

**“The State Fiscal Crisis: What’s at Stake for Women’s Health”  
Kaiser Family Foundation and Women’s Policy, Inc.  
Presentation  
Wednesday, April 30, 2003**

---

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**CINDY HALL:** Hello. I'm Cindy Hall, President of Women's Policy, Inc. Welcome to the seventh briefing in our Capitol Hill briefing series on women's health. It's terrific to see such a wonderful turnout.

Today's briefing is intended to examine the challenges facing the states in maintaining and improving women's health at a time of significant budget constraints. As we will hear today from our distinguished panelists many states have already reduced Medicaid eligibility and or benefits for low-income women and their families.

As Congress comes under increasing pressure from the states to provide some relief we hope this briefing will help shed further light on the challenges, priorities, and potential solutions to addressing this critical issue.

Before we begin the program, I want to extend our special thanks to briefing co-sponsors, Senators Olympia Snowe and Barbara Mikulski and their staff, as well as the co-chairs of the Congressional Caucus for Women's Issues, Congresswomen Shelly Moore Capito and Louise Slaughter and their staff. I also want to thank the Kaiser Family Foundation our partner in this briefing series, particularly Elena Saldanica (misspelled?) and Usha (misspelled?) Rungee (misspelled?). My thanks also to the staff of Women's Policy, Inc. Jennifer Lockwood-Shebot (misspelled?), Sue Ellen Treadwell (misspelled?), Elisha Bond (misspelled?), and Susan Simalare

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

(misspelled?) for their work. A special welcome also to Gracia (misspelled?) Helman (misspelled?) the Chair of the Board of Directors of Women's Policy, Inc. as well as Marie Bass (misspelled?), Nikki Hideacrim (misspelled?), Leslie Wolfe (misspelled?), and Susan Wood (misspelled?) members of our Board who are here today.

The Kaiser Family Foundation is web casting today's briefing. It will be available after 5:00pm today at [kaisernetwork.org](http://kaisernetwork.org). So please let your colleagues who couldn't come know that they can view this then or any time that time permits and finally please don't forget to fill out the blue evaluation sheets provided in your packet. They allow us to respond to any suggestions you may have and help us to select topics of interest for future briefing.

I am very pleased to now introduce to you, two strong women's health advocates who are with us today to provide welcoming remarks, Congresswoman Shelly Moore Capito, and Hilda Solis. Congresswoman Capito who represents West Virginia's 2nd District serves on the House Financial Services, Transportation and Infrastructure and Small Business Communities. She is the Republican co-chair of the Congressional Caucus for Women's Issues for the 108th Congress and is a leader in the fight for prescription drug coverage for seniors.

**CONGRESSWOMAN SHELLY MOORE CAPITO:** Thank you. Really. Well since my job is to welcome you, I'll say welcome. I serve

<sup>1</sup> [kaisernetwork.org](http://kaisernetwork.org) makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

on - as Cindy said, on the Financial Services Committee and we just had a hearing with Chairman Alan Greenspan and if you ask me what he said I can't tell you because I didn't understand him. That's the big joke with him, he comes and talks for two hours and then nobody can really figure out what he's said. So he was successful again, I want to let you know.

S-CHIP is of particular interest to me as the State Legislator I was honored to be on the original committee that wrote the state plan for West Virginia. I was on the Conference Committee. I was on the Task Force Committee because I knew what a tremendously successful program this would be for states such as West Virginia and I want to report that after initial growing pains in West Virginia which I believe the growing pains were suffered across the nation in terms of enrollment and information and how to direct children and mothers and their families to the S-CHIP program. We have 83%, we believe of our children enrolled in the program, either through S-CHIP or Medicaid and that's significant and I know we're continuing to try to make a dent in our state as you are across the nation because I believe that it's tremendously important.

For me, I'm a real wellness and prevention advocate. I believe that S-CHIP is going to create not only healthier children but healthier adults and more viable citizens as we move through and see the successes that S-CHIP has provided in all of our states. So I am certainly concerned about any

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

potential cutbacks in S-CHIP.

