NATIONAL GOVERNORS ASSOCIATION

WINTER MEETING

Saturday, February 20, 2010

CHILDHOOD OBESITY

AND

TRANSFORMING HEALTH CARE DELIVERY

Grand Ballroom

JW Marriott Hotel

1331 Pennsylvania Avenue NW

Washington, DC 20004

PARTICIPANTS:

GOVERNOR JAMES H. DOUGLAS, VERMONT, CHAIR

GOVERNOR JOE MANCHIN III, WV, VICE CHAIR

GUEST:

MICHELLE OBAMA, FIRST LADY OF THE UNITED STATES

GUESTS:

Atul Gawande, M.D., M.P.H., Surgeon,
Department of General/GI Surgery,
Brigham and Women's Hospital, and
Associate Professor,
Harvard Medical and HSPH

Jack Cochran, M.D., Executive Director
The Permanente Federation

P R O C E E D I N G S

(11:03 a.m.)

CHAIRMAN DOUGLAS: Ladies and gentlemen, let's begin the Winter Meeting of the National Governors Association. Thank you all for being here. We've got an exciting program not only today but throughout the course of the next couple of days, and I want to get right into our featured guest in just a few moments.

First of all, I will entertain a motion to adopt the Rules of Procedure for our Winter Meeting. Could I have such a motion?

(Motion duly made.)

CHAIRMAN DOUGLAS: Thank you. Is there a second?

(Motion duly seconded.)

CHAIRMAN DOUGLAS: Seconded. Any discussion?

(No response.)

CHAIRMAN DOUGLAS: If not, all in favor of adopting the Rules please signify by saying aye.

(Chorus of ayes.)

CHAIRMAN DOUGLAS: Opposed, no?

(No response.)

CHAIRMAN DOUGLAS: The ayes have it and you have adopted the Rules, one of which is that any governor who wants to submit a new policy or resolution for adoption at the meeting will need a three-fourths vote to suspend the rules, and any such proposal should be submitted in writing to David Qualm of our NGA staff by 5 p.m. tomorrow.

I want to take a moment to introduce our new colleagues who have joined us since we last gathered: The governor of the great state of New Jersey, Chris Christie. Chris, welcome.

(Applause.)

CHAIRMAN DOUGLAS: The governor of Alaska, Sean Parnell. Sean, thank you for being here.

(Applause.)

CHAIRMAN DOUGLAS: And the governor of Utah, Governor Gary Herbert. Gary, welcome.

(Applause.)

CHAIRMAN DOUGLAS: I don't see Governor

[Robert] McDonnell here, but I expect that we'll see him at some point during the meeting, from Virginia, and we'll welcome him as well.

So congratulations to all the new governors, and welcome to NGA, and we look forward to working with you. We are a pretty good group, I think you'll find, not only of governors but--well, most of the time--

(Laughter.)

CHAIRMAN DOUGLAS: --of not only governors, but other state officials. We've got former governors who attend our meetings, great first spouses who are part of our NGA family; we have corporate partners; foreign dignitaries; the media, of course; a lot of folks at our meetings, and I want to thank you for being here.

Speaking of foreign visitors, we are joined by several whom I want to acknowledge and thank for being with us. The Ambassador of Canada to the United States, Ambassador Gary Doer is here.

(Applause.)

CHAIRMAN DOUGLAS: And he is our host for

the evening at the Canadian Embassy tonight. As many of you know, Gary was a Provincial Premiere for a decade, so he is well familiar with our responsibilities, and we look forward to his hospitality tonight and continued friendship.

We have a number of Canadian parliamentarians with us, as well, and I would like to welcome them to the NGA. There they are, with the ambassador.

(Applause.)

CHAIRMAN DOUGLAS: As well as a delegation from the Canada-United States Interparliamentary Group. We welcome the members of that group who are with us, as well.

And on the other side of the house we've got 20 deputy and district governors from various provinces in Turkey. We are honored to have them with us today.

(Applause.)

CHAIRMAN DOUGLAS: They are here courtesy of the Turkish Minister of the Interior for a Professional Development Program in Public Policy and

Public Administration at Virginia Commonwealth University in Richmond, and we are honored to have them with us.

CHAIRMAN DOUGLAS: Well, over the next few days we are going to be talking about some critical issues that are affecting states, especially the dire economic situation that we're facing. We are going to be talking about the ever-rising cost of health care.

And because of the critical issues in our health care system, I have decided, as you know, to focus my efforts this year as your chair on reforming our health care system. My “Rx for Health Reform” initiative is taking a look at ways that we can deliver high quality, more efficient care to control health care spending and improve health outcomes. I look forward to a lively discussion over the next couple of days on these issues.

As a kickoff to our agenda this weekend, it is a distinct pleasure and honor to introduce our opening speaker. First Lady Michelle Obama has been working tirelessly on behalf of communities across

the country for many years.

Recently she announced a major new initiative in childhood obesity, which has become a serious epidemic in our country. Mrs. Obama's efforts will tackle the health challenges our children face in our homes, communities, and schools. Our efforts must indeed focus on providing children every opportunity to be healthy, productive citizens.

So, governors and guests, please join me in welcoming the First Lady of the United States, Michelle Obama.

(Applause and audience stands.)

MRS. OBAMA: Thank you.

(Continuing applause.)

MRS. OBAMA: Thank you all, so much. Thank you. It is a pleasure for me to be here with all of you today and to welcome you all to Washington.

Thank you, Governor Douglas, for that very kind introduction. And thanks to you and Governor Manchin for your leadership in Vermont, as well as [West] Virginia, and as the Chair and Vice Chair of the NGA.

I also want to recognize all of the governors who are here today, and to thank you for your outstanding leadership and the dedicated service that you provide to states all across this country. We are grateful to you.

Now I would be remiss if I didn't thank all the spouses who are here for all the things you have to put up with.

(Laughter and applause.)

MRS. OBAMA: Absolutely. You all are making the same kind of sacrifices, putting up with long hours and late-night crises, and all I can say is "been there, done that."

(Laughter.)

MRS. OBAMA: I know how you feel, and we are just grateful to have you all. And again, we will give them another round of applause.

(Applause.)

MRS. OBAMA: Now I know that the focus of this year's meeting is the issue of health care. Over the next few days you are going to be talking about spiraling costs that are straining your budgets

and running up all of our deficits. Costs like the nearly $150 billion a year that we spend on obesity-related conditions like diabetes, heart disease, and high blood pressure.

You are going to talk about the staggering Medicaid burdens and how premiums have risen three times faster than wages, often bankrupting families in your states, sinking businesses in states all across this country.

But we all know that there is another set of statistics that have to be a part of this discussion. Like how nearly one in three of our children in this country is now overweight or obese; like how one in three kids today will eventually develop diabetes; and in the African American and Hispanic communities, the number is nearly half.

Because if we think our health care costs are high now, just wait until 10 years from now. Think about the many billions we are going to be spending then. Think about how high those premiums are going to be when our kids are old enough to have families of their own and businesses of their own.

We all know that we cannot solve our health care problems unless we address our childhood obesity problem, too--and that is really why I am here today, to talk about the issue of childhood obesity that is so important to me, and what our states and our nation can do to solve it.

But we have to begin by understanding how we got here and what has caused this crisis in the first place. I have my theories, but when you all think about it, this is a relatively new phenomenon. This was not something we were dealing with when I was growing up.

Back when we were all growing up, most of us led lives that naturally kept us at a healthy weight. We walked to school and we walked home because we usually lived in communities where our schools were close.

All of us ran around all day at school during recess and gym because everybody had to do it. And then when we got home, we would be sent right back outside and told not to come back home until dinner was served. You know your parents didn't let

you in the house.

Back then, we ate sensibly. We had many more home-cooked meals. That was the norm. And much to our dismay at the time, there was always something green on the plate.

(Laughter.)

MRS. OBAMA: Fast food and dessert was a special treat. You had it, but you didn't have it every day, and the portion sizes were reasonable. In my family, I remember, a couple of pints of ice cream, this was a big treat. We'd bet three pints of ice cream for a family of four, and that would last us a week--because you wouldn't eat a pint; you'd get a scoop, and that would be it. You would savor that a spoonful at a time.

And these were not arbitrary rules that our parents just made up. As we know now, it was a way of life they imposed to help keep us active and healthy. They knew back then that kids couldn't and shouldn't sit still for hours. They knew that kids needed to run around and play. They knew that keeping us healthy wasn't about saying no to

everything, but it was about balance, and moderation.

We all had our share of burgers and fries and ice cream growing up, we just didn't have it every day, and not at every meal. But somewhere along the line we kind of lost that sense of perspective and moderation.

We all want the very best for our kids, just like our parents wanted for us, but with the pressures of today's economy and the breakneck pace of modern life, many parents feel like the deck is stacked against them. They want to prepare healthy foods for their kids, but a lot of times they are tight on money and they just can't afford these meals; or, oftentimes they're tight on time because they're juggling longer hours at work, and many of them juggling multiple jobs, so they just can't swing coming home and making a home-cooked meal around the dinner table. It's hard.

They want their kids to be active. But sometimes they live in communities where either it's not practical to walk to school or, worse yet, it's

not safe. Or they live in communities where gym classes and school sports are considered luxuries and not necessities. The first thing to go in a budget crunch.

And those afternoons playing outside have been replaced by afternoons sitting inside in front of the TV, or video games, or the Internet. And as a result, many parents feel like they've lost that sense of being in charge that their parents had.

But we have to be honest with ourselves. Our kids didn't do this to themselves. Our kids didn't decide whether there's time for recess, or gym class. Our kids don't decide what's served to them in the school cafeteria. Our kids don't decide whether to build playgrounds and parks in their neighborhoods, or whether to bring supermarkets and farmers markets to their communities.

We set those priorities. We make those decisions. And even if it doesn't feel like we are in charge, we are. But that is the good news. Because if we make these decisions here, then we can decide to solve this problem. And that is precisely

what so many of you are doing right now in your states.

You are experimenting, and innovating. Many of you are ignoring the naysayers and the old partisan divides and focusing solely on what works.

In Pennsylvania, for example, folks started a Fresh Food Financial Initiative to bring grocery stores to under-served areas. And I got to visit one of those communities yesterday when I spent some time with Governor [Ed] Rendell in Philadelphia.

In that community they started with $30 million. Then they leveraged that for an additional $190 million from the private and nonprofit sectors. And with that money they funded 83 supermarket projects in 34 counties that are making profits, and they are projected to create more than 5,000 jobs.

In North Carolina they have launched a full-scale effort to help kids eat healthier and to exercise more. They've banned snack and soda vending machines from elementary schools. They have given grants to cities and to counties for things like sidewalks, and trails, and community gardens. And

they have trained 41,000 teachers across the state on how to incorporate physical activity into the classroom.

And Arkansas started on the issue of childhood obesity way back in 2003, something former Governor [Mike] Huckabee and I discussed yesterday when I appeared on his TV show. They screened students' BMIs, which was controversial. They got healthier food into their schools, and required regular physical education classes. And as a result, that state was able to halt the rise of childhood obesity completely.

What you all are doing is proof that, if we are creative and committed enough, if we meet this challenge with the kind of energy and determination that it requires, then we can take back control and we can turn back the tide, and we can give our kids the kind of lives they deserve.

And that is why last week we launched this wonderful initiative called "Let's Move!" It's a nationwide campaign to rally this country around a single ambitious goal, and that is to solve the

problem of childhood obesity in a generation so that the kids born today will reach adulthood at a healthy weight.

We have issued a call to action. We have said: Let's move! Let's move to help families and communities make healthier decisions for their kids. And let's move to bring together governors, and mayors, and doctors, nurses, our business leaders, nonprofit community, our educators, our athletes, our parents, to tackle this challenge once and for all. Because it's going to take every last one of us--and particularly folks in the private sector, from the food industry offering healthier options, to retailers who understand that what's good for kids and families can actually be good for businesses, too.

That is why over the next 90 days the First ever, government-wide task force, which includes members of our Cabinet, will develop a national action plan. They won't just review every government program relating to child nutrition and physical activity and advise us on how to marshal those

resources, but they're also going to develop benchmarks to measure our progress and recommend actions that can be taken by the private and the nonprofit sectors.

But we cannot wait 90 days to get to work here. So we have already gotten started on a series of initiatives to achieve our goal. There are four key pillars.

The first: Let's move to offer parents the tools and information they need and that many have been asking for to make healthier choices for their kids. So many parents want to do the right thing, but they are bombarded by conflicting information, and they don't know what to believe or where to start. That is why many of you have been running public education campaigns and creating healthy-living Web sites.

California is leading the way, becoming the first state in the country to require restaurant chains of a certain size to post calorie information on menus and menu boards. Just one part of an aggressive anti-obesity strategy that's making a

difference across that state.

The health care legislation in Congress follows their lead. It includes a similar provision to help parents make informed decisions. "Let's Move!" is going to add to these efforts. We started with a Web site called letsmove.gov. It's going to have helpful tips, and step-by-step strategies for parents.

We are also working with pediatricians and family doctors to encourage them to screen kids for obesity early and then actually write out a prescription for parents with action steps that they can take to address it so they don't feel like they're dealing with this problem alone.

And we have been working with the FDA and the food industry to make our food labels more customer friendly so that people don't spend hours squinting at words they can't pronounce to know if the foods they're buying are healthy.

In fact, the nation's beverage companies, the largest, just announced that they are going to be providing clearly visible information about calories

on the front of their products and on their vending machines and soda fountains. And this is a step in the right direction. It's an important step. But it is still only one step, and we have so many more ahead.

We can't forget, for example, that 31 million of our children participate in federal school meal programs. So we don't want to be in the position where we take one step forward with parents making good decisions, but then we take two steps back when lunch time rolls around in school and kids are faced with poor choices in the school cafeteria.

So let's move to get healthier food into our nation's schools. And that is the second part of this initiative.

There is a reason why our governors are such passionate advocates for our school meal programs. It's because you all know the impact that these programs have. You know that when kids get the nutrition they need, they perform better in the classroom and they miss fewer days of school.

So let's multiply that by 31 million and

we are talking about a serious impact on education in this country. That is why we have set a goal of doubling the number of schools in the Healthier U.S. School Challenge. We have already gotten several major food suppliers to commit to offering healthier school meals.

We are also updating and strengthening the Child Nutrition Act. Secretary [Tom] Vilsack is taking the lead on these efforts, and we plan to invest an additional $10 billion over 10 years to fund that legislation.

This will allow us to serve 1 million more kids in the first five years, and dramatically improve the quality of food in our schools, decreasing sugar, fat, and salt, and increasing fruits, vegetables, and whole grains. But our success here is up to you.

It is up to you to get the most out of these new investments. And maybe that means demanding more from your suppliers in your state. Or maybe renegotiating your contracts to include healthier options. Maybe it means starting a farm-to-school program or insisting on healthier options

in school vending machines, which by the way has actually meant increased revenues in schools in Kentucky and Maine and elsewhere.

But while school meals provide critical nutrition for millions of kids, we also can't forget that kids get plenty of their calories at home right in their own neighborhoods. Many of our kids live in what we call "food deserts." These are areas without access to a grocery store--imagine that, living in a community without a grocery store.

So too many of those calories at home come from fast food, or processed foods from the local gas station or convenience store.

So that is why the third component of "Let's Move!" is let's move to ensure that all our families have access to healthy, affordable food in their communities. Right now there are food deserts in every single state in this country. So we have set an ambitious goal.

That is: To eliminate every last one of those food deserts within seven years, and to achieve this we have created the Healthy Food Financing

Initiative that is modeled on what was so successful in Pennsylvania.

We will start with an initial investment of $400 million a year, and we will use that to leverage hundreds of millions more from the private and nonprofit sectors to bring grocery stores to under-served areas across the country.

Once again, our success here is going to depend so much on what you do. We need you to encourage communities to apply for these grants and provide the right incentives, from helpful zoning laws, to read-map transit routes that help shoppers access stores, to join training to entice grocers with a well-prepared workforce.

But we know that eating right is only part of the battle. We all know that in our own lives. We know that physical activity is critical, too, not just for better health but for better academic achievement.

Experts recommend that kids get at least 60 minutes of active play each day, and we know that many of our kids aren't anywhere close to that.

So, Let's Move! And I mean that literally. We have to move to find new ways for our kids to be physically active both in and out of school. I have to say that many of you have been very creative on this piece already.

Folks in West Virginia have taken the lead in bringing DDR--that's Dance, Dance Revolution--it's a new videogame that gets kids up and moving. Many other states use it, as well. And let me tell you, I can attest to Dance, Dance Revolution. We got it at Camp David, and it will make you sweat.

(Laughter.)

MRS. OBAMA: And it is addictive in a very good way. The President still can't do it.

(Laughter.)

MRS. OBAMA: Georgia is using a program called Hop Sports. They're beaming in videos of famous athletes in the gym classes so kids can learn skills and techniques from their heroes and their role models.

And to build on these efforts, Let's Move! is going to work to modernize and expand the

President's Physical Fitness Challenge. We have already recruited professional athletes from dozens of different sports leagues. They're going to be involved to encourage our kids to get and stay active.

So that is just some of what we are doing, just some of it. That is how we are working to attack this problem from every single angle, because that's the thing about this issue of childhood obesity. It has so many different causes. There are so many different culprits. And it is not enough to tackle any one of them alone, because we can give our kids the healthiest school meals imaginable, but if the rest of their calories come from the corner store, or drive-through, then they still won't get adequate nutrition.

We can have shiny new supermarkets on every block in every community, but if parents don't have the information they need, they'll still struggle to make the right choices for their kids.

So we need a comprehensive, coordinated approach to this problem. But that doesn't

necessarily mean an expensive approach. Because I know that many of you are stretched thinner than ever in these times and don't actually have money to spare. But often it's about doing more with what you already have.

If you're already paving a new road, for example, why not add a sidewalk or a bike path, too? Or if you're already building a housing development, why not add a playground? If you've got school gyms, or playing fields empty after hours, why not find a way to open them up to the community at night or on the weekends?

I also want to be clear that comprehensive and coordinated doesn't mean centralized. I have spoken to so many experts on this issue, and not a single one of them has said that the solution is for the federal government to tell people what to do. That doesn't work.

There is no one-size-fits-all answer to this problem. Because what works in Rhode Island might not work in Arizona. What's perfect for Hawaii might not be right for Minnesota. Different states,

as you know, have different needs, and different priorities, and different resources.

And you all know best what's going to work for the people that you serve. You know what's working, and you know what isn't. That's why the NGA's efforts to support this issue and to provide best-practice is going to be so valuable. It has already been.

That's why I have reached out to so many of you to get your ideas and your input and to learn more about how we can help you. And I want to hear from every single state, of every size, from every region. I want to work with leaders from both parties. Because the way I see this, there is nothing "Democratic" or "Republican." There is nothing liberal or conservative about wanting our kids to lead active, healthy lives.

There is no place for politics when it comes to fighting childhood obesity--and I know all of you agree. I know that.

(Applause.)

MRS. OBAMA: You know that because, with a

phone call, or the stroke of a pen, you can determine whether a child can see a doctor, or get a decent education, or have a safe place to play. Because you all are fighting the real battles every day on behalf of our kids, and you don't have time for the fake battles.

You are interested in what works, what makes a real difference in people's lives, what will make things better for the next generation. It's funny, because that's what drove President Theodore Roosevelt to call the very first meeting of this organization a century ago to speak to America's governors about conservation, about preserving America's beauty and bounty not just for the current generation but for generations to come.

Working for the next generation is what drives so many Americans to do what they do, to work that extra shift, to take that extra job, to go without, themselves, just so that their kids can have more than they did. It's what we've always done in this country.

I know my parents have done it for me.

They measured their success by the success of their children, by whether their children were happier and healthier and had a better shot at fulfilling their dreams than they did.

That's why so many of you got involved in politics in the first place, to leave something better for those who are going to come after you. And in the end, that's what Let's Move! is all about. It is simple.

Let's stop wringing our hands and talking about it and citing statistics. Let's act. Let's move. Let's give our kids the future they deserve.

I look forward to working with all of you in these efforts over the months and years ahead. I'm going to need you. I'm going to need you championing these causes, giving me feedback, giving me direction and guidance. It will not work any other way. And our kids can't afford for us to get this wrong--and we know it.

So thank you in advance for your help, and I look forward to seeing you all on the dance floor tomorrow night.

(Laughter.)

MRS. OBAMA: Thank you, so much.

(Applause and audience stands.)

CHAIRMAN DOUGLAS: Well we thank Mrs. Obama for her compelling remarks on an important challenge for our kids, and indeed for all the American people. Childhood obesity has definitely become a serious problem all across the country, and we need to encourage better health outcomes for all of our kids.

I look forward to seeing Governor Manchin doing that DDR, or whatever it was.

(Laughter.)

UNIDENTIFIED SPEAKER: We'll teach you.

CHAIRMAN DOUGLAS: Not right now, but sometime.

(Laughter.)

CHAIRMAN DOUGLAS: In addition to the efforts that Mrs. Obama described to improve our children's health, our kids need a health care system that supports them along the path to a healthy future. Obesity is just one of the costly conditions

that increase health care spending. Chronic diseases, little prevention, duplication of services, and medical errors all contribute to the ever-increasing cost of care.

Before we hear from our guest speakers this morning, I want to talk for just a moment about the initiative that I've launched for NGA called "Rx for Health Reform," which gives governors the opportunity to explore ways that we can improve our health care systems in our states.

Ranging from prevention and wellness, to payment reform and quality measurement, governors can make their health care systems more efficient and effective, leading to cost containment and better outcomes for our residents.

As part of the initiative, we are going to conduct a summit on state-based health reforms next month. You are all invited to send your state leadership teams to learn from each other, to hear from experts in the field, and plan for efforts you would like to take in your states.

Later in the spring we will be releasing

a delivery system report highlighting the background, evidence, and options for improving delivery systems.

Toward the end of the year, we will kick off a series of regional meetings on how states can implement reforms and look to some of the issues that are similar across various areas of the country.

These activities would not be possible without the generous support of our initiative funders. Without your help, I wouldn't be able to offer the governors of our nation the resources to help them implement health care reforms.

I want to thank the following supporters who have helped make this possible this year:

California Health Care Foundation; the Commonwealth Fund; State Coverage Initiatives; the Robert Woods Johnson Foundation Program; the Centers for Disease Control and Prevention, and Health Services and Resource Administration at the U.S. Department of Health and Human Services; AstraZeneca Pharmaceuticals; Blue Cross Blue Shield; Cerner Corporation; Endo Pharmaceuticals; GlaxoSmithKline;

Hewlett-Packard; Intel; Kaiser Permanente; MAXIMUS; Medco; and Merck.

We appreciate all their support for our health care initiatives for NGA.

(Applause.)

CHAIRMAN DOUGLAS: It is so important that we improve the delivery of care in our country. We spend too much money on health care for too little return. We have a system that encourages inefficiencies, promotes duplication and waste, and too often does not encourage disease prevention; instead, opting for expensive care after patients are already sick--like diabetes, and obese children.

Whenever policymakers discuss health care, they are discussing a complex web of political, economic and social issues that will have a profound impact on the people of our country.

I think that Congress has discovered just how complex and difficult the task is of changing the health care system. Beyond the political complexities, there is the public understanding of what they have now and what they want.

