THE ECONOMIC CLUB

OF WASHINGTON, D.C.

Virtual Signature Event

Congressional and Medical Panels

The Honorable Debbie Dingell
Representative for Michigan's 12th Congressional District

The Honorable Tom Reed
Representative for New York's 23rd Congressional District

Kimberly K. Horn
Executive Vice President and Group President
Markets Outside California, Kaiser Permanente

J. Stephen Jones, M.D.
President and CEO
Inova Health System

Kenneth A. Samet, FACHE
President and CEO
MedStar Health

Moderator:
David M. Rubenstein
President
The Economic Club of Washington, D.C.

Wednesday, January 27, 2021

ANNOUNCER: Please welcome David Rubenstein, president of The Economic Club of Washington, D.C.

DAVID M. RUBENSTEIN: Thank you very much. And welcome to our 13th Virtual Signature Event of our 35th season. Today we're going to have a congressional panel and then we're going to have a medical panel. Our congressional panel will talk about a number of subjects, including the recent attacks on the U.S. Capitol, current political environment, potential reforms to security measures, and the way forward for national unity.

The two members that we have, we're very honored that they're joining us today, are Debbie Dingell representing the 12th District of Michigan. She's a Democrat. And Tom Reed, representing the 23rd District of New York. He is a Republican. And I'll give them more formal introductions in a moment. And in the second segment I'll interview three leading health experts who are also members of The Economic Club of Washington. And I wanted to have them discuss the current surge in COVID-19 cases, the vaccination situation, and ultimately the overall health care situation that they observe now in terms of hospitals.

Those who are on this panel are Kimberly Horn, who's executive vice president and group president of markets outside of California for Kaiser Permanente. She's in charge of all the hospitals outside of California for Kaiser Permanente. Dr. Stephen Jones is the president and CEO of Inova Health System. And Ken Samet, who is the president and CEO of MedStar Health. So I'd like to thank all of them for joining us today.

So let me get on with our discussions now. And let me introduce our two members more formally. Debbie Dingell is well known in Washington because she was in Washington for many years, a native of Michigan. But she was in Washington for many years heading up the General Motors Foundation and doing work for General Motors. She was first elected to the Congress I'd say in 2014. She was elected to Congress and has how been serving since that time as a member of Congress from Michigan. She is an active member of the Democratic Party. And she has, as her most important accomplishment, she was a member of our board before she joined the Congress. And I want to thank you very much, Debbie, for joining us and giving us your insights. Thank you, Debbie.

REP. DEBBIE DINGELL (D-MI): Thank you.

MR. RUBENSTEIN: OK. And I'd also like to introduce Tom Reed. Tom Reed is a member of the House. He was elected first in 2010. He is a person who was a graduate of Alfred University, where he was an all-American swimmer, and a graduate of Ohio Northern Law School. In his bio it pointed out something to me that I had not known. He's the youngest of 12 children and was raised by a single mother. His father, a military hero who passed away when he was only two years old. And so welcome Tom and welcome Debbie.

So let me just kick off at the beginning and ask both of you: What do you think – what was going through your head at the time of the invasion of Congress? Did you know what was going on? Did you think it would be as bad as it turned out to be? Where were you when you first were told something is happening? Debbie, where were you?

REP. DINGELL: Well, I was actually on the House floor when it began. And I began to notice some of our security was becoming a bit intense. You could hear noise. But I really did not realize that anything was not – was out of the ordinary. We knew that there were going to be protesters that day. Then suddenly I saw Steny and the speaker taken off of the floor. But yet, candidly, at the same time staff had come up to me and said: We need to help – we need you to help keep it calm when you go to the mic. And we'll tell you what we need to say. We need you and Jim McGovern to keep the process going. We want to keep things normal.

Shortly after that, they came in, told us to sit in our seats, to take out our escape hoods, to be ready to get on the floor very quickly. You could hear people pounding at the door. Many of the members, Republicans and Democrats – there weren't Republicans and Democrats in that room that day – helped law enforcement try to barricade the doors. But I still felt like we were safe inside the chamber. And then you began to hear glass breaking. We were evacuated. We heard the gunshot, which unfortunately resulted in the death of someone. And we were taken to an undisclosed location, and in there for several hours.

But you know, David, I've become used to this, in a way. Not used to the insurrection we had seen, but if you've ever been the target of a Donald Trump – I was with Tom when one of the worst ones happened. You don't understand what it's like. I've been in his hate tunnel for a couple of years, where I've had militia in front of my house, where my antenna is always up. And I always feel like I'll survive it. You know, they're trying to make my life uncomfortable. I don't think any of us really realized how serious it was – what the threats were, that they wanted to kidnap us or kill us – until it was over, and we began to see the aftermath.

MR. RUBENSTEIN: Tom, you were on the House floor as well. What did you think was going on when you heard the noise?

REP. TOM REED (R-NY): Well, actually, David, I had just left the House floor about 15 minutes before this all went down. And I always go to my office outside, and so I was walking outside, as I always do. And so I was outside when the mob was coming up around the side of the Capitol. And at that point in time, they locked the buildings down. So I was essentially locked outside. And you knew it was different. You knew that this wasn't just a protest. You knew that this was something that needed – that we were not expecting that day. We were obviously prepared for the protesters, but this was going to be a different situation.

But I worked my way into Longworth, showed my ID, got back into my office. That's where they secured us for the duration of that event. And I will just tell you, I watched on TV and I was texting my colleagues. My best friend in Congress is Josh Gottheimer, Democratic member, co-chair of the Problem Solvers Caucus – that both Debbie and I are part of, I founded four years ago with Josh to try to break and bring this country back together. And you know, we checked in on each other that we were safe. And I just watched on TV with tears in my eyes. I mean, it was something I never thought I would see in my lifetime. And I was disheartened.

But I also left that evening, when we went back to the floor and the chamber and completed democracy by completing the task at hand. And there was a lot of folks that wanted us to go off site. They wanted to compete the process not in the chambers of the Senate and the House. And to the credit of both Democrats and Republicans, that they said no. We're going

back to the chamber. We're going to not let the mob win. And I went across the aisle to stand with Josh, gave a speech.

I spoke from the heart on five minutes' notice and just said: You know, what? I'm a proud Republican. I know Josh and Debbie are proud Democrats. But we're going to stand together as Americans and not let the mob win. And we're going to go forward. And we're going to continue these disagreements but we're going to do it not through violence, but we're going to do it by leading the country and letting the ballot box determine our future leaderships. And so glad to see us complete it. And I was energized.

And to the point that Debbie made, you know, right now our country's broken. I have death threats. I had a death threat here in October with a brick and a dead rat left on my front stoop that my wife uncovered with the names of my children that were left from democratic socialists on the left that we are now going to be hopefully arresting here very shortly. Because of this event they've come out and gotten emboldened and are chattering on websites. So the bottom line is extremism is not the future of America. And I think leadership is going to see us through. And I'm just glad that hopefully we can move through this.

And I stood at the inauguration and I sat with members on both sides of the aisle that just said: You know what? It's time to move on. It's time to move forward. And it's time for us to unite as a country.

MR. RUBENSTEIN: OK. So Debbie and Tom, I'll ask you, Debbie, first. In hindsight, was it the fault, to some extent, of the Congressional Capitol Police or the sergeant at arms for not having more security, or the National Guard? Or who do you think failed to provide the adequate security? And I'm also curious if you have all thought about that if those who invaded the Capitol were more, let's say, professional in terms of their abilities to harm people that an enormous amount of death could have occurred.

REP. DINGELL: So I am someone, David, that believes very strongly that we need an independent panel to be looking at what happened. Anybody who has – you know, if you come from Michigan, which has been living with this – we have a governor that they tried to kidnap and potentially hang – knows what some of these groups are capable of. And were there people – and I don't know who the people were that did not want to have a military presence on the Hill that day – the National Guard should have been stationed at a place.

There was no way that this crowd is not going to get under control – out of control. I mean, I don't know how to go on the dark web, but even I know – reading my social media, reading what I was reading in the newspaper – knew that this was going to be a difficult day. I have asked a lot of questions, and every time I have asked a question someone gives me a different answer, a pointed finger a different way. I think we need to – and I think that there's a problem that there are not clear, responsible lines for who is responsible for security on Capitol Hill.

I think that not – I want to say this carefully – I think it's become political, in the sense that people are very respectful of members and they don't want to do anything to offend them. But I think we all need to be treated the same, you know? We got a guest, the guest goes through security. I don't mind going through security. I should be living through the same rules

that everybody else is. This is a very serious national security issue. And we need to make this a professional, from top to bottom, operation.