I was just at a five World Health tour of five community health centers in my District over District work period and I can tell you that the good, solid outreach that S-CHIP is doing in - for children and for women has been tremendous and they're going to continue to do that.

We just raised our eligibility in West Virginia to 200% of poverty and we're excited that we had the funding both federally and the state matching to be able to provide those services throughout West Virginia.

As the co-chair of the Women's Caucus to Congress, health issues are something that I can say gladly are something we really agree on. We are deeply committed on both sides of the aisle to working together to not only improve the quality of the health of women throughout the nation but around the world and I think we're going to be seeing initiatives from the Women's Caucus where we look at issues not only in the United States but across our globe.

Thank you for including me, thank you to the Kaiser Family Foundation and Women's Policy, Inc. for putting this together. I think it's quite a tribute not only to your great organizations but to the subject matter, to the tremendous crowd that's here today. So thank you for letting me be a part of your afternoon.

**CINDY HALL:** Thank you, Congresswoman Capito and we

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

look forward to working with the Women's Caucus on women's health issues.

Congresswoman Louise Slaughter, the Democratic co-chair of the Women's Caucus, was not able to join us today. We are very grateful that the Democratic Vice Chair of the Caucus, Congresswoman Hilda Solis is going to provide welcoming remarks on behalf of the Democrats. Congresswoman Solis represents California's 32nd District and is the Ranking Member on the Energy and Commerce Subcommittee on the Environment and Hazardous Material. She has been a leader on health issues and currently Chairs the Congressional Hispanic Caucus's Task Force of Health.

**CONGRESSWOMAN HILDA SOLIS:** Thank you and bienvenidos, Spanish welcome. This is your health too. It's a pleasure for me to be here to join you, obviously Louise couldn't be here but she does send her warmest regards to all of you and I'm just pleased to be here because this is such a timely, timely topic for all of us to be talking about with respect to the crisis that all of our states, 50 states that are going through major, major deficit spending and trying to figure out what priorities - legislatures are going to be moving forward with and many of those friends that I have in Sacramento are looking to us.

I know they're doing that from across the country to see what kind of remedies and solutions the federal government

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

will help apply and as a former State Legislator and State Senator in California, I was Budget Subcommittee Chair on Health and Labor and many of the reforms that we had passed in California providing preventive measures on diabetes management, asthma, obesity, many innovative programs that we helped to put in place several years ago. Many now to our surprise are being eliminated because of some of the proposals that are being talked about.

I would hope that that discussion doesn't end here and that we go out and we really have that discussion with people that are in the field, to our patients, to our community and really get a better sense of what's happening out there.

In my District alone we had 11, actually in L.A. County 11 of our public health clinics close. So I know very, very pointedly how critical it is to provide access particularly to low income, uninsured families, their children and most of all women, women who rely, in California at least, on Medicare and for those low income and under served populations, Medicaid, a very important program that serves as our safety net.

We have to continue to keep that foundation there. Many of us in the Congress are going to work very hard to see that those voices are heard when there's discussion or bills that are coming up, whether it's to provide a prescription drug benefit, whether it's to expand S-CHIP programs, which I agree wholeheartedly. We need to keep those programs that we know

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

work, that work and were determined by our state governments to allow them to have not just the flexibility but a funding source so that they can continue in some of the trail blazing efforts that they've led. I was happy to be a part of that. I know it works and in my community and because I am the now Chair of the Hispanic Task Force on Health, I know how important it is for young women and for elderly women of particular of Hispanic descent they go many times without treatment, without going to get a mammogram, to get services that they know - that they don't know are available to them, that are free. In many cases it's about accessing information to get to the clinic or get to a doctor, or get to a provider that even speaks their language. That is another barrier that we face, not just of women who are Spanish but women of different backgrounds and even educational backgrounds.