Americans have every right to worry about how reforms will affect the affordability of the care that they receive. They have an equal right to worry about how inaction will affect them.

With so much time and energy spent discussing where the money comes from, we miss the crucial fact that no matter who pays, health care costs are on track to bankrupt our families, businesses, states, and indeed our country if we don't act boldly to reform our delivery system.

While the outcome of federal efforts remains unclear, we as governors have the opportunity to continue to fulfill our roles as the leaders in addressing the key cost drivers, improving the quality of our system, and providing better access to care.

We need to continue to make changes in how we deliver care, how we direct and align payments, and how we realize health and wellness to promote a healthier population.

These are the things that will truly reform health care and contain spending. We must

drive value in our system, but it will take a range of efforts to be successful and sustainable.

Think about it. When Americans are healthier they spend fewer dollars on health care services. Insurance companies and government programs pay fewer claims, and taxpayers and policy owners ultimately save money.

In Vermont we have gained national recognition for successfully implementing comprehensive reforms. Our blueprint for health is built on the premise that prevention and improved care for chronic illness will result in a healthier population, appropriate and timely treatment, and significant cost savings for individuals and for government.

All of our payers--Medicaid, private insurers, large employers, and we hope soon Medicare--participate in the blueprint efforts. These aren't just theories about what will happen sometime in the far off future, these reforms are having a real impact on people's lives today.

Innovative state programs like ours can

serve as models for the federal government and for other states. If we focus on improving our delivery system, we will reduce health spending and improve health outcomes.

Here to give their perspectives on the gaps in the system, as well as what we can do to make our system more efficient and effective, I am pleased to welcome two respected and experienced speakers. They are both physicians. In fact, both are surgeons. They have first-hand experience with the way our system works. They are both leading thinkers, as well, who strongly believe that our system must change to provide Americans with high-quality, cost-effective care.

I am going to invite each of them to make their remarks before we open it up for questions from the governors.

Our first speaker this morning is a surgeon and writer. You may be familiar with his articles in *The New Yorker*, as well as his recent best-selling book, *The Checklist Manifesto*. Dr. Atul Gawande is a surgeon at Brigham and Women's Hospital.

He's a staff member of the Dana Farber Cancer Institute, and he teaches and conducts research at Harvard University. I'm not sure what he does in his free time, but we're glad he has a little to join us this morning.

He has published research studies in areas ranging from surgical technique to U.S. military care for the wounded, to error and performance in medicine. Dr. Gawande has received much recent attention for his ideas on improving our health care delivery system, and it is a real honor to have him with us at NGA today.

Let's all welcome Dr. Atul Gawande.

(Applause.)

DR. GAWANDE: Well I am deeply flattered you would ask me to come talk to you. I am coming to you not as a particular expert but as a still-young doctor. I came into my practice six years ago, where I joined the faculty, and what I have been interested in even from the time that I was in medical school is understanding what it means for us to be great at what we do in medicine.

Along the way, the deepest struggle that you encounter when you're trying to become a good clinician is not actually the money, or the insurance hassles, or the malpractice issues--though those all make our lives more difficult; instead, I think the thing that we miss in this debate that goes on nationally, the hardest thing, is the complexity of what we are trying to pull off.

Medicine half a century ago was not costly, and it wasn't effective. Today, at the start of this new Century, we have since then accumulated what are now 6,000 drugs that I can prescribe, 4,000 medical and surgical procedures, and we have identified treatments for now more than 13,000 different diagnoses--13,000 different ways the human body can fail.

What we are trying to pull off in medicine is deploying all of this, town by town, no matter how big or small the town, and making sure that this gets to every person alive in the country. Is it any surprise that we are struggling to be able to do this?

Now all of those discoveries have proved to be hugely valuable. Life expectancy since 1960 has increased by 5 years. That is almost entirely in people over the age of 65. So now people over the age of 65 live on average 19 years more. They have longer lives and face disability much later in life. And that has its own problems, especially when we are in a society now where retirement, oddly enough, has declined. The average age of retirement went from 67 to 61 during this period. And so we are struggling with that, but that is kind of a separate issue.

The other, the deep issue of cost and quality in medicine has to do with the structure of medicine we have for handling all of those thousands of drugs and operations and everything we provide. We are still small, and fragmented, and artisanal in nature.

The volume and complexity of the discoveries we have has now exceeded our ability as individual specialists or artisans to deliver optimal care reliably and safely and without wasting resources of our patients and the public.

Now there is no question that part of the reason why is that because the technologies that I just described are very expensive. But the piecemeal fee-for-service system that we've worked in has exaggerated these costs. It has led to care that you all know is uncoordinated and inconsistent. It has led to neglect of low-profit services like mental health care, geriatrics, primary care, and it has led to almost giddy, I think, overuse of high-cost technologies like radiology imaging, brand-name drugs, and elective surgical procedures some of which I do.

But the result that we can see is 40 percent of coronary artery disease patients, pneumonia patients, asthma patients, are receiving incomplete or inappropriate care, as just a small example. And the other result is the explosion in our costs where, if we are doing nothing, by 2019 we will have those family insurance plans that we are already seeing 30-plus percent increases in the next coming year heading up to $27,000 by 2019; labor costs rising for health care from 10 percent of wages

to 17 percent; and doubling of state budgets.

There is underneath this, however, a remarkable variability in the cost and the quality of care that different medical communities provide. And you will find that two communities within your own states, which have the same levels of poverty and health, can differ by as much as 50 percent in their costs of care.

That is both frustrating, and the hope, because those that are getting better results are not necessarily--in fact, most often aren't--the most expensive ones. They are often the least expensive communities.

This led us to the painful realization that our local health systems are not really systems at all. We are a big country, and it has been distressing to watch us discover that it is not clear we are capable of even trying to solve the problem of cost and coverage on a national level. But there is no reason states can't.

What we are up against is trying to recognize that we are trying to drive local medicine

to create local health systems where there really hadn't been ones. That means local health systems that feel they are taking responsibility as communities for getting better results at lower costs for their communities.

I am speaking here of physicians, and hospitals, and nurses, and nurse practitioners, and all of the other people involved in the system of care.

There are three missing functions that are required to get there that are not now served by us as clinicians, or insurers, or others along the way.

Number one is transparency. We need to make the health systems results visible to all that are involved. Each of us have become more and more specialized in our training, and we are very good at what we do, but we are increasingly in narrow jobs with little sense of the big picture and our effect on what is happening.

I worked with and got to know a team of surgeons in Cedar Rapids who asked an interesting question. They said: We're a town of 300,000

people. How many CT scans did we order for our town of 300,000 people in a year?

It took them three months to find out. It was extremely hard trying to get insurance information and, you know, it was so fragmented you couldn't get it together. But after three months they found the answer.

In 2008 they had done 52,000 CT scans for a population of 300,000 people. And they were embarrassed. They were embarrassed because they had not realized. And what's even more embarrassing is that that is likely the average across the country. They are not an unusually profligate community. They just happen to be one of the few that asked the question: How many do we do?

It is like trying to ask clinicians to do better with quality and cost at this moment is like trying to ask people to drive a car without a speedometer. We have good county-by-county unemployment statistics. We have county-by-county livestock statistics. We cannot tell you how many operations were done, how many CT scans were ordered,

let alone how many died from those operations, or died from pneumonia.

The information is three to four years out of date nationally, and not at a level that can help us guide in our local communities what can be done.

But there are efforts that are underway in multiple states now to create what are called All-Payer Databases, but essentially asking that you get the public and private insurers together to gather the information and make timely information available to the people at the front lines about how they actually are doing on that broad level. Tell us how we're doing on costs, how we're doing on quality.

That is the first place to start, making the system visible to ourselves.

The second is payment innovation. We are not exactly sure how to make it so that hospitals and clinicians are more accountable for higher quality and lower costs, but we know the fee-for-service approach has been a disaster for ourselves.

There are a few states that are beginning

to walk down this path, and multiple insurers that are beginning to work down this path, of transformative changes to reward those health systems that bring the fragmented parties together and have them drive towards higher quality and cost of care as the way that they are actually paid.

The best example I can give that illustrates both the problem and the kind of solution we're trying to get to is:

Children's Hospital in Boston, right across the street from me, decided to work on a project to reduce their costs and improve their quality of asthma care. They instituted basically a checklist for any kid admitted to the hospital for the first time or coming to the emergency room with an asthma attack.

It turned out to be some very simple things. Make sure they've been prescribed inhalers. Make sure that a nurse has called the family at home to go over--a couple of months after the admission--to make sure they know how to give the inhalers to their kids. Make sure they have an actual

appointment for follow-up with the physician within two weeks.

And, interestingly, make sure that they've got a vacuum cleaner, because the conditions in homes of dust accumulation has been enough that they've started giving out vacuum cleaners. Not something you normally see doctors do.

But after putting in this checklist, they had a greater than 80 percent reduction in admissions and emergency room visits for that population of patients and a two-thirds reduction in their costs.

Now guess what their number one admission is at Children's Hospital? Asthma kids. And emptying out those beds was going to prove to be a financial disaster for them--unless the state began to come in and find ways to begin to make it so that they were not going to go bankrupt because they were doing the right thing. And that is what the state has started to do.

You have seen it in other places like Pennsylvania where their Chronic Care Commission is trying to change the math so that what you're

working towards is healthier patients. The irony here is, the healthier you make them, the more the clinicians lose, and that has to be a change.

The third component besides the speedometer, making things transparent, change in the way people are paid, is creating the kinds of collaboratives where you can have people working towards those, the checklist, those half-dozen things that should happen, whether it's the asthma patient, the heart attack patient, the surgical patient, that can give both higher quality and lower cost.

That has been successful in multiple states where you've seen everything from the Rhode Island Quality Initiative, to the collaboration in Washington state between the governor's office and the hospital association for convening clinicians to work on specific quality and public health initiatives, and also the cost goals.

The only complaint I would have is these have been too small. They have focused on narrow, clinical areas--one place working on asthma and diabetes; another working on a surgical problem--when

what is needed, when you've got a system that works across so many conditions--I said 6,000 drugs, 4,000 surgical and medical procedures, it has to be work that hits every clinical area, from emergency rooms, to child delivery, to pediatric care, to chronic care.

That means specifically working on problems of infection in hospitals, asthma care, heart attack care, pneumonia, stroke, end-of-life and how we handle both making the quality of death improved and access to the right kinds of care; reducing major complications from surgery, and other areas.

But if we create the collaboratives, create the visibility so you can see whether we are improving as we go along, and have the payment innovations, together you can have a system that does not learn how to squeeze as much money out of a system as we can, but learns how to make a functioning system, locality by locality, better over time. Only do one of these, though, and it breaks down.

And that is where it comes to the last step that I would suggest. It feels enormous and hard to pull off, community by community. It is multiple problems trying to be tackled at once. And I know that if I were trying to take this one, I would want to have almost in my back pocket what you would call a beacon community, a county or a town that you are working with as your early adopter to make sure that you have all of these happening state-wide, but you have one place that is willing to commit and work with you towards identifying how they can be better quality and actually be lower cost and demonstrated over the next three to four years.

We have lost faith I think that we can handle the complexity of modern society. But just by being governors you have declared yourself among the few who think that loss of faith is wrong. I thank you for it, and I thank you for all your efforts to work on this major problem.

(Applause.)

CHAIRMAN DOUGLAS: Well, Dr. Gawande, thank you so much for your perspective and insight.

You have given us a lot of food for thought, and we look forward to our discussion shortly.

Our second speaker comes to us from one of the most touted real-world successes of delivery system reform, Kaiser Permanente. Dr. Jack Cochran is Executive Director of the Permanente Foundation. That is the organization that represents Kaiser's physicians.

He works with the more than 14,000 physicians employed directly by the organization to ensure that high quality appropriate care is delivered to the members through innovation and coordinated models.

Prior to becoming head of the Federation, Dr. Cochran was head of the Colorado Permanente Medical Group. He is also a surgeon, focusing on head and neck, as well as plastic and reconstructive surgery.

Let's all welcome Dr. Jack Cochran.

(Applause.)

DR. COCHRAN: Well thank you. It is really a privilege to be here.

As we look at the challenges that are facing the country right now in terms of health care reform, the economy, joblessness, *et cetera*, it is very clear that the states and the state leadership are going to be central to finding the ways that we can move forward, and that you have some of the greatest challenges of leaders anywhere and in many ways at any time. It actually makes me glad that I actually am a physician and not a governor, but as Atul said, I think we are very fortunate that you have taken the mantle seriously.

I think that there is a good opportunity for us to really do some learning together. I believe that Kaiser Permanente is a model that has some time and has some real track record of improvement, and of performance, but I also am really particularly interested in sharing with you what we have done in the last very few years. Because I think we are starting to ramp up the kinds of performance based on the principles that the health reform experts really study and look at. And I think we have got some approaches that can be applicable

beyond just our fully integrated system.

I am always reminded, as we start even thinking about these discussions or giving these talks, as the First Lady and Dr. Gawande reminded us, this is really about patients. And let's not forget that the role of a patient is an involuntary state.

Nobody wakes up in the morning and says; You know, I haven't been a patient for awhile; I think that would be something to do today.

So they are the vulnerable ones. They are the ones that are caught in the holes in the net, and they are the ones that are experiencing some of the fabulous care and also some of the problematic care.

I am reminded of a quote by the great polio researcher, Jonas Salk. He said: Our greatest responsibility is to be good ancestors. And I wonder about that as I travel the autumn of my career as a physician: what am I going to leave behind? What is my legacy going to be for a care system that works, that's safe, equitable, accessible, affordable?

And more than that, what am I going to leave behind for careers? Are we going to create an

area, a place where people want to be nurses, want to be primary care physicians? I think our legacy has got to be one of the things we all look at as we have these jobs where we serve.

So I am going to outline a little bit why I think Kaiser Permanente and similar systems--and they are in many of your states if not all of your states--of care are often mentioned as potential solutions. So a very brief overview.

Kaiser Permanente is a fully integrated care delivery system with the Permanente Medical Groups, of which I am a representative, and the Kaiser Foundation Health Plan and Hospitals. We are aligned between both financing and care delivery, which is a great advantage.

We are in nine states. We have 8.7 million members. And we are an organization that is continuing to try to learn how to get better, but I am just going to go over some of the things that I think are important.

I am going to contrast, first of all, the difference between my experience of 10 years in the

fee-for-service practice environment versus working in a system; talk about the advantage of integrated systems and identify components that can actually be translated and applied in your communities; and then suggest how this can all fit with reform at the state level.

So after completing my surgery training, I joined a three-physician group practice in Denver, Colorado. I worked with excellent physicians, delivered great care, enjoyed it; the necessary emphasis was on building a practice and keeping my surgical schedule full. That was what surgeons get paid for. They don't get paid for necessarily giving advice. So there is a necessary tendency to say keep that surgical schedule full, as we both know.

My results were largely managed by myself in my office, and the people who observed my results were myself and my patients. And I had a paper chart. So that was an experience of sort of a small business person working in that kind of an environment.

At that time there was a trend going on in

this country--it was in the 1980s--called "managed care." An innocuous enough term, "managed care"; sounds like something that might be important to coordinate patients' experiences. But was care truly being "managed" at that time? And by whom?

I think what I observed was that decisions were being interfered with, and care was being manipulated more than managed, and it wasn't being run by the physicians where I think the care that the patients trust should be.

So the alienation that occurred in that era of managed care was so profound that it went away, and that particular version of managed care was gone. But I believe we have all learned that we do have to manage the process of how people get their health care, and to manage it well, and to manage it by clinicians.

Interestingly, there was an exception in my practice in those days, and that was a system called Kaiser Permanente which was down the street, but it had been in Denver for 15 years, was growing, and what was interesting was that their philosophy

was that if care needed to be delivered, one of their physicians would call or write me and say please deliver the case, please do the surgery on this child, please carry out what's necessary. And it was a very different model. It was sort of clinician led and the clinicians were very involved.

I think that philosophy was very refreshing to me. And the contrast became a little clearer to me over time. It became clearer also that they had and were continuing to recruit excellent physicians with pretty happy careers. It looked like they were doing really good work.

As they grew, they then started to recruit specialists. I was approached, and over a couple of years I decided to join them. So that was a chapter where I then left an autonomous sense of a small group practice which I loved, my friends and colleagues, and went into a system.

And it was a bit of a shock, because their mantra was: Do the right thing, but accept more accountability. There are a lot of issues in health care, and physicians need to be more broadly

accountable.

I was also introduced into a culture of measurement. They kept track of what was going on and what the results were, and the measurement took a little getting used to because it wasn't just my chart, and it wasn't just me monitoring, there was a sense of pure scrutiny. But there was also a sense of pure support. It was a group practice, truly.

And I also learned it was a very good system. And before I close I am going to tell you how I think it has become a great system and why.

I'll tell you a story of two internists. One internist was saying--this was about three years ago before I left Denver to move to California--two internists were talking about their practice. One was in about his 60s, been in practice about 30 years, and declared: “You know, all this talk about a medical home? I've been a medical home my whole career. I've taken care of my patients. I've coordinated their care. I've been the source for all the care that they need, and people come to me. I am the medical home, and I'm a great practitioner.”

The other one said: “You know, George, you are. You're one of the best internists I've ever worked with. But let me tell you what happened to me 10 years ago when I left practice, because I used to compete against you, and went to work for Kaiser Permanente.

“They started bringing me data and information, and showing me what they called ‘care gaps.’ And I looked at these rather younger doctors and said: Well what are you showing me care gaps for? I'm sort of the dean of this specialty around these parts.

“And actually he said it was interesting, because there really were gaps in what I was doing as far as prevention, usually prescribed things. We had data, and we had guidelines, and he said they then showed it to me and I could close those care gaps.

“He said what was wonderful was to watch my practice be documented as a higher quality practice over time. So I actually now not only believe I deliver great care, but I have proof, and I have proof to the most important critic, which is myself.”

It is a very moving comparison of experience.

So why a system of care? The Institute of Medicine in 2001 published something called "Crossing The Quality Chasm." They talked about the current systems of care can't do the job, and trying harder will not work. I'm going to talk a little bit about what Dr. Gawande said about why complexity was important.

And they said--these are the best thinkers in health care, not a political group--organizations needed to negotiate six challenges:

Redesign care processes based on best evidence, the honest, best science;

Effective use of information technology--you have to have IT to make this happen;

Knowledge and skills management;

Development of effective teams;

Coordination of care across conditions, services, and settings; and

Use of performance outcomes and measurement to make adjustments and to learn.

Newer concepts of this sort of thinking

are coming out in some of the policy around accountable care organizations. I think organizations like Kaiser and Geysinger, and many others, are accountable care models for care.

And yet there are many, many dedicated, caring, intelligent physicians in our communities and our states, but as Dr. Gawande said, there has been an explosion in complexity, and we are all, in spite of our good training and good backgrounds, we are all human.

Patients with current complex conditions and co-morbidities are becoming more prevalent. Patients are living to develop multiple complications, multiple diseases, on multiple medications that are all requiring a certain amount of sensitive interaction.

The medical literature and medical information has exploded. The number of journals during my career has gone from a few--I mean, Marcus Welby could actually read every night and read most of the literature, and today the number of journals is vast, and the number of articles is vast. And the

other sources of information--the Web, the various things that we can look at, and our patients can look at. Patients go online with groups with their type of illness and find out things about that.

So we have to be able to manage all that complexity. The diagnostic capabilities. He talked about the use of CT scans in one community. And the types of therapies are also, as outlined previously.

So the best physicians, the best ones need support in a practice to negotiate these kinds of challenges. I think support looks:

Health IT;

Aligned colleagues;

Good health care teams; and

The availability at the moment of practice of more knowledge than just you can translate into your head.

So I just want to share three examples of why a system that's integrated with IT can really make some changes. These are just brief clinical examples. They're all real. They're all published.

The first one is called Collaborative

Cardiac Care. Patients who have myocardial infarctions, a very, very serious condition, need secondary prevention. After they've had their event, there is a significant mortality to have a second event. And secondary prevention involves a lot of things.

This particular part of the organization decided they would take these patients and put them into a computer registry where all the information was available. And then they created a team with a physician, with a nurse, with a clinical pharmacist. And the clinical pharmacist is one of the keys to a lot of these programs because they're an asset that we often under-leverage.

They then take this registry of patients and monitor them over time. They monitor their weight, their smoking habits. They monitor their activities, blood pressure, medications, and laboratory, and patients are actually being monitored by teams when they're not even sitting in front of the patient--not even sitting in front of the physician.

And guess what? When you really take on something like secondary prevention and you stay in a program like this for three-and-a-half years, there is a 73 percent decrease in the overall mortality: 135 averted deaths. That is based on historical controls and the data is published. Plus, 260 emergency interventions.

Those interventions are expensive to the health care system, but just imagine the patient who has already been through the terror of having one myocardial event to their heart, and now back having another event. So it is really about what it does to the patient.

Next, upstream we had another thing called PHASED, Preventing Heart Attacks and Strokes Every Day. This is another upstream use of data, information, and teams to prevent heart disease. So patients at risk are identified. Their laboratory tests are monitored, and the appropriate medications are prescribed. And over time, a significant decrease in myocardial events again happens there, primarily, not secondarily.

And the last example is a program we call "Healthy Bones." Osteoporosis is a big problem in our aging population. Patients are at risk for hip fractures. And hip fractures in the elderly have a significant mortality. I mean, they hurt. They are disabling. And they also cause death.

This again, a multi-disciplinary team identified patients at risk; do the appropriate laboratory screening; getting them their DEXASCANS, their laboratory, and then giving them the right prevention, the right instructions. And what happens?

Historically, this region would have 2500 hip fractures in a year, and in 2007 they had 1500 hip fractures, 907-some less hip fractures, and that is a $36 million savings.

Why do I tell you these examples? Well, because a lot of the stuff you hear in the policy world sounds theoretical; it sounds possible; it's actually doable, and it is actually being done.

What is really good about this kind of program is, if you have an orthopaedic surgeon on the

team to prevent fractures, that is very cool. Because what you are doing then to that orthopaedic surgeon is you are paying her well to do well. You're not paying her more to do more. So it is really a great use of a specialist, besides just fixing fractures.

So the key features in learning that I think can be taken back from this are:

Integration of care is a very important process toward creating systems, and it can be done virtually. And I'm going to talk about that;

IT and information technology is important; and

Payment methodologies such as bundled payment really allow the ability to distribute care in the right ways and to create opportunities for people to collaborate differently, and great team development, and we have great relationships with our labor partners in our organization.

The learnings from this are quite simple. You need information, and it's got to be in front of you. And that's why the last three or four years

we've seen Kaiser Permanente take another leap in terms of our ability to function. And that's IT systems with real data.

You then have to have some methodology of surveillance, either electronically or by teams. You are following patients along, and then you outreach to them and reach out to them. And actually you can care for patients without even seeing them sometimes.

This allows you to ask different questions. The question of our broken system is how many patients can you see? You're now able to ask questions like how many patients' problems can you solve? And that is a very different model and it allows for this kind of innovation.

I just want to finish this part before I close by saying: Don't say, well, you can do this because you're Kaiser Permanente. We couldn't do it until we did it. And there are places in your communities that are doing it right now.

Cedar Rapids, Iowa, is doing some great work through a collaborative there to create community integration at a virtual level.

In Phoenix, the Arizona Integrated Physician Group has created a virtually integrated group that's measuring data and creating different outcomes.