MR. RUBENSTEIN: OK. Tom, what is your view? Who was at fault in terms of providing security? And do you think there should be a commission, or what will be done to look at how you can improve the security?

REP. REED: Well, I mean, I agree with Debbie. An independent commission – we can always learn from these events. But the tension that we always face on the Hill is, remember, this is the people's house. And when people come to the Capitol, what we pride ourselves in is we've gone through 1993 bombings, as we've gone through 9/11, as we see the ratcheting up of security, it's always on the backdrop of remember we are a free and democratic country. And the Capitol represents that wholeheartedly. And that's where we wrestle with this. And I know talking to Capitol Police, talking to law enforcement that guard us and guard the Capitol, you wrestle with that mission that they're under.

It's, like, we want to keep that openness. You know, as you walk through the Capitol and you see the speaker walk through the halls, you see the elected officials walking through the halls. It's a functioning democracy that people can just – you never know who you're going to see there. And so you got to wrestle that need for security with that freedom that is represented by the Capitol. And I think with that independent commission we can find that how we can do it better, how we can make sure that this event never happens again.

But I will tell you, the law enforcement at – the men and women of the Capitol Police, I applaud them. They – thank God. You know, some members were, like, they should have opened up. They should have knocked all these people down. They should have opened up their weapons and things like that. But think about what that image would have – the imagery across the world was so bad as to what happened if you had a few thousand dead Americans that would be. We are the leaders of the world of democracy, yet you have to keep that in perspective as to what that would have represented to the world. And so thank God there was not more death.

We're going to learn from it. We're going to secure the Capitol. But I think we can do this in a way that recognizes we need to be that beacon of hope and democracy going forward, secure the Capitol, but at the same time make sure it's still free and it is not a lockdown situation that we see across the world that people tend to run to because of the need for security.

REP. DINGELL: I want to – can I just say one thing? That Tom's really right about that. And one of the things that I want to say is, you know, I didn't see any of the television clips until after we finished at 4:00 in the morning. And I've had a lot of people say, oh, that person did this, or that person didn't let in. We would not be here today, people like Tom and I, if it were not for the men and women's courage that day at the United States Capitol. Clips are taken out of context, they're not understood. They defended the Capitol. And I'm very grateful to the law enforcement that kept so many people safe that day.

REP. REED: And to follow up on that because there's been – David, there's been, like, clips of, you know, law enforcement opening up the bicycle gates and things like that. And oh, they're in conspiracy with these folks. Those were tactical decisions. And if you watch the law enforcement, Capitol Police, they went to a position of higher tactical positions to control the

mob. They were controlling some of these folks, these people that were being escorted, elderly people, to take them away from the mob that was behind them to put them – to move to places of safety.

So each one of these actions, be very careful to judge what you see in a picture. We got to make sure we give law enforcement the ability to explain exactly what they were doing in each one of those moments, because the men and women of the Capitol Police, they were trying to do the best they could with the situation at hand. And it was a dire situation that got out of hand, real quick.

MR. RUBENSTEIN: OK. So after it occurred there was a vote subsequently in the House to impeach the president of the United States. Debbie, I think every Democrat supported that. And did you think at the time that many Republicans would support that? And was it – did you get a lot of feedback from your district about whether you should support that or not?

REP. DINGELL: Actually, Tom and I were part of a groups of friends and colleagues that had a lot of discussions about what was the right thing to do and how should one proceed. In the end, I think that all the Democrats did vote for it. I raised issues. I do believe that President Trump needed to be held accountable. But I have for years talked about the fear and the hatred that's dividing this country. And I think it's very important that even as we go forward now that we not contribute future to the division in this country.

I think as more and more videotapes came out and people saw some of the actions, people began to feel stronger about it. And, you know, I – as Tom was saying – there are people with very, very, very strong feelings on both sides of this issue. And a lot of the members are hearing from people on both sides.

MR. RUBENSTEIN: OK. Tom, you voted against impeaching the president. And your reasoning was, what?

REP. REED: So I did a New York Times op-ed on this. And where I looked at it, impeachment is a constitutional tool that you really have to look at the full picture. You have to look at the constitutional impacts. And what I saw was a snap impeachment. What I saw was people demanding an emotional response given the events of January 6th. And I understand that.

But when I looked at impeachment and I looked at the due process rights that needed to be included there, when I saw that the president was leaving on January 20th, where I saw what that would do to further divide the country, what I saw with the issues of constitutional free speech that needed to be debated in the country that occurred on the mall, even though I saw some issues that caused me great concern and I came out in support of censure of President Trump in regards to the activity that occurred on the mall that day and the speech that I watched and I witnessed myself.

And so I recognize the accountability. And that's why I thought censure was a more measured and appropriate immediate response to respond to the situation. And remember, censure is not a slap on the wrist. Censure is a historic – we've only censured one president officially from Congress to the president. So it's not like it's a nonexistent penalty. It's a historic penalty. And so I got a lot of heat from my party in regards to the position on that. But I

was really concerned about why – you pursue an impeachment that quick, with that many days left in the administration.

And remember, impeachment's about overturning the will of an election. So the votes that were cast in 2016, that was an election that was – put President Trump in place. And if you're going to overturn that election, you still got to take all the consideration of impeachment into effect. And so I just was against impeachment for all those reasons. And I just think, you know, this impeachment in the Senate is going to further divide this nation. And it is going to play into this gasoline that the 74 million folks of America that voted for President Trump that do not believe – many of them do not believe this election was legitimate.

I had no problem recognizing at this point in time that President Biden is our president. But there are millions of Americans – and not just because President Trump says it, but they do believe it. I can tell you I've heard from it. And we have to heal this nation and we have to listen to that frustration and anger of those 74 million people and make sure that their concerns about the election and others are heard, David.

MR. RUBENSTEIN: If there is no conviction in the Senate, and it looks like it may be difficult to get a conviction in the Senate, do you think either house will pass a censure, or that will be the end of this whole matter with respect to President Trump? Tom, do you expect there would be a censure approval in the House later?

REP. REED: My hope – my hope is that we move forward. And I take President Biden at his inauguration speech of trying to unite this country. And I think President Biden has an opportunity to heal the nation. And that would be, I hope, the road that he takes, and forgiveness to start part of the – part of bringing the country together and move us forward. And further picking at this division I think is not going to serve anyone well. But we'll see. And that's something that the political offices, they'll want to divide this possibly. And hopefully their voice doesn't win, and we just move forward for the sake of the country.

MR. RUBENSTEIN: OK. So, Debbie, let me ask you – let's go forward and talk about legislation. The president has proposed $1.9 trillion stimulus bill. Do you think that the Democrats in the House will support that bill pretty much the way he wants it, or do you think there'll be a lot of give and take and he will not be able to get all of what he wants, or even most of it?

REP. DINGELL: I think that the general outlines of the bill that President Biden wants will be there. We are already in discussions with Tom and others trying to find a way that we can all agree and move it forward. I mean, they're very clearly – what he is asking for we all need – needs to happen. We have to increase the production of vaccines. We got to increase the production of syringes and alcohol swab. We have to do more COVID testing. We've got kids with student loans that need help, people who are in danger of being evicted from their homes, small businesses, restaurants.

It's the same group of challenges that we faced since the beginning of the pandemic, but yet when the president walked it in was worse than he thought that it was. And we cannot rebuild our economy until we have a national COVID strategy and get it under control. So I'm hopeful that we can find bipartisan. I'm like the president. I am one of the – I think we need to

unite. I'm tired of partisan bickering. I think a lot of people in America are tired of partisan bickering. And I think we need to figure out a way to get this done.

MR. RUBENSTEIN: Tom, do you think that Republicans are likely to support President Biden's legislative agenda, at least what we've seen so far in the stimulus proposal? Or that's unlikely?

REP. REED: Well, I mean, we're engaging in good faith. And I appreciate the White House reaching out to us, especially in the Problem Solvers Caucus. You know, the 56-number group. And with a slim majority in the House, and a 50/50 split in the Senate, our group is, I think, going to be critical. And I appreciate Debbie. You know, she's part of that group. And we're really trying to get to yes, because if the president succeeds we all succeed in America. And so hopefully we can get there.

And there are things that we can agree to, I think, readily. COVID vaccine, COVID distribution money. That should be able to get people together. That could pass maybe on its own on suspension in the House and Senate and get taken care of. But when you're – when you're talking about $900 billion that we just got signed into law, that we in the Problem Solvers Caucus, working with our group in the Senate, that Common Sense Coalition, the 16 members in the Senate got to the president's desk and signed into law – we still are seeing the impacts of that $900 billion.

