork, even though they remain eligible to prove that they remain eligible.

FURMAN: One interesting thing about your proposal is, you know, when I teach intro economics with you, here's normative, here's positive, you can start with different normative frames and then mix it up with the positive and get your answer. Most of the policy proposals you read in Washington sort of skip the normative stage and maybe assume everyone wants progressive taxes, for example, or everyone wants freedom or, you know, whatever it is everyone wants. You're very explicit about the principles, almost the philosophical principles you're coming from. Why don't you tell us about those? Tell us why that mattered and also how that affects the answer you get.

FINKELSTEIN: It completely drives the answer. And that was sort of-- you know, when my father-in-law posed this question and we started thinking about it, what we quickly came to realize is you can't start talking about a solution until you've defined a goal. And I think this is true of all policy. But because I do most of my work on health economics, you see it particularly there, that people are arguing for single-payer or Medicare for All or health savings accounts, with ever-- without ever articulating what is the goal of this policy. And of course, there are many potential goals. You can want to improve population health. You can want to help low-income and poor individuals. You can want to, as Liran and I had done an enormous amount of work on, fix sort of marketplace malfunctions in the medical market.

You know, you can, you can believe that health care is a human right. You can go on and on and on. We tried to ask the question of, "What is it-- when we look at our history of health care policy and our current policy, what is it that we are trying, if failing, to accomplish?" And what became very clear to us, and as you said, we do spend an enormous amount of time in the book trying to make this argument because we think if we can agree on the goal, then actually the solution is very simple. We argue that, in fact there is a strong implicit social contract in the United States to provide access to essential medical care, regardless of resources.

And while it may seem strange to make that claim, given that we are, of course, famously the only high-income country without universal coverage, and we have a tradition of, you know, individualism and pulling oneself up by one's bootstraps, if you look at our history, if you look at our current policy, it becomes very clear that when we gain salience that there is a group of people who are not able to access essential medical care. We step in with policy proposals and policy patches. And that's part of the reason we have all of this, you know, uncertainty of insurance coverage because there are all these different pathways — you can qualify this way if you're poor with this disease, and this way if you're poor with that disease — and they're all sort of motivated by this. You know, it gains political salience that a particular group, often through it, through well-financed advocacy, you know, is lacking essential medical care. And we put a pact in place for them.

FURMAN: Great. So I wanted to sort of go a little bit deeper on understanding what you're saying and in particular the basic plan. And in particular, I was a believer if you're in government, the worst thing you can do is sell the president on everything great about something, he announces it, and then all sorts of people complain about it. And he's like, "Wait, you never told me that I would hear a complaint X, Y, and Z." So can you sort of warn us if we went down this road, what complaints we'd see? And in particular, I'd love sort of graphic, gory detail about all the ways in which the basic coverage you're talking about is actually sort of bad, unpleasant, people won't like it, and what their letters to the president would look like after.

FINKELSTEIN: So that's, that's great. And I'm glad to know there's even more commonality than I realize between policy work, or at least advising the president —which I've never done — and research, which I have done. I always tell my students, like, "You need to tell the reader, like, what is the Achilles heel of this, you know, of your research? And then, then we can have a discussion about it. Don't make us guess." So, happy, happy to engage. It's great to stand up and say "Universal, automatic, free," but the basic is a really important part as well. It's partly motivated by our definition of what the goal is, which is to provide access to essential medical care — not to give everyone a high-end luxury experience. And relatedly, for budgetary concerns. So, so there's three aspects — I guess, well. two aspects of it. One, you know, what is covered, and the other is, what is the experience like? And I think more of the gory stuff comes in on what is the experience like. In terms of what is covered, you know, anything that we have revealed through our public policy is to be essentially considered essential medical care should be covered, and that— we talk about in the book — includes private, you know, primary care, preventive care, prescription drugs, emergency care, or hospital care. So, you know, that's the good news.

On paper, you know, everything essential would be covered. There's, of course, a big gray area of things. And other countries have gone through this, you know — do we cover infertility treatments? Do we cover physiotherapy? do we cover Viagra? Do we cover dental? And there, the answer is, it depends in part on what we decide the budget is and how decisions are made. But I think, as you said, it would look a lot like Medicare on paper. So, in that sense, you can think about what many Medicaid programs cover. I think the complaints would come on the, you know, the non-covered aspects of the experience. So namely, it would be very light on non-medical amenities like the nature of hospital room. So one thing that a lot of countries do —Singapore is an example —they, you know, the basic plan gets you hospital care and you recover in a hospital room with ten beds in a notoriously hot and humid, humid climate. The brochures refer to the basic plan as providing, quote-unquote, "natural ventilation" in the rooms, right? And if you, if you supplement as many people do, you get a private-- you know, at the highest end, you can get a private air-conditioned room with a private bath and high-speed internet and very good food. Australia does something very similar. And so the view is, yes, of course, those are all nice, but they're not essential. So non-medical amenities would be less good than probably most current private plans or what Medicare will get you.

Second way, I think, is wait times, which you hear a lot about. Wait times for non-urgent care in Medicaid are longer than they are if you have private insurance or Medicare. There have been a lot of audit studies that have made this point. They are about the ones that Congress, in its infinite wisdom, decreed was okay for veterans who get health care in the United States through the Veterans Administration, where they they said, "You know, this is the acceptable wait time. And if it's more than that, will pay for you to go to

the private sector." That's what a lot of other countries around the world have done, by the way, on wait times as well. So, wait times would be longer, nonmedical amenities would be not nearly as nice.

And the third thing is, there would be more, I think the euphemism is 'care coordination.' It's also known as gatekeeping or administrative oversight, which many of us have in our private insurance plans. You need to get a referral or off-- prior authorization before something. But Medicare, at least traditional Medicare, famously doesn't have that. Medicare administrative costs are extremely low because it doesn't administer anything. It just pays the bills. Anything the patient wants or the doctor wants to order can get done. And there would be you know, that would be, you know, there would be more oversight, more managed care, as it were. So we suspect that, you know, as I said, people who currently have Medicaid, we think would actually be better off because they wouldn't risk losing the coverage. The uninsured would also be better off. But the-- half of the population that has private health insurance, primarily through an employer, and the fifth of the population that currently has Medicare, would probably all supplement.

FURMAN: Great. I think we're doing questions on cards, right, for the cards that are coming around. If you were like a chair of a key committee in Congress when the Affordable Care Act was passed, you can also ask your question out loud, and you don't need to write it on a card. But the rest of you need to write it on on cards. So, you know, wanted to — by the way, do you have any guess as to what fraction of health is sort of needed for health, and what fraction is amenities?

I was thinking about it in the hotel space. People spend $150 billion dollars a year in the United States in hotels. And my guess is, if your sole goal was to, like, have a place to stay overnight and a place to shower, probably could do that for like $30 billion dollars. And 80% of what we spend is on hotel rooms that are larger than they need to be in order to get a night's sleep. I made that number up, but can you make one up for health care?

FINKELSTEIN: You asked me--.