And in Colorado, the Denver Health System, which is a safety net organization, is fully automated and takes care of patients in a very integrated manner.

So Kaiser Permanente I think is an excellent model, but some of the learnings are applicable broadly.

So I will finish by saying, from the policy point of view what does this mean to me? I think we need to create incentives systems; that's an excellent way to manage the complexities and care. And I think that the incremental paying of fee-for-service misses the opportunity to really develop systems, and systems that can coordinate care and deal with the complexity that Dr. Gawande talked about.

Delivery system reform and payment reform are essential. They must be central to policy

reform. Coverage is important, but it is simply a start along the way.

And what a group you have. First of all, you have among you some of the greatest thinkers in this area, some early adopters who have really moved forward. I think some of you--I've met with people from some of the states--say yes, we have. We're halfway across the river. And that's a very interesting place to be, because halfway gives you two options. And I think what you all are saying is, well, I think we need to get to the other side because we're learning.

I met with some people from Minnesota, Massachusetts, and Vermont in the fall and they are really understanding that they have opened it, and the complexity is really something that they are dealing with. But it can be done.

So I think you have to look at issues of coverage. Payment pilots, as Dr. Gawande talked about. Look at what makes an accountable care organization, and why it is more than just a structure or a political construct.

Health IT. We could not do the things that we are doing without Health IT. There is a measure of clinical quality. The National Committee on Quality Assurance, NCQA, measures. And Kaiser Permanente as an organization about 10 years ago said, you know I think in the nation we ought to be in about the top quartile. We ought to get to the top quartile, be better than 75 percent.

Then about five years ago we were there, and we thought maybe we could get to the top decile. And then what has happened over the last few years is we now have IT systems where there is undeniable data sitting in front of us, and we're looking at it, and we're saying, my goodness, we've got these gaps. And we are now in many measures tops in the nation and number one.

If you look at NCQA's assessment of Medicare programs, of the top 15 of all the hundreds of programs in the country, Kaiser regions are sixth of the top 15. So we have really learned, and we are continuing to learn how to leverage integration and IT and systems.

So I will just finish with one point, if it's not obvious: Physician leadership is essential. If you are sitting in a community and saying, you know, we really want to do this but the doctors aren't on board, I would say keep looking.

I think every community has physicians who are frustrated with the system and who want to create a better system. I think they are in your communities. You have to identify them, recruit them, and support them. But I think that physician leadership is essential because to develop systems you have to have the clinicians who are thinking together and look at the bigger picture and have a bigger point of view.

I think you have to understand and support the power of IT. For us it's been a great transformation. And then payment reform. Payment reform gives you the opportunity to be much more innovative in how care is delivered because you can take an orthopaedic surgeon, and again pay her well for doing well, and be part of a team that creates better outcomes and preventions.

And then the standards of best care and practice, as we've talked about, must be developed.

So in summary, I think I tried to contrast for me the difference between a system that was a nonsystem that I worked in, that I frankly quite liked, how I thought there was a better system ahead, got into it clinically, ended up in leadership, and I believe that there are applications from what we've learned that are useful in your communities as well as in your policy thinking.

So thank you for taking on these jobs. It is a tough time to be a governor, and I certainly add my appreciation to your work. So thank you.

(Applause.)

CHAIRMAN DOUGLAS: Well thank you, Dr. Cochran. We really appreciate your perspective and the experience that you bring to this discussion and how it might be applied to all of our states.

We have got some time for questions of our two guests. Governors? Governor Lynch.

GOVERNOR [John] LYNCH: First of all, Governor Douglas, thank you for focusing on this. This

obviously is not just a health care issue; it's an economic development issue.

So many business people I talk with, because of the rising cost of health care, are forced into a position of reducing coverage for their employees, and in some cases dropping coverage for their employees. Their costs are going up, and they cannot raise prices obviously. And it is also impeding their ability to grow and hire more people.

But my question has to do with, we could do all of the things that you are suggesting--transparency, getting away from fee-for-service, accountable care organizations focused on prevention and wellness, IT--and I still worry whether that will be enough to stop the growth in costs.

My question is: Don't you think we need cost targets? Because if we don't have cost targets, we could do all of these things, do them well, and costs will still go up. And whether it is a cost target at the state level, percent of gross state product, or per capita costs, or whether in a

community getting people to work toward a cost obviously while at the same time not sacrificing quality.

So that's my question to you all, that I'm concerned we could do all of this and still not stem the cost increases that we are seeing on an annual basis.

DR. GAWANDE: I'll jump in here and say a couple of things.

One is that, where we got in trouble was where we started to have purely cost targets, because it lost the public's trust that this was anything except about the money. It was not about making a better health system for them.

And the gamble here is the idea that we can set our goals on quality and be able to achieve those cost goals, as well.

I sat in my own hospital's financial meeting for our department of surgery, and what was interesting to me was we have a cost target. Our target is a 7 percent revenue increase every year for the next few years. And that actually is the average

for American hospitals. The average American hospital expects a 7 percent increase in revenue each year.

And unless we have the clinicians and hospitals on the same page, which is that every other industry is expecting a 2 percent increase in revenue each year and is learning to live within that, then what will happen is you can have the transparency about quality, have the payment innovation, have the collaboratives, but then they will find other ways to fill those hospitals' beds and have elective, you know, other services on the side that get it in.

And so part of the transparency I think is also having both the quality and cost markers out there.

Maine has tried the approach of having a cost target as a voluntary matter, and just by making it visible they found that they were able to lower the cost growth rate. And this isn't about simply lower the costs, it is just trying to take us off a trajectory that is three times faster than wages are growing, and begin to point us in the right

direction.

CHAIRMAN DOUGLAS: Dr. Cochran.

DR. COCHRAN: I would say that, as we get better at the transparency that Atul talked about, we will really have a greater sense of corporate or personal responsibility.

There was a study that was done a few years ago in the British Medical Journal by a professor who studied the National Health Service versus Kaiser Permanente.

He came out saying that, you know, pound for pound, pound for dollar, and quality for quality, that they got better results, Kaiser got better results for its quality, and better results in terms of finance and affordability. And he had good data.

Now his conclusions were threefold. We had an integrated system. We didn't have an incentive toward fee-for-service as a methodology for growing business. And, three, we had competition. And he felt like competition was extremely important.

So, you know, as much as I like Kaiser Permanente, you're probably better off to have four

Kaiser Permanentes in your state than one taking care of the whole state. I think competition is going to be an important, enduring part of this. But transparency of data, I'm learning in an organization that's getting better and getting more transparency, is very powerful. Because that's when you start to get that impetus of a coalition of people that are saying, actually, you know, this is real and we really need to act on it. And at that point in time, the old methods of rationalization get a little pale.

CHAIRMAN DOUGLAS: Governor [Jennifer] Granholm.

GOVERNOR GRANHOLM: I am so grateful that you brought these two speakers here.

Dr. Gawande, I didn't realize that you were going to be here, but I have been distributing your article in *The New Yorker* to everyone I know of. If you haven't read it, it is the single best article, most accessible article that you can read, I think, about bending that cost curve.

So this really isn't a question. Just a statement that I encourage you all to read it. And perhaps if it hasn't been distributed, Governor

Douglas, we can do that through this session so that people have access to it. It is a terrific, terrific piece.

CHAIRMAN DOUGLAS: That's a great idea, unless it's a copyright violation.

DR. GAWANDE: It's all yours.

(Laughter.)

CHAIRMAN DOUGLAS: That's a great suggestion, governor. Thank you.

Governor [Deval] Patrick?

GOVERNOR PATRICK: Thank you, as well, and thanks to our speakers for being here. Those were wonderful presentations.

I wanted to just come back to the payment reform point. Dr. Gawande will know that we have had a payment reform commission at home in Massachusetts, and they have unanimously recommended we move away from the fee-for-service custom to a medical home or global payments structure.

But the breakdown has come over the pace of transitioning from where we are to where we need to go. And five years is viewed as too fast. And I

would like you to comment on that. Because while it is too fast from the perspective of some of those hospitals and provider groups and so forth, to John's point, small businesses and families are drowning under these double-digit increases in premiums year over year.

DR. GAWANDE: I am in the middle of this. I am a fee-for-service paid surgeon in Massachusetts, and we are embracing the idea that we have recognized that I can't be paid the way I used to be paid.

And now you sit there saying, okay, for let's say a kind of cancer I take care of, that we would receive a bundled payment. And our fear is, how do you make that work in such a way--how do I make that work in such a way my patients get better care, and also I am not somehow screwed along the way. And the reality hits us right in the face.

I am going to get a fixed payment with a team of people, and how are we going to divide up the money between the radiation therapist, and the oncologist, and me, and the primary care? It's a battle we don't want, and you are pushing us towards,

and we need to have, and it's the right place to be pushing us.

Five years feels very fast because we've been paid the same way for a century now. And we also don't know what it actually looks like in the details. And the short answer for this, I would say, is that once you make it work in one place it is much more likely to move faster in the others. But the reality is that we have not seen the transition.

So Kaiser Permanente, or Cleveland Clinic, and other places have made a transition to global payment models over many years, over decade. We have not taken any community anywhere in the country and made it go the other way.

And so my sense of it is that if you're able to take one forward, the others will fall much faster. We have seen it in lots of other places. I have led an effort to reduce surgical deaths by bringing checklists into operating rooms, and I have been thrown out of a lot of operating rooms not just in the U.S. but around the world.

The idea that we would transition to using

this checklist was thought to be too fast when we said that the target would be two years. We have achieved it now in 20 countries, by starting first with the early adopters and making sure we could prove it could happen for a group of 10 percent.

Once we hit about 10 or 15 percent, we could move within a year to being population-wide in many countries. So that is what I would say: that you're going to get those barbs that five years is too fast; but if you can make it happen in one place first, the rest is more likely to follow.

CHAIRMAN DOUGLAS: By the way, I recommend Dr. Gawande's latest bestseller. I'm not being paid for this, but it's a real look at how an innovation can make a significant difference in quality of outcome and surgical procedures and reduce costs at the same time.

Dr. Cochran?

DR. COCHRAN: I would actually echo that. He's a prolific writer. I read all of his books, so it is always a pleasure to see a new one.

I think we have to be a little intentional

around the process, because I think speed is important, but I think you have to start off with a process that says we're going to convene enough people to get the context right so we're looking at the same problem.

That way, you have physician leaders and people who are going to be involved. And that is a little iterative and takes a little time, but once you sort of have the context agreed upon that we understand what the problem is, then you set forward that this is where we need to go. And you have to invest in training, and in IT, and the necessary systems so that it can happen.

I think then you find the early adopters. Make them take the systems you have invested in with the agreed upon sort of mission, if you will, and get some success. I think you will see slow change, and then you will start to see momentum. And I think the momentum is when the early adopters, who are now the peers--they're not the governors, or the leaders--but when the peers say this is really working, then I think you have the opportunity to create momentum.

GOVERNOR LINGLE: Jim?

CHAIRMAN DOUGLAS: Governor [Linda] Lingle.

GOVERNOR LINGLE: Thank you. Just to be equally complimentary to our speakers, and I appreciate Mr. Cochran being here. Hawaii is one of the states that has Kaiser, and they do a terrific [job].

I received a book from George Halvorson, your president, called *Health Care Will Not Reform Itself.* If you haven't read that, it is about 110 Pages, but it's an outstanding publication, and I would assume every governor got it. I don't know. But I found it extremely helpful.

In listening to you today, and listening to your own transition, and knowing the doctors I know on a personal level, it seems to me this is very generational. It is going to be very, very difficult to convince a person who has been in fee-for-service for a long time that this is the way we're going to move as a country and that we should move. And I think the chances of achieving that are minimal.

Which brings you to the next point that it

seems to me this should be a function in the medical schools. And in those states that have state-sponsored medical schools like Hawaii, that is what I thought of in listening to you both today, is to go home and to talk at the medical school about are the students getting discussions about these issues.

Perhaps they are already, as opposed to just care of patients, but it seems to me for the country to move--and your point about physician leadership is essential. If it's essential, then it needs to be taught. Is that something going on? Or is that something you could speak to?

DR. COCHRAN: Yes. Actually, that is exactly on point. It is not a part of the core curriculum of medical education to teach one leadership. So you come out as a professional with training in your craft, but not training in leadership.

An organization like the U.S. Army would never do that. They teach you about your craft, and they also teach you about leadership.

Actually, I do a lot of training of

physicians around leadership because it is very easy to take a system that's broken and issues that are this complex and assume the role of victim. You know, if the insurance companies, and the lawyers, and all these other people will change, it will be okay.

Whereas, it is a little more lonely and a little more courageous to say actually the patients depend on us as physicians to lead this. We have to start opting into the conversation and take some of the complex conversations straight on and represent what could look like a different future.

Capitation and global payment and structured systems is not scary; it's a fabulous way to practice medicine. And so Atul and I were talking that I often give talks to physicians, and he's decided that his generation and my generation are not quite as different as I think they are. Because I will often find people who I'll talk about physicians broadening their sense of accountability, because the patients exist more than just in the exam room; they've also got financial problems, and access

problems. And who better to be accountable to patients than physicians.

And what's interesting is I will give those kind of talks, and it's a little provocative, and there will be a group of physicians in the room who will get sort of upset with me, and another group who will say, you know, actually that kind of makes sense.

And so I think we as a profession need to be in transition away from, there's nothing we can do; you're going to have to fix it to we're going to step in and be as present as we can on behalf of our patients, and whatever that takes in terms of my role I'm going to accept that.

CHAIRMAN DOUGLAS: Several more Governors have questions. I'm conscious of the time, so if they could be as expeditious as possible I'd be grateful.

Governor [Tim] Pawlenty?

GOVERNOR PAWLENTY: Thank you both for the excellent presentation.

In Minnesota I guess we would describe

ourselves as being in that middle-of-the-river position. We want to pay well for well, not more for more, as you suggested. And we've made some good progress in a couple of chronic disease categories for paying for outcomes.

However, in the near-term, as a proxy for outcomes we are trying to identify best-practice treatment protocols and then, at the very least, pay for following not the checklist but the best practice protocols.

We have a hard time, of course, corralling the profession around agreement on what those best practice protocols are. We have a little bit of an advantage in Minnesota because a group affiliated with the Mayo Clinic weighs in on these issues, and we challenge our professionals to say would you really like to argue with the Mayo Clinic? Please proceed. We'd like to hear your argument.

But in any event, there is a lot of delay, or at least a lot of work around how do you identify and get professional buy-in and sign-off on those protocols, and it takes a long time.

Could you give us any insight or advice about how that process could be accelerated and agreed upon?

DR. GAWANDE: I'll just say quickly, when we were trying to come to agreement among surgeons, anestheologists, and nurses about the half-dozen most life-saving things we've got to make sure happen over and over again, it looked like it was going to take about a year.

And then we put patients in the room and moved a lot faster. People are--clinicians become much less willing to say we can't do it, it takes more time when you've got--we brought in a man whose daughter died for lack of oxygen on an operating table.

DR. COCHRAN: I'll go back to what I alluded to earlier about the process. You know, you can't go too fast to try to just say, well, just get on board, get on board. But if you really embed that kind of process thinking into it, the first one will take quite awhile. The second one should start to get a little bit easier because people have figured

out that they've had their say, they've been able to get supported, and they understand why we would do that.

I think that, you know, physicians are a very heterogenous group. I mean, I serve in some ways 14,000 of them. I can assure you they don't all wake up every morning saying, boy, I hope Jack's having a good day.

(Laughter.)

DR. COCHRAN: I mean, we are a different group. We're independent, like journalists and governors, very, very independent thinking people.

But I also think that over time the more physicians get into the conversations, as opposed to saying, you know, somebody is doing that to us, we've got to own it and be, you know, the people who say we want to be in those conversations. Because otherwise, some regulator will do it to you. And that's really a tough way to manage professionals, just to dictate what to do.

CHAIRMAN DOUGLAS: Governor [Don] Carcieri.

GOVERNOR CARCIERI: Thanks, Jim. Let me

add my thanks to both speakers.

One of the angles I'd like to get a reaction to is, you know, we talk about "the system." And part of the system is utilization. And clearly the patient is what's driving that. And if I'm correct, a high percentage of the cost is related to disease that, frankly, is preventable, or the onset could be delayed much further if people took more responsibility.

And one of the things I think we've evolved in the system here is that we've just all gotten used to the idea that, once we get sick, no problem, we'll be taken care of.

And so what we've tried to do--and I'm interested in your thoughts--is we have a big focus on wellness, and have had great success actually by building incentives in, for instance, to our state employees health care program.

We will now give a $500 deduction for the share of the premiums that the state employees pay if the employee is undertaking a whole host of things: primary care physician; if you're diabetic, making

sure that you check with your endocrinologist; and a whole series of things.

We've been able to actually see the costs start to begin to flatten out. And so I'm interested in your thoughts because you can reform the system, but at the end of the day a lot of this is driven by utilization. And how do we incentivize in our state, or incentivize individuals to begin to take more responsibility for things that they can do to really delay the onset of disease?

DR. COCHRAN: I would say that, to link back to the First Lady's comments, if you look at the total things that contribute to health, health care is in the 10 to 20 percent range.

On top of that is your DNA, your habits, your lifestyle, your diet, and so you're right. There are many places where health can be significantly augmented besides health care. And I think that's what we're also learning in this country. If you look at the employers in your states, many of them are very, very vigorously looking at employee-engagement programs around health

and wellness.

So health care is not the major determinant of one's health. And so all these other things, you know, your DNA is not changeable--or I would say, "yet"--but some of the other things really are very much within the realm of programs, employers, governments.

DR. GAWANDE: You said it as well as I think I could possibly say it, so I'll leave it at that.

CHAIRMAN DOUGLAS: Governor [Mike] Rounds?

GOVERNOR ROUNDS: Just a thought. Bringing it back kind of into the practical side of things, Medicaid provides a huge amount of the dollars going into the health care systems today. The reimbursement in our part of the country is between 50 and 52 percent of the billed charges.

I'm just curious. In each of your two types of practices and systems, you obviously take Medicaid recipients. How does the payment under the Medicaid schedules, how does that fit into the way that the reimbursement schedules are set up for the

providers that practice in each type of system?

DR. COCHRAN: Medicaid obviously varies significantly from state to state, and in some states the program is looked upon as something where a lot of people want to be in, and in some states it's where fewer people want to be in, and actually they find it challenging from a financial point of view.

Having said that, I think that there's two things we need to do. Number one, we need to fund programs adequately. Then number two, we need to continue to push on the issues of waste, and cost shifting, and the kind of things we think in care delivery is where the impact can be done.

So, you know, as Atul talked about, in a city where you have 50,000-some CTs for 300,000 people, that is an amazing ratio. If you told people from other countries about that, that would be an amazing ratio.

So I think it is both. We need to make sure the programs are funded adequately, number one. But number two, we need to continue to be relentless on the issues of how we streamline care and create

efficiency.

DR. GAWANDE: There's no question that, you know, Medicaid under-provides, and that you're trying to cross-subsidize across a practice. The place I saw it the most was growing up in rural Ohio. I grew up in Athens, Ohio, in the southeastern corner. My mother is a pediatrician there, and her practice was one where we had about a third who were uninsured or on Medicaid, and then two-thirds who have private insurance of some kind or another.

And she was the only pediatrician in the county for a long time that took Medicaid. And the result was that suddenly that one-third became half, and it became harder and harder to be viable unless she joined along with the other colleagues. And so we cross-subsidized across the family because my father is a surgeon and we could have his income subsidize hers. But that is not the best way to do it.

And so, you know, I think as physicians we have a responsibility, as long as there are uninsured people, to find ways to do what we can for those who

are uninsured, and handle as many Medicaid patients as we can, but also in the bottom line we are in these small business models.

I do think that as we move to being better integrated systems that we also have to hold our feet to the fire for the Kaisers, and Mayos of the world, and so on, that they are helping with their share just the way that other smaller doctors are in providing care for those Medicaid and uninsured patients.

But in the long run, if Medicaid is to be viable, as private insurers start pushing down on that balloon you are stuck in the problem of either watching providers no longer accepted, or trying to find a way to raise the rates.

CHAIRMAN DOUGLAS: Jim Fitial.

GOVERNOR FITIAL: I don't have any question. I just want to close this session by warning all of you that, according to Dr. Jeff Novak, a renowned nutritionist:

What you eat is what you are.

CHAIRMAN DOUGLAS: And we will get to that

in just a moment, governor.

(Laughter.)

CHAIRMAN DOUGLAS: Well put. We are very fortunate to have had Dr. Gawande and Dr. Cochran with us today, two real innovators in the area of health care delivery reform. On behalf of NGA, thank you, gentlemen, very much. We appreciate that.

(Applause.)

CHAIRMAN DOUGLAS: But before we break, first of all I want to thank Governor [Haley] Barbour for his gracious hospitality last summer at our annual meeting. It was a real success, Haley, and thanks to you and Marsha for doing such a great job.

(Applause.)

CHAIRMAN DOUGLAS: And I would like to call Governor Patrick up to talk about our next annual meeting that will be a tremendous success, as well.

GOVERNOR PATRICK: I know I am between you and lunch, so I will be very brief. But Diane and I want to warmly welcome you all and encourage you all to come to the NGA Summer Meeting in Boston in July.

We have a very exciting and fun program organized. By then, substantively, we may have a health care bill, God willing and the creek don't rise, so we can talk about that.

But for families and attendees, we are planning some fun occasions, including an outing at Fenway Park, a reception at Fenway Park; and an evening at Fort Independence on the waterfront.

We will be based in Back Bay, which is right in the center of the City. It's a very walking city, lots of historic sites to get to easily around that part of the City, wonderful shopping and lots of food--Governor Fitial--lots of great foods.

For families we are organizing something called the "Come Early, Stay Late" program. There's a brochure about it which is available at the booth just outside of this session.

We have concierge service to organize your family visits to the Cape, or to the Berkshires out in western Massachusetts, organize visits to great restaurants, or recreational facilities, or college visits for your kids. We can do it all, and we look

forward to doing it.

There is a very small gesture to encourage you to think about coming to Boston at your place in this blue envelope, which is a CD from the Boston Pops signed by Maestro Keith Lockhart, and I hope you will all enjoy it and that we will see you in Boston in July.

Thank you, very much.

(Applause.)

CHAIRMAN DOUGLAS: Governor Patrick, thank you very much. I know it's a lot of work to put on an annual meeting, and we appreciate your stepping forward to provide that opportunity for us this summer.

Well, governors, we'll be having lunch and I'm sure our staffs will tell us where it is. To everyone else, thank you for being with us at this session.

(Whereupon, at 12:42 p.m., Saturday, February 20, 2010, the plenary session was concluded.)

NATIONAL GOVERNORS ASSOCIATION

WINTER MEETING

Sunday, February 21, 2010

HEALTH CARE AND THE ECONOMY

Grand Ballroom

JW Marriott Hotel

1331 Pennsylvania Avenue NW

Washington, DC 20004

PARTICIPANTS:

GOVERNOR JAMES H. DOUGLAS, VERMONT, CHAIR

GOVERNOR JOE MANCHIN III, WV, VICE CHAIR

GUEST:

MARIA BARTIROMO, ANCHOR, CNBC

P R O C E E D I N G S

(11:16 a.m.)

