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**JOHN IGLEHART:** Anybody who has done any work in Washington in relation to health policy, or for that matter most anything knows that it's staff and in this case congressional staff that does much of the heavy lifting in terms of development of proposals, structuring of hearings, and moving right through to the enactment of laws. And we have four congressional staff with us today, all distinguished in their fields and they are going to open with brief comments, probably 5 to 7 minutes, about their thoughts about what their respective committees or members are thinking in relation to healthcare. But my plan is really to devote at least half of this hour and a half to your questions and comments to these four individuals. Joel White had to cancel out at the last minute but we have four people that are certainly up to the task; three of them from the senate and Bridgette Taylor from the House of Representatives. I won't spend time going over their biographic information it's in your materials, Mark Hayes will begin. Mark is the Health Chief of the Senate Finance Committee and he will be followed by Liz Fowler who is Democratic counterpart on the Senate Finance Committee, followed by Dean Rosen who is Senate Majority Leader Bill Frist's Health Chief and Bridgette Taylor will follow. Bridgette represents and works for the Democrats on the House

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Energy and Commerce Committee. You'll note that three of the four are from the senate and I supposed it's fair to say at least my opinion would be if there's going to be any flickers of bipartisanship in the health policy realm today not to speak of all the other realms and these three individuals who come from the senate will be key players in that equation. So with that we'll begin with Mark Hayes.

**MARK HAYES:** Morning. I was going to be lazy and I was going to sit down, John is going to make stand up, which I'm happy to do. Good morning everyone thank you very much for the opportunity to be here and spend just a few moments talking about the agenda for the year and I'm going to keep my remarks really short so we can get to the most important part of the program which is your all's questions. As I was writing in this morning I was listening to CSPAN radio and they were playing the coverage of the National Prayer Breakfast and there were many senators and members of congress who were talking about the role that the National Prayer Breakfast plays in their lives and how much they draw from their faith as we take on the challenges of the country and I think that as we kind of look out in front of a year that look's like it's going to be a very challenging year on the budget front, I must say that I took a lot of comfort myself from the things I was hearing about the challenges we face and the prayers that were being said at the National Prayer Breakfast this morning. And this

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is probably not the best segue that I could come up with but in some ways, well I will just say that Senator Grassley who is the Chairman of the Finance Committee and my boss also refers to CBO in their role in this process as of sort of God-like. So I'm going to start by quoting Douglas Holtz-Eakin who is the Director of CBO, he just a few weeks ago was quoted as saying that in 2050 the federal cost of Medicare and Medicaid will exceed the entire cost of the federal budget. And he said it's the critical economic policy question of our time. And certainly that makes a lot of sense to me if both of these programs are going to, if nothing is done, swallow the federal budget by 2050 you can see right away we have a big challenge that we have to face. We have mandatory spending that is rising faster than the economy and has been for quite some time and this year there is renewed interest in looking at mandatory spending, you've no doubt heard that from the budget committee, from actually both sides of the aisle during the presidential campaigns and so I expect that, we expect to see that to continue to be a dominant theme and as the Senate Budget Committee gets under way I know that we will be tackling that, Senator Grassley's a member of the budget committee and we expect to be very active in that debate because whatever the budget committee does, if there is budget resolution, a budget agreement, which I believe that there will be then the heavy lifting for how to achieve those savings has to occur in the

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finance committee. The finance committee has jurisdiction over about all of the money that comes in and about half the money that goes out of the federal government and when we are talking about the growth in mandatory spending a huge degree of that mandatory spending is under the finance committee's jurisdiction. I think there are three areas that we will have to focus on. One will be no surprise to anyone here if you've paying attention to the discussions of late and that's Medicaid. Medicaid seems due for a very hard look at how the program is running, that we have some challenges there. I will say, though, that I don't think there's an appetite, at least in the senate to pass a draconian cap on the program that just shifts costs to the states. I don't believe we have the votes for that in finance committee and so we have to look at creative ways to improve the program, give states flexibility, give states more tools to control spending, utilization, but also improve quality and you know do this in a responsible way that improves the programs and takes care of vulnerable populations in a way that blends good policy and good policy making and politics with what we need to do on the mandatory spending front. So that's Medicaid. I'm sure we might get questions on that that seems to be the hot topic. And there's certainly a lot we can say there, we're all anxious to see what will be in the president's budget when it comes out.

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The second theme, I think, for the year is quality and quality tends to be kind of a throw away word a lot of times, we always talk about well we want to improve quality, we want to do more about quality, we ought to improve quality, but this year with MedPac's work on pay for performance and Dr. McClellan's commitment to this as administrator of CMS my sense is that we have an opportunity here to move the ball down the field in tying payments to quality and really rewarding high quality in the system in Medicare payment systems in a way that will have a long lasting effect and by the way also incentivize the adoption of health care IT by making it part of the business model so if you're buy IT and you improve quality as a result and you get paid more that makes the return on investment for that IT transition, a much more conceivable idea than it is today for a lot of providers.

So the third theme that I would bring up then will be healthcare access. And there's a lot of synergy I think around what we will be doing in the Medicaid area and in healthcare access we have to look at what we can do to improve access, make healthcare coverage more affordable. There's going to be a renewed look at the tax credit proposals and help low income individuals and families afford good health coverage and have that protection that every should have. So with that I will step aside, let Liz pick up where I've left off and I look

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forward to trying to answer your questions when we get to the committee.

**ELIZABETH FOWLER:** Actually I was hoping we could stay at our seats too but it's okay. Thanks again for the invitation to come and speak Academy Health and thanks to Academy Health for organizing another great conference, to David Helms and John Iglehart. This is really one of the preeminent health policy conferences of the year based on the scope and the breadth of the issues that are covered and those who come and the presenters that you have. I am always very happy to be asked to come. And also thanks to my colleagues, for those of you who don't know the other panel members, at least for me working on the Hill the other panel members are my favorite colleagues on the Hill, I can say that because they're here and others aren't [laughed] but it is true in term of there's a lot more collegiality on the Hill than you might expect despite the rhetoric in the press and a lot of the partisanship that seems to happen, a lot of us get along quite well. So I'm pleased to be here to talk about the agenda for the 109<sup>th</sup> Congress in the area of healthcare. I'll probably spend more time on two areas I think will get more attention than others, Medicaid reform and the implementation of the Medicare bill.

Medicaid, and as Mark mentioned you're hearing a lot more about the Medicaid program. I think in a time of record

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deficits it's undoubtedly the case that we're going to start looking across all federal spending to find ways to reduce the deficit. But I think unfortunately my sense is that we're not looking across the entire federal budget and federal spending to find savings. It seems that we're focusing in my view on programs that effect the poorest of the poor and I think that's unfortunate but it does seem that Medicaid is a target in that context. And for what will be called modernization and reform. Secretary Levitt, the new Secretary of Health and Human Services has a great reputation and I think many were very pleased at his appointment for the HHS Secretary spot. He said in a speech on Tuesday that he has identified 60 billion dollars in Medicaid spending that could be reduced, in the area primarily of fraud and abuse, state loopholes 40 billion, 4 and a half billion to try to close down those who might too wealthy for Medicaid and spend down their assets or hide their assets to qualify for the program, and 15 billion in the area of pharmacy costs and overpaying for prescription drugs. I think that his speech typifies what we're going to hear over the next few weeks as the budget is being debated. And we hear this a lot that Medicaid spending is out of control, that it provides Cadillac coverage in a time when many want or lack just a simple Chevy coverage. That the program is rigid and inflexible, it binds states and their ability to make changes, and that the program is rife with fraud and abuse. I think

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reasonable people can disagree and I only ask that everyone keep a couple of points in mind when thinking about Medicaid. First, it's counter-cyclical program and that means in a time of recession rules go up. That certainly happened in our latest economic downturn, from 2001 to 2003 7,500,000 people were added the Medicaid rolls. I think that's important to keep in mind. I think the other important piece of Medicaid spending to keep mind is that per capita cost growth in Medicaid is actually lower than what it is in the private insurance market. I think another thing to keep in mind that is important going down this road, there's a lot of talk about this Cadillac coverage notion and comparing Medicaid coverage to private insurance or what state employees have. But remember that Medicaid covers long term care and in fact it's the financing mechanism for 50% of long term care spending in this country. I don't want to leave you with the notion that the program doesn't bear a closer look, I think that it does. I think in some sense Congress has advocated its role to keep the program current and to keep looking at it and making changes and updating the program. So I don't want to give you the impression that it doesn't need to be changed, but I think that the time Congress has spend on Medicaid has been in the area of fraud and abuse. Closing down provider taxes, looking at IGTs [misspelled?], closing down UPLs, the upper payment limits, so I think we need to keep that in mind too, that it's

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been awhile since we've looked at the program and who it serves. I think another point that I'd like to make is that it's unlikely that you can cut \$60,000,000,000.00 from a program and not affect real people, with real issues, that right now get real coverage.