So there is, I think, in the conversations I've had bipartisan concern. Well, let's see. This isn't Monopoly money. Let's see where the money's at. Let's see what's going on with the economy. Let's see where the status of the virus is. So maybe a little bit down the road what is needed about of the $1.9 trillion we can come to common ground on. There are things like eviction moratorium, for example, taking care of that liability that's accrued. We're going to have to deal with that issue.

State and local aid, with the liability reforms, because you're starting to see property casualty carriers starting to disclaim defense coverage, as well as the indemnification liabilities. That's starting to stack up. So you're going to get individuals and businesses losing defense coverage. So these issues are going to ripen as we go forward. But I think we're in the position to be reasonable good-faith members and good-faith partners to see what we can do to come to an agreement on that $1.9 trillion.

MR. RUBENSTEIN: Tom, who do you regard as the leader of the Republican Party now, since you don't control the House or the Senate and the White House is controlled by the Democrats as well. So is there a leader of the Republican Party? Or is it still, you could say, President Trump, or nobody's the leader?

REP. REED: Well, you know, that's a great question. And right now who gave me a great amount of leadership inspiration through January 6th and elsewhere? I will tell you, Mitch McConnell, Mike Pence did what I think was needed in that period of time. They looked to the Constitution, they stood for the Constitution. And I think they gained a lot of respect by a lot of members. And I will tell you, Mike Pence in particular – who I served with – I think is raising in ranks. So keep an eye on Mike Pence as a leader of the Republican Party.

And I will tell you, President Trump is not gone from Republican leadership in regards to he's got a tremendous amount of influence and a tremendous amount of folks. But if you think of the Trump leadership effect of the folks that went to the floor of the House and Senate, those folks are going to be purged from the Republican Party, and rightfully so. So if that's the Trump leadership that you're referring to, I don't think that's going to be part of the Republican Party in the future.

MR. RUBENSTEIN: Debbie, for the last four years the Democrats in the House, more or less, were the leaders of the Democratic Party. And they were to some extent, you could say, in opposition to what was going on from the White House. But now you have a Democratic president. is it hard to adjust to having to listen to somebody at the White House or in the Cabinet offices when they're in your own party, and you can't just say: This is what the Democrats stand for, because we are the Democrats in the House? How do you adjust the way you operate when you have a Democratic president?

REP. DINGELL: Well, you know, no matter what party you've been in, that's always a challenge. And both parties have found very commonly after they take the White House what happens to the United States House of Representatives in two years is that they frequently lose it. Doesn't matter if you're a Republican or a Democrat. I think that those who don't study history are bound to repeat it. And you have a lot of people who do not want to repeat modern history. But you also are dealing with people who know each other.

You know, one of the things I want to say about the team of people – not the younger, newer members that have been coming in. But leadership is a seasoned group of people. They have relationships. You know, that's one of the things we've lost in politics, and one of the problems. We don't have relationships. People don't trust each other. That's how a lot of things used to get done. You could totally disagree on an issue but, you know, you'd go have a drink at night and you'd talk, or you'd play paddle ball in the gym, or you did – you had relationships.

The good thing I think right now for Democrats is this leadership has known each other for a long time. They trust each other. They know when they want to, you know, maybe go after somebody. But I think they're going to work together. And we're trying to help the newer members understand and see that as well, and have a voice, be at the table.

MR. RUBENSTEIN: So, Debbie, you've been in the House for a number of years now, but you were in the private sector for a while. What is the pleasure of being in the House when people criticize you all the time, you have to go back every weekend to your district, people are threatening you with things? Is this job as much fun as you thought it was going to be, and do you sometimes say, hey, maybe this isn't worth the aggravation factor?

REP. DINGELL: So I would lie – I would be totally lying if I didn't say that there are days that I wonder. I quite frankly wonder some days if I was more effective in the private sector than I am in the public sector. Except, you know what's happened in this country, David? We started to demonize the public sector. And we need the public sector. Our government is as strong as the people that we willing to serve in it and to fight for it. I've made great friends. One of the things about being seasoned, I say – Tom will tell you, I'm always in trouble – I say what I think. And there are not enough people that say what needs to be said in a room, and just say it as it is.

And I love this country. I mean, this country's worth fighting for. And I'll be – I won't use the word I want to use – if I'm going to let people attack our democracy or hurt it in any way.

MR. RUBENSTEIN: OK. Tom, what's the pleasure of being in the minority in the House of Representatives? You could argue being in the majority's not that pleasurable but being in the minority is really unpopular or not that – not that pleasurable, I assume. So what is the pleasure you get out of being a member of the House of Representatives, going back to your district, getting all of the vilification, and also being in the minority? What's the pleasure of that? Plus the high compensation you get.

REP. REED: Well, I will tell you, being part of the Problem Solvers Caucus, where I think we fundamentally – we changed the rules of the House, for example, last Congress using our relationships that are deep – in regards to the relationships I have with guys like Josh Gottheimer, who's my best friend in Congress on the Democratic side. You know, using those opportunities to get things done and signed into law has been very rewarding.

But I still – and as I said on the floor before, I love the institution of the United States Congress. I got mentors like John Boehner; Bob Michel, God rest his soul; Amo Houghton, God rest his soul, who mentored me. And they said early on: Identify some people across the aisle that are good people and become good friends with them. And guys like Jimmy Panetta, Tom Suozzi, folks that serve on Ways and Means with me, you get to know these people. And I will tell you, it still reminds me that in Congress there are honorable men and women, people like Debbie, who come to the table in good faith and are committed to the country and love the institution. And the institution is filled with those folks.

Now, what you see on cable TV, I'm not going to sugarcoat it, we are – there's a lot of division. There's a lot of polarization. And there's a lot of people on cable TV that are just looking for their five minutes of fame. We just don't – I don't associate with those people on a regular basis. I associate myself with good people like Debbie and Josh and just try to get things done for the sake of the institution and the country.

REP. DINGELL: You know, David, I want to say something really fast. We think of Congress like this – you know, the Washington side of it, the Washington. You don't know the good we do back home, the people that we serve, the difference that you can make in people's lives working with – I mean, I got a steel plant taken down that sat idle for 25 years. The waters that we've gotten cleaned up. I worked with Tom on – in the Great Lakes. The casework that we do, the people that are desperate on COVID. That's why we do it. We do it to help the people that are counting on us and we can make a difference for.

MR. RUBENSTEIN: OK. So let me ask you, Debbie, in your case, you think that Congress will have as its highest priority the stimulus bill. But after the stimulus bill, what do you think the House of Representatives is most likely to focus its attention on?

REP. DINGELL: I think the next bill that you're going to see is going to be what the White House I think is going to want to do too, is an infrastructure bill. We've needed one for a very long time. And it will be a broad infrastructure bill. Not only, I'll quote my governor, will it fix the damn roads – excuse my language, but that is her saying – and bridges, but we need broadband. I mean, COVID has just shined a light on the disparity of broadband between urban

and rural areas. We need to fix our broken pipes and infrastructure. For the environment we got to build out an electric vehicle infrastructure. There are many – we have to rebuild our schools. I could – I think that an infrastructure bill will most likely be the next big bill out. I don't know what you think, Tom.

REP. REED: If I could – I wholeheartedly agree. I think it's crying out for us to demonstrate to the country that we can work together. And an infrastructure bill, at least a trillion dollar bill – I went on national TV, and I'm not supposed to do this as an elected official, but I said: A trillion dollar infrastructure bill, there is broad bipartisan support. Not only what we need to do, but financing it, doing it. With zero percent, essentially, interest rates out there, now is the time to seize the moment.

Learn a lesson from Republicans. We led with health care when President Trump came in. Wrong path to take. Infrastructure heals the wounds, brings the country together, and the roadmap is already there. We've already, in the Problem Solvers Caucus, laid it out. Bipartisan support for what needs to be done. And the money can be there. And the country needs that fiscal stimulus too, in my opinion. And we're ready to do it.

MR. RUBENSTEIN: To pay for some of the stimulus and other things some people advocate increasing taxes. You're on the Ways and Means Committee. Do you expect a tax increase this year or next, Tom?

REP. REED: Well, I think, you know, there is an appetite on the left for, you know, the fair share argument and raising revenues. So I think that's going to be part of the conversation. You know, the gas tax, I still don't see a gas tax increase on the horizon. Maybe an inflationary raise there. That could be something maybe that gets folks together. But there's other revenue increases that are out there. But the financing of it – that financing, plus some additional new revenue.