So we have a lot of work to do before us and I'm very excited about the opportunity to work with all of you. I'm so pleased to see the outpouring of support here. Yesterday I joined other colleagues in the Congress and we held a series a Tri-Caucus if you will conference on the uninsured and the whole issue of providing assistance and extending a helping hand to make sure that those communities at risk particularly women and their children receive the kind of help and support that they need here from the federal government.

So I'm happy to be here and I commend the Kaiser

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Foundation and also all the individuals that are here, more importantly Cindy for bringing this all to the forefront and let us continue and begin our work that needs to take place. Our communities and women are counting on us. Thank you, very much for having me.

**CINDY HALL:** Thank you, so much, Congresswoman Solis, we are so fortunate I think you all would agree to have these wonderful leaders, leading the Women's Caucus and out there advocating for women's health. So thank you so much.

I am now pleased to introduce Elena Salganakoff (misspelled?), Vice President and Director of Women's Health Policy at the Kaiser Family Foundation who will be moderating our program today.

**ELENA SALGANAKOFF:** Wow! It is such a pleasure to see so many faces here today. The interest in this issue has really quite honestly surprised us and we are really glad to see so many people engaged and worried about this issue because we too have been very worried about what's going to happen to all of the important accomplishments that we've made in the past decade for women particularly at the state level.

Part of the objective of this series is to look both at national and state health policy issues for a woman's (unintelligible). Focusing when possible on issues that are of importance to you and Congress or the Administration and all sorts of federal agencies.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

As you've probably heard, states are facing some of the biggest economic crises that they've seen in years. In the past decade many states had surpluses and they were able to expand as we heard in California and really expand programs that really benefited women particularly women who were low income but not just low income women.

Today the story is very different. The economic downturn and the resultant increase in tax revenues has hit the states very hard. States are now taking hard looks at their budgets and in some cases they're being forced to make some very painful cuts and I recently read an article that stated that some states are looking like they're raiding the change jar. I mean that's how desperate they are in terms of programs that they're cutting and I think that's what we're seeing.

The states however, unlike the federal government don't have the option, most of them are running in deficit and virtually no state is unscathed. My own state of California, as we heard, appears to be the big winner of them all. Really looking at a budget shortfall of upwards of \$30 billion dollars and I mean from what I've heard April 15th was not very good to the State of California. So in a couple of weeks we're going to get the revised budget and it could be even larger.

There has also been quite a bit of press about the budget crisis and the impact on the uninsured, but what hasn't been clearly articulated is how this is likely to effect women

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

both in terms of Medicaid coverage and in eligibility and also in terms of the scope of benefits that women are getting.

In addition, there are other discretionary programs that are of importance to women that are also being cut that are related in some cases funded separately than Medicaid. These are programs that states use for education and training but Medicaid is really the big issue that we need to discuss.

Medicaid at the state level is typically the second largest item in the state budgets following K-12 education and in the states a lot of the attention has really been focused on how to manage Medicaid spending. Because of the importance of Medicaid today particularly we need to appreciate that Medicaid plays a vital role to low income women, both mothers and pregnant women, women with disabilities, to senior women covering both their prescription drug costs, their long term care costs, women have a lot riding on the outcome of this budget debate both at the state level and here in Washington and the states have been searching for solutions that are going to give them fiscal relief.

Several options have been forwarded from giving states additional federal funds through an enhanced match to an ambitious new restructuring proposal developed by the Bush Administration that would give the states the option of using a block grant to cover certain Medicaid services for optional population and this clearly will have major implications for

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the individual entitlement that we now have under Medicaid.

We hope you're going to leave today with a better understanding of what's at stake for women and we've enlisted a great panel of experts to help us.

We're going to start off today with Judy Waxman (misspelled?) who recently joined the National Women's Law Center as the Vice President for Health and Reproductive Rights. Judy has extensive experience working on health issues and in the interests of time I'll refer you to her bio along with the other bios that are in the briefing packet.

Judy's going to be giving us an overview of Medicaid's role for women and some of the progress that many states have made in improving coverage for women. Judy and her colleagues have been hard at work at the National Women's Law Center preparing a state by state analysis for the foundation of key policies affecting women's access to care and that report should be ready for distribution by the end of the month we're all eagerly awaiting it and we will be sure to get copies to all of you when its available.

