
**"Who Needs to do What to Improve Healthcare" Presentation
Wednesday, November 9, 2011**

Paul Ahern: Well, let me make an introduction of Brent McQuiston here. Brent is the Chairman of our equity committee. Some of you were here a couple of weeks ago when we did our workshop on the topic of inflation and deflation but we have three committees here and Brent is the head of I believe the most challenging one right now with the equities. We've got a lot of issues going on in Europe right now and how that might spread around the world. So I want to show you that we're constantly keeping an eye on every day's developments and in fact is there any news today or anything in particular you want to mention?

Brent McQuiston: Well, it's jumping from one crisis to the next. Italy was in the spotlight today and so what we saw was the bonds, sovereign bonds of Italy really took a nice jump today which that has the opposite effect of Italian bonds. So those bonds fell in value. So the fear is, is there potential contagion and how does that affect the banking system because the banks own a lot of the bonds and so those assets just drop in value. So their capital reserves are falling as the interest rates spike. So that causes issues with the European banks. So that was the news of the day today and the markets had a very volatile session down over 420 points at one point and closed down at 389 I think. It was a pretty bad day in the markets.

Paul Ahern: Well, you should be getting your October statements, too, the best you'll see in a long time. October turned out to be one of the best months we've had in years. So headline risk is all over the place right now. I want to introduce Megan, too, who's in the hallway. I know Brent and Megan want to get home and get on with their night with their families but Megan Thornes is one of our estate attorneys here. As you know we integrate estate planning with financial planning and Megan is one of the estate attorneys we work with. So Megan is here and Megan is going to be conducting the last workshop of the

year. You all have a flyer on your desk, 'Preparing for the Death of a Loved One'.

Anybody in this room, did you come to that earlier on this year? Okay. It was the most well attended workshop we've ever done. Unfortunately, it's something we all have to go through and if you're not prepared, it takes a very horrible situation and makes it that much worse. So what we're trying to do is preventing it from having anxiety added to grief. It's a very comprehensive workshop. We give out a lot of good materials with that, so we want to encourage you to try and make it to that. That will be with Megan and her partner, David Colby, on December 14th and 15th.

For those of you who are registered, come join us on Tuesday of next week. We'll be at the Ritz Carlton. Valet parking will be included so please pull on up. We'll be having heavy appetizers and some premium cocktails there up on the second floor. If you haven't registered, we are at capacity but if you want to be on the list of cancelations then please let your adviser know and we'll get you added on that list. Otherwise, we'll see you next Tuesday as well.

We have a couple more people coming in but I want to say thank you to you guys for coming out tonight and I will see you tomorrow.

Well, if I could, let me get on with the introduction with our speaker that I know of. Bob Smoldt is our speaker tonight and Bob as most of you know who'd been in this room and had been with us for a while, you've heard the story before but Bob's originally from Iowa. He married his high school sweetheart before going out to California and getting his MBA from USC. After that, he spent some time here in Arizona in the Air Force before moving to Rochester, Minnesota where he spent 34 of his 37 years working with Mayo Clinic. He retired in 2008. He retired as the emeritus chief administrative officer, and since that time he's gone to work for Arizona State University and in essence what is a think tank.

We've had the privilege of working with Bob in the past and earlier this year we asked him is there some topics that we can maybe present to our clients that would be on the subject of healthcare, and he had several topics we could pick from. So what we decided to do is a three-part workshop and tonight it's all going to end with who's going to put the next steps and who's going to really pay for healthcare moving forward and what needs to be done.

So I'm going to turn it over to Bob to complete our final workshop tonight and at the end if you haven't ever filled out a comment card - most of you have - I would like to ask that you please do write down your thoughts and comments and leave them in the boxes as you go out tonight. If you have filled out a comment card, then don't worry about it. I know Bob's a great speaker and I've had nothing but very positive reviews, so thank you for that. With that, I'll turn it over to Bob.

Bob Smoldt:

Thanks, Paul. Alright, are you ready for this session? I know that I've seen part of the community here before. We talked initially about the deficit, a terrible time, the deficit in healthcare because healthcare is a pretty big part of it. Then I last session [unintelligible] about some fallacies that I think we hear general comments about how to improve healthcare. So if those things were fallacies and I think really wouldn't improve US healthcare, what are the things that we could do? So that's what we want to talk about tonight. Again, as I've said before, what you're getting are my views and you can certainly find people who will have different views than the ones that I have. But here we go.

Who needs to do what? From my standpoint, if you're thinking about what you're going to do about healthcare, the first thing you should do is step back and say, "What are we trying to achieve?" This was one of the disappointing things for me I can tell you in this last period when we had this big discussion about health reform, to go to Washington, be a member of Congress and say,

“What is your vision for what we should be trying to do?” and you usually got a blank stare. Then you get something like, “Oh, we aren’t getting what we pay for,” or something like that. But I really didn’t get very many people who had thought it through, what are we trying to achieve and I think it’s critically important.

So from my perspective, we should not be trying to have the cheapest healthcare system in the world. But I think we should be striving to have the highest value healthcare system in the world. Now what’s value? It’s quality over cost. In the healthcare arena, quality then I think really is patient outcomes. So what’s happening in mortality rate, what’s happening to when you get back to normal life activities if you have a medical problem, from an employer’s standpoint are you able to get back to work - those sorts of outcomes. It’s a safe environment. If you go into hospital, you end up with a bigger problem with something that happens in the hospital and you have a fall. Are you given the wrong prescriptions and you’d have an issue there. And so is there patient satisfaction?

Then the bottom is cost, but cost is an interesting issue. What to me we should be looking for is cost per patient over time, cost per patient per year. Now the reason I say this, I think most people would say yes, it makes sense, but when you read articles about healthcare cost, because I look at a lot of them around the country, I take the service every day. It gives me for the major newspapers in the United States, any article that’s related to healthcare. Often when it’s about cost, it’s about what’s the price for an MRI scan at hospital. I still remember the Boston Globe had a big series on this. What was the cost price of an MRI scan at Mass General versus Beth Israel? They completely missed the point from my perspective. What they should have been concerned about, what was the cost per patient per year that got their care from Mass General versus Beth Israel? Those are different issues. We’d better keep focused on what we really want to achieve as we move this way. So that’s what I think we should - this is what I think we should be doing.