And then also you got to think infrastructure over the horizon. You know, as we go to wireless cars, VMT - vehicle miles traveled - the whole electronic vehicle, how you're going to do a user fee based on that model, there's some legitimate conversations going on how to take care of that revenue that could be included in the conversation.

MR. RUBENSTEIN: Final question for you, Tom. You are the youngest of 12 children. What is it like to grow up with 11 siblings? I had none. And how many nieces and nephews do you have now? And can you remember their names?

REP. REED: I am not going to hazard a guess to know all their names. And they keep popping, the nieces and nephews. So it's tough to keep track of that number. But you know, I guess it's a little bit like being in Congress. I guess that's what served me well, is mom always told us, you know, when you guys fight – and we have family fights, it's just like in Congress right now – it's just, you kids figure it out and get the job done. And so how we always got together was, you know, we always loved each other. We fought, but we always loved each other at the end of the day. And that's what made us work. And you never knew any different. I wouldn't change it for the world. It was a happy household.

MR. RUBENSTEIN: OK. Debbie, final question for you. Right now the Congress is in sort of a lockdown so visitors cannot come in. How can the Congress survive without lobbyists coming up, being in Capitol Hill? How are you able to cast legislation without lobbyists coming around and lobbying?

REP. DINGELL: I don't want to insult the members of the Washington Economic Club, but it's been kind of nice and quiet. [Laughs.] But the fact of the matter is, is that when we're working on bills we're talking – I mean, you know, I don't think of lobbyists as evil. I think of them as sources of information. And we all study. We want to get all the background information. I miss seeing people. I'm a – everybody who knows me knows that I'm at 18 events a day. I like – and I like to dig in. I'm a person that digs in. So I miss seeing people on the Hill. But I want us to be safe on the Hill as well. So it's good to see everybody virtually. And I'm always available for a Zoom.

MR. RUBENSTEIN: All right, Debbie and Tom, thank you very much for your time and your service to the country. Thank you. Stay safe.

REP. DINGELL: You too. Thank you, David.

REP. REED: Thank you, David. Thanks, everybody.

MR. RUBENSTEIN: OK. So now we have three medical experts. Let me introduce them again. Kim Horn, who is the executive vice president and group president of markets outside of California for Kaiser Permanente. She's finishing up her first year in that position, but previously headed the Mid-Atlantic region for Kaiser Permanente. And then we have Ken Samet, who has been from 2008 the president and CEO of MedStar Health System in this region. And then Steve Jones who has, for the last three years, been the president and CEO of Inova.

So why don't we just start, and Kim I'll start with you. How – are the hospitals being inundated today with COVID-19 patients? Are your ICUs at capacity? And how bad is it if you come into the hospital today to get first priority treatment for COVID, if you have it?

KIMBERLY HORN: Yeah. So it really varies across the country, David. It's – in terms of the infection rate and hospitalization rate. We just came off from the – arguably the largest surge in the country outside of New York, in southern California most recently. And where ICUs were way past capacity, you know, and as well as our hospitals. And so it was enormously difficult. And I – you know, it's just remarkable how the health care industry and our workers just responded to that. I mean, it was – you know, it – day in and day out, working incredible shifts and, you know, that sort of thing.

So thankfully, knock on wood, we're seeing a little bit of a decline, you know, in the surge that's occurring, particularly in Southern California. But, you know, we're seeing really high hospitalization rates still in places like Atlanta. And even in the Mid-Atlantic, in Virginia and Maryland in particular, you know, we're not out of the – out of the woods yet. So, but it has been – it's very interesting how, you know, the surge has impacted different parts of the country at different times.

MR. RUBENSTEIN: Well, in the beginning of the pandemic there was a shortage apparently of ventilators and PPE. Is that still the case? Do you have the masks you need, the gowns, the other equipment? Or is that still a bit of a challenge?

MS. HORN: No, I mean, that – you know, in the very beginning, you're absolutely right, it was all around, first of all, understanding what kinds of masks that were, you know, effective, and having ventilators, and that sort of thing. So we've got that under control. Now it's staff. That's our biggest issue. And you know, so many people have been impacted by COVID. We're not able to get travelers – you know, health care traveler workers where there's peaks. And so that's a major, you know, issue.

And so right now – and not just the surge, you know, taking care of COVID patients, but even as we think about the vaccination, you know, this phase – hopefully the final phase of COVID, you know, preparing for mass vaccinations, having enough staff and – you know, to be able to do that. And that's really why – I mean, particularly with my colleagues here – why it's so important that we work together with public health and the private sector and the health care industry to really get organized around mass vaccination.

MR. RUBENSTEIN: OK. Ken, in your – at MedStar, are you having a – do you have enough ICUs and enough equipment to deal with the COVID patients that are coming in? Or are the COVID patients coming in going up or going down in terms of their coming into the hospital now?

KENNETH SAMET: So I'd say for the region we're in now, thankfully, the last two weeks we've seen a bit of a downturn, which is really good. Coming out of the Christmas holiday we did see a surge. We went up, at MedStar, to about 650 COVID patients across MedStar two weeks ago. We're down to about 540 today. So that's really good. And if I tied that 650 back to the spring when we had that surge, the initial surge, we were at about 725. Which, interesting in the region is, in the spring Montgomery and Prince George's County were 50 percent of all of the COVID hospitalizations in the state of Maryland. That was the epicenter. So for hospitals in our region, combined with the District of Columbia and Northern Virginia, we saw a more significant load of COVID patients. It's been spread across the state differently this time, which has helped in our immediate – in our immediate area.

But the big difference right now, and I'd connect to Kim's point on staffing, PPE, and ventilators, and all of those issues are not the issues for MedStar, Inova, and the big systems here. Staff is the issue. To Kim's point, we're not able to get travelers from across the country, but also we're not cancelling elective cases. And elective – and I know we'll all talk about that – is really a big definition. So let's make that non-COVID cases – cancer, cardiac, a host of other cases that got cancelled in the spring. That actually let us have more staff internally but was a really bad decision relative to trying to take care of our patients who needed care. That's not happening today. We're fighting very hard to take care of COVID and non-COVID patients, which stresses staffing all the more.

MR. RUBENSTEIN: OK. Steve, let me ask you a question about Inova. So how is Inova doing in terms of too many patients coming in for COVID-19 treatment? And let me ask you, you're a doctor, if you got COVID nine months ago and came into your hospital did you get better

treatment then than you're getting now, or better treatment now than you got then because we know more?

J. STEPHEN JONES: Getting unequivocally better treatment at this point. We know a lot more. Even to your question on ventilators, initially we were – had patients on ventilators that we learned subsequently probably we, across the country, across the world, were using ventilators too early, because that was the traditional way that you took care of patients with serious respiratory diseases. At this point, we do almost everything we can to keep patients off the ventilators. So we've got hundreds of extra ventilators around. But it goes to even the pulmonary care and the positioning of the patients. And we now have some therapeutics – both in-patient and out-patient therapeutics. So your care now is exponentially better than it would have been even nine months ago. The mortality rates have dropped dramatically as a result of that.

MR. RUBENSTEIN: And what about the therapeutic that President Trump got when he went to Walter Reed. It seemed to be, like, a miracle drug. Maybe there's some side effects, but it seemed like a miracle drug. Is that something that you can readily give people, or is it only experimental still?

DR. JONES: Well, it's under an authorization so not fully approved, but we are using it on a routine basis. We've given that, those drugs – there's two – we've given to over 800 patients at this point. We're now giving them even in our emergency department. So as opposed to being diagnosed and set up a day or two later for the infusions, we're routinely pulling patients right down the hall and giving them the infusion right there, so you get the effect immediately. The results are a little bit controversial, if you look at the studies, of how much their impact is.

But from those results and from our own experiences we believe that we're keeping patients out of the hospital, for sure – not all patients, of course, unfortunately. But importantly, even if we don't keep them out of the hospital, if they eventually end up in, their disease course appears to be less severe than it would have been otherwise. So we're very enthusiastic on these at this point. We're going to continue to study them, and that may evolve. But at this point, we're being fairly active in their use.

MR. RUBENSTEIN: OK. So I – this morning I got my maybe 10th test for COVID. And all 10 have been negative. And the tests are a little bit less painful. They used to put the stick all the way up to your brain, now not quite as bad. But let's suppose it turned out positive. Should I rush to a hospital and say: Put me in the ICU, because I turned positive? Or what should somebody do if they turn – they have a positive rating that comes back from one of these tests?