FURMAN: Not the 150, I looked it up.

FINKELSTEIN: Yeah. You asked me that question, I think, when you first read the book, and Liran and I talked about it. It's a great question. We couldn't figure out a good way to do it, Bu, but, you know, I do share your sense that certainly, I mean, so hospitals are the single biggest driver of the single biggest component of health care spending compared to, say, physicians. And I don't know how much, you know. We know that in Medicare Part A, some of that goes to the hospital — just room and board — or all of it does, not the actual physician. And yeah, one would think one could do that cheaper, but I don't-- I couldn't come up with a good estimate and I'm not quite ready to just totally make it up. Give me a few more days in Washington.

FURMAN: Oh, I think economists are good at giving you 90% confidence intervals for anything.

FINKELSTEIN: Fair enough.

FURMAN: Cost. We spend, not counting employer, not counting the exclusion for an employer coverage, I think we spend something like 8% of GDP to cover 40% of people. You want to cover 100% of people. Does that mean like your thing's going to cost two and a half times as much as what we're spending now? And if not, why not?

FINKELSTEIN: No, so we could choose to raise taxes if we want a basic program that's more expensive. But one of the key sorts of 'aha' moments for us was to realize that, yes, as a country we spend twice as much as any other high-income country as a share of the economy on health care. But in most other high-income countries, that's essentially all publicly financed. Whereas in the United States, only half of it is publicly financed and you know, half of twice as much is the same amount. So in other words, our tax dollars are already spent contributing 9% of GDP to health care spending. That's about how much, on average, the OECD countries pay for their universal basic coverage. We've just chosen to spend it differently. And to get more precisely to your point, there's, first, there's a tax exclusion to employer-provided health insurance, which is also regressive and inefficient. So I would shed no tears on diverting those dollars elsewhere. But a lot of it is really in Medicare, which on the one hand is not as generous as our basic coverage would be, because there's these, you know, 20% cost sharing for physician payments and other deductibles that we would have none of that. But on most dimensions, it's way, way more generous than what basic coverage would be. By law, Medicare is not allowed to take costs into account in deciding what to cover. You know, there's no gatekeeping in traditional Medicare, and the list goes on and on. And so that is where I think a lot of the — not, I wouldn't say savings, but the re-designation of tax funds would come, right?

FURMAN: And any clue, just in terms of continuing on the Achilles heels, with sort of what things you'd be taking away in order to do that? And isn't a bunch of our problem that our prices are higher, not that our quantity is higher? In which case, that 9% actually isn't enough to cover everyone, even if, at the prices — and you know, those cheap bargain-basement European countries— it is.

FINKELSTEIN: You could potentially lower the said prices. But I would say--.

FURMAN: But you don't have a plan for that in the book.

FINKELSTEIN: So what we say — no, we don't — but what we say in the book is, you know, you can view this as a feature or a bug. We view it, of course, as a feature, which is, we don't tackle the multitrillion-dollar problem, as it were, of health care delivery — how to get better health outcomes for the same spending, or depending on your preferences, just spend less to get the same health outcomes. And we don't do that for two reasons. One, we don't think there's an easy solution. We know how to lower health

care spending. You can just, you know, close down hospitals. But we don't really know how to lower health care spending without potentially harming outcomes. And all the solutions out there are lower prices, you know, lower administrative costs, get rid of unnecessary care. All of them involve tradeoffs. But we're not against them, we just don't know. They're obviously good, and I'm happy to talk about that. But the second reason is, it seems that most policy discussions lump them together. We can't solve the problem of insurance coverage unless we get costs under control. And that calculation that I just described says, yes, we can. Maybe, in fact, imposing a budget of 9% of GDP, of taxpayer-financed money on this universal basic plan will then finally force us to start making the hard choices of how to reduce that spending.

FURMAN: We've experimented with a lot of different ways to reduce health spending: things like the gatekeepers, the longer wait time, the narrow networks — you don't get to choose who you see —and also cost sharing. You have the first three of those. You had taught me in your research that cost-sharing sort of does actually reduce spending a decent amount, and it might, in some dynamic sense, reduce it even more in the way that it reshapes innovation. But now you've taken everything I thought I had learned from you and just sort of left me sad because you think the opposite. So, why do you think that? And in particular, what's the argument for having cost sharing in your plan that's 0% for a bunch of things and then 100% for everything that's not included in it? You know, surely you'd think in an optimal plan there'd be some numbers between zero and 100 that would make sense, at least for some things, if not prevention, for example.

FINKELSTEIN: Totally. I mean, I think we say quite we said quite explicitly in the book, we've arg-- we as economists and as particular economists have preach the gospel of the importance of cost sharing in health insurance for generations. That, you know, it is unequivocal that our research and many others show that, you know, in fact, health care is like any other good; that when you make people pay something for it, they use less. And it's about as close to professional heresy as I think you can come as a health economist to come out and say, "Let's not have cost sharing in the basic plan." So just to be clear, we're all fine for cost sharing and the supplemental plans that are being designed in the market to meet, you know, equate demand and supply or whatever. But why do we come out against it in the universal basic plan? Not because the research was wrong. We're going to stand by that, so don't be too sad. It is, you know, it's unequivocal that, you know, what, we and many, many others have found, that if you make people pay something for their health care, they use less of. It is true.

We concluded that the implications we drew from it were incorrect in the context of universal basic coverage. And the reason actually is quite simple. It's because we looked at what happened to countries around the world that have all the other high-income countries that have universal basic coverage, and that, as they faced budgetary pressures, followed the advice of economists and introduced or increased cost

sharing, in that, their basic plan. Countries like France, Germany, the U.K. — we give a lot of examples in the book. And what you see in each of these cases, it's really stunning that almost simultaneously, along with introducing or expanding that cost sharing, they introduce pro-- publicly funded programs to cover that cost sharing for many, many individuals. So, for example, in the U.K., they introduced co-pays, small co-pays for dental, vision, prescription drugs, and then they introduced the exceptions and the exemptions for low-income individuals, for the elderly, for children and babies, for the disabled, for veterans, for students, for people with cancer. The list goes on and on. And basically what they ended up creating is the patchwork approach we currently have to health insurance coverage in the U.S., for the microcosm of cost sharing in their basic plan, so that at the end of the day, people have estimated that 90% of prescriptions in the U.K. are dispensed to people who are exempted from their cost sharing.

Similarly, in a country like France, which famously has actually quite high-cost sharing and universal basic coverage — sometimes 30 to 40% for some things —they have a public program to cover the cost-sharing for low-income individuals going fairly high up the income distribution, and they have tax subsidies to encourage higher income individuals to purchase supplemental coverage to cover the cost-sharing they introduced. So at the end of the day, 95% of people in France actually are exempted from the cost sharing. So the reason we took it back, Jason, is not because our research was wrong, it's because cost-sharing doesn't do anything when it's exempted. And empirically, it gets exempted because, again, if the purpose of this health-- of this health insurance policy is to make sure that people have access to essential medical care regardless of resources, what countries find is that inevitably there are people in circumstances who can't afford the co-pays and they create the exceptions and the exemptions.