CHAIRMAN DOUGLAS: Colleagues and guests, why don't we begin our plenary session. We have an important discussion this morning on health care and the economy, and we are going to get underway, if I could have everyone's attention.

Ladies and gentlemen, let's all find a seat and begin our discussion of health care and the economy this morning. I want to welcome all the governors back, and all of our guests as well. I think this is going to be a great opportunity to have a moderated discussion on health care and its impact on the economy.

I am really pleased to introduce the leader of our discussion today, Maria Bartiromo. You might find it interesting to know that someone who is the bearer of occasionally bad economic news has become a real celebrity in her own right, but Maria has certainly done that. You can see her every weekday afternoon on CNBC giving the ups and downs of the day's market activity on "Closing Bell."

She has also distinguished herself as the host and managing editor of “The Wall Street Journal Report,” which is the number one financial news program in the United States. She has received high honors for the quality of her work. She is considered a true authority in her field. In fact, this past December she was featured in *The Financial Times* as one of the 50 who shaped the decade.

We are really fortunate that she would take time on a weekend to be with the nation's governors today. She is a soon-to-be author, as well. Her new book is entitled *The Ten Laws of Enduring Success.* It is out at the end of March, and we will look forward to seeing her thoughts in this new book.

So let's give a great NGA welcome to Maria Bartiromo.

(Applause.)

MS. BARTIROMO: Thank you very much.

Thank you very much, Governor Douglas. Thank you for having me. Thank you all for having me.

I find it increasingly interesting that, as I talk about the economy on CNBC and on “The Wall Street Journal Report,” almost all the time health care is part of the discussion, and the cost of health care and its impact on our economy. So I am very pleased to be with you today to try and talk about controlling costs, insuring more, and what we can see happen on a state-by-state level.

I thought I would roam today. I would love to make this conversation as interactive as possible. I have asked some of you to please jump in if you hear something that you agree with, or your disagree with, so that we could really have a dialogue here, as opposed to a Q&A, me asking each of you questions.

And of course we all know the statistics, and they are not pretty. Health care spending in 2007 reached $2.25 trillion. We're talking about 16 percent of the Gross Domestic Product (GDP). We continue to see a national and really international debate on how we will get our arms around this spiraling expense that continues to hurt our economy.

Many of you have seen the impact on very, very important industries like the autos, and so many others, and how it has impacted our economy and our everybody life.

So, Governor Douglas, let me kick it off with you. Give us the state of state from your standpoint in Vermont and tell us where you think we can be on a state by state level.

CHAIRMAN DOUGLAS: Well, Maria, I recall when I took office seven years ago, looking at the economic impact of rising health care costs on businesses and families in Vermont and the fiscal impact on state government--because it is a large and increasing percentage of state spending every year--and I realized that we had to get those costs under control.

There is a lot of debate in Washington and state capitals about how we structure paying for health care in America, whether it is a publicly funded plan or a privately funded system, but in the end I am not sure that matters. Because if we do not get costs under control, if we do not bend that curve

that is rising in multiples of inflation every year, we are going to be broke either way.

So we put in place what is called "The Blueprint For Health," a strategy of preventive care, of managing chronic disease, of screening for chronic illness, of wellness, of good nutrition; and over the last six or seven years it has paid off.

We focused on our Medicaid population, which is among the highest in the nation. We have 26 percent of our population on Medicaid. It's going to be 28 percent next year. So we have to control those costs. And with a waiver from the federal government, we have realized about a quarter billion dollars of savings in our Medicaid program over a five-year period through this strategy of managing chronic disease and providing preventive care.

It's not something that happens overnight, and I think that is important for the American people to understand. It is about bending a curve and making progress over time. But we have shown over the last six or seven years that it really can be done, and I hope that we can continue to talk as

governors about initiatives we have had and ideas that work in our states so that others can replicate them.

And just in the last couple of years, twice now, national surveys have rated Vermont the healthiest state.

MS. BARTIROMO: We would like to look at some plans that have worked, whether it's Vermont, Massachusetts, and also some plans that may not have worked so well.

Governor, let's talk about Tennessee. Let's talk about what happened when you put a plan forward back in the 1990s with all the best intentions, and yet in retrospect what went wrong?

GOVERNOR [Phil] BREDESEN: We had--this was long before my time--a plan called TENCARE. Tennessee in 1994 was kind of the Massachusetts of its day in terms of trying to expand health care through a massive series of waivers with the Medicaid program.

We expanded dramatically the number of people on Medicaid by adding a number of categories--the uninsured. If you were uninsured you could get

on Medicaid. If you were uninsurable, you had diseases which caused you to be rejected, you could get on.

The problem was, I guess it was just the classic business problem, that when you add as many benefits and as many people in a quick period of time, the expenses all came true perfectly on target on Monday morning. The savings which were supposed to pay for all of those over time not only stretched out a long time, but in many cases did not come to fruition. And we ended up a decade later, when I came in, with a system which was just completely on its back.

We were spending more money in the pharmacy benefit in Medicaid than we were spending on our higher education system. We were spending more money for one drug on Medicaid than we spent to support the UT Medical School.

And it just took some very difficult actions to bring it back, including substantial cuts in benefits, taking some people off the rolls. It was very painful, but I do think there's a lesson

there of maybe taking things a step at a time instead of just leaping off the end of the dock when it comes to how you deal with some of these issues.

MS. BARTIROMO: This is an important point. And, Governor [Joe] Manchin, you said earlier what is really important to consider is once you put a benefit in place it's very tough to take it away.

VICE CHAIR MANCHIN: It's almost impossible. And that's where you'll find most of the governors here that will agree to that.

We took a position, Maria, that we had to start with our youngest. Obesity in our children. I think all of our states had problems, but in America it's a problem, so in West Virginia it was a problem. We started Healthy Lifestyles trying to get people to where we could spend as much time and effort with a child trying to keep them from getting a chronic illness or a life-threatening illness, and hopefully that would permeate up to their parents to where we could change the whole social aspect of health care.

The bottom line, the way we see it in West Virginia, is very few people have a value because

they don't pay for it. It's always somebody else that's paying the bill. And when you don't have a value, sometimes you'll over-use it or mis-use it.

With that being said, and as a culture, if we don't put as much emphasis on wellness as we do on repairing you when you're broke, the costs can get out of hand. And we think that's what's happened.

The consumer is not in the market. It's the only service in America that you and I don't shop. We don't really look at our bill that close; we don't really understand the bills--because they keep coming at you six months, maybe a year later. And all you care about is did I satisfy my co-pay.

I've said something very simple: Why don't we have universal billing? Why don't we all agree that the first piece of legislation we should pass to get the market back, the market forces working, is any medical procedure you have anywhere in America has to be a complete, concise, and itemized bill that you and I can understand.

So maybe then I can ask the question. That five-minute visit cost me $275? Could it not be

maybe a little bit more competitive? And are you sure that pill was that costly? And I don't remember getting that blood test.

We have nobody in the market, and we're trying to control something that's so big and we've got nobody trying to help us control it. And everybody's on one side winning, and the other people that are paying, you know, we've always said in the political world, if the constituents . . . there's no constituents favoring the change, because no one really cares.

We did something in West Virginia Called . . . we asked for a waiver from Medicaid called "Mountain Choices." We've called it Mountain Choices. We have a lot of people basically that if you're on Medicaid you don't get your eye care. You might not get dental care, unless there's pain and suffering. But, we said, if you will enter into a healthy lifestyle choice, if you will go to your doctor's visits and not use the emergency room when it's not needed, you can start earning points and rewards for glasses, for health care.

And the cost starts coming down because there's a value. There is that reward system. And we are trying to expand on that. And when you hear us all talk, we talk about flexibility. Because as Governor Bredesen just said, he inherited a program that had all the good intentions. All the costs got loaded to the front end, and then the savings never came from the back end. And everybody else was sacrificing in his society to make up for the costs that they couldn't reduce.

We are trying to prevent that. And if you hear us talking when we say flexibility, before we expand, make sure we can live within our means.

MS. BARTIROMO: This is a really important point. You have said a lot of very critical things to the national discussion, about the national discussion, because what we've been hearing a lot about is really health insurance on a national conversation, and not necessarily health care, which is why I am so delighted and really thrilled that the First Lady, Michelle, has taken on this issue of childhood obesity, to really get into early on the

issues and prevention, and so that we don't spend as much as we do later on in life on these preventable diseases.

Thoughts on this issue from the table, as far as expanding care and prevention, and putting things in place sooner rather than later to get a handle on costs?

GOVERNOR GRANHOLM: Thank you, Maria. Jennifer Granholm from Michigan.

In Michigan we wanted to model ourselves after a plan that worked, because obviously if you open up Medicaid to anybody who comes, you're going to be taking on a lot of expenses. And so you have to figure out on the front side how do you do the prevention and the primary care. How do you make sure that people have a stake in this so that there's a shared responsibility? How do you make sure that the benefit package is one that you can afford? And how do you make sure that it's transparent?

So we looked at Massachusetts because they had done a huge effort in health care reform. And it required some cooperation on the part of the federal

government, and there was a shared responsibility both of individuals, and businesses, and government. And to me I would love to hear from Governor Patrick about how that has worked in Massachusetts, because I think that is a model that we can all look at as governors if in fact it has been successful. And what would you change?

GOVERNOR [Duval] PATRICK: We didn't work this out in advance, just to be clear.

(Laughter.)

MS. BARTIROMO: No, this is perfect. Thank you so much, Governor Granholm.

GOVERNOR PATRICK: But thank you for the setup. We have a hybrid system, as you may know. It's a combination of both market and public contributions.

It builds very much on a strong private insurance market in Massachusetts. It was invented on a bipartisan basis under the leadership of my Republican predecessor, a Democratic legislature, Senator [Ted] Kennedy, and at the time the Bush Administration, which was absolutely essential in

terms of approving the Medicaid waiver.

The implementation fell to me, starting on the very first day in office, and we have now nearly 98 percent of our residents insured today. I don't think there's another state that can touch us.

Jim Douglas is coming on strong from Vermont.

MS. BARTIROMO: He's catching up.

GOVERNOR PATRICK: He is. He won't catch us, but he is making progress.

(Laughter.)

CHAIRMAN DOUGLAS: We'll see.

(Laughter.)

GOVERNOR PATRICK: To Joe's point, though, Joe Manchin's point, everybody starts from a different place. Because we were using so many other patches and plugs in the health care safety net, if you will, in other elements of the budget, a universal system in the reform that we've pursued has added only about 1 percent to our total budget.

And we have saved in the Uncompensated Care Pool and moving people out of emergency room

primary care to primary care settings, which is huge. But the big hiccup, and the remaining challenge, is cost control.

And that is not unique, or even special to Massachusetts, that's everybody's issue. And to the premise of your question, your last comment about prevention, that's an absolutely critical part of it.

There is a responsibility, and as we talk about shared responsibility, there is a shared responsibility that individuals and families must take around wellness so that we can move to a health care system and away from a sick-care system, which is what we have today.

We have some ideas around cost control, particularly around payment reform, that we're looking to implement right now, and that we talked about in yesterday's session, but it cannot be understated: the importance of each of us doing what we can to look after our own health and our own healthy choices.

MS. BARTIROMO: You know, actually, Governor Manchin made a good point because in other

areas of our lives there are repercussions and implications for your behavior.

In car insurance, if you get into a lot of accidents your insurance goes up. So the point that you make is duly noted, really important.

Governor [Tim] Pawlenty.

GOVERNOR PAWLENTY: Thank you, Maria.

Just some things that have worked in Minnesota that may be helpful for the discussion. One is we have the highest concentration of health savings accounts in the country in Minnesota. And for those who participate, we've been able to document some relative savings, which has been a good thing, and they've helped contain costs in our state.

We have another program that we've put together with our state employees around payment reform, and we have said: Look, people tend to spend money differently if it's their own money, or at least some of it is their own money.

Now they need to have guard rails in place for consumer protection, but we said to our state employees, you can go anywhere you'd like. But if

you choose to go somewhere that is poor in quality and high in cost, you're paying more. And if you choose to go somewhere that is more efficient with respect to cost and higher in quality, you'll pay less.

Ninety percent of them, nine zero, have migrated to higher quality, more efficient providers. And in three of the last five years, the premium increases in that program have been zero percent. In the other two years, close to zero percent.

That is on fairly primitive measurements of cost and quality and the ability to make that even more advanced is progressing very nicely. So we're going to have an even better look into that in the future. So that has worked nicely.

We have another program called Q Care, which we've said for all of the public programs that we pay for health care we're going to begin to pay for performance. We're no longer going to pay just for volumes of procedures in diabetes and heart disease and some other chronic care conditions. We expect the practitioners to follow best protocols and

achieve better outcomes. And if they do, they get a financial bonus. And that has some early promising results.

And then lastly, in the medical malpractice area, there's lots of ideas for reform here, but clearly some improvement can be made. We have a system that says if you're going to sue a health care provider, a doctor, for medical malpractice you have to submit an affidavit at the front end from another doctor in good standing in our state indicating that there's reason to believe malpractice occurred. And now we'd like to take that to the next step where it's not just a doctor, but a specialist or a subspecialist in that same area, if it involves a specialty practice, making that same affidavit.

That has been a very good gate keeping role to try to minimize, or at least reduce frivolous lawsuits.

Then lastly I'll put a plug in for what Ed mentioned yesterday. We know in other areas of insurance, like life insurance--again, assuming

consumer protections are in place through a compact or otherwise--that competition is a good thing. In many states there's very little choice about where you can get your health plans.

In my state, three health plans control almost 90 percent of the market. They really don't compete very vigorously on price. And I don't think that's robust enough competition.

So I think it would be very helpful, like with life insurance and other forms of insurance, if we could have our citizens have the chance to choose for more options across the country, again with proper consumer protections in place.

MS. BARTIROMO: It is really interesting how there have been great successes in certain areas, and in other areas programs have fallen short. Because one size doesn't fit all, right? I mean, the demographics of the states are different.

And so while we should be looking at some things that we take away and use all of us, there are also lessons to be learned.

GOVERNOR PAWLENTY: On that point, we have

failed on many of our government entitlement programs. They are out of control. We have publicly subsidized health care programs that were growing 30-plus percent a year, but they are the old model of fee-for-service, meet certain requirements, show up and we pay the bill no matter how many show up, and what the bill is.

Those models are rising so quickly in our state's budget that we can't sustain them. So the ones I pointed to are successes, but we also have our share of programs that are financially out of control.

CHAIRMAN DOUGLAS: Governor Barbour.

GOVERNOR [Haley] BARBOUR: Thank you, Maria, for taking the conversation this way, and for Joe and Jim, because I really do think that we need to recognize the states are a big part of the solution.

In my state, when I became governor, Medicaid spending was going up more than 20 percent a year. In my first six years it went up less than 2 percent a year.

One of the ways we did that, we got

control of our pharmaceutical benefit with a PDL. We've gone to about 75 percent generic.

Secondly, we have face-to-face redeterminations for eligibility. And one of the things that has resulted from that is, just last week CMS said our error rate in Medicaid is .13 percent, which they've only audited 17 states so far, but I don't believe there's anybody that'll beat .13 percent.

Now let me put it in focus with the other side of that coin. Robert Pear, the health reporter for *The New York Times*, and Frawley the number one health reporter in the United States, wrote an article last month about health care spending taken from the federal government's numbers, said that private health insurance premiums in 2008, the last year we have figures, went up 3.1 percent. Private health insurance benefits went up 3.9 percent.

Cost of Medicaid went up 8.4 percent. And the cost of Medicare went up 8.6 percent. Which is why I am so excited ya'll are talking about what states can do, because those numbers don't convince

me we ought to turn this over to the folks that run Medicare.

MS. BARTIROMO: Thoughts? Governor [Ed] Rendell?

GOVERNOR RENDELL: Maria, I want to go back to what Tim said. We are looking for common ground here in this health care debate. And everyone, Democrats and Republicans alike, say we've got to get competition into the marketplace to drive down costs.

Well the idea that Tim came up with is a good idea, and one that most of us could sign off on as long as they're the right protections.

For example, I have nothing against an Idaho company coming in and selling in Pennsylvania; it would help competition. But--and this is an important "but"--they've got to adhere to Pennsylvania standards.

For example, we require health insurance companies to provide aid to autistic children and families. Other states may not. So the way to get around this is the way we do it for life insurance.

We have a model compact which sets standards. States can sign on to that model compact, and if they do then if you're a health insurer you can go into any . . . a life insurer, you can go into any of those states and sell your product.

If we could do that, it would be noncontroversial, I think, and it would help us lower competition. It's not the only way to lower--to lower costs through increased competition. It's not the only way, but it's an important way.

But I think if you went around the room and talked to all 53 of us, you would find that there are commonsense ideas everywhere that can cut costs. And one of the things I think we have failed to do federally is enough cost cutting in the bill itself.

For example, I'll just take one, and I know my colleagues can throw in many, but emergency room costs. We know that the emergency room is the most expensive venue in the whole health care delivery system.

How do we cut emergency room costs? Well, people go to emergency rooms because we've designed a

health care delivery system that's open from 8:00 in the morning till 4:30 in the afternoon, Monday through Friday. Anytime else, even if you have a noncritical problem, you have to go to an emergency room.

We in Pennsylvania are starting to require all of our emergency room facilities to have a nonemergent care facility open 24/7. That means it's staffed by a nurse practitioner, or a physician assistant, and they can administer the stitches that are necessary to close a dog bite wound, and you have no waiting, and you are getting billed for a physician's assistant's time instead of a doctor's. Bingo! Thirty-three percent of the cost.

Nonemergent 24/7 rooms can be a big answer to the overload to the system in the cost of emergency care. It didn't take a genius to figure that out. And I think that is true with a lot of cost-saving ideas in chronic care.

Hospital-acquired infections. In every state the health care delivery system loses millions of dollars a year through the cost of a hospital-

acquired infection.

The average hospital stay is about $30,000 in Pennsylvania. If you get a hospital-acquired infection, it is $185,000. So we have got to cut down on hospital-acquired infections. There are simple protocols which can cut them down dramatically, but we haven't put them in place.

In Pennsylvania we're starting to. So there are a thousand good ideas out here among the 50 states, and we haven't taken a look at them.

MS. BARTIROMO: Do you think that people, though, are going to be worried about the quality of health care in the scenario that you're talking about?

GOVERNOR RENDELL: Well the good news is, cost savings improves quality, in most cases. For example, in that emergency room thing, if you go in with a dog bite now, Maria, on a busy Friday night in Philadelphia, they'll say the most dreaded words known to human beings: We'll get to you as soon as we can.

Four-and-a-half hours later, a doctor, a

high-priced doctor cleans out your wound with mercurochrome and stitches it. If you had a nonemergent care 24/7 facility, a nurse practitioner does it in half an hour.

Hospital-acquired infections. If we make hospitals do a better job of policing them, it saves life and saves horrible health outcomes.

MS. BARTIROMO: Governor [Gary] Herbert.

GOVERNOR HERBERT: Thank you, Maria.

As one of the newer governors here, it is my observation that I think in the national health care debate the state's significant role has been somewhat forgotten here in Washington.

I think, as Governor Patrick has mentioned, we all start from maybe different places in our own experiences and our own unique circumstances.

We have followed what Massachusetts is doing with the health exchange in Utah, and did it just a little bit differently with the idea of trying to come up with a defined contribution as opposed to a defined benefit, and working with our small

business people.

They are really having a hard time with their bottom line, and having predictability because of the rising costs of health care. With a defined contribution they now have a predictability that's entered into.

Then we've opened up an exchange where the consumer, the employee, actually takes this defined contribution and can go shopping. It's like a Travelocity.com window that's opened up, and they can take their dollars of that--$700 or $800 a month--and see what they can find in this window that's uniquely suited for their own circumstances.

So there's nobody that manages their money better than those that control their own dollars. So it's a win-win for the employee and for the employer.

We opened up in August 9th of last year. We now have a number of small and larger businesses with over 40,000 employees that are now impacted with this opportunity. And it's introducing competition.

Now insurance companies are trying to find the right policy to attract customers. And although

I don't know that it's anything perfect by any means, it is the first steps in a longer journey. At least we in Utah are trying to put together a 10-year health care reform plan to see what we can do with the states taking the lead, as opposed to waiting for the federal government.

Again, I think states are uniquely suited to do this. We are a lot more nimble. As we find problems in the reform efforts, we can change and modify. We are a lot easier at finding those things that will serve our public and our constituents better I think at the state level.

So again, last but not least, our approach is pretty inexpensive. We only have two employees, two staff people to manage this exchange. And so it is very cost effective in our early beginnings, and is introducing competition and lowering costs for the employee.

MS. BARTIROMO: Thank you for that.

Governor [John] Lynch, and then we'll . . .

GOVERNOR LYNCH: Thank you, Maria.

The question that you asked I think is a

fundamental one that we need to discuss. And the question is: Can you stabilize costs, or lower costs, and not affect quality?

I would contend that we can do that. I think technology is an important aspect, an important element of how we deal with the costs in order to make us more efficient.

Technology should be able to do for health care what it has done for virtually every other industry in the private sector. It ought to be able to improve quality, improve customer service, and stabilize costs.

That means providers being able to prescribe medication electronically and evolving toward electronic medical records. Transparency is something that was discussed yesterday. We need to continue to push transparency in all that we do, not only around costs but also around outcome.

In New Hampshire we are piloting medical homes similar to accountable care organizations that again were discussed yesterday evolving away from fee-for-service and more toward total care of the

patient. And obviously stronger focus on prevention and wellness.

In New Hampshire, my wife Susan, who is a doctor, specializes in pediatric cholesterol management and initiated a program years ago called Walk New Hampshire, getting school kids to walk a distance over time equal to the length of New Hampshire, 190 miles.

Governor Pawlenty talked about a number of initiatives in Minnesota that I think are very important ones. But I think it is an important issue that we need to see if there's a consensus as to whether or not we can stabilize costs or lower costs and still not only keep quality high but improve quality.

CHAIRMAN DOUGLAS: Maria, let me offer a couple of thoughts on some of the issues my colleagues have mentioned.

We have to, I think, reform how we deliver care. It's not just about money. And if we make the kinds of reforms that we've discussed this morning, we can indeed get a handle on those costs.

The medical home concept that Governor Lynch mentioned is something we're doing in Vermont, and other states are. I was pleased that Secretary [Kathleen] Sebelius announced that Medicare very shortly will begin some pilot programs to participate in that strategy, because we have to have all the payers, public and private, at the table.

That leads to another important element of what we need to do. And that is, change the way we pay for care. Now it is volume driven. We pay for procedures, and tests, and drugs, and admissions. We pay for stuff. We don't pay for outcomes. We don't pay for the quality of that care. And we have to align that, I think, if we are going to make progress on quality improvement and cost containment.

So what we do in Vermont is pay an incremental amount to our medical home primary care practices on a per-patient per-month basis if they adhere to certain national quality standards. And that is the kind of incentive that works.

It can be significant in a practice with several thousand patients. So if we align our

payment with the outcomes we want, I think we can get a handle on the cost of medical care in our country.

MS. BARTIROMO: Paying for outcomes only, or mostly, and not for that volume that we're doing right now.

We're going to go to Governor [Bev] Perdue, and then I'm coming back to you, Governor Manchin.