Now the interesting thing is to me, these are all measurable today with publicly available data. When I was at Mayo Clinic I thought we ought to say how is Mayo Clinic doing on this? So I took publicly available data on what for every hospital in the United States I used the subset of hospitals that were teaching hospitals where they take physicians and they train them in their residency. So you take the mortality rate for patients that are at hospital, their actual mortality compared to their expected mortality given the severity of their patients and their case mix. That's publicly available data. Patient satisfaction scores for every hospital are publicly available.

So I used that and I costed care. Dartmouth has created this database that looks at the cost for care for hospital and physician services and outpatient services, for Medicare patients in both the last six months before a person dies and the last two years. So the dataset is Medicare beneficiaries who died in that year. Then you look at the cost in the previous six months and the previous two years. It's a good measure of efficiency because the average person you add up the total healthcare cost you had in your lifetime, the majority will be spent near the end of your life because that's when you have big problems. So these things are measurable. I actually got a list, I created a value index for every teaching hospital in the United States and I discovered what I thought would be the case. Mayo Clinic was pretty good but we weren't the best. There were people we could learn from.

Okay, so what are we doing? When we look at healthcare, everybody wants high quality. We want low cost, we want easy access. So where are we, what have we learned so far? A quick review of some of the things we looked at before in terms of the country, this is mortality amenable to healthcare, people 75 and younger, and they have died of a medical problem that could have been preventable with appropriate care. In the United States that's terrible on this, but huge variability, the top five countries are as good as the rest of the world and our top state Minnesota is the best in the world on this.

So the US is terrible but we have places that are the best. That means the places that are the worst are absolutely atrocious.

Now if you do this back to the state level, now if you do it at the hospital level, say teaching hospitals, is mortality actual compared to expected, is this available publicly? The best teaching hospital, their mortality is only half of what you would have expected it to be given the experience in the United States for their case mix and their severity. That's really good, really good. And you say, well, that might be the case because teaching hospitals have all the latest things that could happen in medicine. But then let's look at the worst teaching hospital. It's 50% worse than would be expected in the average hospital in the United States. The variability is incredible. So we have high quality but it's variable. Easy access, looking at just the physicians through population, we're about the same as other industrialized countries.

I personally don't think we need additional physicians. I say that because if you look at some integrated practices, Kaiser, Group Health and Puget Sound in Seattle, Health Partners in Minneapolis, they have defined populations. They use 69 primary care physicians per 100,000 people. The US has 93. So the gist of this is they use 26% fewer physicians than we already have in the United States. They use 32% fewer specialists than we already have in the United States. Now granted the whole country isn't going to operate this efficiently but I think it's more slack than we really need is my opinion.

Low cost. We're the most expensive country for healthcare in the world by a lot. We're not the only country where health expenses are increasing more rapidly than the GDP. This is GDP growth or with this [unintelligible] annual, this is health growth. Same thing for Canada, France and the UK, this is happening. Health costs are growing more rapidly than the GDP basically in all of the industrialized countries. There is huge variability in cost by hospital. Each of these dots is a hospital. This is total Medicare reimbursement per decedent in the last two years of life, and every dot is a

teaching hospital. So the most expensive teaching hospital in this space is over \$120,000.00 per person per year. The best is down around \$40,000.00. That's a lot of variability, a lot of variability.

Now what's this? This is that mortality ratio but now we switched it so the higher you are, the better you are. So these teaching hospitals up here in this quadrant give you good outcomes and they do it for a lot fewer resources. This is the variability in cost. It's huge. The other interesting thing on this, if I drew a regression line in here, which direction would it go? It would go down. What that means, because otherwise you'd think, well, the more money we spend the better outcomes we should get, right? It's not what's happening. It's the other way around.

Okay, cost is an overriding issue. It's the biggest issue in our debt problem as we look at it going forward, the cost of health programs. Then we have the affordability for an American citizen. This is one of the graphs we showed as cumulative percentage change from 65. This is GDP, this is health federal expenditures, total, here are the defense expenditures, less, so less going higher. This is entitlement spend. The entitlement programs are the biggest single issue of our deficits in our debt problem going forward, and Social Security and Medicare are the two biggest ones. This is the unfunded liabilities that we have in Social Security and what we have in Medicare. Social Security is not a big problem compared with the Medicare issue.

We have countries just mentioned tonight about Italy and Greece and I love this quote that Hemingway started, "How did you go bankrupt?" Two ways: gradually then suddenly. And that's what I think we're seeing in Europe. And all this thing going along, we've got more promises than we have in this country, too. I hope we don't end up in the same boat. So it goes along, goes along, goes along and bam, all of a sudden you're in trouble.

Now the second part of the cost is the affordability for the average citizen. This is some interesting data and I get interested in this because I've got kids

and grandkids. So in 2009 immediate family income for working couples was \$70,000.00. This is not the median household income in the United States. It's a little bit higher. This is a family where both the husband and wife are in the family and working, two working people in the same family. Let's take that family. The average family healthcare premium was \$13,000.00, so healthcare premium as a percent of this salary was 19%.

Now I recognize that doesn't mean this family spent 19% of that income on healthcare because most likely the majority of these people were working for an employer who paid or provided health insurance coverage, and that isn't included in this number. The value of that is not included. But still, take what I'm showing you here. And then we're going to take this forward twenty years and we're going to assume that what's happened for the last ten years, this has been going up at a little over 3% per year. Then we [unintelligible] health insurance cost has been going up a little over 8% per year. Compound that out over twenty years and this is what we have: healthcare cost, 53% of income. Are my kids and grandkids going to be able to afford this? I think we've got to do some - have some changes.

Okay. The cost of that, if [unintelligible] I showed a bunch of articles about there was an article that said, 'It's the Price, Stupid,' and I have a completely different view. It's not the price you pay for an MRI scan; it's the number of MRI scans you do. It's not the price you pay for a hospital day; it's the number of hospital days that you use. So to me, and that article wasn't surprising but I'm going to say to me it's the use rates, too. Total cost, simple formula, price per unit of service times the number of units. If you look at, and Dartmouth has done this, if you look at high cost areas in the United States and compare the low cost areas in the United States, 80% of the difference is from this: the number of hospital days, the number of ICU days, the number of physician visits per year per patient. Only 20% is caused by higher prices for an MRI scan, the thing that the Boston Globe had a whole series on it when they were comparing the various providers in Massachusetts.