DR. JONES: Unless they're acutely ill, they should stay home and quarantine. And when we say "stay home," for some people they can't, of course, distance and quarantine well if they live in a house with multiple people. But keeping distance and not rebreathing air is really critical to that. Only if you really get to the point where you're having breathing or other difficulties should you go to the hospital for evaluation. And not even assume you go in, but again you might have an infusion as opposed to have to be admitted. But importantly, the infusions need to be in the early days. You can't, you know, be two weeks in and think that they're going to have any impact.

MR. RUBENSTEIN: OK. Kim, let me ask you this. How do I get vaccinated in this area? I don't have a vaccine. I'm in the – the private equity profession doesn't seem to be at the top of the list of people that deserve to get vaccinated first. So how easy is it to get vaccinated? Do you have enough supplies for all the people who show up? And how do you decide who gets them?

MS. HORN: OK. So let's start with the supply, first of all. And so every one of our locations across the country, including here, you know, were approved vaccination sites. And we've been very proactive in identifying, based upon the jurisdictions, you know, guidelines of what age, 1a, 1b. But quite frankly, we've given about 29,000 vaccines so far in this region – Kaiser Permanente. And it's just really a fraction of what, you know, the universe of people under certain guidelines would entail. So – and that's just true across the country.

You know, and in – so, you know, the availability of vaccine supply is critically important, you know, to – you know, to this. And the second is, once we have it, then, you know, given the numbers of people that we need to get through the vaccination is something we really need to work on, I believe, mass vaccination sites and strategies. Where we're being very planful about the number of people that we need to vaccinate, locations. We got to think about space. You know, you have to have enough for social distancing as well as, you know, people need to stay around for a while to be observed. And you know, literally we have millions of people that need to get vaccinated.

So, no, we don't have enough vaccine. We're optimistic. And we're planning. As soon as we get it, it's – like, within – you know, we're scheduling people immediately. And there's never, you know, vaccine that isn't used or put into an arm, you know, as soon as possible. So a lot more work on logistics, vaccination supplies, and a really huge opportunity in this region to do coordinative efforts, you know, across the region and within jurisdictions to work together and – you know, on these strategies.

MR. RUBENSTEIN: Based on what you've heard, if I have a choice of using Pfizer or Moderna does it make a difference, if somebody said which one do you want? Or they're both the same, pretty much.

MS. HORN: I would say that there is no difference at all. Just make sure that you get the vaccine. They're both – there's no indication that one's more effective than the other. What we do try to do is to make sure that each – whatever your first vaccine is, that we're consistent, you know, with the second vaccine. So that's just part of the scheduling logistics challenges, that we get people back in for their subsequent vaccine with the same – either the Moderna or the Pfizer.

MR. SAMET: Hey, David, could I just jump in for a second? Because I think what's behind your question that certainly is one of the biggest frustrations for all the citizens, and it is absolutely the biggest issue for Stephen and Kim and me and our colleagues, is it's the lack of understanding of predictable level of supply that we will receive on a weekly basis, if we understood the schedule. And that's true for America. And it's about leadership, because if we actually said to the country: This is what we have, this is what the supply line looks like, this is how it will roll out.

After that moment, once we know that number, it's a math equation to then design distribution at the mass level, at hospital levels. And we can work within the guidelines of who can actually get a vaccine. But because there is a false set of expectations, fed by a lot of communication and conversation over time on this, people think actually – every 58-year-old friend and 65-year-old friend I have can't believe they don't have a vaccine on January the 27th. And it was only December 11th that the first EUA for Pfizer came out, December 18th for Moderna. If you think about that, we were never going to be in that moment unless somehow there were 200 million vaccines coming off the line.

So we need a reset. And then we really do need to understand in a predictable way what we – Inova, MedStar, Kaiser – what will we get? And then we can actually work directly with our patients, whether they're in private equity or not, to actually tell them: Register. This is when you'll be able to get a vaccine. And this is what you need to do until then, which starts with wearing a mask.

MR. RUBENSTEIN: Well, Ken, let me ask you this, are people calling up and saying they're having a health care emergency, they have to get it, even if they're not otherwise qualified? Are people coming in with fake IDs about their age? Are people cheating in some ways that is very discernable to you? And all of your health care employees, have they been vaccinated yet?

MR. SAMET: So I would say that overwhelmingly people are trying to do the right thing. There's always examples, and we all see them at times in the news, that some would try to cheat the system. That's not the overwhelming issue. We are getting tens of thousands of people reaching out asking how they can get a vaccine. As it relates to our – to MedStar associates, 31,000 associates. Sixty percent have – they've all been offered. Sixty percent have taken the vaccine at this point.

But, as my colleagues could talk about, the real important part of that story is the variability that happens with the diversity of our – of our associates. And people of color are taking it at much lower percentages than our general associate population. That is also playing out true in our region. If you look at the rates in Prince George's County being different than Montgomery County. It's really not a good thing. It's an education, it's a trusted voice issue, and we all have to do the best we can on that.

MR. RUBENSTEIN: OK. Stephen, what about in your organization? Do you have enough supplies, or are people standing in line? Have all your health care employees been vaccinated? Have you been vaccinated?

DR. JONES: I have been. I'm a practicing physician, so I've been vaccinated on the second say that we had access. All of our employees have had the opportunity. We've had probably about 60 percent uptake, similar to what Ken just described. We see a disproportionate hesitancy among many members of our Black and brown communities. Our inclusion council took this on before the vaccines even arrived, to address very legitimate concerns on vaccine safety and effectiveness. And fortunately we're seeing that break down, but break down nowhere near as fast as it should.

MR. RUBENSTEIN: And now, you've been vaccinated. Did you have any side effects?

DR. JONES: I had zero. I have certainly spoken with others who have had some side effects. But similarly, when I had my Shingrix shot, which is for shingles, I had a significant reaction. I felt bad for about 36 hours, and then I felt good knowing that for the rest of my life I was protected. Even for those individuals who have responses to these current vaccines, or any that come forward, even if they have those responses they should feel very good about the fact that they've gotten 95 percent protection against one of the most horrific diseases that's come along in our lifetime.

So it's absolutely worth it, even if you have the side effects. But most people don't. I tease that I go through the area where people are waiting the 15 minutes after their vaccine every day. And it's the most boring part of my day because most people are sitting back there simply waiting for when they're told that they can leave the building.

MR. RUBENSTEIN: So you're a medical doctor. Tell me the answer to this: Let's suppose I get the first vaccine, but then I – you know, I just never get around to getting the second one, or I don't get it for a long time. Is the first vaccine therefore useless at that point?

DR. JONES: We don't know the answer to that. There's a lot of hypothesizing going on on that topic. You know, we tend to be very diligent at Inova at focusing on the science. And the science indicates that you need both of those doses at the timetable that the studies showed. We may – again, science evolves, and we find out. We may find out differently in the future. We so far found that 95 percent of folks do come back in that window. And interestingly, if they don't come back in that window, at least through, again, a very short period of time, they don't appear to come back. So about 5 percent are choosing not to come back. We don't know why, and we'll continue to look into that. But that's unfortunate.

MR. RUBENSTEIN: Suppose somebody calls you up – and has this happened – says: I'd like to make a contribution to your – something, part of your hospital system. Here's some money. By the way, could I get a vaccine quicker? Does that work?

DR. JONES: It absolutely will not work. And I think that the one good thing across the country, I think we've seen extremely few instances of that. And people often ask, well, you know, why can't I get – you know, everybody wants to be next. And I say, call my own wife and ask her, because she's not eligible yet. The first time she's eligible, and there are doses appropriately available, she'll be in line. But right now I think we've done a good job as a country of largely avoiding that skipping in line concept. You'll never get completely away from it, but I think we've done a great job across the country.

MR. RUBENSTEIN: OK. Kim, let me ask you, in your case, at your hospitals, who pays for all this? Do I just show up and – if I walk into Kaiser Permanente and say: Guess what? I'm a Kaiser Permanente member. I'm 65 or older – or 70 or older, whatever the age is. And then they just stand in line? How do you get in line? And how do you decide who's going to get, and who's actually paying for it?