On Medicare implementation we're all watching very closely particularly those of us who have a real stake in the implementation, for example my boss who played a big role in passing the bill, I think cares very much how the bill is implemented. The final rule was just published last week and we're still reviewing the several hundred pages of regulatory guidance and in fact we're still awaiting sub-regulatory guidance which CMS has told will be published some time soon and will hopefully answer some of the questions that were still left open from the final rule. Just to give you couple of examples of issues that we're following, the consumer protections, we're concerned about the appeals standard and whether they're sufficient, whether you have access to an emergency supply if you're turned down at the pharmacy for coverage reasons. Still I expect to see the formulary rules, the rules for reviewing formularies, those are not part of the final rule, as well the standards for any willing pharmacy and the review that will be placed on plans that provide standards for pharmacy participation. The transition for dual eligibles is another big area, we were pleased to see that CMS has

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adopted automatic enrollment for the duals, but we still are concerned that the time frame is very, very short and that the transition from a Medicaid coverage to tighter formulary under private plan, still are waiting the rules for that which I guess is part of the sub-regulatory guidance. There's a lot of concern, at least in my office about what's going to happen to Native Americans. We just learned that IHS will not be able to, or tribes will not be able to pay the Part D premium for Native Americans even though they can do so under Part B and also that IHS coverage does not count towards covering the doughnut hole under the, through out of pocket plan. I think let me just finish with a couple of other points and I think I might have used up more than my share of time, so I want to close quickly. On the uninsured, I think it's unfortunate we're not hearing a lot about that this year other than maybe lip services and sincere attempts by a few proud and dedicated members who continue to care about the uninsured. It's not that we don't care about the uninsured it's just that I think there's a couple reasons. First of all under deficit time it's hard to find the money to cover the uninsured and second of all there doesn't seem to be a lot of agreement or consensus on how to move forward in covering those who lack health insurance. Quality in IT information technology Mark mentioned, there's a working group of health committee and finance committee members who are trying to see if we can find common ground, it's a

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bipartisan group. I think that area holds a lot of promise for working something out. Pay for performance in Medicare, which as I learned last week physicians and providers don't like the term pay for performance because circus animals perform and physicians provide quality care, so those of you in the audience I'm sorry I just used the term again and I think we need to find another name for it, perhaps value purchasing or pay for quality, I'm not sure. But anyway we're looking at that, I think there's a lot of interest in that, we've had several meetings with MedPac on that issue and discussions with CMS on how to move forward. I think any physician fix in the physician payment will try to include or incorporate some level of quality measure, probably tied to process measures rather than outcome measures but we are still, I think, in the early stages of looking at that. Medical errors, I'll let Dean talk about that, that's not our committee's jurisdiction and medical malpractice obviously there's a lot of that in the news too but those are not jurisdiction, thankfully. Boy, I wouldn't want to have medical malpractice in the finance committee but with that I will close and be happy to answer any questions that you have. Thanks [applause].

**DEAN ROSE:** Thank you Liz, thank you David, thank you John. I appreciate being here again and associate myself with Liz's comments about the quality of this conference and the quality of this panel and leadership, the leadership role that

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I have, I have to say that I really like everyone who works on the Hill [laughter] and all the members of the Senate, they're all great.

Let me just try to talk about a couple of things, every time I'm on a panel with Liz, and Mark, and Bridgette and other folks it always amazes me how much they do and know and how little substance I do anymore. Now that I'm working on the leadership, I used to work on the committee and pay attention to these things, now we just do big messages. In any event, they are really some very skilled folks who do work on these issues and a lot does get done at the staff level. I think you can see their relationships across party lines, a lot of times talk about partisanship in Washington but they really are important even when you disagree that these kinds of relationships over the years we really do help get things done.

Let me start with the State of the Union since that was just last night, so it's timely. I don't know how many of you got a chance to watch it, or read about the coverage, or listen to the coverage this morning. But obviously, for me anyway, it was an extremely moving speech sort of I think regardless of your party affiliation that at that moment with the Iraqi woman who had voted and the mother of the soldier who had died embraced spontaneously, I don't think you could have planned that or otherwise. It symbolized I think a lot of what the president has been talking about in terms of spreading freedom,

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and hope, and opportunity around the world through democracy. I think that theme obviously if you listen to the speech he started out with domestic policy was very much the theme of the domestic policy as well, from Social Security to healthcare to education he sort of providing and it is not necessarily a conservative message that you might have heard 20 or 30 years ago, it is not an anti-government speech at all. In fact government plays a prominent role in all those policies but it's government toward an end of liberating folks and giving people the tools that they need to make decisions. So very much a speech about freedom, I thought, even domestically.

A couple of observations again, I want to try to provide a little bit of framework for some of the policy debates that we're going to have in healthcare this year and then you know let Mark and Bridgette and Liz as they started to do, sort of fill in the specifics. But the president talked last night, there was sort of this litany during his speech about Social Security and about the daunting budget pressure that the program is going to face 15, 20, 30 years from now and it was sort of striking to me as a health policy sort of wonk that if would have talked about those same numbers and those some years with Medicaid and Medicare, it would have been much worse and it would have been much sooner. So I think Mark is exactly right that the budget pressures overall, over the next few years, we always take these things in 2 year bites, but

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over the next 5 or 10 years are really going to be critical and the changes that we make now, I think Governor Litt [misspelled?] had a good, very important line in his speech the other day when he talked about Medicaid, which is – he was talking about Medicaid but this is really true of entitlement programs generally – the problem is big enough to see but not so large that we can't do anything about it that it's too late and so I think it is the time to begin to look at these things and begin to take some action, begin to lay some groundwork for changes. And that's, I think the debate that we'll have. I was also interested, and the last thing I say about the State of the Union, that one of the biggest applause lines of the night was when the president talked about his healthcare agenda. And I'm sure it was mainly from the Republican side as you watch these things. But it is interesting even though healthcare didn't get the same kind of focus and won't get the same kind of focus probably in the press as Social Security, it is increasingly a focus of policy makers here in Washington, it's increasingly a focus of this president, and I think it will be a focus for all of us here over the next years. Let me talk just for a minute about kind of the congressional Republican agenda as I see it just from a broad sense and then I'll sit down and let Bridgette talk and go to questions.