So we all need to change. Pay off can be substantial. I like these cowboy quotes and this one is so appropriate. If you find yourself in a hole, the first thing you do is stop digging. We find ourselves in a hole and we just keep digging. And what have we been doing? We've been trying to get out of our cost problem by reducing the price that we pay per unit. This is what the Medicare program does, and basically it's what insurance companies do in trying to negotiate down the price you pay and it's the use rate is what the difference is.

Now if you look at it broadly, we individually can do more to improve health, health in the United States, and we providers can and the hospitals and physicians. That's because of this. What influences your health over a lifetime [unintelligible] to the medicine, because junk is your own personal behavior and then healthcare is only 10%. So these are the things that we all know. You can see them listed here: smoking, diet, weight, seatbelts, helmets - those are often mentioned. These last two don't get as much attention: following treatments especially for chronic disease - high blood pressure, high cholesterol, diabetes. All kinds of people that have those, and I'm really aware of this because I'm an insulin-dependent diabetic, don't really get all the treatments and follow them. It is really important because what happens if you don't? If you're diabetic, you end up perhaps having your leg amputated. You could have significant problems with eyes and spend a lot of money and actually end up going blind. This is really important and I'll show you in a little bit it has cost implications as well.

Another one that doesn't get mentioned that I think is important that we all realize that healthcare is not free. Even if somebody else pays for it, it's not free. I think we would better recognize that if we have to pay for a lot of this or some of it or whatever ourselves. I'll show you how in a bit how I think we could do that.

Now those first things though, things we should do, exercise, weight, if you have high blood pressure get in under control - people know that. We've had public education. We still don't do very well. So, well, financial incentives work and Safeway has had an interesting experience [unintelligible]. This is for their management staff. Their unions haven't accepted this yet. So the company provides health insurance benefits and the employee pays a portion of that premium. If you're an employee of Safeway and you're in management, how much your premium is depends on these four things. If you smoke you're going to pay more. If you're overweight you're going to pay more. If you have high blood pressure you're going to pay more. If you have high cholesterol you're going to pay more. There's a dollar increment for every one of those attached.

Unidentified Female: I have one question. How does Safeway find out if they said [you're going on?]

Bob Smoldt: You can test for each of them.

Unidentified Female: Oh, so they would take all of their employees and do testing on them?

Bob Smoldt: Yes.

Unidentified Male: How about controlled?

Bob Smoldt: Pardon me?

Unidentified Male: How about control, if they're controlled?

Bob Smoldt: Then they'd pay less for their premium.

Unidentified Male: They still have high blood pressure. They just said they're effectively being treated for it.

Bob Smoldt: Yes, exactly. That's exactly what they're looking for because they want you to effectively be treated for it, and these are things that if you do your treatments you can get them in control. Now the other thing that you do, if at the end of the year, for instance I know what this would mean, if you have high cholesterol, you paid \$400.00 more per year for your premium than if you don't have. Now if at the end of the year, for each of these things that you've been over and you've got it in control, Safeway then rebates you the additional you paid. So if you had high cholesterol, the end of the year before the next premium year you're in control, they rebate \$400.00. What do you think happened to behavior here?

Unidentified Male: It changed?

Bob Smoldt: I mean \$400.00 we get somebody to actually control their cholesterol? They had a 40% reduction in people with high cholesterol, 40%. I don't know of any public education program telling people to get their cholesterol that would be anywhere close to 40%. Maybe 4%, 10%, so I think financial incentives can help.

The third party payers then like the Safeways, they can encourage these things. They can have what people call value-based benefits. It's kind of what we just went through. Then the other thing, they could pay providers for value, and that's one of the most important ones and I'll talk about that and it's one that I really think Medicare should do. But Safeway part two on their benefit plan, they also encouraged employees to get into high deductible plans where you then have a health savings account and if you don't spend the money in your health savings account you can carry it over. You can put money into it tax-free. So I'm not sure if I have here what the deductible is but it's probably like \$4,000.00 to \$5,000.00 for a family, but 100% of service for preventative services, so for flu shots and things like that, noted [unintelligible] 100%.

Unidentified Female: What about mammograms?

Bob Smoldt: Probably in here but I don't know for sure. Then the company puts half of the dollars so you have \$4,000.00 in deductible, you can put money in there, the company puts \$2,000.00 in there, something like that. Now you decide when to spend it, and if you don't spend it in that year you carry it over. Especially for young people, I think that these are great plans because when you're young you usually don't have a lot of money for providence. You can start building up a health nest egg. You can't take that money out and buy a car, but that's great because you've got a nest egg to cover expenses because at some time as you get older you'll probably need it.

Unidentified Female: That's assuming that they have the money upfront to be able to put into the account in the first place.

Bob Smoldt: Yes.

Unidentified Female: And most of them are living hand to mouth.

Bob Smoldt: Well...

Unidentified Male: Payroll deductions.

Bob Smoldt: Payroll deductions. This is an employed group of people, so you're talking about in this case \$2,000.00 a year to get to the maximum you could put in that pay deductible plan. So that is divide that by twelve it's less than \$200.00 a year. I don't know what it is, whoever is quick at math. And I'll tell you this, how many of our kids don't spend that much on electronics? A friend of mine whose daughter was complaining about the cost of their health insurance said, "Let's go through and see how much you spend on electronics," far dwarfed this person's healthcare premium. So it gets into what are your priorities. Is health a priority enough?

Okay. Well, what is the result of this and are we worried about healthcare cost? Do we want healthcare cost to go down? If you take what they did and Safeway did, they looked at the total cost for the company and for the employees. The total cost went down 12% so both the company and the employees actually wanted this.

They're not the only ones. Indiana, interesting story, in 2006 they offered two high deductible plans. They called them consumer-driven health plans. It's a high deductible plan. Preventive service is 100%, family deductible and it's here, and here's how they built into this encouraging you to live healthy. \$5,000.00 deductible unless you did not smoke, so then it was a \$4,500.00 deductible. So if you were a smoker you had to pay \$500.00 of the deductible. So that's how they built that in. They put in \$2,250.00 of the deductible amount into this account. So then they decided to ask for an independent review of it. They asked Mercer, one of the consulting firms, to come in.

After adjusting for the demographic factors, age, gender and family size and health status, and that's actually important because if you look at people who enroll in these HSAs do tend to be younger people and they are healthier people on average. So you need to make those adjustments. But after they did that, they actually reduced cost 10% per year. The State's saving, and that's again total cost, employee and the employer, so in 2010 the State saved between \$17 million and \$23 million and the employees saved between \$7 million and \$8 million with this plan.