MS. HORN: So, first of all, you know, it is free to the public, right – members of Kaiser Permanente and non-members of Kaiser Permanente. We're an approved provider in all locations, and we've – in our case, we're – we take non-members and members, but for our members we have – we actually do reach out to them. And so we know, you know, their age,

their comorbidities, often their occupation. Sometimes they call in to us and we put them in a – you know, kind of a standby list depending upon, you know, how we're – you know, the phasing of vaccination in each one of the jurisdictions. But if they're not – if they're not coming in or calling, we're reaching out for – you know, to get people vaccinated, get them scheduled.

But getting back to what Ken had mentioned, the really frustrating thing is – you know, because people – this is a – this is a, you know, high anxiety. There are some weeks we get in 60,000 doses of vaccine. And so we schedule – you have to schedule ahead. And then that next week you've got people scheduled, and then you find out you don't – you know, you have a fraction of that, you know, dosage. So that – so it is a – you know, as soon as we get the vaccine we've got people in queue, I would call it, and ready. Because we've got to make sure that it doesn't sit around and that we get as many people vaccinated as possible. So we are keeping a standby list of people who are either calling on, or who we know meet the criteria, you know, based upon the phasing in jurisdictions.

MR. RUBENSTEIN: Now, in testing, when I've been tested, like 10 times, usually people, they want to put something up my nose, and so forth. And I always like to ask them, as a courtesy, how long have you been doing this and what were you trained as? And you get a varying number of answers. And they seem to be doing OK. But who actually is trained to put the needle in your arm? Do you have to be a nurse to do that, or can you train non-nurses to do that? And should I worry that they're going to put the needle in the wrong place, or something?

DR. JONES: I think it's important that we address that, David. It's a real issue, because we have lots of people who right now we need in the intensive care unit or in the emergency department, but unfortunately they're in the vaccination centers. And so I would, at least during the current emergency, advocate that we allow other folks – physical therapists, occupational therapists, and medical assistants – those are all totally capable of doing that. And a clarification at a federal and state level I think would be helpful to expanding the number of people who can do that.

MR. RUBENSTEIN: But is it hard to screw up putting the needle in the arm, or does it take a lot of training to do that? I don't think I could do it, but how long does it take to get trained to do that?

DR. JONES: I think I could teach you in about three or four minutes.

MR. RUBENSTEIN: Yeah, but you've never seen my physical capabilities. It would probably take a couple hours, but OK.

MR. SAMET: I'm going to jump in and say, to Stephen's point, we had actually delivered a quick simulation training model. It's literally six minutes, with the introduction, because medical students, nursing students, and ultimately the National Guard tied to big scale-up sites. This isn't complex medicine. We just have to get people ready for that, because the staff really does need to be taken care of. They do need to be taking care of the COVID patients and non-COVID patients in the hospitals.

MR. RUBENSTEIN: So, Ken, let me ask you this. What about the new strains that we're hearing about coming from South Africa, England, Brazil? Do you see evidence in your hospitals yet of a new strain of COVID-19, or whatever we're calling it, or you don't see it yet?

MR. SAMET: So we see the early signs of that, and we test for that. We haven't seen the South African piece. But I think it would be silly – as you're hearing from the national leaders and Dr. Fauci – it would be silly to assume they're not all here in the United States. And they'll have implications for us. I don't think we should go to the panic stage of saying: So don't get a vaccine because they won't be worthwhile, they won't be beneficial. They'll be beneficial from everything we're hearing. We'll find out about the efficacy on that. But even if it somehow took efficacy to 70 percent from 90, we need to do that. It is far better.

But the other thing that is so important about these variants is they transmit quicker. Which means we have to do everything possible not to let that happen. That means take vaccines when you can. And it definitely means – we have to keep beating this drumbeat – wear a mask, social distance, be smart. We can control this. And I know this has become a political issue, but it's absolutely not. It's the simplest science that there is. We'll save lives while we're getting to, hopefully, some community immunity. It is so important. And yet, for some reason, still seems to be a debatable point for some people.

MR. RUBENSTEIN: All right. Let me ask a medical question again to Stephen. If I've had COVID-19 – and some members of my family have had it – should I get the vaccine or should I say I don't need it, because I already have the relevant antibodies? What should I do?

DR. JONES: Current science would say that for at least 90 days you've got protection. The number of people who've had COVID and then have had COVID again is very low. And to my knowledge, no one has had severe COVID after an initial case of COVID. So there's a lot of protection there. So our recommendation is that people wait. And in that 90-day window if they're eligible, go ahead and get their COVID vaccination.

MR. RUBENSTEIN: And, Kim, in all the hospitals that you are involved with around the country is there an advantage to living at one state versus another state to get treatment or to get the vaccine? Or should I forum shop? Should I say – let's suppose I have five different homes – which I don't have – but if I had five different homes, can I use one of those homes as the place to go to the right place to get the vaccine? Are people doing that? Or is there an advantage to doing that?

MS. HORN: So I have heard people, you know – you know, contemplate that. And first thing I would like to say, that if – you know, if you're eligible and there's – there are lots of different providers of vaccine. You know, that we're really encouraging people to – you know, to get vaccinated wherever they can if they're eligible. So there are different – you know, interestingly enough, across the country, the allocations are not consistent per capita. And so we're hoping that changes. That – you know, so we're finding some places in the country – none of them have enough.

So let me just say that. There's no place that I'm aware that would say, oh, we've got it all. Don't worry about us. But there is varying degrees of allocation by state. And I think we're all really hopeful now with a more concerted, planful COVID response that the allocation will be

predictable, as Ken had said, and then the allocation methodology, you know, will have – you know, take into account, you know, the numbers of people that are eligible in each of the phases.

MR. SAMET: So, David, I'd just add, though, that question's really important for The Economic Club members listening in this region, because we obviously have a tristate area. And as it relates to who can get vaccines, right now we have three different sets of rules. So Virginia's in a certain place, D.C.'s in a certain place, and Maryland's in a different place relative to age, relative to other comorbid conditions and can they be considered. But yet, we take care of patients – all three of our organizations – who live in all three jurisdictions.

And so this gets back to the need to ultimately have a federal plan, because we – it's so hard to tell a patient, for us, that lives in Northern Virginia: We can't take care of you yet because it's a jurisdictional issue. The same would be true in reverse for Stephen, of course, for a patient in Maryland. So I'm hoping that we can get that complication out of the way, and then we can prioritize those patients that actually need the – the limited vaccines we have at the highest level.

MS. HORN: Boy, if we could do that, that would just alleviate so much of the anxiety and angst that – and the resources that it's taking within the health care system to try to sort that out. You know, we have – we have members and patients in all three jurisdictions. And the – you know, the methodology that we have to use – and it changes, you know, in terms of how we're queuing up people and notify them, this is really, really important. And something, if we don't get it at the federal level, I would argue maybe it's something we can do in the region, just given the metropolitan, you know, regional nature of our region.

MR. RUBENSTEIN: So, Kim, in your organization, since COVID has started, has it cost you a lot of money? Have you made some more money than you thought? Or did you basically break even on COVID – on the overall financial situation, because of federal reimbursement or whatever? Or you lost money because you couldn't do elective surgery? How do you calibrate what the impact has been on your organization?

MS. HORN: Well, you know, I think it's cost all of the economy, not just health care. And but I would say different parts of the country it's impacted differently. But overall, I mean, it's been a huge economic drain, you know, on all of our organizations. Preparing for the surge in the very beginning, taking care of patients. Ken had mentioned that we had to delay in the very beginning – we didn't know if we'd have enough beds, and then the transmission of COVID. So we cancelled not just elective procedures. I would say those things that could be delayed or kind of put off, that were not urgent.

And then once we brought back on, then we had to get enough staff. And, you know, and run, you know, even at greater capacities. And so that – and now we're – and then with the testing. So the testing, you know, cost. And now we're in the phase of finding enough staff. So we're getting the vaccine. We're not paying for the vaccine. But we're paying for the distribution – the actual administration and scheduling, and many other kinds of things. So it's been – you know, it's been taxing on the health care industry, no doubt about it.

MR. RUBENSTEIN: So, Stephen, I have all the body parts that I was born with. I don't have any artificial ones that I'm planning to get. But let's suppose I wanted to get an artificial hip,

just because all my friends had them. I want to get one. Is now a bad time to come in and get one? Because I might be afraid that I'm going to get COVID in one of your hospitals. Is there a risk that somebody comes in for elective surgery, unrelated to COVID, and he or she comes down with COVID because you're not adequately able to protect?

DR. JONES: It's important – that's a great question, David. That originally when we saw some of the terrible things that happened in New York and Italy, where there weren't protections, there's no doubt that there was significant transmission of COVID, both to the team members who were providing the care and potentially to other patients. But we know now how to prevent transmission of this disease. Ken's already mentioned several of them here – with masks and distancing. They're not rocket science, but the science supports that they protect us. There's a way that we know that.