We're going to then turn to Jocelyn Guyer (misspelled?) who is the Senior Policy Analyst with the Kaiser Commission on Medicaid and the Uninsured. Jocelyn's going to share some of the work that the Kaiser Commission has been conducting on what's been happening to state budgets and how states have cut their Medicaid programs in response to the fiscal crisis,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

really to (unintelligible) what with low income women would be facing.

Then we're going to have response and talk a little bit more about them after we hear the first two panelists. I'm going to ask that you hold your questions until the end, we've (unintelligible) some time, we're trying to leave some time for questions after the session. We also have green cards in your packet if you have a question and you'd like to write it down the card will ask it that way too. Now I'll turn to Judy.

**JUDY WAXMAN:** Thank you and I'm very thrilled to be here in this capacity and I hope you're enjoying your lunch.

My role this morning is to talk about what Medicaid means to women and I'm going to do a little bit of a primer so that that becomes clear but let me start off by saying that 70% of beneficiaries of Medicaid over the age of 15 are women. I know that's a little further down on my slide but that is a point that maybe I should've put first and that is - I will explain how that is so but the point is Medicaid is by and large a women's program. Let me say it again, 70% of the beneficiaries of Medicaid over the age of 15 are women.

So when we talk about what Medicaid is, who it serves, we are really primarily talking about women. Medicaid as I'm sure all of you know, is a program that serves many low income people in this country although not all but at this point it is serving 50 million people, which actually means its bigger than

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Medicare. Medicare does not cover 50 million people, it's more like 40 million people so that's another thing that I think that's little known.

Additionally, as Elena mentioned it's what we call an entitlement program, in other words, this program has some federal rules, some state rules but if an individual is covered under the state plan, then the federal government will give money to the states that's an entitlement to the states and anybody who meets that eligibility criteria will be enrolled and get access to services. That's what an entitlement program is and Medicaid is run like that as is Medicare.

As we all know when we turn 65 if we have enough quarters and we're getting Social Security, we will get Medicare because it is an entitlement and Medicaid works that way too.

Additionally, another point to know that one fifth of low income elderly women are covered by Medicaid. So while that is a huge number, it's important to realize that not all low income women are covered by the program - next slide - this is kind of self explanatory and I won't go through all the numbers but it gives you another idea, another way of looking at who is actually covered by the program. So you can see the Medicaid is the lighter colored and the darker colored blue is the uninsured so you could imagine what would happen to low income women if we didn't have Medicaid or it gets cut back. Again

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

this explanation of course the rest of the numbers that is in there is people that are privately insured or otherwise covered. Next.

This is a little chart to explain the categories of people who are covered and why only some low-income women are covered by the program. Who are the women that are covered? Let's start out with the elderly, if you are over 65 and your income is very low, maybe you have a very low Social Security check or maybe you don't get Social Security because you were a maid or a childcare worker or something else and you never actually had that taken from your salary, had your FICA and so forth, you have a really low income, Medicaid will cover you.

It also covers elderly people for some long term care services and I should say that while the elderly are a small part of the population they of course take up a bigger part of the money because of the expenses that elderly obviously need. I'm going to get a little bit later into some of the services that are covered for each group.

Who are the people that are disabled? Well they're women, also very low income, women who have HIV, women who have mental illness, women who have multiple sclerosis, that's the disabled population.

Then we get to the parents with children; generally in this case we are talking about the moms because these are the moms, usually the single moms who are the lowest income folks

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

in the country. At one time you had to be on the Welfare program to get Medicaid but a number of years ago we say that link was severed and no longer do you have to be on the state's now it's called the PANEF (misspelled?) program to get Medicaid but most people who are on PANEF (misspelled?) will get Medicaid but it also the states have and we will get to the eligibility levels, but many states have increased their income eligibility levels so that women who are struggling to get off of Medicaid - pardon me I've just got startled by my five minute notice - women who are struggling to get off the PANEF (misspelled?) will get some extra time to be on Medicaid and also those lower income working women may be able to get Medicaid. You have to have a child to be in this category. So that's why it's Parent's with Children.