Why did they save money? Please remember what I said before. My phrase on this and I'm not saying that we're all stupid. I'm just saying this phrase to paraphrase that it's the price, stupid; it's the use rate, stupid. Why did they save money Mercer looked at? Here's why. The other plan was a PPO. Here are the ER visits per 1,000. When they went to the high deductible plan ER visits went down 39%. When they went to the high deductible plan physician visits went down 37%. When they went to the high deductible plan hospital

days went down 56%. The use rate went down that's why everybody saved money, the State of Indiana as an employer and the employees of the State of Indiana.

Now a different subject, the idea of this treatment compliance that I said didn't get enough attention in my view. This was a study done, I can't remember which State it was in but it was like an insurance company that gave a researcher access to this data and they looked at patients with congestive heart failure, hypertension and diabetes, so chronic diseases. They had these big sizes, samples here that they were following. What they did then, they looked at for each of these categories, they could tell from the database whether people filled their prescriptions for the whole year, in other words treatment compliance, or whether they didn't, and they broke them into two categories. So here's a group of people that actually got their prescriptions filled and those who didn't get their prescriptions filled.

Now when you look at them, obviously if you're filling prescriptions the medication cost for the insurance company is going to go up. I mean that just makes sense. So for those that filled their prescriptions for congestive heart failure, they spent \$1,000.00 more per year on medication cost than those who weren't filling their prescriptions and you can see what it was here. But what happened for those who filled their prescriptions? What happened to their total cost? It went down significantly, significantly because what happens if you aren't taking your prescriptions, you're much more likely to have a complication. What's expensive? Complications.

These are pretty big savings and it had to make up for increased medication cost. This is a big deal for people with chronic disease and we have a huge area for improvement. Why did they lower cost with prescriptions? It's the use rate, stupid. When they analyzed this, here's why. Those that took their prescriptions for congestive heart failure had 5.7 fewer days in the hospital - 2.1, 2.3. It's the use rate.

Recommendations on payers, so what would I do if I was czar and what I'd really want the payers to do or if I was the payer, what I would really put in place, I would establish a high deductible plan covering free Medicare at 100%. I'd set the employee contributions of how much you'd have to pay for your share of the premium in a way that would encourage people to do this. Some employers are offering these high deductible plans and you look at how they set the employers/employees share of that and it's no surprise that they don't get a lot of people enrolled. It's absolutely that way with Arizona State employees because I looked at it. Hardly anybody is in the high deductible plan and you look, why, and you see why. Because they don't make much of a difference in terms of how much the employee has to spend to get into those plans even though when they look at the cost per beneficiary in those plans, I can't remember the multiple now but it's multiples less expensive than before they were on the plans.

I would vary the premium at least on these same four things that Safeway has done, and I would - Safeway has not done this but looking at that cost and if you filled your prescriptions, if you had one of these chronic diseases, I'd track who was filling their prescriptions through the year and who wasn't. And if you were filling them through the time of the year I'd give a rebate for that cost as an incentive for people to do it.

Then this is one you don't see much about. I'd eliminate the co-insurance if you went to a coordinating provider. Why would I do that? Because the people who are sick usually have more than one medical problem, and that's when it's really important to coordinate the care, because if you all of a sudden for problem A you're seeing somebody here, for problem B you're seeing somebody here, they don't talk to each other, problem C you're seeing somebody over here and none of those people talk to each other, there's a pretty good chance you're going to be doing stuff that's not going to work. You need somebody to coordinate the care.

We did this at Mayo Clinic. I think it was 2003, we were looking at our own health employee benefit cost and they were going like crazy. What Mayo has and no one has, we pride ourselves in coordinating the care for patients and we took a look at what our own employees were doing. They weren't getting coordinated care. They were just flitting all over the place without having anybody coordinate the care. We weren't doing with our own employees what we pride ourselves on for patients at large. So we eliminated the co-insurance if they had a coordinating provider. We also then increased a little bit what the individuals had to pay. Those two changes, we reduced our total health benefit cost for Mayo and for the employee by 13%. It took five years to get back to the level it had been at six years previously.

This can be a huge deal I think. I only know of one other organization that's done that. But I've seen there could well be them but IBM did it in one of their plans. Why is it important? Coordinated care, spend a lot less money. These are four locations in the United States that have - they're not real large places, Salt Lake City is the biggest, but they have integrated practices that have their own hospitals so it's coordinated care, integrated care. These are the number of ICU days in the last six months allotted for people that die. What do you think the US is compared to the coordinated care? Double, and so if the US is double and the low places are down there, where do you think the highest places are? I'll tell you, Miami and Los Angeles, if you want less inexpensive care, you don't go there. Why is it expensive? Use rates are through the roof. 5.8 times the number of ICU days in Miami as these places, and they get better outcomes. They have better mortality rates than Miami does. LA, four times as many. California is an interesting one. LA is probably, it can be more but I'm guessing 50% to 60% higher than San Francisco. It's crazy.

This is the same thing with physician visits at the end of life. I mean you still get those huge variations. These integrated places use fewer services. You get better outcomes. So changing provider patient settings can lead to cost savings. The potential impact I think we can get in this country, we could

get somewhere between 12% to 18% savings in healthcare cost. Another reason, one reason is what I just showed you on the use rate. This is one that looks at hospital referral regions and this is the Medicare spending per beneficiary after every standardized risk adjusted per capita cost.

The Institute of Medicine did this because they adjusted for everything you could think of, because every time you'd look at cost in Los Angeles compared to San Francisco, Los Angeles would say we have sicker patients, we have older patients, we have poorer patients. So they're trying to explain it that way. So the Institute of Medicine made an adjusted draw on stuff, and they still found this huge variation. So the hospital referral regions that are in the top 10% cost 17% less than the country as a whole. So you can imagine what the differential is down here. I guess if you can calculate just having put it on here. If we could get to the top 20% it would be 12.5%.

So government programs need to change from my view. The financial viability of the country, there has to be some change in the Medicare program. If you look at the data and project this stuff out, it just isn't sustainable. And Medicare for reimbursement encourages quantity over value, more services. The more times I have you come back and see a physician, the more times I put you in the hospital, guess what happens? More [unintelligible]. We need to change it to pay per value and if Medicare did it, I think other payers would. Now Medicare you're going to read about it. If you read the papers they're going to pay for performance and they even have a program that was in the Reform Bill that is called value-based purchasing. That sounds like exactly what I'm asking for, doesn't it? Pay-for-value, value-based purchasing. It isn't.