I think as you sort of watch how the debates play out in congress there clearly will be a focus on some of the budget

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issues, what I would sort of identify for you all at least from my standpoint are three kind of guide posts in terms of where we are going overall and a lot of this won't get done in the next year or the next two years, but I think at least in term of a vision or roadmap for the future. One clearly is the president's agenda and what he outlined last night and what he's continued to talk about from the campaign trail through the election to even events of the last couple weeks, this notion of expanding health savings accounts, focusing on a number of initiatives to give folks more choice and control over their healthcare, control costs. The other second thing, the first is clearly the Bush agenda and the way the president has laid that out and I think some of which we'll see in his budget next week. The other is, in the Senate anyway, Joel's not here to talk about the House Republicans, in the Senate anyway we will introduce in the next couple of weeks one of our leadership, S4 is comprehensive health bill, the Healthy America Act. It focuses really on three pillars, costs reducing costs, number two improving coverage, number three improving care and that followed on the recommendations of a Republican task force that the leader, Senator Frist set up last year, chaired by Judd Gregg who has been the Chairman of the Health, Education, Labor Committee is now the Chairman of the Budget Committee. Senator Grassley, Senator Enzy who are both now chairs of the other two relevant health committees in

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the senate played a prominent role. And that bill, I think provides a guidepost for where we'll go to. We have an outline of that bill, I think it speaks a lot about the importance of healthcare that we reserve one of the top ten numbers for those bills. That's sort of how we do things, those bills tend to try to signal where we're going. For example last year in the last congress, S1 was the Medicare bill. To show you what priority we place on it this year S1 is the Social Security bill and S4, one through ten, is the healthcare bill. And then finally, I just note this, that my boss has sort of laid out his vision of healthcare reform and moving toward a better system over the next decade in a New England Journal article that was published on January 20<sup>th</sup> called "21<sup>st</sup> Century Healthcare." So I sort of commend those three things to you at least from my own perspective, at least to try to give some perspective of where we're going, which again is this vision of a patient-centered, more consumer-driven system and sort of forward to the future. A couple of specifics and then I'll end. Mark talked about Medicaid and Liz did as well, I'm sure Bridgette will as well, I would just note that that 60,000,000,000 out of context and even in context can sound like a lot of money but \$60,000,000,000.00 over the next 10 years out of Medicaid is about 2% of Medicaid spending. It is, as I read the speech, and I know we'll see more it's about a .2 reduction over the next 10 years in the rate of growth. The

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Medicaid program is estimated to spend about 2.8 trillion in federal dollars over the next ten years, so it's 60,000,000,000 out of 2.8 trillion is about 2% so I think that context is important. I think there'll be more discussion about that too and it'll be an interesting debate. On the cost and access issues that I mentioned the bill focusing on health savings account, medical liability reform, patient safety, health information technology, association health plans giving small employers the opportunity to band together to purchase more affordable coverage, we'll also focus a lot on safety net issues. And the president talked about these safety net issues last night. The community health center, we've had an historic expansion of community health centers the last couple of years. He wants to extend them to every poor community, tax credits, and then finally let me just end, there are a couple things that sort of were not on the president's list but things that I'll be focusing a lot on for Senator Frist and his last two years that he cares a great deal about. One is healthcare disparities, we had a bipartisan bill last year to try close gaps in healthcare quality and we'll try to make a push to get something significant done on that this year. And then we'll also focus on a number of other global healthcare issues, senator testified yesterday before the Health Commerce Committee about the need for greater focus globally on clean water, sanitation world wide, we don't have as much focus on

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that as we should in our foreign assistance programs, and on creating a global health corps to help spread democracy and good will as well as assistance around the world. And also bioterror and the need to continue to build on the work we've done the last couple years with bioshield and with the Bioterrorism Protection Act to continue to secure the homeland from what is really potentially the greatest threat here domestically and that is the threat of biological warfare or bioterrorist. So that's it for me, thank you all very much and I look forward to Bridgette's talk and questions [applause].

**BRIDGETTE TAYLOR:** Good morning. I'd like to obviously thank both David and John for putting this conference together but I also want to take a minute to thank all of you in putting together research. We, as Hill staff, may ultimately pull together the policy but we rely tremendously on the work that all of you all do in hoping that we'll actually do the right thing in terms of putting the kinds of things we do together. So thank you very much for that. I feel compelled to also say that my favorite Hill staffers that I work with on a daily basis are the people on this panel. But I would just say that if Steve and Mark do the wrong thing on Medicaid I might have to reconsider that status [laughter]. I also am very happy to be the voice of the House today. I'm not sure that Joe Barton and Bill Thomas would agree that and Tom DeLay might have a heart attack but I like being the one who can say what we're

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going to do, it's kind of fun. We're obviously in our committee, the Energy and Commerce Committee going to have several things to do and look at. The SGR, which is the payment for physicians, is of concern because as many of you know they keep getting huge reductions in their payments. We on our committee, particularly the Democrats I'll at least identify that, believe that we can't have Medicare without physicians because we obviously prefer fee for service managed care, so we don't have anything happen to that. So I believe, but it's also shared with our majority that we need to look at that and try to do what we can to at least keep them afloat for right now even if we're not able to do the fix or the big dig or whatever you want to call it. Medical errors, as Liz says the doctors don't like that word either, they like for us to patient safety is something that we - I actually already got a call from a majority yesterday - we actually introduced, marked up in committee, and passed a bill in the house last congress. And never actually got to conference with the senate but I'm hopeful that this year we'll actually be able to achieve that goal because I think given all the debates that's going on around medical liability reform right now that there are many experts, researchers out there that identified this notion of reporting your errors before they happen, looking at the data, trying to develop it in such a fashion so that it keeps things from happening that might have been accidental then we would

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obviously benefit from that and might not actually have to have a reason medical liability reform because then the cases that are left would actually be for people who were harmed intentionally. Information technology is an area that we'll be looking at we haven't, the Senate is much further along than the House in development of policies in that regard but I feel confident that we're going to, with the president actually talking about it too, it seems that it's a bipartisan thing and like medical errors would make the healthcare system operate more efficiently. Medicaid is something that is obviously going to be in the debate and as many of you know this is something that is very important to Mr. Dingle and the program is very important and very, very important to the millions of people who depend on it. Medicaid came out of a notion that there was private health insurance that weren't covering people, for example, who were disabled and still probably wouldn't in terms of covering the services that they need. They weren't covering really poor children, they weren't covering pregnant woman. And finally the elderly who need nursing home care, we still don't have a health policy in this country for nursing home care and if it weren't Medicaid we would have a lot of people who were in dire straights or who had Alzheimer's might not have a place to go and the burden would fall on the families. Mark mentioned the fact that Medicaid and Medicare are eating up the federal budget. I

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would say that healthcare in general is also eating up families' budgets. I don't know many of you all saw the recent study that came out that talked about the number of bankruptcies that continue. I just don't think we can talk about Medicaid and Medicare without talking about the whole healthcare system because they're just all intertwined. I mean if we decide to cut Medicaid it's inevitable that there are people that are going to lose their health care coverage. We're going to increase the number of uninsured and it's just going to be a vicious cycle. Liz already mentioned the fact that the Medicaid program is efficient and its per capita growth rate, it's actually at 6.1, Medicare's at 7.1, and private health insurance is 12.6. So when people try to tell you Medicaid's not efficient, I would argue with that point too. I believe that the problems in Medicaid are universal problems. The number of enrolled is going up because the number of employers are dropping coverage. The cost of healthcare is going up, but it's also going up for everybody else. The cost of prescription drugs is going up but it's going up for everybody else. And the beneficiaries who are in Medicare, who are very low income get a good bit of their healthcare coverage paid for by Medicaid so they can actually get their Medicare coverage. They wouldn't be able to do it if they didn't have some of their cost sharing assisted in that context. It was interesting because I just heard about a

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Harris poll recently, it was actually for private health insurance but it said that by and large the more premiums go up for people the more noncompliance there is in terms of getting their services. That would be tenfold for the people who are poor because by and large it's difficult enough to get them to the doctor because of all the things sometimes they have to go through in terms of changing busses, transportation, and taking off work and things like that; so you can imagine if we made it even more unaffordable for them what that might do. Finally one of the cost drivers, and I just mentioned this, for Medicaid is long term care and if we don't get a national policy for that I don't know how we can do things to hurt the Medicaid program in that regard. The number of \$60,000,000,000.00 was mentioned in terms of what our committees are going to look for to get out of the program and Dean mentioned that it was only a 2% cut. And that doesn't sound like very much money in some ways when you talk about, but the SCHIP program costs that same amount of money. So think of it in that terms, we can obliterate the SCHIP program and save \$60,000,000,000.00 it's no small change when you're talking about poor people and how they get their health care coverage. We could do some other things to help Medicaid, we could fix this prescription drug rebate and I believe that that's going to be in the President's budget too. In Medicaid we're paying currently based on the average wholesale prices