GOVERNOR PERDUE: Thank you. We pay for outcomes in North Carolina, too. We are one of the initial states that began the medical home. We're in our fourth or fifth iteration, and we have just gotten one of the two 646 waivers in North Carolina to provide managed, if you will, Medicare care.

We believe that a medical home has to be much more comprehensive than just a primary care provider, although that's the onus of care. That's where you start. But then we have a network of community care providers, Maria, anchored with a case manager.

So that if I'm a Medicaid recipient I don't necessarily go to the doc initially. I use my

case manager to put me in a wellness program to help manage my asthma, or my diabetes. We are not only bringing down the cost of care in North Carolina for our Medicaid population, and I believe for soon to be our Medicare, we actually are trying to make sure the services that our patients receive are the services they need. And then front-load the system with a complete community-based wellness initiative so that folks do realize it's how they manage their disease.

I don't believe you can just provide a medical home with a doc. I've never believed that. I think you've got to have that comprehensive array of services from the moment of entry into the system as you navigate through different levels of acuity and care to the ultimate outcome for us, which is a cheaper benefit with a healthier citizen.

VICE CHAIR MANCHIN: The greatest savings I believe that all of us could prosper by is the technology, and Governor Lynch just mentioned that.

We have Telecare Health Information Technology, but the exchange of this technology--the

Administration, the Obama Administration predicts that there could be as much as 30 percent savings, a 30 percent savings, by this type of technology and exchange.

In my little state that would be $3 billion of health care savings. That means $1 billion of savings just in my Medicaid program.

MS. BARTIROMO: How is it saving so much money? What exactly is it doing?

VICE CHAIR MANCHIN: Basically what you have is unnecessary tests and prescriptions, the redundancies, the mistakes, the lawsuits, it just keeps piling on.

These are things that we could all have tremendous savings immediately from. We seem to be bogged down in debate how we're going to deliver it, and who's going to be the winners and the losers, but we all win on this one, Democrats and Republicans.

MS. BARTIROMO: Governor [Bill] Ritter.

GOVERNOR RITTER: Thank you. We adopted sort of a way of going about this called Building Blocks To Reform. We had a commission that said the

least expensive statewide plan we could implement would cost us $1.2 billion, and people in Colorado think the systems' broken and we're not going to put another $1.2 billion into a system that is broken. So we've gone about it in a step-by-step fashion.

What's interesting as part of this conversation is almost everything that's been mentioned we are working on. We have an initiative on. And there seems to be a great deal of consensus among states about the things that are necessary.

We have a technology initiative. We have a transparency. We have a hospital report card. We have medical homes for children. We have both delivery and payment reform that we're working on.

We did tort reform in 1988 before it was cool. We put in place caps on noneconomic damages, and on economic damages we only changed it once since. So it's not, you know, tort reform is not the beginning and the end in Colorado, and yet we are the seventh most expensive state for health care.

And so with all of these--we have an initiative currently looking at the value of care,

and I think I agree with what Governor Rendell said at first about this relationship between cost and value. The quality of care, that you can improve the quality of care and actually reduce the cost in doing that. We really need to focus on that.

But one of the big cost drivers for us has been uncompensated care. Our inner-city hospital did $375 million in unreimbursed care last year, the Denver Health System.

So what we did was pass a thing called Health Care Affordability Act. The more you treat Medicaid patients, we put in place a . . . it's called a fee. Every patient bed there's a fee, a provider fee, that's paid in. The federal government matches what goes into that. And so if you're providing care for unreimbursed care, then you're going to get additional money. And if you're not, you're going to be paying into that fee.

We're going to cover 100,000 people with doing that. So the last thing I would say is, with all of this sort of consensus that there does seem to be about these things that would drive down costs and

also help us focus on quality of care, we have to be able to get to some common ground that they've been unable to get to here in Washington, D.C.

MS. BARTIROMO: Right.

GOVERNOR RITTER: It strikes me that this is something we can't fail. As a country, if we fail to do it we're in really big trouble because the amount we'll spend on GDP just makes us not competitive; and yet, we have things that we--I think--can come to some common ground on. And that may be what's necessary to form the basis for a bipartisan solution to health care.

MS. BARTIROMO: Yes. I mean, we face these dilemmas, and it's going on in other industries as well; whereas, we want the services that are so important to our people to be low in cost, we want them to be available, we want everyone to have access; and it's the same as banking. Plain-vanilla banking and our deposit money.

And yet, many of the companies that are in leadership positions in these areas are looking at shareholders, facing a different constituency in

terms of making sure they have revenue growth, profitability, and yet from the other side of things we need their services to be there for the people.

So we all really are in a very, very interesting time right now and it is creating amazing dilemmas.

Yes, governor.

GOVERNOR [Chris] GREGOIRE: Well yesterday, Maria, we heard from a couple of wonderful physicians and authors that I think answer your question about can we increase quality and reduce cost.

When I first came into office in 2005, Dr. [George]Halvorson had written a book entitled, *Epidemic of Care*. There was a study done that I think is most telling.

Approximately 115 physicians were given the same patient with the exact same diagnosis. What was interesting about it is: Back came 80 different treatments.

Now clearly some of those were effective, but by and large many of them were not. Thus, outcome for patient: Poor. Cost: Dramatic.

So among the things that Governor Ritter talked about we are trying, but one is a panel of experts that are looking at common diagnoses and asking what is the most effective treatment. And we're not doing it based on cost.

Because if in fact the treatment works better, it costs a little more, it's better than other treatments along the way in search of that ultimate positive treatment.

Back pain is a perfect example where all too often in certain segments of my state, and of the country, you will find doctors who immediately resort to surgical procedure--which is very costly--yet the outcome for the patient is no better than physical therapy would be; much less intrusive; and the patient is served better.

So when we talk about what Congress is doing versus what we're seeing, the frustration I think we share is we want real health care reform. It's not about health insurance reform. It's about health care reform.

So things like point-of-service, things

like getting better quality care at a reduced cost to patients, is really where we think we ought to be headed.

MS. BARTIROMO: And the 24/7 care.

GOVERNOR GREGOIRE: Correct.

MS. BARTIROMO: Even if it's not a doctor necessarily doing lower type procedures.

Yes, Governor [Jack] Markell.

GOVERNOR MARKELL: Thank you. And, first of all, I want to thank Governor Douglas for putting this together. I think this has been a great conversation, and I've taken very careful notes based on a number of suggestions from my fellow Governors.

I really just have another question that has to do with long-term care. I am wondering whether any governors have had any particular success--it's obviously a hot issue with an aging population; in our state it's a particular issue. We've got a very rapidly aging population because we have a lot of retirees moving in, thanks to our low property taxes.

And there has been a lot of discussion

about having people--that was a little plug, yes, that was a little plug--

(Laughter.)

GOVERNOR MARKELL: I thought I was being subtle. But the point being, there's a lot of talk about having people not go into the very expensive institutions, and having them served more in the community.

And yet some studies would suggest that in the end, although there's a lot of promise that costs get lower, they're not always delivered. Sort of along the lines of what Governor Bredesen was talking about.

I would be interested whether any governors have come up with anything specifically with respect to long-term care.

MS. BARTIROMO: Anybody? Governor Rendell?

GOVERNOR RENDELL: We've had great success transitioning people out of nursing homes. Right now, nursing homes in our Medicaid program are our single biggest cost driver. We are a very old state.

It costs us almost $30,000 a year for one person in a nursing home. For a family of three, a young mother with two children, it costs us about $3,200 a year in the Medicaid program.

So to take that individual out of a nursing home, put them in home care, is, number one, in most cases what they prefer, seniors prefer that; and, number two, it's a significant cost reducer.

There are some up-front costs to transition, but you reap the savings fairly quickly. And by the way, Pennsylvania doesn't tax retirement income.

(Laughter.)

CHAIRMAN DOUGLAS: Maria, we have a program in Vermont called Choices For Care. It has resulted, as Governor Rendell suggested, in real cost savings.

We got a waiver from the Medicaid authorities to offer equal access to at-home care as institutional care. We've de-licensed several hundred nursing home beds around our state, which is significant in a small state, and we've saved

literally several million dollars in our long-term care Medicaid budget as a result of this effort.

Ed's right. That's where people would rather be: at home cared for by either their own family members or professionals in their home. So it has worked. It can work. And this raises another important issue, and that is flexibility because we had to go to the folks in Washington and get a waiver and go through an onerous process of applying for it and amending it from time to time.

What we really want and need I think from the federal government is flexibility to do it our way. And that alone will save costs.

MS. BARTIROMO: That's an important point.

More success stories; to answer Governor Markell's question?

GOVERNOR [Don] CARCIERI: Yes. Let me just say, Maria, let me add to what's been said to Jim's point.

One of the things we did in Rhode Island is, before the end of the last Administration, negotiated a global Medicaid waiver. The premise

behind that was to allow the state to have more flexibility, more control over exactly the kinds of issues that Jack has brought up.

It has been enormously successful. We are in the process of implementing it. All the savings that Ed, Jack, Jim have talked about we are seeing, the diversion of people in the nursing home.

Most elderly people prefer to stay in their home. There is no support mechanism, particularly for those eligible for Medicaid. They've all had to go and get individual waivers.

So we negotiated a global waiver allowing us as a state to manage that, and it's been enormously successful. We're saving tens of millions of dollars. We've diverted hundreds of people. Some who were already in nursing homes didn't need to be there and chose to come out.

But you need to develop within the community the support systems that are there so that you can give them the kind of support that they need to either stay in their home or an assisted living or some kind of intermediate facility. But clearly, for

all of us that is a huge part of the Medicaid expenditure and it is going to grow as the population is aging.

MS. BARTIROMO: Governor [Dave] Heineman.

GOVERNOR HEINEMAN: Maria, I want to go back to where we were talking about technology. You see this every day; you report on it in the financial sector, and several of us around the table has been state treasurers.

Funding, information, all that moves electronically real-time every day. If any of us want to go online right now and find out how much money is in our banking account, we could do it; how much we owe on our credit card.

If we wanted to go online right now and find out anything about health care, particularly as it relates to us individually, we can't do it. We need a comprehensive electronic medical system that connects doctor's office, hospitals, pharmacies, the entire system.

MS. BARTIROMO: Which opens up, though, a can of worms on privacy, doesn't it?

GOVERNOR HEINEMAN: It does, but we've got a situation going on in my state right now where we're conducting a pilot project in that regard in the sharing of information. You have to opt in. Ninety-eight percent of our citizens have opted in. It's up to you. You've got to say. In terms of privacy, we can provide it and your records will be secure.

But if any of us around the table today had to go see a doctor, they would start over. We can't afford that. We ought to be able to share those records. We ought to be able to share our prescription data, assuming we agree to it. And that could drive down costs significantly, eliminate duplication, a number of things.

MS. BARTIROMO: Yes?

GOVERNOR [John] HOEVEN: Following on that point, that's very real. In North Dakota we've had people that go over to the Mayo Clinic, and then to take all their records with them; yes, I knew you'd like that, Governor Pawlenty--

(Laughter.)

GOVERNOR HOEVEN: It's a real challenge, a real difficulty. So it's not only a cost savings; it goes back to that quality of care.

The point I wanted to make, though, is Governor Markell talked about, or was asking about ways to save costs on long-term care.

One of the things we've found is most productive and helpful in that regard is providing incentives for individuals to purchase long-term care insurance. It creates the right kind of incentives.

So both tax credits on the front end, as well as sheltering their assets that they can then pass on to family members is a real incentive to buy that long-term care insurance. That's very effective in terms of cost savings for the state, but also very good for the individuals and their families.

MS. BARTIROMO: If they can be shared. If they can be shared, the insurance; it can be passed on.

GOVERNOR HOEVEN: Well, what it does is, in essence then their insurance pays for their long-term care rather than Medicaid. So it's a tremendous cost

savings to the state.

The other types of incentives are incentives that encourage family members and others to take care of individuals, home-based care, and community-based care, rather than going into institutional care. And significant cost savings can be achieved that way, as well.

MS. BARTIROMO: Yes, sir.

GOVERNOR BALDACCI: Maria, John Baldacci from Maine.

I just wanted to point out that, in all of the discussion what seems to be lacking sometimes is about the patient themselves, the consumer, the individual, because I think we have a sense as governors that everybody's got a responsibility, including the patient.

I think bringing them into the discussion and making them part of the decision making, what we've done in our state is we've focused on primary and preventative health at the local level.

We use our tobacco funds to have 34 Maine Healthy Partnerships throughout state, which are at-

home visits or primary care or preventative care.

Also, we've used a ITV Network where people can log on from anywhere in the state and do their own health risk assessment sort of and be able to, at the end of that, to be able to plug them into local resources.

So that, while all the debate is going on, at least people begin to take tools on their own that are there, that are either free or reduced cost, and they know where it is. Because there really is a lot of confusion to the lay person as to where to go for care and what care is available.

So it is part of a beginning education program. And I think that needs to be done more of nationally, though, too.

MS. BARTIROMOBARTIROMO: Well it seems like the tools are in place for states to really control some of this cost, and yet we still want more progress.

Jennifer Granholm, how much of a factor was rising health care to the, I don't want to say the demise, but upset in the auto sector?

GOVERNOR GRANHOLM: You know, Maria, a

couple of years ago Lee Scott, head of Wal-Mart, came and spoke to the National Governors Association about the importance in a global economy of having a uniquely American solution to the cost of health care. Because in a global economy our competitor countries are providing health care to their businesses, and that puts a disadvantage on ours.

The auto industry is the poster child industry of an older legacy business that has been significantly impacted negatively by global competition because of the cost of health care.

MS. BARTIROMOBARTIROMO: So you're saying the Japanese, the Chinese, they have better health care costs?

GOVERNOR GRANHOLM: They provide. They have a better cost-sharing arrangement with business. There is no doubt about it. And so we hurt our businesses--this is exactly what Lee Scott was saying. It's one of the reasons why initially in this health care debate the Chamber of Commerce was on board with finding, again, a uniquely American solution.

Now this doesn't mean--you know, I've been listening to all of us here talking, and there's a lot of great ideas that have come from the states. I mean, for example Governor Douglas and I, when we first came on, we teamed up to pool our buying power to get rebates on prescription drugs. That power of largeness is really an important way to reduce those costs.

You know, everybody has agreed, I think, here that they would like to see flexibility; that they would like to have managed care in some way so that you don't have fee-for-service that's driving up the costs. Everybody has agreed they'd like to see the states have more impact on being able to drive those costs down; that we'd like to see the experts listened to in terms of what are best practices.

People want to see transparency in health care IT both from the consumer point of view, as well as the ability to use IT to reduce the costs. We all agree that we want to see competition, which includes a good part of this being driven and operated by the private sector.

We all agree that there should be incentives for outcomes, both for the doctors who are rewarded for achieving healthy outcomes as well as for individuals making decisions about their own behavior, that perhaps their costs are less if they engage in healthy behavior.

We all agree that there should be--I think--a primary medical home that people turn to. I think we all agree about the shared responsibility that it's government, individual, and business that everybody has to have some skin in the game.

We all agree that there are creative solutions like pooling that could reduce the cost of health care. We all agree I think that there shouldn't be automatic denial for preexisting coverage, and I think we all agree that it would be best if we could cover as many people as possible so that we don't jack up the cost for subsidizing those for uncompensated care.

These are basic principles that I think most of us could agree on and sign onto, and these are the kinds of things that could make businesses in

America competitive if we were to come out with a health care plan that was a no-frills benefit plan that provided flexibility and options but didn't put the entire burden on the back of business.

MS. BARTIROMOBARTIROMO: Governor Pawlenty.

GOVERNOR PAWLENTY: I think the auto industry may be instructive, by analogy, for other reasons as well. Just to move away from that specifically, but what you had was an entire industry that over time management and labor together bargained up the price of their model, the cost of their model, so high that it could no longer be sustained by any reasonable projections on revenue growth, and largely insulated from market forces and entrepreneurial dynamics.

I mean, Peter Drucker, amongst others, studied General Motors and other companies over the decades and said, you know, it became what used to be a dynamic industry with entrepreneurial spirit into basically a mindless bureaucracy insulated from market forces.

So I think those lessons and the ghosts of

the past in that industry--hopefully better now going forward--is instructive for what we've seen in the legacy system that is large, command and control, one-size-fits-all legacy systems in government, including entitlement programs and the mentality that's underneath that.

We know that individual responsibility matters. Markets work. Price and value matters, if you give people good information with protection to shop. Those kinds of things help. And those dynamic qualities are largely missing from one-size-fits-all bureaucracies.

In the case of the automobile industry, they get their run to federal court and get restructured by a judge. You know, they get their pension plans restructured, their health care plans restructured, or there's some extraordinary intervention by the federal government, but the states don't have the ability to do that.

We don't want to do that, but I mean how does our entitlement legacy structure get redone? It isn't going to be by a bankruptcy court--I hope

not. So dramatic forces or events have to intercede, because I think we had the same legacy mentality, looking back, as General Motors did or the automobile industry did.

MS. BARTIROMOBARTIROMO: That's a really good point.

Governor [Mike] Rounds?

GOVERNOR ROUNDS: Thank you. I think Governor Pawlenty and Governor Granholm have both hit on something that probably leads us into a discussion about what is going on in Washington with regards to the existing proposals in health care reform.

The federal government finds itself in the same position, perhaps, as the auto industries have. You have a promise of entitlement programs which I think we all recognize government can't continue to pay for. Sustainability of health care on behalf of the federal government and the required co-payment on behalf of the states is greater than what we can afford.

In doing so, one of the ways in which we now manage Medicaid is by reducing the amount that we

pay providers. In the upper Midwest we reimburse between 50 and 52 percent of the billed charge.

Now if a physician is getting paid 50 to 52 percent, or a hospital 50 to 52 percent of an increasing number of individuals, because Medicaid numbers are increasing particularly during a time of a recession, you then have a cost shift onto the private sector, which then drives up the costs of health care for the other industries that are trying to employ individuals.

So we now have the beginning of a death spiral with the very basics of our entitlement program. It's not something which was started by this Administration, or the last Administration; it has been going on literally for decades.

But now in the middle of a recession it has pressure being brought to bear on a system which really is not sustainable. And as long as we continue to look at solutions that would add more individuals to a government-paid system which doesn't properly fund the full costs of case, you're going to continue to make it more expensive for the private

sector to be involved in picking up health care as they have in the past for their individual employees.

MS. BARTIROMOBARTIROMO: You know, it's a fascinating thing that's happening here. Because you've got the entitlements that are so expensive, and yet the fundamentals that require those entitlements are changing so much.

We're living longer. We are not retiring at 65. I mean, when you look at Social Security, obviously that has been pushed out a couple of years. But it seems like the fundamentals sort of requiring, and as the backdrop of the entitlements, have changed so much, requiring change of paying out the entitlements.

But of course very few people believe that we will actually see a substantial change in the entitlements. Is that a fair statement?

Governor Barbour, go ahead.

GOVERNOR BARBOUR: Well, Maria, if we don't see a change in some control, then we're going to be so deeply in debt--I think the figure is by 2020 under current policy 90 percent of federal

revenue will go to pay interest on the debt that we would be borrowing to pay for these entitlements.

Obviously as you know from what you do for a living there comes a time when people won't buy your paper.

MS. BARTIROMO: Yep.

GOVERNOR BARBOUR: So something's going to have to happen sometime.

MS. BARTIROMOBARTIROMO: Oh, people have definitely stopped buying papers, speaking to the technologists in the room.

GOVERNOR CARCIERI: Maria, over here.

MS. BARTIROMO: Yes.

GOVERNOR CARCIERI: It strikes me as I listen, because having spent most of my career in the private sector, we've all identified costs, and the inflation rate of health care costs is the number one issue we all face, whether it be state budgets or businesses, *et cetera*.

When you look at it from a business model, the drivers of cost are volume and price. And what we have here is, when you listen to a lot of what's

being discussed about some great things happening in some individual states, and frankly all states, we are all working on issues around the costs and the delivery system, *et cetera*, all the things you are hearing here.

I said in the first session that Jim hosted here, you know, who has the incentive to control the costs? We've almost got a cost-plus system here that nobody seems to have an incentive to control the costs.

At the end of the day, the person that ought to be controlling it is all of us, as individuals. And part of the problem has been there hasn't been enough of a buy-in and enough of an incentive for individuals.

The data I've seen is that 75 to 80 percent of the costs of health care is disease that is preventable, or the onset preventable, or delayed, if people took more responsibility for their own health care. All of the issues around wellness.

I know this is long term, but we've got to get at that. One of the things we've done in our

little state for state employees is we've put in place a $500 credit off of their share of the health care premium if they do certain things:

Fill out a health assessment form;

Go see their primary care physician at least once a year;

Get into a weight management program; and

Smoking cessation.

Whatever it is, a whole series of these things. The only way we're going to lower utilization as we age is to have people take better care of themselves and be incentivized to do that.

MS. BARTIROMO: And corporations are doing that right now.

GOVERNOR CARCIERI: And the biggest incentive for people is when they see some money in their pockets, some savings from doing that. Nobody wants to be sick. We know that. That ought to be the incentive. But what we've gotten used to as a nation is that if we get sick we've got the best system in the world that's going to make us better.

What we need to do is to change that

mentality to say we need to do things as individual citizens to take better care of ourselves, and hopefully delay. Then we need a system to support those kinds of things, the management structure if you will to support the kind of care that's necessary.

That is the only way we're going to drive utilization down, or slow it down, if you will, and that is one of the key drivers here in terms of what is pushing the cost up, as well as the cost of the system.

MS. BARTIROMO: It is a very important point. I guess it was . . . we did a special on this at CNBC, and one of the attendees said that an obese person will cost a company four times what a smoker will cost the company, because that person may develop heart disease and diabetes. So the incentive program is certainly what we are all talking about.

Governor Rendell?

GOVERNOR RENDELL: I want to go back to what Haley said. At the risk of losing my card as a Democrat, I want to agree with Haley.

(Laughter.)

GOVERNOR RENDELL: He's right. We have no choice but to deal with the entitlement question. The only way we're going to deal with it is if somehow, some way, and maybe it is the commission that the President is going to appoint, if we can deal with it without getting it into the political system.

If you look at the current debate, the president's plan says it will save $500 million out of--excuse me, $500 billion out of--the Medicaid system over the course of time. And that has been turned into a political football.

And yet we all know we can and should reduce entitlements to some degree. We have got to get away from the politics of this game, or else we are never going to solve this problem. And it has to be Republicans and Democrats standing up together and saying to the country: Look, we don't agree on a lot of things, but this is one thing we know, and we have to do it.

Is there going to be some pain to it?

Gosh, in the last two years every one at this table has administered a lot of pain to their citizens, not because we want to but because we had no choice. And we've got to get down to the business of making real decisions for the country that are going to set us on the right path. And you've got to have people willing to accept a little bit of political peril, or else we are in big trouble.

MS. BARTIROMO: I think we all agree.

Governor Bredesen?

GOVERNOR BREDESEN: Just to add to what Ed said, this all is happening today in the context of things going on in the Congress. This is not a discussion in a vacuum here about what we might do about health care.

There have been some of us who have been working on trying to put together some common stuff. Jennifer, you railed off a long list of things we all could agree on, but it was our experience we couldn't agree on them.

(Laughter.)

GOVERNOR BREDESEN: I think Mike would

agree with that.

I mean, with Jim's permission, I would like to just ask people. I mean, are there things of this group around the table, are there messages that we could send as the NGA about--as you consider this we're the ones who've got our feet on the ground and out there and trying to actually run these things--that we could inject into the discussion?