FURMAN: If I was being unfair, I'd say for most of your plan, you're just doing sort of blue sky, pie in the sky, not worrying about constraints. But then for this one thing, you start worrying about political reality.

FINKELSTEIN: Yeah, if you're being unfair.

FURMAN: Which I'm not. Do you have anything to say? Otherwise, I'm going to start doing the cards. Nothing to say? Okay, great. So there's two questions here that are sort of flip sides of the same question. One asks the concern that once you have this just basic, crappy thing that doesn't have the amenities, etc., aren't you going to leave intact the-- all the inequities of the current system, and that people who can afford it will get this better thing? And then maybe even politically, because they're paying to get this better thing, they won't care about maintaining and keeping the other thing good? And you have some examples, I think, of countries of that. And then there's sort of a flip side one, which is that private insurance, you argue, functions really poorly and is messed up in lots of ways. Why won't all the same problems get

reproduced into the supplemental coverage? So is this unfairly good to the people paying for it? Is it gonna be like a bad deal for the people paying for it? What could you do about either of those?

FINKELSTEIN: Right. So those are great questions. So there are two concerns with supplemental. One, as you said, said on the card, that you're, you know, creating current inequities. Our view on that is like, yes, but that's, you know, we have, that — maybe you're going to say this is unfair of what we choose to accept as reality and what we don't— that, I think, is reality in the United States and in every other country. In fact, the only places in the world that outlaw this form of, you know, supplemental coverage to cover what is already, you know, a better version of what the basic would cover are North Korea, Cuba, and a few Canadian provinces, literally. So we are--.

FURMAN: Really bad places.

FINKELSTEIN: Exactly. We're, we're comfortable with that. We spend a bunch of time in the book talking about some of the-- you know, it turns out a bunch of philosophers like Rawls and Daniels have come to similar conclusions, in case you don't want to take our word for it. We think the much, much more important and difficult one is the, is the supplemental going to erode the adequacy of the base. Because if the if the purpose of the social contract is about providing access to essential medical care, and you have, by our estimates, 70% of the population supplementing, there is the concern, as you said, both politically that support for taxpayer dollars to support the base that could be undermined, or just, you know, in an economic sense that the, you know, the best doctors are going to want to practice where they can make more money and there'll be a shortage of doctors or highly qualified doctors in the basic system. These are very real concerns.

And as you alluded to, we have-- there are many examples, many of them in Latin America, of countries that have fallen victim to this, such that, you know, the these-- their systems are described as medical apartheid, where the public basic program is really just simply inadequate. It's underfunded and undersupplied. There are also many countries around the world that have successfully dealt with this issue. And the way they deal with it — it's not it's not particularly inspired or catchy, but it works — is, first of all, vigilance. So, you know, in Israel, for example, which had introduced universal basic coverage in 1995, and about 15-20 years later, started to notice that wait times were getting really long in the pub-- in the basic part, and everyone more was going to the supplement. They did two things. First, they raised the public funding for the basic. And second, they — and other countries like the U.K. have done this —they introduced a series of regulations and financial incentives so that most doctors would find it, do find it, very unappealing to practice solely in the supplemental as opposed to in both. And then you also have countries like Australia, which, far from worrying that the supplemental system is going to erode the basic, they actually provide tax

subsidies to encourage higher income people to purchase supplemental coverage because they believe that that supplemental coverage is cross-subsidizing the hospitals for the basic care. So it's a real problem, but I think there are surmountable solutions. I apologize [inaudible].

FURMAN: The other, the other was just, are we worried that we're going to reproduce a lot of the scrappiness of current health insurance in this new thing? Or is this as big a problem as the fact that there are people out there who spend $2,000 dollars for an overnight stay in a hotel when they could have spent $100 dollars? It's probably not a big public policy problem.

FINKELSTEIN: So there are many issues with private insurance markets. What I'm least concerned about is exactly if people, you know, quote-unquote overpaying. If it's private money and not tax-subsidized insurance, you know, we don't — I don't worry about people buying fancier cars than I think they need or hotel rooms, etc. That's not to say that, you know, there are many reasons that private health insurance markets don't function well. And in fact, a lot of the work Liran and I had done, and a lot of our thinking about public policy, was around those issues. We just decided, in this context, it wasn't the first-order issue, but they were real issues. And that's why the supplementary market, as we describe in the book, would be regulated to deal with issues like, you know, adverse selection and cream skimming. I don't think we have panaceas for those problems, but we actually can do pretty well. And we discussed that as well in the book.

FURMAN: Great. I'm going to read this one word for word. What did Obamacare get right?

FINKELSTEIN: Do you want to take that one, Jason?

FURMAN: You can do it. A lot of people here that could answer it?

FINKELSTEIN: So, I, actually, in all seriousness, I think stepping back, one thing we we tried to be clear on in the proposal — and we got really helpful feedback on this from the authors' conference— is we're describing what an ideal system freed from political constraints, but not economic constraints would look like. We view that as a useful goal either for people committed to trying to work incrementally within the system, just to know where we're trying to get, and therefore how costly or not different compromises are. And second, because who knows what policy windows may open in the future at the state or the federal level, and we'd like to, hopefully, have persuaded people of our ideas and be ready for that moment. So, you know, all of that to say is, you know, the Affordable Care Act achieved far more than I ever have, and a lot on an absolute scale, right? Most notably, the Medicaid expansions, which reduced the share of the population that's uninsured at a moment in time from a fifth to a tenth. And that is, you know, dramatic progress.

I think, you know, in the ideal world — which my understanding is not what people who are working on the Affordable Care Act were getting to work in — you know, the concern we have is that even with these expansions when it's always piecemeal and patchwork, which is often all you can accomplish politically —

"Let's expand this program. Let's create a new program" — you end up with people who, even though they may be eligible for coverage, don't end up insured because research suggests they don't know that they're eligible, or which program they're eligible for, or how to file the paperwork to make sure they get covered. We'll talk about this in the next session as well. Or end up, you know, qualifying, but then failing to recertify and stay on the rolls. So that-- you know, one fact of the ACA that is well known is that it halved the share of the population that's uninsured at a point in time. That's an enormous accomplishment. On the other hand, that insurance uncertainty I mentioned, the share of the population that will lose coverage over a two-year period, it didn't move the needle on that.

FURMAN: I want to explore whether some of those political constraints are not just annoying things that happened because of interest groups and the stupidity of people but reflect a certain wisdom of-- you know, our system is very far from perfect. It's-- when you're on a slope, it's easy to look locally and figure out, "Here's how I can make it a little bit better. Here's how I can make it a little bit worse." Your plan isn't doing that. It's leaping to this other thing that you think is a tall mountain over there. But maybe you end up like in the valley and in something even worse. You know, the Khmer Rouge had a plan to remake society from the ground up, and it worked out badly there. I don't think your plan is like that. But some of the sort of most utopian — you know, 'if on a blank slate, none of this makes sense' — changes throughout history have sort of run roughshod over all these sorts of intricate interconnections that have evolved over time. A lot of people actually do like their health plan, like their doctor. There's a reason that President Obama said that over and over again, and I think it was 98% true, which I think is close enough. That wasn't the judgment of history on that remark. You know, is there some wisdom to a small-c conservatism? You don't sort of blow everything up just because a professor somewhere thought from scratch they could design a better system.