What's value? Outcomes over cost. Do you think in how they're going to pay they're going to reward providers under the value-based purchasing? Either outcomes or costs are involved in how they're going to do their performance rewards? Neither one, neither one are. What they're going to do, there are going to be bonus payments to medical centers if you do selective process

standards. It's things like if you're an MI patient did you give them an aspirin? It's like if you're an MI patient did you give them smoking cessation counseling? These are things we should do. I'm not saying we shouldn't do them as providers. But that's what we're basing rewards on? Not on the outcomes or the costs? It just doesn't make sense and I'm not the only person who thinks so.

This is a book by Michael Porter and Elizabeth Teisberg. Michael Porter is a business school professor who's gotten interested in healthcare. The London Times says he's the second most influential person of business policy thought in the world. Interesting guy, we've had him out at Mayo about three times to talk to us. The current pay-for-performance what Medicare is going to be doing, he doesn't agree with them. He says they carry risks because it's not about results but processes and they're really paying for compliance, and it is. Here's his other point. Compliance with too many process standards runs the risk of inhibiting innovation. Medicine is filled with things that we think we should be doing right now that five years from now we're going to find out is absolutely the wrong thing to do. The whole history is that way.

Here are just a couple of them. Beta blockers for congestive heart failure, bad risk after an MI, we don't do those anymore. But when they were vogue you put them in your process list, who is going to be - and that's what you're going to get a financial reward on? Who's going to be cut and dried to look and do it differently? That's why he says there's a risk in going to patients for your future care the way we're setting this up. It's crazy. I'll show you why it gives a reward to the wrong institution.

So I'm going to show you two hospitals in California, two teaching hospitals in California. They're both good hospitals you would recognize them if I said the name. They're both in urban areas in California. Because they just have these processes in place, they will complete the process list. Yes, give the aspirin when the patient comes in with a heart attack. They'll put them in place so they're going to get the reward and it's going to be about a 5%

reward to the medical centers that do that. Okay, this is actual data from the care provider near the end of life for these two hospitals, both California teaching centers.

Medical center A uses half as many hospital days. Medical center A uses less than half as many physician visits per patient. So the cost is a heck of a lot less in A because A's use rate is less. Now what are the results? The mortality ratio, this is adjusted for severity and your case mix. Here it's 43% better than you would have expected. Here it's 12% worse than you would have expected. So medical center B costs you not quite but almost twice as much and you're getting results that are about half as good. Should this center get the financial reward? The way Medicare is doing it I can tell you you're going to get a 5% reward on what your charges were or what the allowed payments were for your Medicare, they're going to get a bigger reward.

It's the exact opposite of what we should be doing because this is not a value-based purchasing. It's a process-based purchasing, not looking at outcomes, not looking at costs. We're not going to get there unless we change. So how do we start? Start with the expensive patients, the hospitalized patients. What I would do if I was czar, hospitals right now get a DRG payment from Medicare. So if you go in for a hip replacement they're going to pay the hospital a lump sum number of dollars. I would continue doing a lump sum but I would change it two ways. A longer time in the hospitalization, so if it's a hip replacement it starts the day you go in and it may go for six months or a year. All the care for your hip problems are going to be covered in one lump sum payment, and it's going to cover more than the hospital; it's going to cover all the physician services as well.

Now what's the financial incentive? It's to make sure you do not have a complication because if you have a complication you're going to get readmitted. You'll do everything you can to follow up and make sure that doesn't happen. Places like those integrated systems that I mentioned, those

four in Temple Texas, Salt Lake City, the Mayo Clinics of the world, no problem, we could switch to that tomorrow. But most places aren't set up like that. The hospitals and the physicians, the physicians are all independent, the hospital is a separate organization, and all of a sudden now you're going to get a lump sum payment and the physicians and the hospital have to decide how to divvy that up and how they're going to provide the care. That's going to take some time.

I would announce this program and I'd say two years from now that's what we're going to do. You guys figure it out. You're going to have to self-organize to do it. I'd start with the most expensive DRGs and I'd just work my way down one by one. As you do that, you've got to define the outcomes but I'd have the providers who deal with a little hip replacements define what the total hip outcomes are going to be. If you know what they're - you know what you could listen right now. It's going to be mortality, it's going to be no infection, it's going to be get back to normal activity. Those sorts of things, you can measure those things.

Then the important thing is somebody has to set the penal amount. If you came to the fallacies talk that we did, I gave you the formulas for how Medicare does this now. It's crazy. I would not do this by [unintelligible]. I would use a concept that was first proposed that I know of by Dr. [Haloff], an economist at the University of California, San Francisco. He says let's measure the outcomes DRG by DRG. Then let's look at the actual cost of resources used by the medical centers that get the best results. So I'll show you graphically what this looks like. Every dot here is a hospital. We're going to do an extended DRG, maybe it's total hips, and these are the outcomes, the higher the number the better. I've drawn a line across here for the top one third of the hospitals that are up here, so they get the best outcomes.

This is the cost over whatever time period in the past year or two for those medical centers. You draw this in the median. Now let's use these people,

the actual experience of these people, these medical centers to set how much we're going to pay, reality-based pricing. So you just take it at the median for that group, draw your line and this is the payment amount. Now it's going to be pretty hard for these people down here whose cost per episode is about twice what it is you really get paid who say, well, we can't do that. Why is going to be difficult to say that we can't do that? Because these people are all doing it and they're getting better results.

Now what's the financial incentive? What are these medical centers going to do down here? They're going to be calling up everybody they know up here and they're going to be saying, "What are you doing to get that kind of results and be able to do that?" They're going to be putting those things in place in their institution to get there. And there's pressure then to move up here. The way I see it, if we want value in healthcare we're much more likely to get it if we pay for it. This would be paying for it. Doing the 5% bonus for compliance with process items gives you the opposite incentive.

Now in one of our earlier sessions we said if you take the Medicare program itself, what would you do? And we took a vote. I'm going to show you the ones that got the most votes and only the ones that had a majority of the people in the audiences when I gave that program that were above 50%. So the one that got the most votes was raise the eligibility age, increase the beneficiary share cost, limit the benefits, move more to a high deductible sort of a plan, increase Medicare taxes, change the policies so you can encourage efficiency - kind of the things I just talked about. Move Medicare to premium support which would be kind of private insurance, the government would not be the insurance company anymore. You offer private insurance companies just the way federal employees have private insurance options and you would pick one, or some combination.