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which is a number that's established by the pharmaceutical industry, so we can adjust that and try to get some savings there although I don't think it will get us anywhere close to \$60,000,000,000.00. We can expand home and community based care services which we've all talked about. I know that Senator Grassley has got a bill that actually would not only enhance the ability for the disabled to get into Medicaid but would also look at ways to do somethings more for home and community based care and money follows the people. A way to allow the disabled to stay at home and get some money so that they can for example pick their own caregiver as opposed to having one given to them. I would just point out though that one of the other things Secretary Levitt was talking about in terms of making sure that the Medicaid program operated more efficiently was to give states more flexibility with the disabled because they're an optional population. Well, the disabled are the ones that use home and community based care services and it is only optional disabled that use home and community care services so I don't quite see how these two pictures match up. Finally on the notion of flexibility, flexibility sounds good but again if flexibility means the flexibility to cut people off or to, for example, reduce the amount of coverage that someone under \$12,000.00 a year in income gets to give coverage to a family that's at \$18,000.00 I don't like that picture. It's sort of like taking away from

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Peter to pay Paul. If we're going to make a commitment to expanding coverage we ought to try find the dollars from someplace and [inaudible], you know that tax cut that goes to those rich people, maybe we could do something about that. Anyway, I guess I'll just close with saying this, please keep up your good work and if you've got any information that will help us in this Medicaid debate, I would really welcome it. Regardless of what it says, I think we do want to have an informed decision, debate here, so and I'll be happy to take any questions you have, thank you [applause].

**JOHN IGLEHART:** Thank you, thank you all. It's now your opportunity to ask questions of the panel. If you would identify yourself and your organization, that would be helpful. Yes sir.

**ERIC SEALE:** My name is Eric Seale [misspelled?] I'm the Chief Medical Officer of a seven hospital healthcare system in rural Maine and I have a specific question but I just wanted to give you a brief outline of the ground level that your work is going to hit at some point. In Maine one of those loopholes in Medicaid that you're talking about is the cornerstone of the Dirigo Health Plan which is the state government's attempt to find health insurance for the 320,000 Mainers without insurance. The state Medicaid program hasn't raised pay to physicians in 17 years, they owe the state's 36 hospitals \$300,000,000.00. We have two neurosurgeons only for the

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northern half of the state, we have one urologist in the entire state who is willing to take pediatric Medicaid patients.

There are nights in the state when there is no oral surgeon on call in the entire state of Maine. 30% of the physicians state now are employed by hospitals, primarily because they can't otherwise make it on their own and we can't keep physician manpower in the state if we don't employ them, making our physician workforce now exquisitely sensitive to what happens to hospitals. So after all of that I guess my question is what do you think is going to happen to reimbursement for physicians and hospitals in the next budget from Medicaid and Medicare?

**MARK HAYES:** That's not an easy question to answer [laughter]. I will say though that if they offer me the job of being the Medicaid Director for the State of Maine I will know that I should think twice about that after what you just say. But I will say that the physician payment problem is certainly a looming one over this whole situation and we didn't delve into great detail around the budget challenge here but when you look at Medicare and the fact that in the Medicare bill practically anything that was politically doable as a saver, as a measure to reduce spending in Medicare was just done in 2003 to offset preventive benefits, and cardiology screens and preventive, the Welcome to Medicare physical and all the things that were included in to the Medicare bill and you have this physician payment problem that if we do a permanent fix of that

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could cost anywhere from 80, 90, \$100,000,000,000.00 over ten years, so that means we're going to have a huge budget challenge in addressing physicians this year. I think the other big problem is that there isn't a emerging level agreement around what the solution is on physicians but when it comes to all these pieces that you've mentioned and I assume you're talking about both Medicare and Medicaid when you're talking about provider payments. I think that's the challenge that we have and you saw last year that when the physician payment fix that was included in the Medicare bill became hugely controversial because it raised Part B premiums by 17%. That was the biggest driver, that was most of the cost of the increase in the Part B premium. So AARP has come by to talk to us about their concerns about the impact on the Part B premium. So none of these things have easy solutions and I think that is what is making it so difficult and it is a balance between assuring access and protecting low income individuals and we have the Quimby Slimby NQI 1 [misspelled?] Program. We have a very generous benefit for low income populations for drugs that will kick in in '06. But plugging these things all together and balancing those concerns is a key thing that we have on our plates, that's for sure.

**JOHN IGLEHART:** We'll move on. Please keep your questions short though so we can get as many as possible. Al.

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**AL DOBSON:** Yes, Al Dobson [misspelled?] the Lonen Group [misspelled?]. For each panel member, what is the probability that Medicare will be expanded to the 55 to 65 in the next ten years to cover that big gap of uninsured for those folks that are hardest to cover?

**ELIZABETH FOWLER:** Well Senator Bakas [misspelled?] and he included that provision that he introduced that a couple of years ago and I know a lot of Democrats are supportive of that notion. I don't know that it's politically popular on the other side of the aisle and perhaps I should let my colleagues answer but I think that some feel, well I don't want to speak from them answer, but I'll let them add their own [laughter].

**DEAN ROSE:** I think .025% is the chance [laughter]. I don't think there's much support on the Republican side of the aisle so I think that I would calculate the chances based on the likelihood that Democrats would take over the House or the Senate or maybe both and that the presidency was switched in four years. I mean quite honestly I think that we have put forward a number of proposals to try to address cost in this particular gap of folks who are near retirement and a lot of pressure is obviously on companies globally but the solutions are less about expanding existing government programs for a whole host of reasons. I think the chances in the current political environment, just to be frank, are very slim for that proposal.

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**JOHN IGLEHART:** Before I take the next question I neglected to mention that the staff asked that if you quote any one of them you do it, not by name, but as Democratic or Republican staffer, it makes their lives a little easier.

**JEAN PAUL GANGIN:** Jean Paul Gangin [misspelled?], Director Of Public Policy at Sinoff Adventis [misspelled?] I just want to also thank the staff for taking the time, I know how busy they are with their work to come here and share their thoughts. But my question basically is when you're looking at the budget with regard to Medicare or the Healthy American Act you mentioned different silos to look at from drugs to long term care to the different silos but I just wonder if you're thinking about being somewhat creative in looking across the budget. We have been involved in funding a program with 5 employers looking at saving total healthcare costs if you will by having pharmacists involved in delivering services for diabetics and then waiving the co-pay. It's produced significant savings in the other parts of the healthcare system medical and hospital compared to the drug budget. But when you think of solutions are you thinking across the different components so that you can get to a total savings as opposed to looking at different silos.

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**MARK HAYES:** Certainly from a policy standpoint we look across those programs and I think when we approach the Medicare in wanting to expand Medicare Advantage which was then Medicare Plus Choice, until we renamed cleverly into a better name Medicare Advantage. That the integrated benefit provides that opportunity to expand upon disease management and break away the silos, have medication therapy management play a bigger role because the savings all come back into the same silo and it's a lot harder to do on the fee for service side. I think it's one of our concerns really, is in the stand alone plans and the incentives that are different there for them reducing costs and drugs is perhaps a big part of the name of the game even though it might impact spending in Part A and Part B but that's not part of their silo. I think that's a real challenge on the fee for service side of the program is trying to figure out how to connect those dots. I think pay for performance, I'm sorry pay for quality [laughter], I'm learning, will get us an opportunity to reward when those connectings happen. Right now the reason why it doesn't work very well is because if we improve quality in one area, we lower in patients length of stay or utilization overhaul and revenues go down the hospital side and that doesn't work out very well on the fee for service side. A lot of care management demos and different things that are going on will help us move forward in that I don't really think we'll ever get as far along as we want on the fee for

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service side, I think Medicare Advantage holds a greater promise there but there are things we can do help bridge those gaps.

**ELIZABETH FOWLER:** Another angle is that the Congressional Budget Office doesn't spend savings and as creative as our initiatives are it's not like when we put definitions in place, the CBO says, "Oh and the concurrent savings to the federal government tax." We actually get scored for the spending but we get no credit for the savings and that makes the policies a lot harder.