So for example, you know, we've had about 10 percent of our employees at Inova who have had COVID. Which sounds like a big number, until you see that the CDC said back in November – some months ago – that 15 percent of all Americans had COVID. So there's this concern that the hospital's the place where COVID is. The hospital's the one place in the country that's actually adequately protecting ourselves from COVID. And so you should absolutely get the necessary medical care – none that's unnecessary, of course – but the necessary medical care.

In fact, we saw tragedies across the country that – where people withheld care, sometimes because perhaps the industry was forced to hold it back, perhaps because people were afraid. And we know that the number of actual deaths has been higher than the number of COVID deaths in these last 10 months. Well, part of that is unequivocally due to delaying necessary medical care. So we would feel very strongly, you are safe – at least as safe in the hospital or health care setting as you are anywhere else that you go.

MR. SAMET: And, David, if I could just add to Stephen's comment, because I think it's really important. Because the communities have to see hospitals as safe zones. And it's been proven. So even with Stephen's numbers on the percentage of Inova associates that became positive, similar across the region. Inside his hospital, I venture to say – and I know it's true at MedStar – the transmission rate between patient and associate in the hospital is actually less than 1 percent.

Our people who are getting sick – or, getting positive, they're positive from the community. We're not seeing transmission because, as Stephen said, of all of the protections. Everyone is conscious of creating that safe zone in the hospital. So if you have needed care, you absolutely should be doing that. And I think that's a really important message that nobody should hear differently relative to seeking care when you need it, in a physician's office or whatever it might be.

MR. RUBENSTEIN: So what's been the impact, Ken, on your organization financially? Have you lost money from where you would otherwise be because of COVID?

MR. SAMET: Yeah, significantly. Again, part of our – part of our mission to do all the right things and worry about – as Steve and I talked with you about and The Economic Club about, back in April. It is the single biggest financial crisis in the history of America's hospitals. And we went all in to do the things that the community expects us to do and needs us to do. To give

you some numbers, in our Q4 – so, in Q2, the spring of 2020, we projected a $3-400 million deficit at MedStar. Took a bunch of management interventions on both the expense and revenue side. And let's say for rounding that was a $200 million number in Q4. This is all without CARES and support that comes from the government.

When we looked at this fiscal year for us, July 1 – and we're obviously now into two quarters of that – another $100 million worth of impact from the expenses that Kim talked about to take care of all the issues related to COVID. And we're still seeing – even though we haven't stopped doing non-COVID cases, none of us are back to historical levels, for a host of reasons. So, again, that's a $300 million number before what might come from the government in support. So it's a significant issue.

MR. RUBENSTEIN: So, Ken, somebody once said: Anybody who wants a test can get a test. Is that yet the case? Can anybody get a test today? And if I want a test, what do I do? I just show up at your hospital and say: Give me a test?

MR. SAMET: Yeah, I don't think testing any longer is the issue. So for MedStar, if you have – if you have a symptom – if you're symptomatic you can show up at our urgent care centers, at our E.D.s. Obviously, you can go to all the primary care physicians. If you simply want a test, though, there are major drive-through scaled-up sites all over the region. Getting a test is not an issue.

MR. RUBENSTEIN: OK. Stephen, I may ask you, if I get positive on my COVID test, which I haven't had yet – I mean, I haven't been positive yet. And you say I should quarantine at home if I don't feel too bad. What should I do when I'm quarantining at home? Should I drink a lot of water? Should I drink a lot of Diet Coke? Should I – should I, you know, go to McDonald's and get things delivered? Or what should I eat that's going to make me recover more quickly? Anything I can do to help myself recover?

DR. JONES: At this point there's nothing other than just taking the normal good care of yourself and staying away from others in that period of time where you are potentially transmitting. Because we still don't understand why so many cases are mild and so many cases are severe or fatal. And so staying away from other people is the only advice I would give you in that window.

MR. RUBENSTEIN: OK. And have you had a vacation since COVID started? And are you planning to have a vacation ever? Or when are you going to get your next vacation?

DR. JONES: So my wife and I drove to Maine and rented a cabin on the water back in early September. It was a great week for us. I currently am scheduled to go skiing in about six weeks. And a lot of that will be, one, is I'm vaccinated. Two will be what happens between now and then. We fortunately are seeing the COVID cases going down pretty significantly. But it's always easy to predict the past, not as easy to predict the future. And so whether I actually go hit the slopes, I haven't bought my ticket yet.

MR. RUBENSTEIN: So what's more dangerous? Going there without – with your being vaccinated but everybody else might not be, or just skiing? Is that more dangerous for you?

DR. JONES: [Laughs.] I'm a pretty safe skier.

David, there's one thing we haven't talked about I think is worth talking about. On vaccine availability, though, one of the things that hasn't been discussed nationally is the fact that we're throwing away a lot of vaccine in the bottom of the bottles. And I think it's time for us to look seriously at that. You know, our pharmacists have looked at it and been able to get about 8 to 10 percent more dose out of the bottles. Right now we're not allowed to do that, but my understanding it's being looked at that we would potentially be able to do that. You know, that's – you think those drops in the bottom don't matter, but if you can get even 5 percent more, that's pretty significant on the number of Americans that need to be vaccinated. That's one that I hope will be taken into consideration as well.

MR. RUBENSTEIN: Now, I know that it's being looked at and so forth. So have you ever talked to Dr. Fauci about this? Do you think he's, you know, basically feeling a little bit better today than he was a couple months ago?

DR. JONES: He looks like he's doing well. I haven't spoken specifically with – on that topic with him, but I have had the opportunity to speak to him a couple times during this. And I, as always, appreciate his leadership.

MR. RUBENSTEIN: OK. So I think we're out of our time. And I want to say to all of our guests – Kim, and Stephen, and Ken – thank you very much for giving us this information. I assume if anybody has any health questions they should go to one of your three organizations, and no other organization, is that right?

MR. SAMET: Exactly. [Laughter.]

MR. RUBENSTEIN: OK. Thank you all. Thanks very much for participating.

MS. HORN: Thank you.

The Honorable Debbie Dingell
Representative for Michigan's 12th Congressional District

Congresswoman Debbie Dingell represents the 12th District of Michigan in the U.S. House of Representatives. Before being elected to Congress, Debbie was the Chair of the Wayne State University (WSU) Board of Governors. An active civic and community leader, she is a recognized national advocate for women and children.

For more than 30 years Debbie served one of Michigan's largest employers, the General Motors (GM) Corporation, where she was President of the GM Foundation and a senior executive responsible for public affairs. In her commitment to job creation, Debbie led the effort to bring the 10,000 Small Businesses initiative, a $20 million partnership designed to help create jobs and economic growth, to southeast Michigan. She is a past chair of the Manufacturing Initiative at the American Automotive Policy Council.

With values instilled by her Catholic education, Debbie's activism took root in her passion for issues important to women and children. She successfully fought to have women included in federally-funded health research, and advocated for greater awareness of issues directly related to women's health, including breast cancer and women's heart health. She is a founder and past chair of the National Women's Health Resource Center and the Children's Inn at the National Institutes of Health (NIH). She has served on numerous boards related to women's issues including the advisory boards for the NIH Panel for Women's Research, the Michigan Women's Economic Club, the Susan G. Komen Foundation, and the board of the Michigan Women's Foundation. She was a co-founder of both the first Race for the Cures in Michigan and in Washington, D.C.

Debbie has led a number of efforts and initiatives related to young people and education stemming from her role as a WSU Governor and co-chair of the Children's Leadership Council, a business-led advocacy group that promotes investment in early childhood education. She chaired the Michigan Infant Mortality Task Force, the Baby Your Baby public education campaign that reduced infant mortality rates in Michigan, and has served on the board of Michigan's Children, the only statewide independent voice working to ensure that public policies are made in the best interest of children from cradle to career. She was appointed by Michigan Governor Jennifer Granholm to serve on the Early Childhood Investment Corporation and the Cherry Commission on Higher Education and Economic Growth.

Much of Debbie's recent work has been focused on ethical issues and social responsibility as they relate to government and business. She co-chaired One United Michigan, which sought to preserve and support programs that ensure equal opportunity in Michigan. She chairs the Metropolitan Affairs Coalition, a statewide organization that brings business, labor and government together to find commonality on issues. She continues to serve on the Parade Company board of directors of which she is past chair, where she helped save America's

Thanksgiving Parade, an important Detroit tradition. A known "bridge-builder," she continues to promote and lead efforts toward greater understanding among people of differing points of views and backgrounds.