So when we did that, the one that got the most votes, and I love this because my favorite deal is to change how we pay for care and that's what everybody had the most votes to actually do that, and I think that is the thing we should

do. The next one was to raise the eligibility age. I actually think this being happening from the deficit reduction curves. The next one was interesting to me was to move to premium support to a different sort of model, and then to limit the benefits and move more to this sort of catastrophic sort of approach. Those were the ones that had at least over 50%. So it was actually some combination. I actually personally agree with every one of those. If I was health czar that's how I would try to move the program.

Now some people on premium support, some people will say with insurance options you won't be able to understand them. But the prescription drug benefit Part D is actually a case in point because that basically is a premium support model. Private insurance companies offer you drug coverage and the Medicare beneficiaries choose. There are mixed views on this approach especially when it was first started. Here's a great quote from a well-known economist, he is a Nobel awardee. "The new Medicare Part D prescription drug insurance market illustrates that leaving a large block of uninformed consumers to sink or swim and relying on their self-interest to achieve satisfactory outcomes is unrealistic." So he didn't like this approach clearly.

But look at that. Read that. Do you not interpret that the way I do? I think that's quite an arrogant statement. You know what he's saying? He's saying every one of us in this room is too dumb to be able to pick out an insurance plan that would fit our needs. That's what he's saying. Well, now it's been around long enough they can actually study this, and there are several economists that just released a study in October and there's an economist at ASU that was part of this team, actually interesting. I haven't met him. It was interesting to me that there was an ASU economist in there. They found the exact opposite.

Their analysis shows that the decisions for switching plans shows that people aren't able to interpret what's happening to them and make wise decisions. How are they doing it? Here is what they found. There's an expanded - this program led to expanded use of prescription drugs and we just saw if you get

prescription drugs filled you're more likely to save money in the long run. It expanded the people that were using it. It lowered out-of-pocket prices, there was high satisfaction from the people, and the most important one from the government standpoint should be the costs of this program are below what the Congressional Budget Office forecasted it would be.

What do you think happened with the actual cost and the regular Medicare program? Far different. It was way more than it was initially. It could have been how the forecasts were done, I grant you that, but at any rate there are some very positives that are coming out of that. If Medicare continues as a separate program, I think it should move to premium support, but I think we really should examine having a federal employee type of plan. So you'd have an exchange, private insurance options, insurers have to take all comers for everybody.

Why do we have separate programs for all our little sectors? We've got Medicare. We've got Medicaid. We've got the VA. We have the military. We have Champus. We have the Indian Health Service. We have employers. Why do we have so many systems in the US? Why don't they put everybody in the same thing? You know what this would be? It would be putting everybody on what members of Congress have right now, and I can tell you members of Congress strive to stay on the federal employees' health benefit plan.

Then you'd have to pay for, the government would have to decide who they're going to subsidize. That could be based on age and that could be based on income - whatever the decision is, but if we're going to subsidize my main view would be we have to pay for it with real dollars. To me how you would do it is how a Brookings economist recommended before this health reform bill came in and I wish they would have used it, to eliminate the tax-free nature of employer-sponsored health benefits. So I work for Mayo Clinic, it provided me health benefits and I didn't pay tax on the value

of that benefit. So anybody that gets their healthcare from an employer, you don't pay tax on the value.

So what's the incentive? The incentive is that's basically tax-free money. So I could get really insured. So when you're really insured, what happens to the use rate? It goes up, cost would grow. It's amazing but the Health Reform Bill that was passed and we provided expanded, well, we're going to. We're moving to provide expanded health insurance coverage and we're going to subsidize that for low income people, not eliminating and if we have just flattened it out to the level it was in 2008, the value of that benefit it wouldn't increase as you went with time. That would have completely paid for that Health Reform Bill. Instead, how are we paying for it? A hodge-podge of tax increases and this is a tax increase for sure.

But the other way we're paying for it, half of that \$500 billion is for across-the-board reductions in what Medicare is going to pay providers who already lose money in Medicare patients. I can tell you, I'm onto Medicare. That's not a good prescription for us in Medicare. Either the quality is going to go down or the access is going to go down for us or both with what's happening, with the way it's going to go. So specific recommendations from me, the first thing I would do, change how we pay for care. Start with the most expensive, these hospitalized patients, these expanded DRGs.

There are other payment approaches as well. For the chronic disease patients, they're expensive, there's something called a medical home so you pay a capitation amount per member per month to a provider who agrees to really track the chronic disease patients, make sure that they follow their treatment regimen. That would be their physician would take responsibility for. And there's some data that shows that we could save money there. You could experiment with capitation or condition-specific capitation.

What's condition-specific capitation? Basically every transplant that's done in the United States is done on that. Mayo Clinic has the largest transplant

program in the world if you take all the transplants together. Every transplant patient that's done in Mayo Clinic is a capitated contract. That means we get so many lump sum of dollars for that transplant and it starts from the time the patient is hospitalized and usually it goes for about six months or a year. We get so many dollars; we're responsible for the care of that patient.

The incentive is to really find ways and the results, the outcomes are on the internet for every prospective transplant patient to see. So they know what our survival rates are compared to everybody else for every specific transplant organ that you would be involved in. You can really encourage savings that way.

The other thing, we need to establish a common billing formal process to reduce the administrative overhead cost. Many people think they could save about \$100 million here. Expand coverage with evidence development. This is kind of - what this does, new developments in medicine, the FDA approves them and then what happens? You see them advertised like crazy on the television. But that doesn't mean they're really more effective. That just means that they aren't going to cause you harm. It doesn't mean they're any more effective than a treatment program that's been around for a while.

So if this program, this has been available through the government for years. So you have a new development and then you say nobody gets insurance coverage for this new treatment unless the provider agrees and you as a patient agree to be part of the evaluation, so that we can see for people that get this treatment, do they have better outcomes than the people who get the traditional treatment? As far as I know over the last fifteen years there's only been three times that this has been used. That's crazy. With all the things that we have, we should be doing this more.

Who is against this? Drug companies, medical manufacturers because we might find it really isn't any more. One of the ones actually, did you see the

paper today? One of the studies was to reduce stroke, the bypass operation up here. It was determined that that does nothing to reduce your risk from stroke from just getting prescriptions drugs. That's the sort of thing that we should, and the patient, don't you want to know? Wouldn't you like to know rather than go on through surgery? Man, I don't have any better chance of improving and if I just take drugs, if I could do it with drugs I'd rather not go through a surgical procedure.