**DEAN ROSE:** I just want to add one thing too to kind out of broaden out Mark and Liz's answers which I think focused, your question focused a lot on the federal program because obviously those are ones that we pay directly. But I do think that if you look across some of the things that are being talked about and a lot of agreement on some of these in a bipartisan way, for example the health information technology, some of the liability reforms which are not so bipartisan, but I think the goal of those is really to help send signals across the system and part of that clearly is with Medicare being such a significant payer you need to make sure that your payment systems are in synch. I think Mark's right that we need to look outside of silos but I also think that some of the changes that are being talked about, you know, we look at them in silos on the congressional side, oh this is going to effect the

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private sector, can send very positive signals across the spectrum as well because the care is delivered by the same physician they're just going to get paid by different sources.

**JOHN IGLEHART:** Question back there, yes.

**LISA DWYER:** Hello my name is Lisa Dwyer [misspelled?] and I work for the National Healthcare Statistics, well National Center for Healthcare Statistics in the long term care statistics branch. So I was relieved to hear Bridgette Taylor, just the whole issue of a long term care policy. My question is what do you think are the key components that will make up an effective long term healthcare policy. A couple of days ago there was a spread in the post on the elderly and healthcare and the whole issue of escalating costs, not just in the United States, but in other countries.

**BRIDGETTE TAYLOR:** Sure I'll try. I think that we're trying very hard to look at mechanisms and what we'd actually do, you know, how to develop long term care. There are some ideas out there which are not necessarily mine for giving people tax credits for example for care givers. I think that's something people have looked at in order to be able to help people stay at home. We've looked at home and community based care as a way of expanding that in Medicaid to help people get access to be able to stay at home instead of having to go to a nursing home for those people who can utilize that. I think in the context if we were going to actually do a full blown we'd

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have to look at private health insurance and see what's going on there. I know for example they don't have any inflation protections for people so if you buy a policy today that you get \$100.00 a day for care, you know ten years from now \$100.00 a day isn't going to buy you very much. But at the same time you've got to balance that, if you look at those kinds of things, the long term care policies have become so unaffordable that you're not going to know what to do with it. I have other colleagues who believe that we should just turn long term care into a program just like Medicare so that the federal government is paying for it in that regard. We haven't come to a resolution and in fact, I know that I have seen a couple of papers, which I will just say at this moment, I haven't had a chance to read but that have just recently coming out looking at these different programs and seeing what we can think about and how we can do that. So I'd welcome any information you might want to add to that.

**MARK HAYES:** I just want to jump in and say Senator Bradley [misspelled?] has a bill that would create above the line deduction for long term care policies, increase the tax credits for family givers and my sense is just to add one quick thing too, is within the context of the Social Security debate that I've heard a number of members talk about how we really need to also think about this as a retirement security issue and that could bring in pension reforms and long term care

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reforms into that discussion as well as we think about the sort of long term ramifications of the demographics maybe versus [inaudible] so it's an important point.

**JOHN IGLEHART:** Yes ma'am.

**ELIZABETH CULLEN:** Yes, hi, I'm Elizabeth Cullen [misspelled?] with the American Psychological Association. And hi, we've met before. I guess I have a question about the timing of a Medicaid bill and also on a previous panel you had mentioned that the subject of a medical necessity in the Section 1115 waivers was something that you'd be looking at and I was wondering what are some of the issues surrounding that that you're looking at.

**MARK HAYES:** I was just saying on timing, just to hit the hardest question first. If there is a budget agreement that calls for reconciliation we might be marking up as early as May, which means we have to have this figured out in 12 weeks or so which is a pretty rapid time frame for us. But on 1115 waivers, I'll just try and hit that and then if the others want to chime in on the other points you raised because I'm afraid of my small brain has already forgotten many of them, but on the 1115 waivers we've been really concerned about transparency in the process and that right now the waivers are negotiated between states and [inaudible] there's very little congressional oversight, in fact it's very challenging for us to even find out what is in these waivers until they've been

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negotiated. And we see that as a little bit of a problem. There is this whole issue that we do have two, well three branches of government, but two branches of government between what's happening on the executive side and the congressional side with waivers and I wouldn't be too surprised to see that we would be taking some looks at that to see if we can't add more transparency to that process, make it more accountable in how those waivers are negotiated, maybe change the fundamental nature of that.

**JOHN IGLEHART:** Yes sir.

**PAUL HELDMAN:** Paul Heldman [misspelled?] with Smith Barney. Thanks for being here I have a two fold question. When the president introduces his budget on Monday how will congress use that budget specifically will Medicare and Medicaid savings proposed become a ceiling in terms of what congress considers or will that be a starting point. Is there a potential to go higher and also where is the greatest potential for consensus on Medicaid savings if capping the growth of the program is where the least opportunity for consensus is possible. What's at the other end of the spectrum.

**ELIZABETH FOWLER:** I think one of the Republicans should probably answer the role of the president's budget in drafting the congressional budget.

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**MARK HAYES:** I was going to defer to leadership to answer that question [laughter].

**DEAN ROSE:** I think that unlike years, if you look at some of the years when we did large reconciliation bills in '95 and '97 for example where we had divided government. You know, when President Clinton would send up his budget and essentially it was dead on arrival, you had a Republican congress writing it. I think this year obviously with expanded majorities in the house and the senate and the Republican's by the president, I think the president's budget is a lot more of a real document like it was last year. So I think it does get taken very seriously but at the same time you know we've got a lot of independent folks and we'll rely on our budget committee in the senate and our finance committee in the senate in any way to fill in the details and that's just the way place works. I think it's more serious. I guess I would turn to these guys on areas of Medicaid savings.

**JOHN IGLEHART:** Dean, can I follow up on that? There's obviously a more conservative congress and a more conservative set of Republicans, what's the likelihood that that branch of the party is likely to want to go farther than the president's budget in terms of constraining future growth of entitlements and discretionary spending.

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**DEAN ROSE:** I just don't know in part because I don't know what's going to be in his budget. Overall we've gotten some hints of it from Secretary Levitt's speech, but I just don't know what farther might mean because I don't know what the starting point is, number one. And number two I think regardless of what it is there will probably be members that want to go within our caucus just on the Republican side that want to go farther and some that don't want to go as far and so the only point is that I think that you know the budget proposals will be a significant budget, it will be a starting point. It probably won't be the end point, but it will be the starting point, I just don't know how to gauge yet because it's just not a live issue. I'm not trying to duck it, I just don't know because so much is really uncertain until next week.

**BRIDGETTE TAYLOR:** Can I answer the second part of the question?

**JOHN IGLEHART:** Sure.

**BRIDGETTE TAYLOR:** About the what we could do consensus wise on Medicaid. I mentioned earlier the possibility of fixing the drug rebate although I'm not certain how much money that would get certainly not anywhere close to \$60,000,000,000.00. Moving more people out of nursing homes in the home and community based care, but again I'm not certain that that will actually even save us any money it might cost us a little bit. And then our committee has talked about a little

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bit about looking at the assets test and determining whether or not there are people who are transferring assets inappropriately and we're having people who maybe shouldn't be on the Medicaid program utilizing Medicaid for the nursing home services, although I understand there's a paper that's coming out I think next Friday that may say that that's actually not the case that there are that many people doing that but we have at least a [inaudible] that could do that. To the extent that is fraud and abuse in this program and I'm not convinced that there is all that much but certainly Mr. Dingle is never comfortable looking at fraud and abuse. I think we certainly would be willing to examine that and actually what the president and the administration have that they can show us the exact data then I think we'd be willing to look at it. But I think what we would ask in return is that while there may be things that are going on that are quote fraudulent in the states, that money is still being spend on Medicaid beneficiaries and to the extent that you take that money out of there you because it's being done in a fraudulent manner you ought to put it back into the program so the people who need get it, as opposed to putting it into the treasury, excuse me, but to use it for the president's tax cuts [applause].

**JOHN IGLEHART:** Yes ma'am.

**LAURA TRUMAN:** My name is Laura Truman [misspelled?]

and I'm with the Coalition for Affordable Health Coverage and I

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want to thank you all for your hard work. I know that you spend a lot of time on these and sometimes it can be sticking a finger in a dam one place and in it breaks open in another place. I wanted to ask you about this issue of expanding coverage or getting coverage for people who don't have health insurance, whether it's the 55-65 or the people who earn a little too much for Medicaid currently but not enough to be getting health insurance from their employers. There has been some consensus that does seem to be building, even Senator Kerry had a health care tax credit for individuals to help them purchase health insurance in his plan as has President Bush every year he's been in office. I know that's a part of S4 for the leadership in the senate and so this question perhaps would be most for Liz, because you had said we see a lot of lip service and we want obviously to see everybody to move beyond lip service. I'm wondering if you see some opportunities for consensus either on tax credits or health savings accounts and making them more available to people through some tax incentive.