Debbie is a respected voice in Michigan. She co-hosted Detroit Public Television's "Am I Right," regularly served as a panelist on "Flashpoint," a public affairs program on WDIV-TV4 Detroit, and was named one of the 100 Most Influential Women in Michigan by Crain's Detroit Business.

Debbie resides in Dearborn. She holds both a B.S.F.S. in Foreign Services and an M.S. in Liberal Studies from Georgetown University.

The Honorable Tom Reed
Representative for New York's 23rd Congressional District

Tom Reed, the youngest of 12, was raised by a single mother on a social security check. His father, a decorated career military officer, died when he was 2 but Tom still learned from his legacy of service and loyalty.

These ideals inspired Tom's mission to help people in need.

Before going to Congress, Tom was the mayor of Corning, the town where he was raised and still lives today with his wife Jean and their two children Autumn and Will, under the roof of the home his grandfather built.

As the mayor of his hometown, Tom learned potholes and parking tickets are not partisan issues and that is the approach he brings to Washington.

He co-chairs the Problem Solvers Caucus – a group of 24 Republicans and 24 Democrats who meet weekly to solve some of the most contentious issues facing our country today.

Tom remains committed to being accessible and help anyone in need. He and his team have completed more than 13,000 constituent cases, resolving issues with the Internal Revenue Service (IRS), Veterans Administration (VA), Social Security Administration (SSA) and other federal agencies. He has also held more than 250 public town hall meetings to listen to the thoughts and concerns of his constituents, earning him recognition as one of the most accessible members of Congress.

A former All-American swimmer, Tom graduated from Alfred University in 1993 and from Ohio Northern University College of Law in 1996.

He currently serves on the influential House Ways and Means committee as the Republican Leader of the Social Security Subcommittee.

Kimberly K. Horn
Executive Vice President and Group President
Markets Outside California
Kaiser Permanente

Kim Horn is executive vice president and group president for markets outside California for Kaiser Foundation Health Plan, Inc. and Hospitals.

In this role, Horn is responsible for Kaiser Permanente's strategy, operations, and growth for markets outside of California. These markets include 199 medical facilities and 3 million members.

Horn reports directly to Kaiser Permanente's chairman and chief executive officer and is a member of the National Executive Team.

Prior to her current role, Horn was the president of Kaiser Foundation Health Plan of the Mid-Atlantic States. In this role she oversaw all care delivery and health plan operations in the District of Columbia, Virginia, and Maryland. The Mid-Atlantic States Region operates 33 medical centers and serves nearly 775,000 members. During her tenure, Horn’s focus on ensuring people received an unparalleled health experience helped Kaiser Permanente significantly grow membership and become the largest integrated health care organization in the region.

Prior to joining Kaiser Permanente in October 2012, Horn served as president and chief executive officer of Priority Health, based in Grand Rapids, Michigan. During her 15-year tenure as CEO, the organization grew from 100,000 to nearly 700,000 members and expanded its reach across the state of Michigan. Priority Health consistently delivered high-quality market-leading health solutions and was known for its community and health system partnerships.

Throughout her career, Horn has been active in many community, philanthropic, and industry endeavors. She is a past chair of the Greater Washington Board of Trade and currently serves on the board of The Economic Club. Among the many organizations with which Horn has been involved are the Washington Area Women's Foundation; the Alliance of Community Health Plans; and the Michigan Association of Health Plans, where she served as president. She also served as a director and chair of Tomorrow's Child for more than a decade. Tomorrow's Child is an organization that provides services and programs to prevent infant mortality and support families who have experienced a pregnancy loss or infant death.

Horn is a graduate of the University of Michigan.

J. Stephen Jones, M.D.
President and CEO
Inova Health System

J. Stephen Jones, MD, is President and CEO of Inova, the Washington, DC region's leading not-for-profit healthcare system serving more than 2 million people annually in its five hospitals and numerous ambulatory programs. He is also Professor of Urology at the University of Virginia, which is working with Inova to bring undergraduate medical education and expanded research to the flagship Inova Fairfax Medical Campus.

Stephen previously served as President of Cleveland Clinic Regional Hospitals and Family Health Centers. He also served as Professor of Surgery at Cleveland Clinic Lerner College of Medicine at Case Western Reserve University. He was previously Department Chair and held the Leonard Horvitz and Samuel Miller Distinguished Chair in Urologic Oncology. This endowed chair has now been renamed the J. Stephen Jones Distinguished Chair in Urology Research, and is to be held in perpetuity by the sitting Cleveland Clinic Urology Department chair, currently Dr. Georges Pascal-Haber.

Stephen earned a Bachelor of Science degree in Zoology at the J. William Fulbright College of Arts & Sciences at the University of Arkansas and his medical degree at the University of Arkansas for Medical Sciences (UAMS). After residency at Vanderbilt University, he joined the Springfield Clinic/St. John's Health System in Missouri. Under his chairmanship, the Department of Urological Surgery became the highest rated community urology program in America, according to U.S. News & World Report in 1999.

He has published over 200 peer-reviewed manuscripts and over 40 book chapters. The American Urological Association named him the next Editor of its journal, Urology Practice, in 2018. He has previously been Editor of Urology & Kidney Disease News, Associate Editor for Renal & Urology News and Urology, and has served on the Editorial Board of BJU International, formerly British Journal of Urology. He has published two books for the lay patient population and is editor of five medical textbooks. In 2010, Stephen earned the distinction of admittance to Beta Gamma Sigma, the International Business Honor Society, as one of the top-achieving 20% of business school graduates in the nation upon graduation from the Weatherhead School of Management at Case Western Reserve University.

Castle Connolly consistently lists him as one of America's Top Doctors, signifying the top 1% of all cancer physicians in addition to the top 1% of urologists in the nation. He also was elected to the AMGA (American Medical Group Association) Board of Directors in 2015 and its executive committee in 2018.

Kenneth A. Samet, FACHE
President and CEO
MedStar Health

MedStar Health President and Chief Executive Officer Kenneth A. Samet is responsible for a $5.8 billion not-for-profit, healthcare delivery system. With more than 35 years of experience in healthcare administration, Samet provides strategic oversight and management for MedStar Health—the largest healthcare provider in Maryland and the Washington, D.C., region, comprised of 10 hospitals, a comprehensive network of health-related businesses that includes ambulatory, home health, a large multispecialty physician network, and an insurance product with approximately 94,000 members. MedStar Health has large research and innovation platforms and one of the largest graduate medical education programs in the country. In addition, MedStar Health is one of the region's largest employers, with more than 31,000 associates and 4,200 affiliated physicians, serving more than a million patients and their families each year. MedStar Health is proud to be the long-standing clinical and medical education partner of Georgetown University.

Prior to becoming MedStar Health's president and chief executive officer in January of 2008, Samet served as president and chief operating officer of MedStar Health from 2003-2008; and as the system's first chief operating officer since MedStar Health's inception in 1998.

Samet has dedicated his career to health care. He received his master's degree in health services administration from the University of Michigan in 1982. Samet served as president of MedStar Washington Hospital Center, one of the nation's largest tertiary care hospitals, in the District of Columbia from 1990 to 2000. From the mid-1980s to 1990, Samet held a variety of leadership positions with the Medlantic Healthcare Group, which merged with Helix Health in 1998 to create MedStar Health.

Samet is presently a member of the board of directors of a number of organizations to include: Greater Washington Partnership, Economic Club of Washington, United Way of the National Capital Area, and Goodwill of Greater Washington; and serves on the Executive Committee of the boards of Georgetown University and the Greater Washington Board of Trade. He has held leadership positions on the boards of the American Hospital Association (AHA), District of Columbia Hospital Association (DCHA) and Maryland Hospital Association (MHA), and served on the board of visitors for the University of Maryland School of Nursing. Samet is also a past board member of the Greater Baltimore Committee and a past board member and chair of the Academic Affairs Committee of the Old Dominion University Board of Visitors, where he received his bachelor's degree in business administration in 1980 and an honorary doctorate of humane letters in 2012 following his commencement address to the school's graduating class. In 1996, the American College of Healthcare Executives named Samet the national Young

Healthcare Administrator of the Year. Most recently, Samet was honored with the Anti-Defamation League 2015 Achievement Award, which recognizes leaders who have demonstrated a lifelong commitment to justice, pluralism and understanding.