Develop and communicate the best practices. Use health information technology that uses clinical decision support to help you make decisions. I've showed some of you this. Both Mayo and Banner here have different systems in their intensive care units from electronically tracking the patients and when something is going wrong you either have a green light, a yellow light or a red light. And as a yellow light goes on in the ICU people start doing something.

What happened to the mortality rate with that new IT system? It's amazing to me these are different systems but the same concept. Both at Mayo and at Banner, the mortality rates in ICU went down by 30%. Wouldn't you like that if you were going to be in intensive care unit and know you've got a 30% less chance of dying? What happened to the days in the ICU? They went down about 30% in both places as well. It was amazing to be the similarity in the change in both of them. That's important.

Malpractice reform, we should also keep that. It would save some money, who knows how much? Encourage financial incentives by patients and share decision-making. I've never talked about this. It's an interesting one. For people who are going to have surgery, you get an independent educational program and then before you decide to have surgery for selected conditions. My son is a great example. I have a son who had an [unintelligible] injury in college. So in his late twenties he was having significant back problems and his issue was, was he going to have spine surgery or not. It's a controversial area, the spine surgery.

So he got an independent educational program that goes over what this problem is, describes it and I looked at it, he looked at it independently. I looked at it because I was just interested in how it was done. Then it gives you the options for treatment and the pluses and minuses of these options and then you decide. He decided to do it and he's had a great result, glad he did it. But when you do this for surgical procedures like this, in the United States you get a reduction in the number of people who have the surgery. Take prostate surgery for men, pretty good reduction. I think there's a 30% reduction.

The fascinating thing on this, they've also studied this in countries like England where they don't do nearly as much surgery. In fact it's hard to get surgery done in the United Kingdom. What happened when they did that to men with prostate cancer in England, it went up significantly and it went up higher than what the United States was. I think that's just because they had such a hard time getting surgery. This was a program to give them an option to get surgery and they jumped on it just like that.

So at any rate, I think this is a good one that hasn't received as much attention, and then I think we should have insurance for all and I think it should be the private options with an exchange where the insurers have to take all comers. If I could do just one thing, I'd change those financial incentives. I've said that a lot, but here's the other thing that I would do. I think if I was czar I would not do it through the Medicare program. It's too political. Medicare is supposed to have a value-based purchasing program. Well, are they purchasing on value? No.

I would farm this out to a group like the Dartmouth Advanced Solutions for Healthcare, a national organization. They have a lot of experience looking at all these sorts of data, and I think they could actually put a program pay for value that really would pay for value. I'm not sure the Medicare program can. It's just too political.

Now why do we have to make this? These two men have told us why. You know who both those men are? Do you know either one of those men? Who knows the man in the left?

Unidentified Male: Jerry Garcia.

Bob Smoldt: Very good. I knew we had to have somebody here. Jerry Garcia of the Grateful Dead and he doesn't scrape by. "Somebody has to do something and it's incredibly pathetic that it has to be us." That's true. We have to all step up and [unintelligible]. But I like this one better. Anybody know who that gentleman is, obviously older? That's Will Mayo and it works better for us. I tried this Jerry Garcia quote at Mayo Clinic and it didn't go over real big. But this one did, "The needs of the patient come first." We need to do this because in the United States we can do better for the patients in this country and it's time to get on with it.

So I'm done talking. I've talked too long. We need some questions and discussion. Yes?

Unidentified Male: You mentioned the fact that doctor's reimbursement in Medicare is already at a lower level than the doctor's cost in the office.

Bob Smoldt: Yes.

Unidentified Male: As of January 1 there's a 27.4% cut proposed.

Bob Smoldt: Yes. It actually isn't proposed. It will happen unless they intervene.

Unidentified Male: There are a multiple number of doctors and I'm in Medicare, too, a number of doctors who are already not seeing any Medicare patients. With a 27.4% cut, how many are going to be able to afford this?

Bob Smoldt: It's going to get worse. It's going to get worse and here's the problem.

Unidentified Male: But that's going to happen absolutely right smack on day one.

Bob Smoldt: I know. It's going to get worse than that because you know what's going to happen with the next five years after that? It's going to keep going down. Keep going down and what happens with the Reform Bill? The Reform Bill, boy, you really got me. I'm on my hot buns here. The Reform Bill, half of the \$500 billion is paid for by further across-the-board reductions and let Medicare pay its providers. That's why the CBO when they wrote their report and they said this wasn't going to reduce, it was going to improve the budget deficit, at the very end they said there are provisions in this bill that will be very difficult to actually do.

Then they put in there, that's all they said in the first one. Then the last time when the bill was ready to pass it was like nobody's listening. So they added such as the reductions in what physicians are going to get paid and if that can be done without implications for quality or access or both. And so you're right. It's going to be a nightmare. Do you know what the solution is? Have you seen the solution to this? There is a proposal there to so-called fix this problem.

Unidentified Male: There is one every year.

Bob Smoldt: No, but this is for a so-called long-term fix, a ten-year fix. Here's what it is. In year one, I think the primary care doctors get a 10% increase and then they're held constant for the next ten years, no increase for ten years. The specialists get like a 10% reduction and then they're held at that lower level for ten years. So basically what it is saying is we just won't cut you but you're not going to get any increases. How many of you think the costs of running a practice are going to go up in ten years?

Unidentified Male: It's guaranteed.

Bob Smoldt: It's guaranteed. So from my standpoint, the government needs to recognize they either can afford to do this stuff or they can't, and that's frankly why I think we need to go to premium support, do set it at an amount that we can afford or that we're willing to pay for. If we're willing to tax ourselves, we can increase this but we're really reluctant to tax ourselves.

Unidentified Male: So at the same inefficient system?

Bob Smoldt: Yes. Yes, it's a big problem, no doubt about it. I'll be interested in seeing if they actually intervene so that that reduction doesn't go through this time. I'm not sure they will because of all the concern about the size of that. We'll see.

Unidentified Male: I'm walking around, there are a lot of people here on Medicare that are not going to find a doctor.

Bob Smoldt: Well, it will be more difficult and especially if you have to get a new physician.

Unidentified Male: How can you possibly see a patient in you lose money every time you see him?