FINKELSTEIN: Yeah, two — very good point —two responses. The first, which is the mirror image of the complaints that we're not fixing the delivery side. We don't necessarily-- you could implement this plan without blowing up or changing almost anything in terms of health care delivery, hospitals, you know, doctors, you know. As we said, 70% are going to have supplemental, which is about how many have private now. Now, people who think the current system is totally inefficient might want us to blow up more there, but we're not. So that's-- the real, the blow-up or the tear down is all on the insurance coverage.

And then I think the second thing I'd say is, as I describe the process, we thought it was important to go to first, principles. What are we trying to accomplish? And once we have a goal, how do you best accomplish that? We were, you know, somewhere between gratified and chagrined once we did that from first principles to look around the world and see that this is what every other high-income country does. Now, our particular proposal has details from each of different countries. It's not lock, stock, and barrel any one

country, but the "Let's have universal automatic basic coverage with a budget on how much that taxpayer spending is going to be and the ability to supplement" is what every other country is doing. And that, what, you know, to me, gives me some hope that this isn't just some clever mechanism that we dreamed up on our whiteboard and that once you test it in the world is going to encounter a lot of unforeseen practical constraints.

FURMAN: Have you looked at and learned anything from countries that transition to this? And in particular, any countries that were spending, say, like one-sixth of their GDP on health care in the transition to this.

FINKELSTEIN: Okay, that's unfair because you know, you know the answer to that. We did not look much. There are countries that have transitioned — Taiwan who already had an employer-provided health insurance system and in the early nineties transitioned. Israel as well around '95. To be totally honest, we didn't study those modern transitions in a lot of detail, in part because we feel like if we could get enough people on board with the vision, then there are people far more skilled than we, to navigate that, both the politics and the economics of the transition. One thing I will say that really surprised me and gave me some hope is that the pos-- the narrative out there that, you know, the U.S. was destined to never have universal coverage because, take your favorite argument — you know, we don't have a strong enough labor union, the AMA is too strong, whatever, whatever — and every other country, you know, were destined to have it. You look at the creation of these systems in other countries like the U.K. after the war or Canada in the sixties, and there were violent controversies and protests around them. You know, the doctors went on strike in Canada for several weeks when universal medical insurance was passed. So, another way of saying it is, these transitions have never been easy, but I'm not sure that's a reason not to try.

FURMAN: Got it. Lightning round of a few things. If you have an opinion on — and want to share it with us — waste in the U.S. system with things like long-term care, hospitals, skilled nursing facilities. I realize that's like a little bit more detail than you got into. If you have a thought on that, you can share it. Otherwise, you can write a paper on it.

FINKELSTEIN: We've written a paper that long-term care hospitals are a case study in waste and should be reimbursed like skilled nursing facilities.

FURMAN: Okay. I think hopefully that answered whoever's question that was more succinctly [inaudible] would've guessed. Is our workforce set up to successfully manage universal coverage? And then in particular, how would physicians be affected? And is there something one would need to do on the workforce side in general?

FINKELSTEIN: That's a great question. I think, again, as I said, the positive and the negative is we're not-- we don't-- we're not pushing for any change on that. That's a negative because there's a lot of people who believe, as I do, that there's a lot of waste in how health care is currently delivered. And so if we had great solutions that had no tradeoffs, we would certainly be pushing them. It's a positive in the sense of I don't think it's the massive disruption on the economic side when you think, "Oh my God, this is almost a fifth of GDP and we're going to totally change how physicians practice medicine or how hospitals are structured or paid for." No, we don't actually have to do this. We just need to take the current taxpayer money and, rather than pay for anything under the sun under Medicare, direct some of those resources away from that and towards paying for basic care for everyone.

FURMAN: Great. And my last question, what haven't you said or what do you want to say again, just in case they weren't paying attention?

FINKELSTEIN: I definitely don't support the Khmer Rouge. No, I think I just want to end with the-- my hope is not that, you know, even in my wildest dreams, that we're going to take this to Capitol Hill tomorrow, but that if we can get enough people talking and hopefully agreeing with us about what is the goal and what does the solution look like, that, that will fix ideas of where we're trying to get to, so that other people, or everyone who's far more skilled then Liran and I are at how to actually get things done, can think about either, are there, you know, complicated and intricate pathways that can eventually get us to where hopefully we've persuaded you we want to be, or policy windows at the state and federal level that who knows when they'll come up that we can seize on to try to move forward on this.

FURMAN: Wonderful. Thank you.

FINKELSTEIN: Thank you.

EDELBERG: Wendy Edelberg, the current director of the Hamilton Project. I see that I'm now mic'd. And I may as well just introduce us while everyone's sitting down. So, we're going to have a conversation with Congressman Waxman, who's, obviously, a former congressman and currently the chairman of Waxman Strategies as — [inaudible], please come on up just while I'm introducing us. Esther Krofah, who's from the Milken Institute, where she's executive vice president of health within the Center for Public Health. And Dr. Kyu Rhee, who is president and CEO of the National Association of Community Health Centers. So come on up. And I'd love to start where Amy left off, which is, I am just so proud and delighted to play a small part in introducing —or not introducing, her book introduced them — but in highlighting what I think are her very important ideas that would improve the way we talk about health care policy in this country. And I'll also just quickly note, we also put out another policy proposal today by Gopi Goda and Jason Brown to bring some rationality to the Medicare savings program. And we should adopt their proposal immediately and

make the world better. And also, several months ago, just on a related topic, we put out a proposal by Martha Bailey on extending free contraception to people without health insurance, which is another just obvious good government solution.

Okay, so all three of you have incredible depth of expertise. So the congressman, of course, in working on policy to extend access to health care and insurance. Esther has worn many different hats in both the federal and state government agencies, in the nonprofit world, and in the for-profit sector. And Kyu leads an organization that provides affordable care to more than 30 million people, all generally low-income at over 14,000 sites. So, we're going to talk about the current state of the health care system and how it still creates challenges for the people who are most vulnerable. And a little bit on how we got here, and hopefully shed more light on what priorities we should have going forward and how we need to improve the system to reach the most vulnerable. So let's start with you, Kyu. So tell me about the community health centers and, in particular, the demographics of who the centers reach.

RHEE: Hello? Oh, that works, that works. So I'm a primary care doc. I actually worked at the corner of 14th and Irving. So just-- so that's part of the context that I have, knowing how community health centers work as a physician and as a medical director in those settings. There are 31 and a half million-plus Americans, based on 2022 data, that health centers serve. Ninety percent are below 200% of the poverty level, 64% are minorities, 41% are from rural communities. And they provide comprehensive primary care that often includes oral health, behavioral health, social health services — which includes community health workers, translators — and at a very affordable price.