Pregnant women, AGI Zuttmacher (misspelled?) Institute said about 40% of all births in this country are now covered by Medicaid and for children sometimes are little children but teenage children and some states let it go up to age 21 so you also have people categorized as children who I would say are young women.

So that's who the women are that are on the program. I obviously have to speed up dramatically. Okay the next chart shows you the mandatory income levels and I do want to make one point here that the parents' level is actually not a mandatory level in that all states must cover 41% of poverty. That is

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

based on the states' old Welfare levels from 1996 and the median average - the median number is 41% so some states are as low as 13% of poverty, other as high as about 80% of poverty but this chart shows you why not all low income women are covered. You can see the 100% line right there.

Okay the next three - the next three charts I think we'll go through very quickly and you can really look at your own on your own but the point is states have options to cover more people than just those at mandatory levels. The minimum required level for seniors and disabled is 74% of poverty but you can see that a number of states have gone higher.

Okay for parents, we have the lowest eligibility levels there and again you can see really that most states are below 50% of poverty but a number of them have gone higher. Unfortunately we're seeing some states that have gone higher and are now cutting back but this is the state of the country right at the moment.

The next one is pregnant women, again pregnant women, the minimum is 133% so you have an obviously a much better chance of getting on the program if you're pregnant.

Okay quickly through the services. Why Medicaid's important to women. There really is no other program for long term care in this country. Medicare doesn't cover it and who are the old, old in this country? They're women. So Medicaid will cover nursing home costs and in fact three quarters of the

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

people in nursing homes are women and Medicaid covers about 70% of all home-nursing costs in the country. So this is really a program for women.

Prescription drugs, again as we all are well aware Medicare does not cover prescription drugs. If your income is below 74% of poverty you can't afford drug (unintelligible). I'm not sure any of us really can but that population obviously cannot, so somebody can be what we call dual eligible, eligible for both for Medicare and Medicaid and the big advantage of being on Medicaid is that prescription drugs are covered.

Comprehensive coverage, we're now talking about the parents and in this again, in this country unfortunately if you don't have insurance you may be able to piece together services here or there but if you really get sick you are not going to get the care that you need. So Medicaid covers not only doctor or hospital and lab costs it also covers preventive services such as mammograms, pap smears, et cetera and I particularly wanted to mention family planning services because family planning services are a mandatory service under Medicaid and it covers more family planning services in this country than any other public program. So that it is something to think about as states cut back as to what that will actually mean for family planning services. Next slide.

To finish up, just a little shot of what has been happening to women in the labor force. Since 1994, well really

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

since 2001 you can see that more poor parents, more single moms are in the workforce but look what happens to their healthcare coverage, it has gone down significantly and why is that? Well for one thing when we separated PANEF (misspelled?) and Medicaid, many women lost their Medicaid at that period but additionally women that are moving into the workforce are often moving into part time jobs, low wage jobs, the service sector and those jobs do not carry with them health insurance or maybe they have health insurance and the premiums are so high and the cost sharing is so high that it really isn't affordable for these people.

So that's what we're looking at in this snapshot is why Medicaid is an important issue for women and in my last minute what I'd just like to - I'd like to allude to what Elena said in what terms of what Congress is looking at and I assume we will talk about this a little bit more as we move on but there are two proposals that they're really kicking around right now, one is to give states some fiscal relief, which you will hear more about why that's important.

I understand there was a meeting this morning in the Senate and so maybe somebody can tell us exactly what happened but there is a question about how much money might go to the states and whether it will be for a Medicaid enhancement for a temporary (unintelligible) or not.

The other plan that is in the budget is a Bush Plan

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

which basically looks at Medicaid and says to the states well this a very quick, fast growing program so what we're going to do is limit the federal liability. We will give you more flexibility, which means you can cut benefits and cut people and so forth but we will also when we do that give you a limited pot of money and say that's all you get. So it will not be an entitlement anymore.