Bob Smoldt: Because, I'll tell you what. They're doing it right now and physicians - actually I feel it. I've worked with them a long time. I think they really do want to help patients and especially patients that they've had. If they're already their patient, they kind of say okay, I'm going to take care of them but I just can't take any additional ones. But you're right, you can't do it forever. You cost-shift to our kids and our grandkids, that's what we're doing right now but eventually you run out of the ability to do that.

Unidentified Male: And all the insurance companies follow Medicare.

Bob Smoldt: To an extent, yes, and that's why I said if Medicare would switch how they paid I think the insurance companies would jump on it. There was another question or comment here?

Unidentified Female: Well, number one I'd change my method. I think we need to vote everybody out of Congress. [Laughter] I mean seriously when you think about it, even the election coming up, do you really, all of you people here, really believe the things are going to change at once with a new President or the same one?

Bob Smoldt: I have a good friend whose mother had a policy. It was an interesting policy and as far as I know, my friend told me that she actually did this. This was her policy and who she wrote it for. If they're in office now, I vote against them. So that she kind of followed what you're saying. I'm not sure that really makes sense but that's what she was saying. But it is frustrating. In the past we used to I think have a lot more actual dialogue and people would come to compromises. I remember just before this last Health Reform debate started, several of us from Mayo went down to visit with Howard Baker who was Republican but very moderate Republican. He said the thing that bothered him the most with all this was the [unintelligible] that exists now in Washington. Back when he was there, people would talk to each other. Democrats and Republicans and you try and come up with some solutions, but it didn't happen so much. Yes?

Unidentified Male: Just a couple of comments. Number one, I very much appreciate your series.

Bob Smoldt: Yes, thank you.

Unidentified Male: It's been very helpful. I also really think that your very first slide hit the nail on the head with the point of what is it we're trying to achieve. I think that is the kind of question that's not being answered and needs to - we would do well to focus more on trying to answer that question as opposed to several of these other kinds of questions. I really think that's important. The third point has to do with it's clear to me but it's not clear to me. That is to say

it's a very complex and complicated issue and there are several different pieces of the puzzle which are required to make the whole thing come together. I'm still not sure that I understand - I don't know that I have all the pieces of the jigsaw puzzle laid on the table to be able to even put it together. But part of it has to do with the efficiency and effectiveness of the healthcare organization and how it delivers its services which is one issue. Another one has to do with costs and how they get managed, controlled or dealt with in whatever kind of way. And the third issue has to do with who pays. On top of that, you add in the government and the insurance companies and oh my God.

Bob Smoldt: Then in addition to that, in this country we have the employer because the employers really are the payer for the majority of the people in this country through their programs, how they do it. You have all those players.

Unidentified Male: Are all these pieces of the jigsaw puzzle laying on the table, and we don't even know what kind of picture we want to make to know just how to put the pieces together.

Bob Smoldt: That's why we started that way. We always ask, what are you trying to come to?

Unidentified Male: I really think that's...

Bob Smoldt: Then what they say, well, we're not getting what we pay for, and we say you're getting exactly what you're paying for. Because of how you pay us, you're financially rewarding us to provide all kinds of services regardless of whether it's providing any benefit or not. That's why, if I had one thing, it would be to change how we providers get paid to change our financial incentive. Then I'd also try to do the same thing for all of you as patients and myself as a patient so I have a financial incentive to try and get more efficient care and to do what I should be doing to make sure that I don't end up having to have my legs amputated.

Unidentified Male: Another point in that regard is that I think that's fine for folks in our income brackets and our status. But when you look at the census report the average income is \$25,000.00 or something like that a year. The average household income is less than \$50,000.00 a year. How the hell are these people going to do that? I mean we are so income - the inequity is with the distribution of income is so great that I don't know how these people are able to pay for this stuff.

Bob Smoldt: Well, the real low income are basically getting subsidized care either through Medicaid or through not getting care when they should but eventually going in, and all of us are paying - I know we aren't because we're all on Medicare. We're not paying for it but our kids and grandkids are by paying a higher insurance payment. But with that group, we actually have a project in a couple of locations. Our little ASU program to see if we can improve what happens with the low income people. One is in Taos, New Mexico, a rural area.

Unidentified Male: But these aren't low income. These are the average...

Bob Smoldt: No. You should see the demographics of Taos, New Mexico. Julia Roberts has a place there but I can guarantee you the payer mix for the Taos Hospital you would not want. 50% is Medicaid or no insurance at all - 50%. They are low income. So at any rate, another one is in Temple. Anybody know where Temple University is, the medical school in Philadelphia? That's Medicaid city right there. So we're dealing with them and what is going to happen there with those people, we're trying to put in place programs where you basically take people who come from that geographic area and that background as those people, train them as health aides because they know what it's like to live there and follow up the expensive patients.

There is some data on this that's been successful in Newark, New Jersey. If any of you are interested in this, you ought to read, you should read an

article of Dr. Atul Gawande, it's called Data Mining or something like, it was in the New York, and he talks about what happened in Newark, New Jersey with a physician who started data mining then they recruited people from the areas of these low income places where they're having all these problems. It didn't solve the problem but it really improved it dramatically. So I think that's, I personally think that's what has to be done in those areas and it's a big chunk of the population. Unfortunately, what's happening is it's getting to be a bigger chunk of the population. That's the unfortunate thing. Excellent point, excellent.

Okay, well listen, thank you very much for coming to this. I really appreciate all these groups, excellent questions and excellent points. Thank you.

Paul Ahern:

Thank you, Bob. Thank you very much. This is a real treat for us. Bob was selected by ABC News along with a handful of other people to meet with Obama a while back. So to have a true national healthcare expert speak to our small group here is really a pleasure. So we hope that you found your time was worthwhile. If you haven't filled out a comment card before on this particular topic, I'd like to ask you to do so.

A lot of stuff we do pertains to wealth management but because of our contacts at Mayo and some other people like Barry Brummett and [unintelligible] Economic Council we want to bring their areas of expertise to the table for the benefit of our clients as well. But we won't keep doing it unless you find it's a benefit. So if you would, please fill out the comment card and then leave it in the basket as you leave. That's for those of you who have not already done so because a lot of you are returnees so I know you guys appreciate it and thank you for coming out.

With that, I want to thank you all for being here tonight and I wish you all the very best for a happy Thanksgiving and we hope to see you again soon. So have a good night.

-End of Recording-