If I were to say what they deliver, they deliver in those over 15,000 sites and over 300,000 employed, the quintuple aim. So folks might know the triple aim of improving quality, reducing costs, improving patient experience. The quadruple aim is about provider experience, and the quintuple aim emphasizes equity. I'd say the core guiding light for the work that community health centers do is based on their history in the War on Poverty and the Civil Rights Movement in 1965 when they were created. It's the focus in communities that need it the most, including, you know, what just happened in Maine, sadly, whether it's natural or manmade disasters. I talked to the community health center that was affected by the Maui wildfires, tornadoes, hurricanes. We are not only the first responders, we stay in these communities that need it the most.

EDELBERG: Well, thank you. All right. So, Esther, we so we talked a lot in the last panel, and then Kyu talked a little bit more about lack of coverage and access to health care for the most vulnerable. Tell us about the downstream consequences of that.

KROFAH: Yes, I think it's important to first start with the overall history of how did we get here. I think most of us know, as you just talked about as well, that we have a very fragmented health care system

in the U.S., and it was not by accident. This in some ways was by by design. We stumbled upon employer-sponsored coverage and then made a decision. really largely during the civil rights movement, that there were vulnerable populations then that needed to be covered. And that was the seniors, and much of it was related to desegregating hospitals. And the part of the compromise, of course, was for coverage for these Medicaid populations, right? Those that are poor, as a compromise to states to really— particularly the Southern Democrats — to really support the overall package. And what we have right now is this hodgepodge of different parts of the system that cover different people based on different eligibility requirements.

And that fragmentation in our overall coverage landscape has significant downstream ramifications. In particular, on our medical research enterprise, where I spent a lot of my time, which is all around, are we generating the right kind of evidence? If you think about overall health care outcomes, are we generating the right kind of evidence to answer questions that relate back to the health of an individual? You know, how do we understand what kinds of medicines and products, interventions are helpful for you? And because of the way that our health care system is structured, that same fragmentation that happens upstream on coverage goes downstream into the ecosystem that answers these questions as well.

So what does that mean? Not everybody participates in that evidence-generation system. All of us may go into our physician for coverage and to get access to health services, but we don't actually know if what we're getting is what's best for us. And so certain individuals, largely, really, white men, have access to be part of these clinical trials or clinical research studies. But if you're from a vulnerable community, if you're from an underserved rural community, you don't really participate in that. And we see, of course, what these consequences look like when you see life expectancies as declining. In the U.S., we're at 76.4 years for life expectancy now, which is the shortest it's been in over two decades. We see this translated into the chronic disease epidemic that we have in the United States as well, where the overall health care outcomes are disproportionately worse for underserved communities. If you look at African Americans or Hispanic or Asian communities across any of those chronic diseases — whether it's from cancer, or chronic kidney disease, or cardiovascular disease — and you go down, you have outcomes that are two to three times worse for each of those communities relative to the white population. So, the overall story is that coverage is tied to every other part of the health care system. And the decisions that we make at the top, in terms of who deserves to be covered, how they can enter the health care system, has these ramifications for how do we provide evidence, how do we generate knowledge that can be useful for your health care outcomes.

EDELBERG: So, congressman, now we've heard a fair bit now about the enormous challenges of the ecosystem that is our health care system. You've had a long career working on the significant

expansions to health care coverage in the United States. So tell us about the successes and the challenges in trying to improve our health care system.

WAXMAN: Well, I want to thank the [inaudible] and the Hamilton Project for sponsoring this event and inviting me today. And as I look out, I see people who I've worked with over the years to help get things done that we were able to do. And it's not easy to get legislation passed. It's not easy to get cooperation to make sure that we live up to the promises that we make in some of these programs. But we have, we have a patchwork system. We don't have an ideal system. There are a lot of holes in it. A lot of people fall through those holes, and we need to improve it. But I've come from my own experience that the best we can do is incremental changes, if that. Incremental changes become very important to the people who are affected. We started off with 50% uninsured, we're now down to 7% uninsured. That's a great accomplishment. We've done it in a number of ways.

From my own experience, we expanded the Medicaid program from a welfare-based program to one that covers low-income people without being tied to a welfare standard of age-blind, disabled, or dependent children. We've expanded Medicaid, and I'm proud of the part that I played in that. But the Affordable Care Act, some people say that wasn't good enough, but that that bill accomplished a great deal and expanded health care access to millions of people. Now, we talk about the incremental improvements. We have to remember that we had to fight back the attempts to weaken what we already had. We were able to keep the Affordable Care Act by one vote in the Senate when Trump became president. It was a Republican dogma that we had to repeal the Affordable Care Act and replace it. We never heard what they were going to replace it with because they didn't have any idea how to replace it. They just wanted to repeal it. And one vote that saved us was Senator McCain. Otherwise, they had everything lined up in the House and the Senate and the president to repeal the Affordable Care Act. There were many attempts in the Congress — I don't know how many — 20, 30 times we had to vote to sustain the Affordable Care Act. But we still have it. And people would be outraged if we repeal the Affordable Care Act now, just as they would be outraged if we repealed Medicare or veterans' health care or anything that is now part of the system that we have, as incomplete as it may be.

So I, I don't want us to lose hope. Even though we finally have a new speaker, so the House could meet, but that new speaker's record on all these health care things is pretty far-right. In fact, his record on all of these issues are pretty far-right. That's how he got elected speaker by the Republican conference. But we have a president, we still have the majority in the Senate, and we have public support behind our efforts. And we've got to take advantage of of what we have and to build on it.

EDELBERG: So let's, let's come back at the end to not losing hope. Hopefully, we can end on that note as well. I also want to say, you still have cards. If people want to write down questions, they'll be collected pretty soon, and I will get them. So, Kyu, I want to talk about about Medicaid's role and the expansion of Medicaid. One of the frustrations with how incredibly effective the Affordable Care Act was in expanding coverage is that obviously, not all states took up Medicaid expansion. And so, it's-- and it's an easy, it's an easy point to, like, look at those states and say we just need to get them to expand Medicaid and so many of our problems will go away. But you and I have talked about whether or not that's a-- is that a silver bullet? And can you talk a little bit about whether or not access to Medicaid in the states that have expanded has solved all problems?

RHEE: I mean, the way I frame it, so — and just from the perspective of the largest primary care system in our country, community health centers, 20% are uninsured, 50% are Medicaid, 10% are Medicare, and 20% are commercial. And I do want to highlight that, you know, we focus on Medicaid, but you know, the marketplace, the commercial marketplace, many workers, you know, make, you know, minimum wage. And they're often the types of the patients we see in our community health centers. So you have to think broader than just, you know, Medicaid, Medicare. Often there's a lot of, there's a lot of poverty and there's a lot of challenges with Medicare as well. So in my mind, you know, in general, the broader evidence shows that if you improve access or coverage incremental, as, as Congressman Waxman was referencing it, I mean, science shows — or the Institute of Medicine did that study on insurance — and it showed that you have worse health outcomes if you don't have insurance. And I would also say, when I was the chief medical officer and I saw metrics of success quality measures, it was more challenging for for Medicaid beneficiaries to have the same quality measures that Medicare commercial were.