GOVERNOR BALDACCI: Phil, I . . . over here, Maria.

MS. BARTIROMO: Yes, I'm sorry. My apologies.

GOVERNOR BALDACCI: Phil, I really do believe that we have done that. If you'll just take a tape of this program and send it to every Congressman and Senator's office.

You're right. When we get into a setting that seems to somehow inject politics in it like what Ed was talking about, we seem to find that we don't have as much common ground as we thought we would.

When we're here not talking as Republicans and Democrats but talking about the specific progress

in our respective states, or the plans that have worked that have been emulated by other states, and then when you listen to Jennifer tick off the list that she ticked off that saw virtually all the heads around the room nodding, and when you get Ed and Haley talking about agreeing on something . . . .

(Laughter.)

GOVERNOR BALDACCI: It really does, I think, illustrate the fact that governors--and I hate to be too prideful of my colleagues and of this organization--but governors have to solve these problems, really, and balance a budget.

And they are doing it in virtually every state--a little bit differently from time to time, and learning from each other, and setting a pattern which should and could be followed.

There's very little rhetoric in all this stuff that's been discussed here today. There have been specific examples of programs that worked that did two major things:

One, helped contain costs; and

Two, at the same time, as Jim pointed out,

or maybe it was Governor Lynch, it actually improved quality at the same time.

I mean, you talk about something that actually ought to be transported into the minds of policymakers on the federal level about things that are going on in the respective states that do work, this program and the examples that have been cited here are things that really do matter and really do create solutions.

Are they all perfect? No. And will they all work in every state? Of course not. That's why everybody keeps talking about flexibility over and over. But the fact that the examples that have been pointed out here are real solutions to real problems and starting down a road toward changing the paradigm, if you will, of the delivery and cost of the health care system, are things that aren't unreachable, unapproachable, unagreeable.

There should be no serious contention that partisan politics will be able to derail this. Maybe you just have to do it in a different forum, or in a different focus where it's not in the middle of an

election year; although, that seems to be going on all the time now . . .

(Laughter.)

GOVERNOR BALDACCI: . . . where it's not in a forum where people are divided up on one side of the aisle or on the other side of an aisle.

But the solutions that have been talked about here, the specific examples of workable programs, have been uttered by Republicans and by Democrats and have been copied by one another for the last several years. And they do work.

So, yes, it can be done. I think it can be done, and I think we've got a lot more agreement than we have disagreement if we just stop long enough to listen to the litany that Jennifer and that Tim both said awhile ago were things that they thought most folks could agree on. And the governors do it.

MS. BARTIROMO: And we do need to get that list of successful examples to the Congress to show what has been working. And, by the way, in addition, get that information to the people.

Somehow this should be communicated to the

country so that people have a better understanding of what works and what doesn't work. Because some of this stuff is not brain surgery. I mean, some of it is very complex, but other things people can understand and they can get behind.

But this whole sort of notion of it's just too big to fix, and it's just too problematic, you know, people get upset and they think they don't understand it and they'll never get it, and then it's over their heads, and then they just don't want to talk about it. So it's a problem.

Governor Manchin.

VICE CHAIR MANCHIN: You know, the thing that maybe polarized things was the expansion of Medicaid. Since Medicaid came into being in '65, it was never mandated. None of us have ever been mandated to give Medicaid to everybody just because you fall below the federal poverty guidelines.

A lot of states can't afford it. We've always had to balance our budgets and be fiscally responsible. Now that, saying 133 or 150, whatever, has really got everybody saying, okay, now you're

going to mandate us that we cover everybody, which we all want to--I don't think a Democrat or a Republican doesn't want to cover everybody--but if you make us give the same type of service to an unfortunate person who is financially challenged but very healthy as someone who's financially challenged but very sick, that's very costly.

That's where we keep talking flexibility, flexibility, flexibility. One size does not fit all. What I do in West Virginia is not probably what Jennifer is going to do in Michigan.

MS. BARTIROMO: Right. And we all have different demographics that we're talking about.

VICE CHAIR MANCHIN: What we're saying is, we're hoping that the Administration and Congress is listening to us, because we're going to be the ones saddled with fixing this problem.

They might put some guidelines to it, but we're going to have to live within the playing field, and we're saying: Get us in the game.

MS. BARTIROMO: Governor Rounds.

GOVERNOR ROUNDS: Thank you. And there is

one other item that I think most governors agree on, and Jennifer touched on it a little bit, and that is insurance reform.

In that regard there are some things that we can do that would dramatically improve the delivery of the financing of health care.

Number one is portability, meaning you can move from one group to another group and you don't use your co-pays, you don't lose the deductibles that you paid in.

Second of all is guaranteed renewability for individual policies, and for groups. So that once you're in it, a company can't simply walk in and cancel. A lot of the states have already done that, but putting those guidelines in place on a national level do nothing except help improve what the field looks like.

But along with that you also have to include a ratio. So that as the National Association of Insurance Commissioners proposed back in 1993, I believe, that said there's got to be a ratio between your least expensive group and your most expensive

group. So that if somebody gets sick you don't raise the price on that group and run them up so they can't afford it anymore. You've got to have a ratio built in.

And those are items that have been proven. They work. Insurance companies accept them. And yet, at the same time, if we would do it on a national level it's something that would assure a more consistent pricing across all of the states.

Those are items that I don't think we've had any disagreement on among the governors that are here, and that should be included in any type of a reform package.

MS. BARTIROMO: Governor Douglas, Governor Manchin--final words?

VICE CHAIR MANCHIN: I couldn't be more proud of a group of people that I serve with, my colleagues that are called governors of the United States of America, and I think you see the common sense and the can-do attitude they bring to the table.

We work across party lines better than any

organization I've ever been affiliated with. So I am proud to be part of this organization, and proud to be Vice Chair of this organization now. But I can only say to the Administration and to our Congressional Representatives that we want to be part of the solution. We want to help find the answers. Because I can tell you, we see the problems every day, and we see it up close and personal.

And again what we're asking for is to have that seat at the table, to be able to bring all this knowledge into the arena to fix the problem that we have. And it's all our problems. It's not just part of the problem, it's all of our problems.

So I thank you for allowing us to have this conversation with you.

CHAIRMAN DOUGLAS: Maria, you have helped us articulate the tremendous leadership the governors have provided in the states across the country--the reforms that have been put in place, the ideas that have worked, and the differences that those reforms have made in the lives of the people we represent.

I hope that these experiences, these

examples, these reforms, will help contribute to and inform the national debate. Because while debate goes on in Washington, health care reform is happening in the states. And we believe we have a lot to offer in this national debate and look forward to being a part of that.

On behalf of the National Governors Association, thank you so much for your contribution.

(Applause.)

MS. BARTIROMO: Thank you so much. I appreciate it.

Thank you for having me, and we want to keep you on time. We have heard some fantastic solutions here. We know that the issues are complex, but we also know that there are success stories and some things are very doable.

Thank you for your time today. Thanks.

CHAIRMAN DOUGLAS: Thank you all. We'll break for lunch.

(Whereupon, at 12:28 p.m., the meeting was adjourned.)

NATIONAL GOVERNORS ASSOCIATION

WINTER MEETING

Monday, February 22, 2010

REDESIGNING STATES IN THE POST-RECESSION ECONOMY

Grand Ballroom

JW Marriott Hotel

1331 Pennsylvania Avenue NW

Washington, DC 20004

PARTICIPANTS:

GOVERNOR JAMES H. DOUGLAS, VERMONT, CHAIR

GOVERNOR JOE MANCHIN III, WV, VICE CHAIR

GUEST:

MARK ZANDI, Chief Economist and Co-Founder

Moody's Economy.com

ALAN R. MULALLY, President and CEO

Ford Motor Company

P R O C E E D I N G S

(2:42 p.m.)

CHAIRMAN DOUGLAS: Well, governors and friends, we've had a great Winter Meeting of the National Governors Association. I want to thank everyone for being a part of it. We have had good participation by governors. We have had great presentations at our plenary sessions. We've had strong discussions at committee meetings. We had a great meeting this morning with the President and Vice President, and a number of Cabinet officials. So this has been a very successful winter meeting for the NGA, and we will all look forward to getting back to work in our state capitols tomorrow and joining as a group again this summer in Boston.

Well, we focused on health care principally during the time we've been together. It is, as a number of you have noted, an important part of the economic stress that we are experiencing as state governments and in the business community as well.

Over the past decade the new century has

brought us periods of unprecedented economic growth, as well as times of great hardship. The benefits and risks of globalization have been on center stage, and it has become clear that all economies are intertwined.

We are making now the slow climb out of the crevice that some have called the Great Recession. It might be slow and difficult, and the way we do business both in the public and private sectors will change as a result of it.

Because the economic headwinds remain Strong, and the recovery here and elsewhere remain fragile, both the private sector and government are being tested on our abilities to reinvent ourselves to succeed in this new environment.

The private sector is being challenged to innovate and compete in the unforgiving global marketplace, and the public sector--state government in particular--is being asked to do much with very little to do it with.

For the private sector, wholesale changes to traditional business models are now occurring

throughout the economy. We will hear more about this shortly from someone who is at the forefront of these changes.

For the public sector, as a governor I can tell you that structure, responsibilities, and operation of today's government will undergo profound changes.

Over the next few years, governors will be at the vanguard of major efforts to downsize and streamline state government so it efficiently delivers core services.

These efforts will also challenge citizens' expectations about what government can do, and how much they are willing to pay for those services.

These issues, the challenges of the post-recession economy, the re-engineering of state government, and the creation of new business models, are the subject of this afternoon's plenary session.

I want to first introduce someone who is uniquely skilled at helping us understand the economic challenges.

Mark Zandi is chief economist and co-founder of Moody's Economy.com, where he directs the company's research and consulting. Moody's Economy.com, a division of Moody's Analytics, provides economic research and consulting services to businesses, governments, and other institutions.

Mark's expertise includes macro, financial, and regional economics. He conducts regular briefings on the economy, testifies frequently before Congress, and is often featured in the media.

He is the author of *Financial Shock*. an expose of the subprime financial crisis. Dr. Zandi received his Ph.D. at the University of Pennsylvania where he did his research with Gerard Adams and Nobel Laureate Lawrence Kline. He received his undergraduate degree from the Wharton School at the University of Pennsylvania.

Let's welcome Dr. Mark Zandi.

(Applause.)

MR. ZANDI: Thank you, governor. Thanks to NGA for the opportunity to be here today.

I am going to speak for three hours--

(Laughter.)

MR. ZANDI: No, promise. Does 20 minutes sound okay? All right, 20 minutes.

I am going to make four points.

Point number one: The recession is over. Recovery has begun. The best evidence of that is real GDP, the value of all the things we produce, grew at an annualized rate of 4 percent in the second half of '09. That is strong enough growth to begin to stabilize the job market.

A year ago when we were meeting, when you were meeting, we were losing 700,000 - 750,000 jobs each and every month. Those job losses have nearly abated. I think we have one more month of job loss to go in February, in part because of bad weather, and after that we will start to get some positive job numbers.

The stock market is up 50 percent. Housing values have stabilized in many parts of the country. We are in a measurably better place today than we were a year ago when you were meeting here.

In my view, a lot of this is related to or is due to the policy response, the very aggressive and unprecedented response by the Federal Reserve, the Treasury, the FDIC. They, through their efforts--and there were many, including the zero percent interest rate, the bank stress tests, the higher deposit insurance limits, so forth and so on--the financial system has stabilized.

It is not normal. We are still losing a lot of small banks each and every week. Parts of the credit markets are still dysfunctional. But broadly speaking, the financial system is stable. And that is a necessary condition for an economic recovery. So that is very positive.

And in my view, the fiscal stimulus was very helpful in turning the economy around. I don't think it is any coincidence that the recession ended at just the same time that the stimulus was providing its maximum economic benefit to the economy. That's unemployment insurance benefits; that's aid to state governments; that's the tax cuts; business investment was up strongly in the fourth quarter in part because

of accelerated depreciation benefits included in the stimulus; aid to small businesses in the form of more credit through the SBA; the housing tax credit was very helpful in supporting the housing market this spring and summer; the Cash for Clunkers helped to clear out inventory and laid the foundation for an improvement in the manufacturing sector, which is what we're seeing today.

In fact, manufacturers added to payrolls in January for the first time in three years. And that is in large part because of the turn in vehicle manufacturing sector, in part due to the Cash for Clunkers, and of course the auto bailout.

Now the recovery is uneven. It is uneven across the country. It is not everywhere yet. This map shows where I think each state is in its business cycle. One state, Nevada, is in deep recession obviously related to the housing bust and the problems in trade and tourism.

A large number of other states are still in recession, but the rate of decline is moderating. I suspect they will be in recovery shortly; that we

will see a lot more blue in the map.

In fact, the blue states are states that are in recovery, many in the Farm Belt with energy/resource-based economies. But you will notice, Indiana and South Carolina, those are the two most manufacturing-sensitive sectors, states in the nation. Those states are more sensitive to manufacturing activity than any other states, and they have turned. And that is a very, very positive sign.

So point number one, the recession is over. The Great Recession is over, and economic recovery has taken hold.

Now point number two, the recovery. It's going to be fragile and tentative I think in 2010. The coast is not clear, at least not yet, and let me give you a few reasons for that concern.

First is the job market itself. It has improved. Layoffs have abated. You can see that here. The green line right-hand scale represents the number of initial claims for unemployment insurance. This is a very good proxy for layoffs.

You can see we've made a lot of progress. A year ago this time we had claims of 650,000 per week. We're now down to 450,000 per week. Here's a good rule of thumb. 400,000 claims per week is consistent with a stable job market. 350,000 jobs per week is consistent with enough job growth to stabilize unemployment. And 300,000 initial claims per week is enough to create a boatload of jobs that will start bringing down unemployment in a meaningful way.

So we've made a lot of progress. We're not quite there yet. And moreover, hiring has yet to kick-in in any meaningful way. You can see that in the slide, as well. Continuing claims--this includes regular state benefits, extended and emergency benefits as part of the stimulus--continuing claims are the left-hand scale, and they are running around 10 million. Now that's an awful lot of people getting continuing claims and that has not come down. And until it does, we can't be sure that hiring is starting to kick in.

There are a couple of reasons that I can

proffer for this lack of hiring. One is credit, particularly for small business people. They can't get credit.

Big business, no problem. They can go to the bond market and the commercial paper market, but small businesses rely on small banks. Small banks are under tremendous pressure because of their problems in particular commercial real estate loans. And many of them rely on credit cards.

Here's an interesting statistic. Back in the summer of '08 there were 420 million bank credit cards outstanding. That was the peak. Last month, in January, there were 340 million bank credit cards outstanding.

Now some of that is people clipping those cards and saying I'm not going to borrow, and that's great. But a fair amount of that is credit to small business. They can't get it. They rely on their cards, and as a result they're not hiring.

Another factor is confidence, lack of confidence. Many businesses suffered near-death experiences about a year ago. You don't forget that

quickly. It's hard to overcome that.

And while we need to address things like health care, and energy policy, financial regulatory reform, the Bush tax cuts, those things need to be nailed down, or at least fade away, because it's the uncertainty created by that that is stopping big business from hiring.

They're very important policy efforts. We need to address them, but we need to address them quickly.

The second reason for some concern about the recovery is the ongoing mortgage foreclosure crisis. That is not abating. You can see that here. This is the number of first mortgage loans that are in foreclosure or are clearly headed in that direction. They're 90 days and over delinquent.

As of the end of December, the last data point shown, 4.2 million first mortgage loans were in this predicament. To give you context, there's 52 million first mortgage loans outstanding. This is a boatload of loans.

One of the things that has happened

recently is that the President's load modification plan has slowed down the foreclosure process. Many mortgage servicers and owners are trying to figure out who can qualify for a modification. And so, while they work through the loans, those loans stay in the foreclosure process.

We are now getting to the point where they're going to figure out who qualifies and who doesn't. Many will not qualify and those loans will go to foreclosure, to a foreclosure sale, and that will hit later this summer and fall. In all likelihood, house prices will fall further. The price declines are not over.

Nothing really works well in our economy when house prices are falling. The home is still the largest asset in most people's balance sheet. And of course banks are going to be reluctant to extend credit if people's housing values are falling.

I was a small business owner. I started my company in 1990 before I sold it to the Moody's organization. My first business loan back in the early 1990s--and there was a recession in the early

1990s--I had to put up my home as collateral. But I would not have been able to do that in this environment, given the falling housing values.

So reason number two for some concern about the health of the recovery is the foreclosure crisis.

Third is your situation, the struggles of state and local governments. This is epic. You can see that here. This shows the growth in state and local tax revenue percent change a year ago, and I am showing data all the way back to just after World War II. Revenues have collapsed.

The last data point is for Q4/09. It's my estimate, based on partial data--and you can see revenue year-over-year through Q4/09 is still falling 4 percent. Just to give you more granularity, the level of revenue in Q4 is about where it was in late '06, three years earlier. And of course expenditures have increased because of the demands on government services, given the recession, and thus yawning budget gaps.

Now that budget problem was not a hit to

the broader economy and to payrolls up until now because of the stimulus and the help that the stimulus provided in filling those budget gaps. But unless state and local governments get more help, those budget gaps that they faced for fiscal year 2011 will result in cuts, lots of lost jobs.

I mentioned manufacturers added to payrolls for the first time in January. State and local governments cut 41,000 jobs in the month of January. That obviously is just the beginning of the job cutting that's going to come.

So point number two is that the economic recovery is going to be fragile and tentative. And this gets to point number three.

That is, I think it is very important for policymakers, both the Federal Reserve and fiscal policymakers, to remain aggressive to ensure that the recovery evolves into a self-sustaining economic expansion.

I think without any further policy help we'll make it through. I think the odds are that we won't experience what we're calling a double-dip.

But the risks are all to the downside, as you can glean from my previous comments.

And more importantly than that, I think if we go back into recession it is going to be very difficult to get out. We already have a zero percent Federal Funds Rate target. The federal budget deficit last fiscal year is $1.4 trillion. We'll be lucky if we get $1.4 trillion in fiscal year 2010.

We don't have the policy resources to respond. So it is very important to remain aggressive to ensure that the economy moves forward. That means I think more help for unemployed workers. I think it means more help for state and local governments. I think it is key that states get more FMAP help for 2011. I think that is vital.

Jobs tax credit I think is a reasonably good idea, worth a shot to try to get the job market moving and get that hiring that we need to evolve into a self-sustaining economic expansion.

I think by 2011 and 2012 we should be off and running, with a little bit of luck and some continued aggressive policy support. But here I am

up to point number four.

And that is, even on the other side of all of this when the economy is expanding again, things will look better for you, but they won't look great. There are a number of broader economic forces that are going to weigh on tax revenue growth.

Tax revenues are going to grow, they're just not going to grow at the rate that they have historically. And let me give you three reasons for this view.

First is the job market itself. Even under the best of circumstances it's going to be years before we regain all the jobs that we've lost in this recession and bring unemployment back down to full employment, what we would deem to be full employment.

You can see that here. The orange line, left-hand scale, shows the number of jobs in millions. You can see where history ends and the forecast begins.

You will note that in the recession we lost 8.4 million jobs from peak to bottom. Just to

give you context, in the last recession in the wake of the tech bust we lost 2 million jobs peak to trough. So in this recession, four times--more than four times--as many lost jobs.

And you can see, I don't expect we get back to the previous peak until 2013. And I'll let you know, I am on the optimistic side of economists with respect to job growth in the out-years. So this I would view as an optimistic assumption, or forecast.

Jobless rate? You will note that I don't expect any improvement there until this time next year, and it really won't be until 2014 before the unemployment rate gets back to what anyone would consider to be full employment, somewhere around 5.5 to 6 percent.

The message here is that personal income tax growth will be slower than what you're accustomed to. With high unemployment, that means lower compensation in wage growth, and that means slower growth in personal income tax receipts. And you can see that's going to be the case at least through the

mid part of this decade.

The second revenue source that's going to be under pressure is sales taxes, the most important source of revenue for states in aggregate. States have had a significant tailwind at their back for the last--as you can see here--at least 20 years. The rising share of the nation's economy that is accounted for by consumer spending.

In fact, I could have taken the graph all the way back to 1990 and the consumer spending share has been essentially rising for 30 years. That is the corollary to the decline in personal savings.

Obviously, given what we are now going through, that was unsustainable. But it did provide a lot of juice to sales taxes, as consumers spent beyond their means and powered economic growth not only here in the United States but globally, and that was an important source of support to the growth in sales taxes.

Obviously we're at an inflection point. You can see my forecast. At the very best, consumers hold their own. More likely we'll start to see

savings rates continue to rise and consumers' spending share of GDP fall.

That doesn't mean that sales taxes won't grow; it means that they will grow at a much slower rate than what you've experienced historically.

And then finally--this is obviously more important to local government than states, but their problem is your problem as well--I think it's fair to argue that housing values and commercial real estate values are going to remain depressed for quite some time.

This is a good measure of national house prices. It's an index. It's equal to 100 in 2000/Q1, the beginning of the last decade. You can see the boom and the bubble, the bubble in the mid part of the decade. House prices nearly doubled in that period.

You can see the crash. And when it's all said and done, I think house prices nationwide will fall about 34 percent peak-to-trough, and then you can see even in 2011, 2012, and 2013, 2014, growth--but very, very slow growth.

All those foreclosed properties; it's going to take years to work through them all. As they go to market, they will depress prices and of course slow the rate of growth in house prices. And that will be a constraint on local tax revenues.

So my final point is that even when we are on the other side of this Great Recession financial panic, when the economy is growing again, your troubles will not go away. You will have to continue to struggle with revenue growth that is measurably less than what you've become accustomed to over the past two to three decades.

Now being the good economist I am, I'm sorry I can't end on a positive note.

(Laughter.)

MR. ZANDI: But I am going to turn it back to you. And if you want to--it depends on how you question me, we could end on a positive note. It's really up to you.

(Laughter.)

CHAIRMAN DOUGLAS: Governor [Ed] Rendell.

GOVERNOR RENDELL: Mark, I hate to tell

you but you're wrong for about two-thirds of us who are term-limited. Our troubles will go away.

(Laughter.)

MR. ZANDI: Good point. That was your optimistic note?

(Laughter.)

CHAIRMAN DOUGLAS: Questions?

GOVERNOR [JEREMIAH] NIXON: You indicated right near the end there that you thought that the savings rate, personal savings rate, was going to continue to move up. How do you analyze that? First of all, individual and business? Or just individual? And is there any strategy at the state level we can do to--I mean, ultimately you've got to believe that's a good thing for the country, but give me some flavor as to what you think that means economically?

MR. ZANDI: Right. The personal savings rate I think, just to give you context, was 1 percent at its low before the recession. That was an all-time low.

It's currently about 5 percent. The high was 1980 when it was about 10 percent in 1980. I

don't think we go all the way back to 10 percent, but we're going up from five to somewhere closer to 10, primarily because--well, for two broad reasons.

One is many middle and upper income households have seen their nest eggs diminished significantly. Certainly not as bad as it was a year ago when stock prices were 50 percent lower, but nonetheless they're worth a lot less. And they know that it is going to be very difficult to get the kinds of returns on their assets that will replenish that nest egg without more savings.