To be fair the plan also offers states a little bit more money in the first couple of years but then they would have to pay it back at the end of the 10 year period which this - over which time this plan would last.

So I don't need to say much more about my view of which one of those would be better but we're happy to discuss more details as we move on in the discussion and I hope that I didn't go over too much. Okay. Thank you.

**ELENA SALGANAKOFF:** Okay now we're going to talk in turn to Jocelyn Guyer (misspelled?) who's going to talk in a little bit more detail about what's going on at the state level and some of the difficult choices that some of the states have had to make. As you can tell I'm like a technological whiz at this stuff [laughter]. It's okay.

[ OFF MIC ]

**JOCELYN GUYER:** Thank you, Elena and I'm assuming that's not coming off my time [laughter]? Before I turn to the state fiscal crisis what I want to do is spend a couple more

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

minutes on Medicaid's role and that's outlined in figure one for you and the reason I want to do this is that I think as we go through figure one what you'll see is that the Medicaid program is at the crossroads of some of the most expensive and pressing healthcare problems confronting the country.

As Judy said, Medicaid provides long term care and healthcare coverage for over 50 million people, of those 50 million people, 25 million are children in low income families and 13 million are adults, mostly the parents of some of those children.

Medicaid is particularly vital to the healthcare coverage of children in this country. At present it covers roughly 1 in 4 American children and when we talk about Medicaid's role, one of the things we've seen in recent years is as the economy has declined and more people have lost private coverage, Medicaid has stepped in particularly with respect to children to fill in the gaps and so while we've seen increases in the uninsured rates, similarly in recent years we have not seen a growth in the number of uninsured children because of the protective role that Medicaid plays.

It has not done a good a job protecting women from losing healthcare coverage and that's important because of the kinds of cutbacks states are being forced to make in light of their current fiscal crises.

The other thing that Medicaid does is cover over 12

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

million seniors and people with disabilities including 6 million people who are what we call dual enrollees and these are basically people who both get Medicare coverage but they also get Medicaid coverage and they need Medicaid because Medicaid helps them with their long term care costs, with their prescription drug care costs and also in some cases with their Medicare costs during obligations. This is actually one of the most expensive functions that Medicaid serves. If you look at Medicaid spending, more than a third of it is due to the cost of covering these dual enrollees and that's been a major source of the fiscal crisis that states are facing.

Judy's already talked to you about the guarantees that Medicaid provides to individuals and I wanted to spend a minute to examine the fiscal guarantee it provides to states. The way Medicaid works is states decide how much to spend within (unintelligible) parameters set out by the federal government and they decide about a range of options that they can pick up or not under federal law.

The federal government supports this system by assuring states that it will pay between 50% and 77% of the costs of operating Medicaid with exact share that the federal government picks up depending on a state's Medicaid matching rate and that's open ended funding so the state spending goes up because the state's decided to try to cover more low income working parents and the federal government is there with additional

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

federal funds and this has been one of the defining features of the program since it was started in the 1960's.

In terms of the role that Medicaid plays for state finances when you look at all of the money that the federal government sends to states including transportation funding, Welfare funding, fully 43% of that is Medicaid dollars going to the states and finally when you look at the healthcare system as a whole nearly 1 in 5 healthcare dollars is paid for by Medicaid and as Judy said if you were to look at nursing home care in particular a majority of nursing home care is provided by the Medicaid program.

So with that as some context what I want to do is go through with you what the fiscal situation is in states right now. It's widely characterized as the most dire fiscal situation confronting states since WWII and I think that figure 2 gives you a little bit of a sense of that, both in terms of showing you that states have been facing shortfalls since fiscal year 2002 at this point which means that we're going into a third year of states really struggling with their budget situations and part of what that means is some of the easy options that states have like turning to the rainy day fund that they built up in the 1990's are completely gone at this point. They're really stuck with some very difficult choices in the current budget environment.