So, often we do have a system where it is inequitable in some ways. And to me, having some coverage is better than having no coverage. But as you've stated this, the way the states have approached it —and I was just in Nevada, and this past week I was in Washington, the last Georgia, South Carolina, and Louisiana and talking to health centers across the country, they they do find a way to work with the way the system is. But there's no question they're very concerned about Medicaid redeterminations or the lack of Medicaid expansion for their ability to provide primary care to those folks who need it the most.

EDELBERG: So, congressman, Amy’s proposal — Amy and Liran's proposal — gives us a north star of this is that-- if indeed we have a social contract in this country to provide basic access to health care for everyone, then that should inform the incremental decisions we make. But your time in Washington, you know, you're going to have some insight into like how much consensus we really have and how does one go

about getting consensus within our own, within your own party working in a bipartisan way? How does one get consensus about who is deserving and who's not, who's inside the fence and who's outside?

WAXMAN: I was very pleased to hear Amy's presentation and well-thought-out proposal. There are other approaches that are also very attractive, but it's hard to get something major through in one big lump. It's just too hard. So, my view is you have a goal, which is universal coverage. It's a basic right to have access to health care. It shouldn't just be a privilege for those who can afford it. So if you want to cover everybody, as we, I think, in this room all want to do, you, you start off with what's there and build upon it, in my view. If my view is, you take what you can get, you keep pushing it forward, and occasionally opportunity arises where you can get a big thing done. But those opportunities aren't there that often, but you have to keep pushing it and be prepared to take advantage of those opportunities. But in the meantime, Medicaid is just a good example.

When I first started working on Medicaid, Medicaid was a program attached to those who were on the welfare system. We had, we had a lot of crazy things with it. For example, one of the first changes we made in Medicaid was, that in the dependent children category, a woman who had a baby could get access to Medicaid because she has a dependent child. But what about a woman who's having her first baby? She had no coverage for Medicaid. So I went to a colleague named Henry Hyde, who's famous for the Hyde Amendment, very much against abortions. He succeeded in keeping the federal government from using any of our taxpayers' dollars to pay for abortions. And I said to him, "You're, you're anti-abortion, I'm pro-choice. But we should both agree on the idea that prenatal care is important, and we want children to be born as healthy as possible." So, he and I sponsored expanding Medicaid to women who were having their first child.

And then we broke the link between — over the years — between any welfare category to add eligibility for Medicaid. You didn't have to be on welfare. We wanted to cover children. We started off with all children below the poverty line, whether their family was eligible for welfare or not. We did that. Then we expanded access for children. We adopted the Child Health Insurance Program, or CHIP — or is it, is it CHIP or CHAP?

EDELBERG: CHIP.

WAXMAN: Okay. At one time it was called CHAP. We took CHIP and added it together with the others. And in the Affordable Care Act, we expanded Medicaid. We didn't say it was a state's choice. It was always the law that if you wanted to be on Medicaid, you had to take all the things that Medicaid required of the states. But the Supreme Court wrote the law, and they took the Affordable Care Act and wrote the law that the states have to agree to expanding Medicaid. Well, most states have. There are ten who have not. It's a great disservice to their children, to their seniors, their disabled people, all the people that would go to

Medicaid for the health care coverage. A great disservice to them. And it's even a greater disservice to the providers of care. So states have fought that battle, but I just don't understand why they haven't taken advantage of it. North Carolina recently took advantage of it. Conservative Republicans said it doesn't make sense to turn away money that the federal government was going to give us, which oftentimes, have a goal and try to encourage people to accept that we want to accomplish something, and they should act appropriately. Here we were giving states money, free money, and still, some of the states didn't want to do it because, quite frankly, they didn't care about poor people, and they didn't want to do anything that was attached to President Obama. And there are different reasons, none of which makes sense. So-- I think that's my phone, which is also a good signal that I ought to stop.

EDELBERG: If you have a question, write it on the card. Don't call the congressman.

WAXMAN: What's that?

EDELBERG: If they have a question, they shouldn't call you. They should write it on the card. All right. So, so, Esther, let's pick up where the congressman ended, where he made the the painful and somewhat provocative point that they don't care about poor people. So, in essence, I think I'm asking if you agree. But more substantively, is the lack of universal access to coverage, even for the most vulnerable, is that collateral damage, or is that is that actually the policy choice?

KROFAH: I think we have to look at the states that have not expanded Medicaid, and also look at them historically. And there has to be some component of race that factors into all of that. And I would say that is embedded in this idea of who is deserving or not deserving of health care, and the philosophies within these states, and likely within certain populations in our country, in terms of how do we expand and to whom. For example, you saw even with Medicaid expansion, some states wanted to add work requirements. That whole idea of "We should pull, pull ourselves up by our bootstraps. Some people might be taking advantage of the system, and we need to demonstrate that they were able to contribute back to society in a particular way." And when you look across the states that have not expanded, I would say there is still that same kind of mentality, that is also historical, which relates to what we see from overall access points and health outcomes.

We had a great conversation over lunch with Amy's proposal, which would assume that there are a patchwork of systems that are covering those people, even from a racial and vulnerable group. But I would just argue that it's much more about covering them in the case of emergencies. Not being proactive to say we need to protect the health of our overall population and we're going to provide robust access to primary care as well as other interventions so that everyone can attain the highest level of care. In some ways, it's much more a response to the moral obligation that you should not show up in the ER, and we are not going

to take care of you and turn you away. Nut we have not made the moral decision to say, "Across all vulnerable groups, across all racial and ethnic minorities, whether you're rich, whether you're poor, you're deserving of health care. And we have the results of it, it's quite stark. Again, if you look in particular, you know, the southeast of the United States, across any measure that you can identify, health care outcomes are substantially worse. If you have no access to coverage as just that first point of entry, you're likely not going to get any additional services and be proactive around your care.

EDELBERG: That's an excellent transition into a question I have here from the audience for-- that I think is best posed to Kyu, and also very similar to a question that I saw from our online audience that was put into our system. Which is, we are obviously quite focused, and reasonably so, on coverage to health care insurance, but obviously that's not enough. And so the question here is about the need to expand education around preventative medicine. But I, I think I want you to take that even broader, and I think do a bit of of of scaring us about how we are being far too narrow about the challenge for the population that we've been talking about.

RHEE: Yeah. Look, if I were to simplify so much of where we are, you know, there's a lot of talk in the health care system of value-based care — you know, this concept of quality over costs and managing costs, reducing waste. My simple question — and I do think whether it's access or the role of health centers — we have to ask the question: values-based care, what are the values we have? And I do think one of the values that I have, and I'm clearly biased as a primary care doc, I chose to be a primary care doc in an academic medical center at USC, big county hospital with all these amazing specialists who are brilliant. But I chose to choose a profession that I knew I was going to get paid a third less and work in underserved populations. And in general, that's getting paid another 50% less in many cases. The programs that I had, the National Health Service Corps, as an immigrant, and with my parents who sacrificed so much, gave me a little more confidence in making that decision.