**ELIZABETH FOWLER:** Well let me see Dean and I were actually just talking about the uninsured up here in the couple of moments when no one was looking or at least we thought people weren't paying attention to side chatter. I think there actually is more consensus on who should be covered than there is on how to cover people. I think at least my boss had asked

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me, Senator Bakas had asked me to try to identify the different proposals and see if there are any similarities and I think there are like you mentioned Senator Kerry focusing on some use of tax credits. But I think looking at the population Senator Frist has talked about covering children under 200% of poverty. I think there seems to be consensus about covering all individuals under 100% of poverty so I think if you start with low income children and those at the sort of lowest end of the income scale I think there actually is consensus on who should be covered and then we get to how and I think with the tax credit issue, there's concern at least among some of us about the TAA tax credit. And whether or not the TAA tax credit has worked as effectively as it should and for those of you not following this is a very small program but it provides a 65% tax credit to displaced workers who lost their jobs due to U.S. trade policy. It's a very small population but it was a step forward. Those of us who worked on that bill in 2002 thought that it might be a way to maybe think about using tax credits and I think the problem is there hasn't been a lot of enrollment. The administrative costs have been high and even with a 65% credit with very few controls on what sorts of insurance you can buy some of the premiums have been high enough that even 65% is out of reach. I think at least from my perspective starting to look at maybe fixing some of those problems and getting that tax credit to a point that people

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feel that it works. I think we shouldn't ignore the role that public programs can play, particularly for those who might not be as sophisticated or able to use a tax credit in the market in finding insurance for themselves. I think my boss has typically been pretty skeptical of tax credits in the individual market, however there is an element of that in the TAA program but I think that may be an element that hasn't work as well. Anyway, the short answer to a long answer trying to sum it up, there could be some consensus I think we need to get under the budget hurdles and because of the budget hurdles we just haven't spent enough time on trying to find where that consensus is. I hope that that can come in the next year or two. There certainly seems to be a lot of interest in it and I can tell you that whenever my boss meets with CEOs of various companies around the country they come in and say one of their biggest issues is health care costs and covering the uninsured and because the business community is now putting that as a major issue on their agenda I think that has brought more attention to it as well.

**JOHN IGLEHART:** Yes sir.

**PAUL PRATT:** Paul Pratt [misspelled?] with Inside CMS. Liz you mentioned that CBO tends to score your quality payment initiatives as costing money. Does that mean that if you go that route that you're going to have pair them up with cuts to updates or freezes to updates and doesn't that complicate

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winning the political support among providers for changing your payment methodology?

**ELIZABETH FOWLER:** Well there are some of us who are very confident that these initiatives save money over the long term so we've actually been exploring ways to make it budget neutral and trying to talk to the budget folks about ways to structure the program so we don't actually get scored or maybe there's an upfront score for say the adoption of technology. But we're very convinced that over the long run there would be savings to be gained and trying to figure out how to structure that in a budget neutral way I think has been a challenge but that's the route we're exploring at this point.

**JOHN IGLEHART:** Liz, let me follow up on something you said about children and consensus or at least moving toward a consensus of covering children in families with 200% of the poverty level or lower. The question I would pose to the panel is weather in terms of expanding coverage, putting aside at the moment just how you do it, are children a priority in terms of the first group that ought to be included in expansion of coverage?

**MARK HAYES:** On the subject of children one subject that we haven't really addressed here is the SCHIP program and we have a big challenge we're facing there while we also think about how to expand coverage even additional children. The SCHIP has been a very successful program. We got a lot of

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kids. It's been working really well and I think it's been a model for sort of creative efforts to expand coverage. But at this point in time as we look out over the next few years we have a growing number of states that are going to have shortfalls and the money they'll have in their allotments to just to continue to fund their current programs, as many as 18 states by 2007, including Iowa by the way, that runs out of money. And we also have a whole bunch of other states, a couple dozen or so that have 200, 300, even 400 and 500% more than what they need to run their SCHIP programs and it's really complicated in how these formulas work. We want to get more kids covered, we want to do outreach to get more kids covered and that of course is going to exacerbate the shortfall problem. So before we even get to the job of expanding coverage for kids, we've also got to look this year at the SCHIP program and figure out how we can put it back on firm financial footing for the next few years as well as maybe give it the opportunity to expand coverage. And maybe we'll be looking at this in the context of Medicaid and restructuring there so that we can try to make sense of how these policies all fit together. But hopefully we can make some progress on that front even this year when it comes to kids.

**JOHN IGLEHART:** So kids basically don't have a leg up on competing claims for resources?

**MARK HAYES:** Oh no, I think they absolutely do.

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**JOHN IGLEHART:** They do?

**MARK HAYES:** Sure.

**JOHN IGLEHART:** Bridgette do you have anything to add?  
Okay let's move on. Yes ma'am.

**SUZANNE SMITH:** Suzanne Smith from CDC. When we hear health for Americans we think prevention rather than the healthcare delivery system and I was encouraged to hear Dr. McClellan yesterday talk about an increased emphasis on prevention in Medicare and Mr. Rosen mentioned a number of initiatives that Dr. Frist, Senator Frist, is interested in. My question is what are the prevention initiatives that you think could actually get traction? Have some attention on the Hill? And secondly and most importantly I think is how in the world do we get these issues to get the prominence and attention that they deserve? It always seems to lose out to the healthcare spending issues even though the evidence shows that prevention could do a lot to help healthcare spending.

**ELIZABETH FOWLER:** Well I think and Dr. McClellan was probably talking about this too, the most recent additions on the preventive coverage side on Medicare, cardiovascular screening and diabetes screening that were added in the 2003 Medicare bill. I think we up here don't consider ourselves experts and we rely on CDC and other groups and other experts to bring to us gaps in coverage for example in Medicare and tell us what the program should be covering and a lot of time adding

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a screening benefit or adding preventive benefits to Medicare doesn't necessarily cost as much as for example some of the other changes that we made to the program. So I think in that sense trying to publicize or get that information to congress is helpful. I think we're open and that we agree that it should be a priority and I know Dean's boss is very interested in that as well, as is my boss.

**DEAN ROSE:** I guess I would say too, I think that there is, I think there is a lot of interest in a kind of a narrow congressional budget office view of we put more prevention into the Medicare program, they generally say that it costs money. That's the framework that we generally deal with. I think if you look at just for example three areas that come to mind in the last year, Dr. McClellan talked about yesterday. There's a lot of focus on prevention in the Medicare bill you know we've done a lot since the mid-nineties in terms of waiving the co-pays and deductibility for certain kinds of screenings and certain kinds of prevention, but even beyond that with the welcome to Medicare physical and other things I know we talked about, I think there was a big focus. Second, and I know a lot of folks tend to criticize health savings account for people you know exposed for the first part of the deductible but you know in whatever your arguments are, whatever your beliefs are, pro and con on that one the interesting thing is when the Treasury Department proposed the rules and finalized the rules

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on HSAs it excluded from applicability to the deductible preventive benefits and some prescription drugs. And then you also have targeted public interventions you know like the breast and cervical cancer program and other. So I do think that there actually is a fair amount of focus and we don't necessarily promote it in terms of oh it's going to save money if we put it in but if you look across just a range of programs from Medicare to private insurance to public health from a congressional policy standpoint I think there has been a focus on prevention in the last couple years.

**JOHN IGLEHART:** Dean, does the CBO consider the prevention benefits a coster rather than a saver? Richard.

**MALE SPEAKER:** They tend to find things wrong with your when you do go in for your physical so that's why it costs more money. I just would add that many of the states in the context of Medicaid have done some really good work in terms of trying to do prevention and particularly in the context of dental care and other things like that. And I'm really hopeful that we don't increase cost sharing or cut the program so bad they have to cut those out. Sorry, I have to keep making my advertisements. Thank you.