They're not ready for retirement. They're not ready for their child's college education. They have to save more. And the bulk of saving actually does occur in upper income groups. That's where a lot of the savings occur, and that's the group that's going to be much more cautious in their spending.

The second reason is, I think everyone understands that no matter how you look at it, our fiscal--long-term fiscal--situation is really quite disconcerting, and at the end of the day means higher tax rates. It's going to mean slower spending,

growth, and some spending cuts, but it's also going to mean higher tax rates.

And so I think people understand that and that means that they're going to have to save in preparation for that eventuality; and, fewer benefits in entitlement programs. I think that's an understanding.

So I think savings rates will go higher, and I think it is important that it goes higher to prepare for these kinds of things, and I don't think there's anything states can do, or should do, to stop that.

Now I think they should understand this as a force and prepare for it, and that means if you rely very heavily on sales tax revenue, well, you might want to start thinking about ways of broadening your tax base or in terms of what you tax in terms of sales taxes, and generating other sources of revenue. Because sales taxes just aren't going to be there for you like they have been there for you for the past quarter century.

Governor [Jennifer] Granholm, and then I'll come

back to you.

GOVERNOR GRANHOLM: What would you, if you could wave your magic wand and tell Congress what to do, what would you advise them at this moment?

MR. ZANDI: Two broad things.

First, I would, in the spirit of being aggressive, I would do four things. First, I would extend unemployment insurance benefits for people who lose their jobs in 2010. Right now, if you lose your job in 2010 you get your regular 26 weeks and you're in trouble. Nothing will eviscerate confidence more than running out of benefits.

Second, more help to state government. I think I made a strong case for that. I think that is very important. And it's not that states aren't cutting. If you look at expenditures, they're falling on a nominal basis. So it's not like states aren't pulling back; it's just important that they don't completely crush their budgets because that could obviously hurt the economic recovery later this year.

Third, is a jobs tax credit. There are

three proposals. If I were doing it, I would go with the President's proposal with a few twists, but I think something's substantive that really catches the attention of business people. The proposal in front of the Senate is small, and I don't know that it will generate the excitement that's necessary to turn the light switch on and get businesses to hire. I think that's worthwhile - it's an experiment, and it's hard to evaluate, but I think that has a worthwhile shot at really making a difference in 2010 if it were implemented in the spring and the summer.

And the fourth thing is, I would significantly expand out and empower the SBA to make loans. Part of the stimulus was SBA lending. They need more funding, and I would become more aggressive with the terms of SBA lending. And if you're interested, I can tell you how I would do it. But you can make SBA lending much more effective, and that can make a big difference fast.

You know, the President has a proposal to take TARP money and recapitalize community banks. I don't think that's going to work. It's just not

going to work quickly enough. I don't think you're going to get take up on it by the institutions you want to take you up on the offer. So I would do the SBA. That's the fourth.

Now . . .

GOVERNOR RENDELL: Would you do direct loans, or guarantees?

MR. ZANDI: Direct loans means raise the SBA loan guarantee. So the SBA loan guarantee is 90 percent. I wouldn't go up to 100 percent, but I would raise it to 97-1/2 percent for one year. That's the HUD. If you're going to make a mortgage loan at 97 percent, then I'd make a Small Business loan at 97 percent. That's what I would do.

Now two broad things. The second thing is I would already be pivoting on the long-term fiscal situation because I think we need to make sure that the economy is off and running, because you can't address the long-term fiscal situation unless we're growing.

If we're not growing, nothing works in the long run. So let's spend that money, a couple

hundred billion dollars this year and next and make sure the coast is clear and we're off and running. But we need to pivot fast. And we need to make sure that that fiscal commission is working in a political sense and we get a proposal, because we need tax increases and spending cuts, and we need someone to tell us that, and someone who's bipartisan.

The sooner we believe that we're going to get that medicine, the easier it is for us to respond to these near-term problems.

GOVERNOR [Jack] MARKELL: You talked about the housing market, also about the housing market as one of the things that got us into this problem in the first place, and the shoe appears to be prepared to drop on the commercial loan market soon.

From what I've read, some of the smaller community banks are likely to take a disproportionately bigger hit on those loans, just as the big banks got in trouble sort of on the front end on the housing market. And the question is: Are those reports true? Have they effectively already been factored in not only to the stock market but to

the economy more broadly?

How do we deal with that? And then how do we deal--this is related but slightly separate. Everybody around this table absolutely believes there's been a problem, and continues to be a problem with access to credit for small and medium sized businesses, and I think your thoughts about the SBA are very constructive in that regard.

The question is: Given that some of the lending got us into trouble, some of the lending and related borrowing got us into trouble in the first place, how do we think about that as all of us are pushing for additional lending to small businesses?

MR. ZANDI: The commercial real estate problem is a problem. It's a weight on the recovery. I thought I depressed you enough by the three reasons for concern. It didn't make my top three. It would have been number four, though.

It is an issue. The link between commercial real estate and the economy is in two principal ways. The first is what you mentioned:

small banks have problems with their commercial mortgage loans. If they don't have enough capital, they fail.

We lost 140 banks last year. There's 550 banks on the FDIC trouble list, most of them because of their commercial loans. So small banks are choking on their commercial real estate loans. Small banks are key to small business in small communities.

Here's one more statistic for small business. Businesses that employ fewer than 100 employees--let's call them small businesses--account for one-half of all jobs in the economy, almost to the decimal point. And two-thirds of all the job growth in the last economic expansion.

So if they can't get credit, they can't hire and the job machine can't get going. So this is a significant issue, and it is largely commercial real estate related.

The second link is direct: the collapse in commercial construction. It's been collapsing, and that's a direct hit to the economy.

Now the good news is, as you said, this is

largely factored in. It's no surprise. I think we got this pretty much understood in the financial markets and in the real estate community, and in the banking community. And it's a much smaller problem than the residential mortgage problem.

Just to give you another number, total residential mortgage debt outstanding is close to $10 trillion. Commercial mortgage debt outstanding is $3.5 trillion. So that kind of gives you an order of magnitude.

So I think we can digest this. And I say that in part because there's no good policy response to it. Unlike the residential mortgage market where the government can step in through Fannie, Freddie, and the FHA, there's no good mechanism for them to do it. But I think it's okay, as long as regulators help them, show some forbearance. You know, figure out ways to work with the mortgage owners to not foreclose on them but sort of work through the problems. And I think that's happening. And so I think we will be able to digest it.

It's a negative. It doesn't help. But

it's not going to undo us.

Yes, sir--I can't say no to him.

VICE CHAIR MANCHIN: Yes, you can.

MR. ZANDI: He's bigger than I am.

VICE CHAIR MANCHIN: You can, you can.

Quickly, you mentioned in one of your graphs you showed that government has grown in the last 20-plus years tremendously, all state governments, the revenue going to a government.

MR. ZANDI: Yes.

VICE CHAIR MANCHIN: And then it's dropped off.

MR. ZANDI: Yes.

VICE CHAIR MANCHIN: Do you believe there's ability for us to adjust government? Or it sounds to me like you think it's inevitable that taxes will have to be raised?

MR. ZANDI: I think that gap, which is now in my mind between revenue and expenditure--

VICE CHAIR MANCHIN: Where we are right now.

MR. ZANDI: --is probably about $150

billion right now. I think that gap can be closed with budget cuts, some tax increases, and growth. Once we--you know, revenue isn't going to continue to fall forever. They are going to start to grow with the economy.

So by 2012 and 2013, those budget gaps will narrow. But it really won't be until 2012-13 before--

VICE CHAIR MANCHIN: Before you think any of our states--and I'm understanding you made a comment that the levels of our funding, at 2/08 levels, will be 2012-13-14, that neighborhood there?

MR. ZANDI: Before you get back, right.

VICE CHAIR MANCHIN: So we've got to get from here to there.

MR. ZANDI: You've got to get from here to there, yes. That's the bottom line message. Your work is just starting.

I mean, more broadly speaking, manufacturers--Mr. Mulally represents one of the first sectors to turn. You represent one of the last sectors to turn. Sorry about that. Maybe you can

tax him--no, only kidding.

(Laughter.)

MR. ZANDI: Yes, sir?

GOVERNOR [MARK] SANFORD: I found your presentation really discouraging because it began with a chart of we're now moving into recovery and we're out of the recession, and then you enumerated a long list of facts that were fairly discouraging from the standpoint of state budgets, or from the standpoint of the taxpayers, the standpoint of the consumer.

What you described from the standpoint of policy is in essence the federal government went all in. If you were playing poker, they went all in saying here, we're going to try and put the chips on the table and try and make a change here.

What if we misdiagnosed the whole thing? I mean, because a lot of the remedies that you described, and a lot of what has been attempted has been based on an inventory-driven recession. In an inventory-driven recession you throw some money into the equation and the consumer goes out to spend and

it begins to get the wheels of the cycle turning again and you go from there.

What if this thing was a balance-sheet driven turndown, in which case we probably made things worse by encouraging the consumer, or government to spend at levels maybe that were unsustainable? What if we misdiagnosed the whole thing? What then?

Because then we really would have a problem if things don't resuscitate here very shortly.

MR. ZANDI: Yeah, no, you make a good point and the diagnosis could be wrong. You know, but my sense is that--let me say that in most times I would think what we did here, 99 percent of the time this is not something I would advocate. You know, using stimulus in the way we used it, doing the auto bailouts, helping homeowners, you know, really, as you put it, going all in, I agree with you.

But I think there are times, 1 percent of the time--that's one out of 100 years, the 100-year event--where I think it's very important that we do

go all in. Otherwise, we're never coming out. And I think that was one of those times.

Now that is a judgment call, you're right. I don't know. We don't know what the world would have . . . we don't know what the counter facts were, and that's why we're debating endlessly the merits of the stimulus, right, because we don't know what the world will look like.

But my sense is that if we did not go all in, as you say, we'd still be in a recession and the financial system would be still a mess, and it would have cost taxpayers at the end of the day more.

And again, I don't say that lightly. I'm with you 99 percent of the time.

CHAIRMAN DOUGLAS: We'll take Governor [Linda] Lingle, and then we will have to wrap up, Mark.

GOVERNOR LINGLE: Thank you, Jim.

Mark, it's great to have you back at NGA. I have a variation of the question that Joe and Mark were both asking and trying to get at--

MR. ZANDI: But you want a more upbeat answer.

(Laughter.)

GOVERNOR LINGLE: No, not that part of it, but the emphatic way that you said we have to raise taxes, as if that's just a given and you just have to do it.

And I understand I think the reasoning that you used. I am curious. What's the difference between those people who would say to you that is absolute worst thing that we could do right now? And coming from my perspective as a leader of a state and who has watched spending, and watched what happened when revenues increase, if the assumption is that by taxes going up we will then be able to bring our expenses and our revenues more into alignment without completely decimating government programs or something, I think the history would show that when revenues go up to the government it's not used in that way. It's just a signal that now we can expand, now we can do something else.

What would be the difference between your philosophy that we have to raise taxes, and a person who would come out and say that's the opposite of

what we need to be doing?

How is it that they see economics and a potential recovery that differs from what you're seeing? Because certainly there are people--and again I have tremendous respect for you--but there are people I equally respect who would see it the exact opposite.

So what's the difference in how you reach your conclusion?

MR. ZANDI: Right. And let me say, I don't think we address our long-term fiscal situation by solely raising taxes. I think it's going to be a combination--it has to be a combination of what we're calling spending cuts, or at least much slower growth in the rate of entitlement programs, combined with higher taxes.

I don't think we can address . . . we cannot solve the accounting problem that we have in the long run without both. And I think there are intelligent, smart, efficient ways of doing both that don't--that are going to be painful, but that will allow the economy to grow and prosper, and actually probably

result in a better economy sooner than anyone thinks. Because if we do these things, we'll be rewarded for it from the financial system and financial markets, and it will benefit us.

Now there is a debate, a reasonable debate, about the merits of raising taxes that is a legitimate one. My sort of perspective on this is, you know, the idea is that if I lower tax rates I get people to work harder and do more entrepreneurial things, and it generates more economic activity and more tax revenue.

GOVERNOR LINGLE: Or just let them keep their money and spend it and generate that activity.

MR. ZANDI: And I think that's a good solid argument when tax rates are relatively high, very high, and you bring them down a lot. So that's what we did during the Reagan Administration. We had high marginal tax rates. We brought them down a significant degree and made a really large difference, and arguably helped the economy longer run. I would agree with that.

But I think the tax rates we're talking

about now are much lower than they were, and I think if we raise them--we don't have to raise them a lot; we just have to raise them a little bit in a broad-based way, a VAT tax, for example, that would not have those kind of meaningful negative consequences that those economists to whom you're referring would suggest.

So I think it's a matter--I don't disagree with sort of the philosophy, the idea, but it's the nuts and bolts of it, the numbers, how much are we going to raise taxes, and what kind of taxes are we going to raise, that at the end of the day will make all of the difference.

Thank you. It was a pleasure. Thank you.

(Applause.)

CHAIRMAN DOUGLAS: Thank you very much, as always.

Well, Dr. Zandi, thank you so much. We promise not to shoot the messenger. We really appreciate your taking the time to join NGA again this year.

We are going to turn to someone who is an

innovator in the private sector now, and I would like to invite Governor Granholm to come forward to make the introduction.

GOVERNOR GRANHOLM: I suspect that this introduction will lead you to a speaker that will leave you a little more optimistic than Dr. Zandi did, because Alan Mulally is a tremendous, tremendous leader, innovator, champion, and a positive force of nature.

Chris Gregoire and I know, because we have shared him as a CEO in our states. He was the CEO of Boeing and was with Boeing for 37 years, and then was recruited by Bill Ford to become the president and CEO of Ford Motor Company.

Now many of you who have been watching what's happened with the auto industry know very well that Ford was one of the companies that did not require taxpayer assistance, and has actually done a phenomenal job of emerging and navigating a very, very tough time. And that is really under Alan Mulally's wonderful leadership.

We are very proud in Michigan that Ford is

headquartered in Michigan, and we are very proud to have Alan Mulally as a CEO. We are proud because he has done a great job with Ford. But I have to say just a quick personal story, because he is such a good guy.

My husband, Dan Mulhern, comes from a Ford family. His Dad worked for Ford for 38 years, so we're all Ford all the time in our household. Dan writes an online column, and Alan gets it from time to time, and actually called Dan one day and said, I see your Dad worked for Ford--Dan's Dad has passed away many years ago--and Dan said, yeah, my Dad worked for Ford.

And Alan said, is your Mom still alive?

And Dan said, yeah.

And he said, what's her address?

And Alan sent my mother-in-law this wonderful box of Ford stuff, like an umbrella, Ford auto, and--you know, not a real car, a small car--

(Laughter.)

GOVERNOR GRANHOLM: That would have been really generous--

(Laughter.)

GOVERNOR GRANHOLM: But just to show you the quality of the human being that he is, he wrote her this note. And of course he's never met her. He doesn't have to do this. He wrote her a note saying: Ford stands on the shoulders of men like your husband.

So I would like to introduce you to somebody who is such a quality person that he has not only steered Ford into a successful path, but he truly has made my mother-in-law cry.

Please welcome Alan Mulally.

(Applause.)

MR. MULALLY: That was great. Thank you.

The last time I was with Mark I was testifying--do you remember? Well, it was a big deal to me at the time.

(Laughter.)

MR. MULALLY: I was thinking the same thing, like come on, Mark, we've got to get on with it here. But Mark is a tremendous professional.

Well I know you've been through a lot this

last couple days, but I want you to know it's going to be all okay now.

(Laughter.)

MR. MULALLY: Because Ford is here, and we're going to take care of all of your automobile needs with the finest cars and trucks made in the world. Okay.

(Applause.)

MR. MULALLY: Now in addition, I was very surprised that I was invited to the nation's CEO meeting, and I asked why. And what could I do to serve? And what came back from your team was that you were interested in how Ford had done what we've done. And also, a lot of the things that we've been through you're going through right now, and so were there some lessons learned, some things that we could talk about and share?

And I said I would be glad to come. And so what I would like to do is just spend a few minutes and just tell you a little bit about the Ford story, kind of the rest of the story that you don't maybe see completely on TV. And then highlight some

lessons learned that maybe is applicable to what you're all going through.

And then I'd like to just talk for just a little bit perspective about manufacturing in the United States and global competitiveness of the United States. And then just touch on what I think is the importance of the public/private partnership.

As Governor Granholm just mentioned, after 37 years at Boeing competing with the best in the world worldwide, and now at Ford, I've just been through a lot, like you have, through a lot of cycles. So I'd just like to give you a little bit of perspective about what I think it takes for the United States to move back up and compete with the very best in the world.

And there is no reason that we can't do it. There is no reason we can't do it. And your wonderful Ford Company is doing it today.

Okay, so here's the story. So I got a call--Jennifer mentioned this--I got a call from Ford, and I had been honored to serve on every Boeing airplane except the 707. I worked on it, but I'm not

quite that old. I am getting very old fast. But the 727, the 737, the 747, the 757, the 767, the 777, and the 787. And if you fly, if you look at all the Boeing airplanes that are flying today, 80 percent of all the seats that are flying worldwide are on Boeing.

So I loved serving Boeing. And when I got this call from Bill, I knew I was kind of in trouble because--you've all had this same call where you just don't say no right away. And so the kids, and Nikki and I went online and we started checking out all the Ford products, and of course all we remember was that blue oval in every community across the United States.

And your Ford dealer would take care of you. They'd take care of your car needs. They'd get you home at night. They'd fix it up, wouldn't tell your parents all the time. I mean, Ford was like the fabric of every small, medium and large city in the United States.

And so the more I learned about it, the parallels with Boeing were incredible. I mean, the

technology, the manufacturing, the product line, the global presence, but also the situation that they were in. Because it was pretty dire, as you know, three years ago.

And in the United States, because we had a cost structure where we couldn't make cars in the United States to make them profitably, then we had moved--we, Ford--to larger SUVs and trucks.

It was a good business, but the world was changing--energy independence, energy security, fuel prices--and Ford was not prepared for this future.

They were essentially losing money on all of their vehicles. They were running out of cash. The fuel prices were moving up. The United States was moving into a recession, which was starting to take the rest of the world with it. And so it seemed like a great opportunity to accept this job.

And the kids were excited. They knew all about the Boeing airplanes, only seven new models in the history of Boeing, and they all have a pointy nose and a tail at the end, and now they get a chance to hang out with Mustangs, and Fusions, and Fiestas,

and, you know, maybe even drive an F-150 where you could live in it and pull your house behind it simultaneously.

(Laughter.)

MR. MULALLY: So they were excited. I was excited. And so I made the decision to come to Ford. And so the first thing I'd just like to offer you--and we're going through exactly the same thing; I mean the parallels we've been talking are just absolutely incredible of what you're going through and what we are going through together--but the first thing I'd offer is the importance of coming together around a compelling vision about what you stand for, what you're serving, what your services are, and it needs to be compelling, right? I mean, because we're serving. We're the CEOs. It's our most important job to decide what business we're in, and is that compelling for everybody involved?

In Ford's case we ended up going back to Henry Ford and his original vision. On January 24th of 1925 in *The Saturday Evening Post*, Henry Ford had a full-page advertisement and it said:

"Ford: Opening the highways to all mankind."

And it talked about Ford, how grand it was, how important it was. It was about safe and efficient transportation. It needed to be affordable for all of us. We need to be able to work there. We need to be able to buy the products, have great jobs, contribute to energy independence, energy security--everything we're talking about today, that was Henry Ford's original vision.

And so we pulled together around that vision, it was exciting--all the stakeholders, and so the most important thing is deciding what you're really going to be, which strategically going to determine what you're not going to be.

So the next thing we had to decide was, things were really starting to slow down, so what did we need to do to act on that? And this is really. As leaders you know that the most important thing that we do is we hold a couple of things in our hands simultaneously: despair, because everything is slowing down, it's awful, we can't get out of here;

with hope, and what's the plan for the future?

I propose that the best strategies are ones that deal with both of those, and they treat everybody so everybody knows what the situation is, so you can deal with the reality and also develop a better plan to grow coming out.

So the first thing we had to decide was to take our production down to the real demand. Nobody in the automobile industry in the United States has ever done that. They always argued that their costs were fixed costs; they'd keep the production up; they'd go for the last bit of incremental dollars; they'd flood the distribution network with vehicles that we didn't want. Dealers would all have to discount the vehicles. That would ruin the residual values, and we actually contributed to a slower recovery from the recession.

So we did something that no one has ever done. We took the hurt--and it was awful, I mean just awful for all of us--but we took production down to the real demand. And so we kept everybody going, consolidated our suppliers, our dealers, the entire

Ford network, so we could actually get back to profitably operating during the worst of times. Tough action, but absolutely required because if you don't take it, you can't come back out the other side.

The second thing is that, during the worst of times we decided to accelerate the development of the new vehicles that people really do want and value. And so a really important part of that restructuring was that we sold Aston Martin, we sold Jaguar, we sold Land Rover, we're in the process of selling Volvo today which is held for sale, took down our equity position in Mazda, because on that compelling vision we needed to absolutely focus on the blue oval and that brand.

The next thing we decided was we were going to have a complete family of vehicles, just like the original Ford. We were going to have small, medium, and large ones; cars, utilities, and trucks. And the next decision we made was that every vehicle that we designed and produced from now on would not just be competitive, but they would be best in class

with the best companies in the world.

And that is why you see all of the third-party recognition about Ford, that every vehicle is best in class in quality, fuel efficiency, safety, smart design, and value. You know, *Consumer Reports*, 70 percent of the vehicles are recommended by; J.D. Powers, the finest quality in the world.

But that was a conscious commitment that for us to compete on a global stage we had to be absolutely best in class.

That also meant that we had to have a cost structure that was supportive of that. And over the years, the companies, and the unions have made a lot of agreements together, and we were just not competitive. We could not make cars in the United States and make a profit, which is one of the reasons we bought all those other brands.

So I had the most phenomenal partnership with Ron Gettelfinger of the UAW where we sat down together and said, where do we really want to take this great company? And can we take the actions that would allow us to make cars in the United States and

make a profit and continue to invest in the United States of America?

Our conclusion together was, we could. We went to work. That's where the transformational agreement came out of, where we moved from defined benefits, to defined contribution. We worked the wages to be competitive. We changed all the work rules to allow flexibility, so that we could operate in the United States and we could operate profitably.

And the neatest proof point about that is that we are now converting truck plants to car plants, and we are going to employ U.S. citizens in engineering and manufacturing making the best cars and trucks in the world right here in the United States, competing with the best companies in the world.

The third thing that caught a lot of attention is that we needed a small home improvement loan to do this. I know that you don't have the same flexibility that we have on doing that, but we needed to go get a loan to be able to do this plan, because you can't run out of money when you're doing a

transmission like this.

The bankers believed in us. They believed in the plan. We raised the required liquidity, and now we're actually paying back our loans and raising equity because people believe. And the neatest thing was, to not only go stand in support of the U.S. auto industry last year, but to actually not have to access precious taxpayer money. And everybody in the United States knows that.

And then the last thing I would propose to you is this concept of working together. You've got to include all of the stakeholders. Nobody can be left out. Then it goes right back up to the compelling vision and the actions required to create a viable, profitably growing company.