So, you know, at a core point, what do we value? Do we value prevention — preventing hospitalizations and E.R. visits, which is what primary care clinicians do, even though they're only five cents on the dollar primary care, and they control the remaining 95 cents? Are we going to invest more in that? Are we going to make that, ideally, a quarter of our spend? Do we value disparities or equity right now? I witnessed it. And sadly, because of a lack of insurance, I often had patients come to me, you know, with metastatic breast cancer: "I've been feeling this lump for four years. I don't have insurance. I was worried." Or, you know, I find out their kidneys are failed. They've had diabetes for ten years because of their frequent urination and they have all the signs of diabetes. They've had a heart attack. They didn't get care because of lack of access. So at some point, do you value prevention? Do you value health equity? Do you value

diversity as well? Because reality is, minority health is becoming majority health by 2042, and our workforce isn't as diverse as the population it serves. And this is the beauty of community health centers: we represent the people we serve culturally, linguistically, racially, ethnically, geographically as well. We recruit clinicians who are from those communities to serve in those communities. So my basic question to that one is that we do have to be questioning with all this money we're spending or we truly spending on things we value.

EDELBERG: So when, when you and I were talking about preparing for this program today, you asked me a challenging question, which is, "Are you focused on health care or health?" So can you describe the distinction there?

RHEE: So simply put, I mean, we're known as community health centers, not community health care centers. And when I worked at HRS, it was a health resource and services — not MRSA the Medical Resources and Services Administration — I like to emphasize this: the things I learn in an exam room were not sufficient to address health. In general, health is-- health care or clinical care is only 20% of outcomes. And so you have to think about the broader social drivers of health. You have to think about housing, education, access to healthy choices, food as medicine, food insecurity, labor, employment, you know, people's ability for upward mobility, transportation. So I use the acronym 'health' to add all those other components. And the beauty of our health center movement is that we address those other determinants because the reality is, I was not prepared as a physician out of residency to serve in a community health center. I was focused on the diseases, the drugs, and the diagnoses. But then what I learned with my team of ten, for every clinician, there's generally —you're the quarterback — there are ten other people supporting you. Social workers, translators, community health workers., they helped me understand that health is so much more than health care and what I learned in medical school and residency.

EDELBERG: So, congressman, the — off your phone.

WAXMAN: I turned it off.

EDELBERG: In-- with the, with the challenges in the in the policy environment and getting legislation through, how much should I think that the challenges are really dollars? If I could wave a magic wand and create, you know, a money tree that dropped money, but only for health care, would all of the the challenges in Congress go away? Would, would there be, I mean —I don't mean to say all — would that, would that solve, would that get through the gridlock of all of the necessary changes to get our system fully functional?

WAXMAN: More money helps. Absolutely. If you had more money to spend, we could do more things. It's always a fight for dollars. We spend so much on the defense budget, and we don't hear all that much of an outcry when we find out that some of that money was wasted. But we should have more of an outcry when we find that we're not spending money on the people who need that-- the services that they

should have access to. But let's recognize that we've accomplished a lot. The original Medicare and Medicaid programs were voted on by Congress in 1965. President Johnson pushed them through, but he couldn't get everything he wanted. Medicare was to cover seniors. Medicaid was to cover very poor people. The assumption was if you're working, you had your insurance or your jobs, so everybody was covered. That was the assumption. But the fact that-- why they had a Medicaid program run by the states was because the Democratic Party had a lot of Southern Democrats who were chairmen of the committees, and they wanted the states to run it because the federal government might let too much of the, the funds would go to African Americans. Even Social Security, when it was adopted, excluded people who worked in a lot of the jobs that African Americans held.

So there was a racial inequity in the creation of these programs. We always have to be aware of that racial inequity. But we don't say that we're not going to cover somebody if they're African American or poor. In fact, we have a lot of programs that are geared directly for them. But we have a history that we have to overcome. And if we had a lot more money to spend, we could expand coverage and expand access. Maybe there would be a lot of Republicans, even at that point, that would be against it because they don't want government dollars to be used for— I don't know that it's racial, but in some places it is — they don't care about the people who don't have. They want to be there to help the people who already have. And that's not my philosophy of government, and it's not the philosophy of government that is etched on the monument to President Roosevelt. Government should not help those who have the most, government should be there to help those who have the least. And our society, if we're going to have an equitable, equitable society living up to our values, should make sure that everybody is covered. Everybody should have access to care. And we try to eliminate those inequities not just in health care, but inequities in our society where we have the haves and the have-nots. So that's an answer that expands a little bit beyond what you asked.

EDELBERG: So let's talk about policy steps forward that you'd like to see. So in the last panel, we went back and forth between, you know, do we blow up the system and start anew? I think it was-- there was a mountain and a valley, or incremental change. And so let's, let's all say it would be delightful, insofar as we're talking about incremental change, it would be delightful if all of the states expanded access to Medicaid. Let's put that aside. Are there other incremental changes that you would like to see first that move in the direction of getting everybody who most desperately needs it access to basic health care?

KROFAH: Well, let me first respond to a comment that you made, congressman, which was around the incremental. And I think we, as a country, we take two steps forward, one step back; three steps forward, another step and a half back. I think it's clear during what happened with COVID, which really brought to light these issues around racial and ethnic inequality, and it made it very explicit for everybody to see in real-time,

which helps us to maybe answer this question that you have about what are the policy proposals? Because the first question was, is it biological? Somehow do African Americans or others from underserved communities just somehow magically get COVID in different ways than those white communities? And we found with that, no, it's because of these other structural issues and, you know, the way that we deal with, you know, work and housing and all of the like. So we answered that question and then we created policies that said, "Well, let's make sure that we cover these individuals to have access to vaccines, for example, have access to Medicaid, and keep the enrollment continuous and Medicaid, which could help to solve some of that access gap with regard to health insurance during a very acute period of time." And what happened? We did that well successfully. But as soon as the public health emergency ended, all of that started to get rolled back. So that's an example of two steps forward and a step back.

So, I think there are a few things that we need to do very specifically. One is, we do need universal basic coverage at some level, whether it's incremental additions to Medicaid, whether we're looking across our existing, what we call this sort of this patchwork system, and making sure that we're closing the gaps. And even those who are eligible getting onto the rolls — that's already an existing issue — not everyone who can be covered is covered because we have not done our work to make that system much, much simpler. But if we assume that we can get some kind of a universal basic coverage as outlined in the proposal, I think we need more in that basket than the basic. Because the way that our system operates is that when we have more in the basket, that feeds into my earlier point, which is, do we then know the right interventions for specific patient populations that actually gets us to the overall health care outcomes?