**JOHN IGLEHART:** Yes sir.

**GEORGE PROBANZANO:** George Probanzano [misspelled?] with BATAL [misspelled?]. Since the election the president has also announced that one of his initiatives will be tax

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simplification and I'm wondering to what extent there are conflicts between tax simplification and some of the tax based incentives for increasing access and so forth? Are the conflicts?

**ELIZABETH FOWLER:** That's an excellent question and I think our tax staff, you know the Finance Committee, our jurisdiction includes tax, trade, and health and the tax folks really don't approve of the health folks initiatives on using their tax code to put forward any new initiatives. I know there is definitely, most definitely a conflict. And so tax simplification I think, while it seems like we go through that exercise maybe what, every 20 years or so where we simplify the code and then spend next 20 years sort of adding new things to the code. So it is in conflict, I don't know that that's something that's going to happen this year. But you're right there is that tension there and it's something that we have to deal with.

**MARK HAYES:** Yeah, I'm just saying too, not my department at all [laughter] but that doesn't stop me from say something I guess. But I guess it just depends on what you mean by simplification. It doesn't necessarily mean that there's any conflict at all and simplification tends to me to mean sometimes an overused word and you know do we just mean flat tax? Do we mean value added tax? There's a lot of different things maybe you have a more flexible revenue system

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that actually helps us when it comes to funding some of the health priorities so it's really hard to say on that.

**JOHN IGLEHART:** Let's go back here. Yes ma'am.

**SHIRLEY:** Hi my name is Shirley [misspelled?] and I'm a clinician at Sidley Hospital. My question is considering that two very major national health programs are almost broke and in contrast to that the pharmaceutical industry is flourishing generally, no unless they keep up the Pfizer Vioxx stuff, also to complete that the drug costs seems to be one of the fastest rising cost or expenditure in healthcare spending. What would be the government's role, if any, to control prices? And why it isn't brought up, this subject, it seems so obvious this somewhat needs to be done. The only time I heard it, I mean very rarely Bridgette said something about drug rebate and I'm not from the policy world, so please explain to me why doesn't the government touch this?

**MARK HAYES:** I think one of our biggest challenges is this question of global r and d into pharmaceuticals and who's going to pay for it. And right now the U.S. consumers are paying a much bigger share in the global economy for that R and D than our partners in other developed countries and that doesn't seem like a very fair deal for the U.S. consumer. Senator Grassley has supported drug importation as a trade issue to be able to say we ought to have open borders when it comes to the movement of pharmaceuticals. Also something we

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have to be very careful about, we take steps that reduce the amount of funding for R and D, you know, we're depending on that R and D pipeline to come up with you know discoveries in Alzheimer's and Parkinson's disease, diabetes, some of the biggest challenges of our time, talk about the need for preventive care, we need to address these big challenges and those are many of the things that are driving health care costs when we talk about the need to care for people with diabetes and so on. Those are expensive diseases and we talk about quality of life and we want to see those new therapies come on to the market. So I think it's a really huge challenge. We have to be very careful in not to be short sighted because it seems like a neat and simple thing to try and really, we should just be like everybody else and do hard core price controls on drugs to reduce spending but we won't see the after effects on that in the R and D pipeline for 10, 15, 20 years down the road when you find out that there aren't new drugs coming out for discovery.

**ELIZABETH FOWLER:** Can I also just add a couple few cents to that. Up until the Medicare bill the federal dollars that were going towards prescription drugs under for example DOD programs, the VA programs, Indian Health Service, and the Public Health Service Act, and under Medicaid those programs all do have some sort of price control program. For example the Medicaid Rebate Program and the federal supply schedule.

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The Medicare bill is a bit of a departure and a bit of an experiment from that and I think one of the reasons there hasn't been a big government role is because there hasn't been a big government payer. But I think the Medicare bill brings that to the table and I think the bill sets up a private system to see how well the private sector does in controlling drug costs. And I think it is a bit of an experiment because I think if in two or three years or however long we decide to give these private sector entities, if they don't do a good job of controlling pharmaceutical costs than I think you would see more government intervention, particularly as the cost of these programs are expanding and we talk about how much federal spending is going to entitlement programs and that certainly is one area. But you know at least in the short term I think the Medicare Bill which is now a very big government payer for prescription drugs gets a little bit of a testing time to see whether a private sector can do any better than a government price control.

**MARTY FREECO:** Yes, my name is Marty Freeco [misspelled?] I'm the president of a medium sized medical group out in Modesto, California, Gould Medical Group [misspelled?] about 170 doctors. So I wanted to give you another provider perspective to complement the gentleman from Maine at the beginning. Just to show that this is a coast to coast problem. I've heard several speakers say now that Medicaid is

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controlling per capita costs very well relative to the programs and I guess I would say that it's easy to control your costs if you don't pay for things [laughter]. The Medicaid program in our group pays maybe 30 to 40% of Medicare on average and we're a multi-specialty group and we don't consider Medicare a particularly good payer. And my job as president is to make sure our payer mix is reasonable to insure the survival of the group. So two things have happened. First, we've cost shifted as much as we can to private payers. The second thing is we've significantly restricted access to Medicaid patients. So I guess my concern, and I know California is probably the worst offender because the states have a lot of say in how they reimburse but my concern is two things. One, I know there a lot of optional add on items in the Medicaid program and that that tries to widen the breadth of the program but possibly dilutes the effectiveness, the access to reimbursement. First, are you considering the option items differently than the basic covered items in Medicaid? And the second is do you take into consideration the indirect cost of the Medicaid program through cost shifting because part of the reason the commercial healthcare is going up faster than government programs is exactly that cost shift?

**MARK HAYES:** I just want to spin off of one comment that you made for just a second and say that you know when it came to the Medicare Advantage program and what we did in the

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Medicare Bill it's often criticized because it costs more than the free for service program, certainly more than the Medicaid program on a per capita basis and why is that? Well it's because we didn't put Medicare's administered prices into the Medicare Advantage program the provider reimbursement in Medicare Advantage is set at what the rest of the market says on the private said. To the extent that Medicare and Medicaid are under paying, Medicare Advantage is paying the market rate, it's going to be higher. Keep that in mind whenever you hear people say well the Medicare Advantage program, managed care private insurance was supposed to a better job than Medicare and it doesn't it costs more. Well it's because it pays providers a different way and I think the cost shifting question is one that we have to face and I can flip that back the other way and say well the Medicare program doesn't have to just follow what the private sector is doing either. So if costs are going up on the private side on of the things that MedPac has told us is that because of the managed care backlash that many of the private plans have kind of withdrawn their cost savings tools from the picture. As a result there isn't the same type of cost pressure on the hospital market that there was when managed care tools were on the table. So costs have gone up. Does that Medicare should just follow the lead and say well I guess costs are just going to go up, we'll have to pay more, or does Medicare play a role of being a prudent

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purchaser itself? So that's kind of the two sides of that debate, I think, and we sort have to live in both of those worlds because we have both of those programs operating at the same time in the Medicare program. We have the Medicare Advantage program setting its own provider payment policies and we have fee for service under the kind of command and control system of administered pricing and as result we have right now we have some cost shifting. It goes back and forth historically too, we'll probably be back here in another five years saying that Medicare is the better payer and the private sector hasn't been paying as well as it has been in the past too.

**BRIDGETTE TAYLOR:** I just want to add a point that you asked about optional services and I don't know what you meant by whether we were going to address optional services or whatever I just wanted to sort of read out the optional services are that we might be playing around with. Prescription drugs is an optional service, remedial care furnished by licensed provider, diagnostic screenings, preventative and rehabilitative services, clinic services, dental services, physical therapy, prosthetic devices and eyeglasses, TB related services, and other specified medical services. So I don't know what we're going to do about optional services. I'm not sure that necessarily my colleagues at this table would necessarily would like to mess around with

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optional services, I won't speak for you however. Even though I could speak for the majority on the house. But I just hope that if we do look at those things that we're careful about giving flexibility to the states to actually reduce those services or actually have to reduce those services or decide that they don't have enough money because we've actually done a cut to them at that same time.