So we have included all the stakeholders through this, the dealers, all of our employees, the UAW, our suppliers, the bankers, and especially each of you here, because we operate in just about every state in the United States, and the working together we've had with you to create a viable Ford business that is actually growing now is fantastic.

So 14 out of the last 15 months we have increased market share against the best companies in the world. We actually returned to profitability in all of our Ford operations, including the United States, in the third quarter of last year.

We provided guidance for this year that we're going to be profitable for the entire year. And so we're on a plan I believe, and I hope Mark is right that the recovery, even though it is more gradual because of these bigger systemic issues, that we are going to actually be able to grow and provide fantastic opportunities for so many people in the United States and around the world.

So for my fellow nation's CEOs, that is my report to the board, and I would be glad to take any of your questions.

(Applause.)

MR. MULALLY: Yes, governor.

GOVERNOR [Steven] BESHEAR: First of all, Mr. Malally, let me just thank you and your leadership team for what you've done with Ford. The way you all got yourselves back on your feet and now

are one of the best automakers in the world again, I think it speaks highly of the leadership and of your workforce.

MR. MULALLY: Thank you.

GOVERNOR BESHEAR: You've got a high-quality workforce. We've got a great partnership in Kentucky with Ford, and they employ about 5,000 or 6,000 of our Kentuckians, and produce some great vehicles there.

Let me ask you what your views are of how this country is supporting the manufacturing sector in general, and perhaps are there things that we should be doing, or what should we be paying attention to make sure that we continue to have the kind of strength that we need to be the number one industrial nation in the world.

MR. MULALLY: Well I would be pleased to offer you my thoughts on that, because it's so important. Because as you know personally, and all of you that are associated with manufacturing, we are fighting for the soul of America right now because we have not held manufacturing as a high priority in the

United States.

I think sometimes it's maybe because we've defined manufacturing with a small "m," but when you look at the R&D that we invest in the United States, 70 percent of all the R&D investment in the United States comes from manufacturing.

It's all the science. It's the enabling technology. It's the engineering. It's the manufacturing. So when we think of "manufacturing," and I know you're saying this, too, this is Manufacturing with a big "M."

This is about whether the United States, whether the United States can compete with the best in the world where everybody else around the world will do whatever it takes to get into manufacturing. Because it is the answer and part of the solution for energy independence, energy security, national defense, sustainability; it's so important.

Now with respect to what we can do, I think the most important thing is that we come together with a shared view that manufacturing is important in that kind of a context, in that kind of

a broad context.

The second thing is to move it up on the U.S. agenda. That means that we need to have access to the markets around the world, which we don't today, as you know. So manufacturing ought to be on the trade agenda in every free trade agreement that we're negotiating. That's why we haven't been supportive of the Korean Free Trade Agreement, because we have no access into Korea. And if you've noticed, the Koreans are taking advantage of the U.S. market with a very concerted, integrated Korea, Inc., plan.

So the first thing is access to the markets.

The second thing is access to competitive capital for all of us.

Another big one is a stable, predictable, and globally competitive regulatory environment and tax regime. All the things that we're talking about, this uncertainty that we have, we have no idea what that's going to really mean to business going forward. And if we really believe in manufacturing,

we're going to make sure that we have a stable, understandable, predictable environment.

Another thing I would mention is the skilled and motivated workforce. You mentioned the employees at Ford. I've been all around the world with Boeing and Ford, because 60 percent of our sales are outside the United States, both companies, and I have never seen such a skilled and motivated workforce that we have in the United States.

Everything that made the United States great--the technology, and the innovation--there's nowhere else around the world that has nurtured an environment like we have in the United States.

And so again, making manufacturing important, making it cool again, so that we attract the very best and the brightest in engineering and science, all the enabling technology we're talking about. So that's another big one.

Those are a few--another really big one is let the markets determine the currency exchanges. This currency manipulation is just a killer. I mean, we all know exactly what the countries around the

world are doing. They're targeting manufacturing. They under-value their currency so they can make things and we can't. Right? Are we talking to each other here?

I mean, we have got to have a rule-based trading around the world. And it is not like it's far away from each of you. I mean, you are the CEOs of these fabulous states, and our ability to compete worldwide means that we, the United States, have got to keep pushing to world-based trading so we have access to the markets, we have access to capital, and that we have free trade agreements that allow that to happen with no distortion on the currency.

So those would be the big ones.

VICE CHAIR MANCHIN: Not being critical of your competition, or trying to give them advice on how to run their business, but you were able to change it. You came in and changed it. The workforce saw it, and they changed with you.

MR. MULALLY: Yes.

VICE CHAIR MANCHIN: What's preventing the other companies in America from doing the same?

MR. MULALLY: I really like our Ford plan.

(Laughter.)

MR. MULALLY: Next question?

(Laughter.)

MR. MULALLY: I can't--you know, it's not my place to comment.

VICE CHAIR MANCHIN: Let me ask the question this way: Is it possible, knowing what you know about your competition, is it possible that could be done, maybe, with some adjustments?

MR. MULALLY: I think, as I said, I think that we, the United States, and American companies, can compete with the best in the world. That is a very big starting decision that we have to make. Because if you don't believe that and you're not ready to take the action, including all of the stakeholders, then it is a self-fulfilling prophesy.

VICE CHAIR MANCHIN: But the workforce bought into it?

MR. MULALLY: Right.

VICE CHAIR MANCHIN: UAW, everybody sat down with you and you all worked this out. So it has

to be workable.

MR. MULALLY: I really like where Ford is going.

(Laughter.)

MR. MULALLY: Yes, sir.

GOVERNOR RENDELL: Alan, six years ago Governor Granholm, Governor [Jim] Doyle, and myself testified before a Congressional committee on manufacturing, and we talked about trade. What we said--we were sort of preaching to the choir--but most of all it fell on deaf ears: Can American business, can the manufacturing leaders of this country convince the Administration that we've got to take a strong stand on trade to protect the American--and not just to protect American manufacturing, but to give us equal access to markets?

MR. MULALLY: Absolutely.

GOVERNOR RENDELL: What's waiting--

MR. MULALLY: Absolutely. And again, we have so many things going on in the United States. And I don't want to be kibitzing on everything of

what the priorities are today, but the most important thing that we do right now is get the economy going.

If we don't get the economy growing, nothing can be okay. Right?

GOVERNOR RENDELL: Right.

MR. MULALLY: You can't make it okay unless we're growing. If you're in business, there's only one answer, and that is profitable growth, right? Profitable growth. Because if you grow the business, then there's nothing but opportunity.

And in the United States, the automobile business is going to grow less than GDP because we have a very mature market. Now everywhere else around the world it's going to be growing faster.

So for us to absolutely lead the United States in profitable growth, we need a public/private partnership where we deal with these issues, where we move manufacturing up, and we allow the great businesses in the United States to compete with the best in the world. And we've got to get everybody to come together on that shared view.

GOVERNOR [SONNY] PERDUE: Alan, thank you. I

think you give us all an optimistic confidence with that great American icon blue oval Ford makes, that we all can have a bright future. So thank you for the leadership that turned this around.

But you mentioned some similarities between our situation. One huge difference that we face that is different than in business is that we are countercyclical. When our revenues are down, our demand is up, which has some very unique challenges for we governors.

So could you address that just a second, of where you would attack first?

MR. MULALLY: Well again, all I know is that the most important thing is to deal with reality. And so you're absolutely right, with the specific example that you said. On the other hand of that, on the other side of that is that we have to deal with the reality and get back to staying within that budget.

That means we've got to make choices on the services, what business you're in, and we've got to deal with the cost structure. I mean, we know

where we are on wages and benefits. They need to be dealt with. They're not competitive.

I'm looking for some nodding, or something, here. Come on, work with me on this.

(Laughter.)

MR. MULALLY: I mean, we need to work on these absolutely key things. You're either competitive or you're not. The data sets you free. The data tells you exactly what we need to do on every element of competitiveness. And I know, because I've served on Jennifer's Competitiveness Council, on Christine's, and the minute you get the data in front of you and you pull everybody together around it, whether it's education, whether it's taxes, whether it's the environment, whether it's energy, the data tells you whether we're competitive or not. Wages and benefits.

And, I think, the leadership opportunity and leadership challenge, but the thing that's absolutely unique about leadership is to bring everybody together and address that. Because that's the only way for us to compete and profitably grow our

businesses.

Jennifer?

GOVERNOR GRANHOLM: I think one of the great things that you've done is to play both offense and defense at the same time, which is of course what we're all trying to do, too, in part in response to what Governor Perdue was saying.

One of the ways that you have done a great offense--and that really is a public/private partnership--is the investments that have been made in the electric vehicle.

MR. MULALLY: Absolutely.

GOVERNOR GRANHOLM: And maybe you could share with everybody, given that you've made a commitment to a billion dollars worth of investments--and that means jobs in this country in the electrification of the vehicle.

MR. MULALLY: Absolutely. And, governor, I would like to take it up just one more step. Just being in manufacturing for all of these years, I think another part of this compelling vision is getting to the point about where are we going as a

country?

I really believe that at some time, sooner rather than later, we are going to come together on an energy policy. I think that we are going to come together on a manufacturing policy and where we want our country to go.

I think that energy independence, energy security, national defense, that once we start laying out that compelling vision of where we want to go, that's just going to unleash all of our creativity.

So let's take the automobile industry. We are part of the solution for energy independence and energy security, right? Not necessarily the way we do it with the CAFE policies, but you know that what we're going to get to is we're going to actually generate electricity clean, and we're actually going to use electricity clean.

Some day we're going to come together on that kind of a policy. So in our case, we have taken a long-term view that we are all going to pay more for energy going forward. So that's why we're going to have a complete product line. Every one of them

is going to be the most fuel efficient vehicles in the world.

Plus, we have laid out a technology roadmap that not only improves the internal combustion engine, but just as Jennifer said we have a technology plan to move to more hybrids, then all-electric. We're also keeping fuel cells and battery enabling technology going so we can move to a hydrogen future.

So the minute that we come together as a state, and as a country on where we want to go as a country, the Ford Motor Company is going to be right there with the most enabling technology to help create that future.

But if we don't come together on those broad policies about where want the country to go, then we are all kind of pushing upstream. But that's why we're making the investments today in every state in which we operate.

Yes, sir.

GOVERNOR [ROBERT] McDONNELL: Part of what I think everybody would like to see is repatriating

manufacturing jobs from overseas back home. One of the impediments we seem to have is our corporate income tax rates, 35 percent nationally, and with the state-level taxes well over 40 percent.

How big an impediment do you think that is to getting these jobs to come home?

MR. MULALLY: Absolutely a key element. That's why I tried to say it with a predictable globally competitive regulatory and tax structure.

In our case we continue to make great progress--not progress, but we're actually bringing jobs back now into the United States because we're competitive when you add up all of those elements of competitiveness.

But the tax structure, as we all know, is absolutely key to us being competitive.

CHAIRMAN DOUGLAS: Governor [Bill] Ritter, and then we will have to wrap up.

GOVERNOR RITTER: My question was just about cars and your sort of vision for that. One thing you didn't mention was natural gas. I wanted to bring that up because we had a governors luncheon

where we talked a little bit about natural gas, and now a hundred-year play of natural gas. Do you see that like you see the other parts of the fuel revolution, the technology revolution in fueling cars?

MR. MULALLY: Absolutely. And I was amiss--remiss to mention that. Natural gas is a very clean fuel for use in automobiles.

The only issue with natural gas for us is just the packaging of it in vehicles. So with the big tanks, and the pressurization in smaller vehicles it makes that packaging job tougher.

As you move to bigger vehicles, and especially trucks, then it opens up a lot more possibility. Again, the real issue is where are we going to go as a country? Because the infrastructure that we have to put in place for either electricity, natural gas, or hydrogen, that's a tremendous investment that we all have to make.

And again, as soon as we come together and decide where we're going to take this country when it comes to energy independence and energy security,

then we have the tools on all of those different tools to be able to contribute to that solution.

But the bigger issue is the innovation on the system-wide structure. Natural gas I think is going to be part of the integrated energy solution.

GOVERNOR RITTER: What is the most important thing, then, for you as a group of manufacturers to choose the goal for emissions reduction as a part of that, instead of trying to pick winners and losers sort of within all the different technologies that could be cleaner burning fuel?

MR. MULALLY: Well again, I know I say the same thing over and over again, but we can't choose one of these infrastructure solutions. And so right now in a way we are doing the enabling technology from a manufacturing point of view on all of them. Because if we're going to be in business for the long term and we decide as a country, and every country around the world is going through this same process, and some are very organized; they're very strong partnerships, they decide they're going

electric, they're working on the grid now, they're working on generating electricity clean, they're working on the enabling technology for the batteries and the fuel cells. So the sooner that we get to a shared view in the United States about where we want to go on energy, then the faster we can align our resources, our talent, our technology to help make that happen. But right now it is just a patchwork, as you know.

Now back to the regulations, since you brought it up, and I know this is hard, and I've talked to a number of you about this, but just one thing that we did together that absolutely is fantastic, was to come together on one national standard for fuel efficiency improvement and CO_2 reduction.

The glide slope that we're on takes every bit of technology and innovation to improve fuel efficiency and reduce CO_2 in automobiles that we know of. And if we would have had a different set of requirements for every state and a different set of requirements from the EPA and the Department of

Transportation, we could never have come through for you.

But I'll guarantee you, because we stood tall and came together around one standard, one improvement slope, then we are going to absolutely exceed your expectations going forward.

So it's back to--and we were just talking about this--it's back to the fact that the more that we pull together around where we really want to go and come together on a plan to do it, then I just know that the Ford Motor Company is going to be there and we are going to exceed your expectations.

So again--

GOVERNOR LINGLE: Jim, can I ask a quick--

MR. MULALLY: --I know you have to go. I just want to tell you thanks a lot.

GOVERNOR LINGLE: Jim, can I ask a quick follow-up question on this point?

You seem to be saying that the government has to make this ultimate decision on what the technology is going to be. Why would that be true for cars? I mean, if we have three major

manufacturers, why don't you guys get together and come up with what that is, you know, maybe what sort of technology the DVD is going to be played on, or that sort of thing? What makes that--

MR. MULALLY: Okay, now again the real issue here is the infrastructure. Because if you're going to--I mean, we have the technology now that you could take a fuel cell, a hydrogen tank, mix them together with platinum, water comes out of the tailpipe, electricity goes over to the electric motor.

Now that's great. We can do it, technically. Same thing with electric vehicles. We're getting to the place now where we're making such improvements on the batteries that we can have all-electric vehicles, and plug-in vehicles.

But to get it to be widespread use by the consumers, we need the infrastructure throughout the United States just like we have with gasoline today. And that is a tremendous, tremendous investment that the automobile companies can't make. We have to decide to make that. That's part of the

infrastructure that we need in the United States.

And whichever direction we go there, then we will have the enabling technology that we can compete, provide the best solution for that vision.

GOVERNOR LINGLE: So how do you get out of the chicken-or-egg, though? I mean, if the three of you decided we're going this way, what other infrastructure would there be except whatever it was you decided. You're the only ones who manufacture cars.

MR. MULALLY: We'd just have to decide as a country, are we going all electric? Are we going to go hydrogen? Are we going to keep going with the internal combustion engine? What's going to be our energy policy? Where do we want to go?

I mean, just think about the CAFE legislation. In 1975, we were all in the fuel lines, right? So we passed CAFE. We set a very aggressive approach for improving fuel mileage of cars so that we burn less gasoline, right?

So since 1975 we've improved the fuel mileage by 100 percent on cars, 75 percent on trucks.

We now drive four times the number of miles, and we use three times the amount of gasoline, and we're importing not 28 percent of our oil but 68 percent. How's it going? I don't think it's going so well. I think we can do a lot better.

Thank you, very much.

(Applause.)

CHAIRMAN DOUGLAS: Well, Mr. Mulally, thank you so much for being with us. What a great story of vision, of leadership, of transformation, and we are honored that you would spend time with NGA. Thank you.

Last summer we were facing a lot of challenges at the time of our annual meeting, and our Chairman at the time, Ed Rendell, wasn't able to be with us. We didn't have a chance to formally thank him for his leadership.

But, Ed, on behalf of your colleagues in NGA, thank you for an outstanding year as our chairman. We appreciate it greatly.

(Applause.)

CHAIRMAN DOUGLAS: Four years ago, NGA

created the Public/Private Partnership Awards to recognize our corporate fellow companies that have partnered with the governor's office to implement a program or project that makes a positive contribution to a state and its residents.

This past fall a lot of you governors submitted nominations for a Corporate Fellow company that recognizes the work that demonstrated a significant investment at the state level to perform a public good.

It is a privilege now on behalf of NGA to present this year's winners. I want to thank all the governors who submitted nominations. They were all excellent. It was a tough job for the selection committee which was chaired by Betsy Bishop, the president of the Vermont Chamber of Commerce, and I want to thank Betsy and all of her committee members for their hard work.

Governor [Jan] Brewer couldn't be with us today, so I am going to present the Arizona winning nomination on her behalf. I would like to invite Diana Daggatt of Intel to join me at the podium.

(Applause.)

CHAIRMAN DOUGLAS: Intel is being recognized as a recipient of the Public/Private Partnership Award for its work in Arizona through the Intel Teach Professional Development Program. It helps teachers learn how to effectively incorporate technology in their classrooms, including how teachers teach and how students research, communicate, learn, and present their work.

This is a blended model of face-to-face and online professional development that helps teachers ensure that students develop critical thinking, problem-solving, and collaboration skills that will be applicable to any area of study and help prepare them for careers in the 21st Century.

Over 350,000 educators from all states have completed Intel Teach Professional Development. A growing number of states have joined Arizona in statewide implementation of the program, including Alabama, Louisiana, Mississippi, North Carolina, New York, Pennsylvania, Texas, Virginia, and West Virginia.

These states are united through an Intel Teach Affiliates Network that brings together state program leaders, senior trainers, and master teachers from participating states to share best practices.

Since its beginning almost a decade ago, more than 17,500 educators in Arizona have participated in the Professional Development Program. Intel Teach is a common model for professional development and Arizona, like every state partnering with Intel, customizes the delivery model to meet its needs best. That means using existing infrastructure of 15 education agencies and Intel specialists to deliver the product.

Arizona's partnership with Intel has enhanced teaching and learning in math and science that demonstrates what can be accomplished when partners work collaboratively on issues of common importance.

On behalf of the NGA, congratulations to Intel for its Partnership Award.

(Applause.)

(Award presented.)

CHAIRMAN DOUGLAS: I would like to invite Governor Dave Heineman to come up and present Nebraska's winning award.

GOVERNOR HEINEMAN: I am very pleased to present this second Partnership Award. Before I do that, I would just like to take a moment of personal privilege to thank Jim Douglas for his leadership of this organization. He and Joe have just had a great conference, and we are all very, very proud of both of you and thank you very much.

(Applause.)

GOVERNOR HEINEMAN: Secondly, I am very honored to present this award to one of the premiere companies in America that's headquartered in Nebraska, Union Pacific. Bob Turner, their senior vice president, is here today.

What we're discussing and what we're awarding them for is the Principals Partnership Award where they've spent millions of dollars in my state, and in the 20-plus other states they operate in in America, training more than a thousand high school principals, training them in terms of leadership,

growth, and development.

And as we have heard over the last few days from Secretary [Arne] Duncan and others, when we can have great principals with great teachers, we can have the kind of education system that we want in America that will be world-class, the best in the entire world. We all know that's what we need. It is critical to the future prosperity of America.

So I am very proud today to present to the Union Pacific this second Partnership Award.

(Applause.)

(Award presented.)

CHAIRMAN DOUGLAS: Thank you, Governor Heineman. I would now like to invite Governor [Don] Carcieri to come forward to present an award winner to a Rhode Island recipient.

GOVERNOR CARCIERI: Thank you very much, Jim. As I think all of my fellow governors know by now, Wellness is a mantra of mine and has been. Over the last five years, my team has worked very closely with United Healthcare in the establishment of a State Employee Wellness Program. We call it "Get Fit

RI."

So I would like to invite to the podium Sonya Milsom who is regional vice president for public sector accounts, United Healthcare executive who has been involved in the development of our Wellness Program from its early stages. So please join me, Sonya.

Right now, Get Fit serves something like 13,000 state employees, and our collaboration has resulted, in my mind, in a model wellness program that has received national recognition, inspired other businesses in Rhode Island to adopt wellness programs and policies, has spurred a winning effort to have Rhode Island certified as the first well state in the nation by the Wellness Council of America, and most importantly improve the health and productivity of all of our state employees.

This did not happen without an extraordinary partnership between United Healthcare, their team, all of their efforts, and our team at the state level.

Just to give you a couple of results:

Over the last four years the progress has been remarkable. We've had a 500 percent increase in employee participation in the annual health assessments that I talked about. Health pregnancy program participation increased by 25 percent. Case management program participation by 85 percent. Last year, 68 percent of our employees accessed United's Personal Health Management Web site.

Last year, 68 percent of all of our state employees participated in health screenings, blood pressure, body mass and body index fat screenings at 37 locations throughout the state. And this year we are offering a series of cholesterol and glucose screenings that have already begun in January and are continuing this month.

And lastly, because of all of this partnership, the State of Rhode Island itself as a state earned a gold Well Workplace Award this year from the Wellness Councils of America. And that is a step up from our last award, which was a silver.

So the Get Fit Rhode Island Program has been recognized for two national awards, as well.

So, Sonya, it gives me great pleasure to present to you an NGA Public/Private Partnership Award in honor of the extraordinary effort--I mean that, extraordinary effort--you and your colleagues have dedicated to an important health initiative in the State of Rhode Island.

So thank you.

(Applause.)

(Award presented.)

CHAIRMAN DOUGLAS: Well thank you all. Let's turn now to the Policy recommendations of our committees. They have been sent to the governors a few weeks ago. They've been recommended by the respective committees, and they are in the packet that's at everyone's place.

Let me report on behalf of the Economic Development and Commerce Committee. The committee had a great conversation yesterday with Secretary of Transportation Ray LaHood about surface transportation policy.

They are recommending to the NGA adoption of three policies, two with amendments to existing

policies, one reaffirmation of one of our current policies. One is on transportation conformity with the Clean Air Act. A second is on air transportation. A third is on rail transportation. And I would welcome a motion on behalf of the committee to adopt their recommendations.

GOVERNOR [BRIAN] SCHWEITZER: Mr. Chairman, I would like to broaden that motion to all five of our policies that we have before us. They have been well thought out and have been well discussed and debated, and I believe that we all are here in agreement with the fine job you have done. I would like to move them all as one, and agree that we should accept them as offered.

CHAIRMAN DOUGLAS: Well, I would be happy--

GOVERNOR HEINEMAN: I second that.

CHAIRMAN DOUGLAS: --I would be happy to entertain that as seconded by a chairman of a committee who is foregoing his report, so that's fine. Is there any discussion on the motion, which is to adopt the reports and recommendations of all of

our committees?

(No response.)

CHAIRMAN DOUGLAS: If not, all in favor say aye.

(Chorus of ayes.)

CHAIRMAN DOUGLAS: Opposed, no?

(No response.)

CHAIRMAN DOUGLAS: The ayes have it.

Thank you so much, and without further ado this will complete and conclude the NGA's Winter Meeting.

Thank you all for being here.

(Applause.)

(Whereupon, at 4:04 p.m., the 2010 Winter Meeting of the National Governors Association was adjourned.)