And even when we talked about the overall dollars, I think $4.1 trillion dollars — that's a lot. That's a lot for health care. That's the most in the world. How do we use that more wisely? How do we use that much more efficiently? We need to do a much more thorough job examining all the places of waste, and much of that has to deal with the fragmentation that we have in our health care. Every other part of the ecosystem responds to that first fragmentation. So, we need to close the gap between the employer-sponsored, Medicare, Medicaid, access to the marketplaces, and then there is a stopgap. If we close that first gap, I think the rest of the ecosystem will respond, we'll save more money, and we'll hopefully, with some additions of additional services that matter, particularly in primary care, have better health care outcomes.

EDELBERG: Yes, so you mentioned COVID. So, how has, how has the world changed given the technologies that we, that, you know, particularly the medical system, had to develop or had to expand in, you know, in a really accelerated way? How have those changed health care, and have they been for the good or for the bad?

KROFAH: Well, I think the big success story that happened during COVID was the rapid development of vaccines, which, of course, was based on decades-long research. But being able to deploy safe and effective vaccines 11 months out from the beginning of the pandemic, that was incredible from the science perspective. And then, of course, we leverage technologies that we had used for some time, particularly via around telehealth, in order to increase access to rural patients or to others who should not come into a facility. That being said, we are unfort— and the last thing I would say is that this this issue of inequity has come up. So, that across even, for example, medical product developers and sponsors of research, the idea of how do we close health equity in clinical research, diversity in clinical trials, that's a big area. That's a plus. We see companies that are responding and, you know, and creating their own programs. But it is a bit of a thousand flowers bloom. That's the response coming out of COVID. So where are we now? There is mistrust that happened because we did not adequately reach out to those underserved communities with trusted messengers.

EDELBERG: So, I'm gonna put that in the bad category.

KROFAH: That's a bad category. We understand the power of medical research, but, I think in many ways, we have not fully appreciated what it could be done outside of the pandemic for other disease conditions. We have rolled back into our existing incentive structure. That's the other bad category. And am I'm optimist? Maybe I see more in the bad category than in the optimistic category. Maybe just to say that we have a deeper appreciation for vulnerable communities and the role of community health centers, in particular, as a backstop.

EDELBERG: So, yeah, please go ahead.

RHEE: Well, I mean, I-- to me, when I was at NIH, we often talked about discovery to delivery takes 17 years, and the pandemic made us change 17 years into seven, eight months. And the beauty of what we saw in the pandemic, in my mind, despite all the tragedies and the inequities, is our ability to partner nonprofit, public, and private sectors — for us to value all these different stakeholders that often sometimes aren't collaborating. You know, Pfizer, Moderna, CDC — I was at CVS Health. Very proud of the fact that we delivered 200 million vaccines into communities all across the nation. The health centers, you know, 100 million. So we came together. And I agree, in general, it changes incremental. But at certain moments with that type of urgency, we find a way. And when it comes to issues of health equity or primary care, how do we create that urgency to do something more transformative rather than incremental?

EDELBERG: So, Kyu, talking about community health centers, I have a question of, how would community health centers benefit from universal basic care? But actually, then sitting here thinking about

this, like, why aren't we just doing Amy's proposals for community health centers? I mean, that won't be everything, right? But why isn't that a big part of it?

RHEE: So, my strong belief: the nature of our country, there are inequities. You know, we're a country of immigrants, enslaved, and indigenous people. And those are not just racial and ethnic disparities; there are horrible rural frontier and island disparities. So, I want to highlight that health centers play a role in all of those settings, —41%. The reason why I saw Senator Cassidy today, he supports health centers. I saw Senator Sanders the other day. They both support health centers because it has been an approach for nearly 60 years that has bipartisan support and that has delivered higher quality. Like, our quality measures — despite the populations we serve — are higher than the national averages for blood pressure control, glucose control, low birth weight babies, all these other areas, mammogram rates, etc. So I would agree, and obviously, I was advocating for that in these Congress people's offices, and saying, "If you ever have an investment, why not invest in health centers? Because we're going to be there. We're not leaving until the equity is achieved and we're delivering primary care, which is a big lack in our system.".

So, I believe one in three Americans can and should benefit from health centers. If you look at our demographic data and the health disparities, people suffer. We currently serve one in 11 over 20 years incrementally. We've gone from, you know, we were at 10 million; now we're 31 and a half million. I do believe that we are at the right place to invest. Now, the one area I'd say about the basic coverage that I'm concerned about when I read it, I did read that insurance companies would decide what is basic. I did--- or maybe I misread that then. The main thing I want to highlight is, to me, the five cents on the dollar for primary care should be 20 cents. And when you add all the components, like inpatient care, how do you invest more in prevention versus, you know, specialty care and hospital care? I'm very respectful of the role of hospitals — they trained me. But I also know, when we look at our system, we need to invest more in primary care and prevention in communities that need it the most and often. You know, hospitals are not staying in those communities. As I'm talking to rural communities, a lot of hospitals are leaving. The health centers will remain. So, my, my hope is that we can get to a quarter of our health care spend in primary care, as a north star.

EDELBERG: And again, I wanna give an advertisement to the proposal that we have up on the Hamilton Project's website from Martha Bailey to make contraception, particularly for uninsured women, free. And a lot of that would be through those low-income women getting their contraception at community health care centers. So, all right. So, congressman, I'm going to charge you with ending us on a positive, optimistic note. So, we look across the landscape, we have all of the challenges that that we've just discussed. We have this state of Congress that we all in this city know much too much about. Why should we be optimistic?

WAXMAN: Because it's too important of a topic when we talk about health care for all Americans for us to say, "We're gonna give up." We've got to fight to advance what we believe in and know that what we believe in is what most Americans believe in. Secondly, take advantage of any positive move we can make. And there are a lot of positive things that we've done. President Biden's expanded a lot of Medicaid by executive order. The-- a lot of, a lot of things that we want, we could get, and we've got to focus on them and get what we can. There's nothing wrong with incremental changes, but I think we also have to appreciate where we've-- how far we've come because some of the comments seem to be that we, we have this large growing uninsured population. But because of the ACA, because of Medicaid, because of Medicaid, we have 7% uninsured. I'm not bragging about it, but we've been far worse in the past. There were comments about what we can do to get more take-- uptake of what is available. Well, it's partly educational. But health care is not just health care, it relates to all the inequities in our society. And we've got to push for a fairer, more equitable society for everybody.

Oh, I didn't know you had cards. Yeah, I just, I just noticed a guy that says time is up. Well, I'm not finished yet.

I think we can be optimistic because we need to be. And I think the American people are not so enamored of the far right as we sometimes fear they may be. We've got to fight, keep fighting, grab what we can have goals that are clear, and recognize that those goals are consistent with the values of of America and what we all believe in. Even in some of the states where they don't vote Democratic, people do believe in this. And we've got to make clear that their votes matter on these issues that they care about. So that's my reason for hope.

EDELBERG: Thank you. So please join me in thanking our excellent panelists and thank you for attending.