**JOHN IGLEHART:** Thank you. We have time for one more questions with apologies to those that are standing up. I think the individual who has been standing up the longest is the woman in the back, yes ma'am.

**JEANETTE CLUMSACK:** Thank you. Jeanette Clumsack, Chief Nurse Executive for Michigan. As I listened to the discussions and the presentations of the last two days, I hear exciting and new initiatives in what I call healthcare coordination, the disease management, case management, [inaudible] health medication management, all of those bring to mind the healthcare workforce that will be needed and expanded particularly if we go to the more community based services. My question is really about what thought discussion around this in policy and planning in terms of healthcare workforce and the education of healthcare workforce in helping to meet these new initiatives is taking place? Are there links and dialogue happening between the appropriate congregational HHS bureaus and the Department of Labor going on?

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**MARK HAYES:** That's a very good question, we were all just muttering to ourselves while you asking it and we're not sure, at least, I'm not sure I know the answer, I'll say that. But certainly that has to happen, the healthcare professionals that are in training today and at teaching institutions have to be providing those individuals with the knowledge they need to be able to go out and operate in that market place. My sense is from talking to people that the people who are coming out of medical schools and pharmacy schools and nursing schools today are so much more equipped on the technology side and will to take on those changes maybe then people that have been out of school for a long time, that part of our transition to better use of information technology will kind of evolve into the system as people sort of come into the system out of school. But if there are recommendations that you would have for us in terms of how Medicare pays a lot of money for teaching hospitals in a variety ways and if we need to think about how to better incentivize training in those areas and you have proposals around that, we should hear about it I guess.

**DEAN ROSE:** I just want to add too, I think it's a good question and for those of who work in the health services research area, it's been an area where I know there have been some things done but I don't think enough looking at some of these serious issues. We focus a lot on the budget implications of the sort of baby boomer tidal wave that's

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coming but we haven't done a lot of looking at the burden that that's going to place on the healthcare workers of tomorrow and the same numbers sort of hold true. We've done a little bit of research on it but not enough. I haven't found a lot out there, there's been some just really looking at some of these projections but one thing in the short term is that in the senate there is going to be some look at the health professions legislation which is sort of a public health service act workforce initiative that the authorization's been expired. So there will be some focus on that issue, but I just want to add that I frankly worry a great deal about this whole issue about the demographic growth in this country regardless of how wired we may be in the future and looking at the tremendous burdens in terms of reimbursement but also in terms of the liability situation that I think you have a lot of folks in this generation of physicians and a lot in the next generation who are looking at their kids and saying I'm not sure this is the place I want to go because of that. That's across the board, we know now with nurses, pharmacists, technicians, you know folks, radiologists and others. But I think that there are some projections and I am frankly concerned looking at some of those pressures that the physician workforce of the next 10 or 20 or 30 years is not going to be sufficient to meet demand. So it's a good question I think for those of who are working in this area, if you know good data that we ought to look at that

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I really welcome that and if you haven't I'd encourage folks to look in that area because I think we do need to look at it seriously.

**JOHN IGLEHART:** I'd like to ask one final question of the panel. Secretary Levitt suggested in his first public remarks as secretary on Tuesday a strong attraction to what Medicaid has done in Utah through its waiver. Essentially reducing the scope of Medicaid benefits but expanding the number of people that are eligible for Medicaid coverage. The question is as you see down the road and obviously think about the grand tradeoffs that might occur as the administration tries to reduce the growth of Medicaid, is that one of the options that could well be on the table?

**ELIZABETH FOWLER:** Because I just respond to that because my boss, Senator Bakas has expressed a lot of concerns about the direction that the waivers have taken, the program, the Medicaid program. And one of the concerns that we have primarily is that if you look at states like Utah and what they've done, I applaud that they're trying to cover more people but if you look at the level of coverage that they have, it's not comprehensive coverage. For example you might get primary care, but not specialty care, not hospital care, and not a lot of the other elements of healthcare that we would consider to be comprehensive coverage and I think there's a lot of us out there who are worried about lowering the bar for

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what's considered comprehensive coverage. I think not including hospital coverage and counting it as newly insured I'm not sure is a fair way to characterize new coverage and I think the other piece of that is looking at the trade of and what services and new cost sharing you're imposing for people who already had coverage. I think it's a debate and I think you know I understand the policy objectives of covering more people but without expanding the amount of money that your spending and trying to do it in a budget neutral just a little bit of something I not sure it count as covering the uninsured and that's my fear.

**MARK HAYES:** I think that we have to step back for just a second and think about the problem that states face with Medicaid. Medicaid spending has given so much pressure to state budgets that it is eating up other resources like education, like some critical infrastructure projects that states need to fund, and other priorities and when we think about sort of the U.S. being competitive in the future, our ability to have a trained workforce and when you think about education, we have to think about how all these things fit together. States really, they often remind us that they have to abide by a balanced budget requirement most of them, where the federal government does not. They face different challenges than we do at the federal level when it comes to financing and we have to really think carefully about how those

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priorities are set and what happens at the state level with funding when we don't give states the tools to manage these programs. The observation I would make is that today's situation from a second standpoint is difficult in that these things like the Utah waiver and other waivers to the extent that there are concerns about them are happening today. So if we do nothing at the federal level those waivers can continue to be put forward and approved with low congressional oversight and you know there is this broad waiver authority in fact that's what's happening the whole program, really, today is being managed through the waiver process, more than half the states are operating under caps for those populations today. So the Medicaid program has been reformed and it's happening through these waivers and I think a question for is does the federal government kind of step in here [laughter] and say there should be some standards around what those waivers are, what states can do, let's give you some flexibility but let's also have some accountability with that and figure out how to better manage the program. Because today's situation actually sounds as bad as some of things that we're concerned might happen in reform.

**ELIZABETH FOWLER:** It's unquestionable that we should be providing more oversight and it's a very big concern that the program is being undermined now as Mark mentioned and some of the fundamental nature of the entitlement program is being

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changed through this waiver program, we should be providing more oversight and we have been lax in that area. I think Senator Grassley and Senator Bakas have tried, we've signed several letters together. We have a GAO report that has come out and said that the administration is overstepping their statutory bounds in these waiver programs. I think there is oversight out there, there needs to be more oversight and there needs to be more attention paid. We've tried to do what we can. Again we're not in the majority, but we absolutely should be taking on more responsibility.

**BRIDGETTE TAYLOR:** I just want to say, you heard it here you have bipartisan agreement, we're getting rid the waivers [laughter].

**DEAN ROSE:** I just want to say one sort of note of caution because I'm always worried whenever you know I think that there ought to be oversight and there ought to be transparency, I'm totally for it but I'm also do worry about us who don't face those same kind of pressures that the states do really getting in a heavy handed way and defining what is and what isn't and I think the states do have to retain some of the flexibility. I won't go into a lot of detail but the Tennessee situation which happens to be sort of close to my heart, and thank God it's a Democratic governor down there but it really is an interesting situation. And just looking at the other side of it, I was looking at data just yesterday on it, that as

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a result of a court decision having to do with essentially pharmacy benefits there are no real limits in Tennessee in the Medicaid program on pharmacy benefits at all, not managed by the government, not managed by the private plans, and at the same that time that that decision went into place all the health plans who were at risk for delivering for those benefits, decided not to go at risk for a whole host of reasons and as result of that change within in two years the pharmacy cost at the state level from about 500,000,000 a year to 1.2 billion a year and at the same time all the other services in patient, out patient services to go along at the same general level. This is a lesson in terms of a whole bunch of things but I think we have to be extremely cautious because at the same time I think we need to have oversight, we need to have transparency we also need to recognize that a whole host of other things including legal challenges that are going on in the states and I do think the governors need to reserve some flexibility to work those, they've got unique populations and unique challenges so just a note a caution as well.

**JOHN IGLEHART:** Thank you Dean. This is as friendly as it gets. Please join me in thanking the panel [applause].  
We'll break until 11:00.

[END RECORDING]

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