In figure 3, you get a sense of where a key source of

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the problem is for states; really what's happening here is that states have experienced dramatic declines in their revenue growth. As you can see throughout the 1990's states experienced positive revenue growth of 5% or 6% a year and this happened even though at the same time they were cutting taxes but by 2001 the revenue growth had slowed down and in 2002 revenue actually declined roughly 6% below the level states had experienced in 2001. So that's really a shocking turn about in states' revenue situations.

At the same time that revenue has declined states are facing spending pressures including most notably in the Medicaid program.

In figure 4, it gives you a sense of the sources of Medicaid spending growth. In fiscal year 2002, Medicaid grew roughly 13% a year. I mean a really couple of key reasons for that; I'll just highlight a few of them that are noted here.

First, in general as a country we're experiencing a renewal of health translation, the private sector is also struggling with this renewal in health translation. Our Kaiser studies have found that in the last year private employers have seen their healthcare premiums go up 13%. Medicaid is facing that same set of circumstances.

Unlike the private sector, Medicaid is a program designed to step in during economic downturns and to enroll more people. So while private employers may be dropping people

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

from coverage, the Medicaid program actually now has a larger responsibility because we have more Americans without jobs and without access to employer based coverage, who then turn to the Medicaid program in some cases for health and that's why we've seen these relatively rapid growth in Medicaid spending in recent years.

What figure 5 does is try to give you a little bit more of a kind of concrete sense of really where that spending growth is coming from in terms of the people that this program serves. Judy mentioned that there may not be compared to children that many elderly and disabled people on the program but they happen to be quite sick and in need of extensive healthcare services and so when we look at the expected growth in federal Medicaid spending over the next year more than three quarters of it is due to the cost of serving the elderly and the disabled and again that's because of rising costs in prescription drugs and long term care services for this group.

Figure 6 is designed to give you a sense of the relative contributions of the revenue growth of the falloff in revenues that we discussed versus the increase in Medicaid spending and I think this is important to kind of understand as a whole what's happening with state finances and what this shows you is that the unexpectedly high rate of growth in Medicaid spending contributed about \$7 billion dollars to state shortfalls in fiscal year 2002. In contrast the drop off in

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

revenues contributed roughly \$62 billion dollars to state shortfalls. So when we look at what's going on here it's not primarily Medicaid that's the source of the state budget problems it really is primarily the revenue situation that states are confronting.

In response to these very difficult situations, states have looked to Medicaid as a source of savings in part because as Elena said it's the second largest item in their budgets and what I hope you'll take from figure 7 which is based on a survey we do of state Medicaid officials is that states have been having to turn to Medicaid for cuts for a couple of years now and one of the things I think emerges from this figure is that in fiscal year 2002 states really tried to cut costs that really primarily affected providers that primarily got them more money for Medicaid from prescription drugs - on the prescription drug side. They tried to stay away from cutting eligibility and other cuts that would directly harm beneficiaries.

By fiscal year 2003, states have used up some of those easy options and were having to start to take those cuts that really directly harm beneficiaries and as Judy said we know 70% of them are women. So really it comes down to cuts that directly cut into the coverage that's available for women under Medicaid.

What I'd like to do in figures 8 and 9 is just give you

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

a little bit of a specific sense of what those cuts look like and I'm going to start with seniors because they really are primarily women and every state has turned to reducing nursing home payment rates but increasingly they're also resorting to some rather (unintelligible) measures to cut background prescription drugs for seniors.

Mississippi for example, has reduced the number of prescriptions a Medicaid beneficiary can receive from 10 to 5 per month; similarly we're also seeing some pretty dramatic cutbacks in actual eligibility for seniors. One of Medicaid's key programs for seniors helps women with high medical bills qualify for coverage. Basically you're allowed to subtract from your income your high medical bills including your nursing home care and that's how a lot of middle-income women and other seniors get into the Medicaid program. In some cases they're simply eliminating those programs including Oklahoma is an example that's listed here.

The other cuts that we're seeing relate to coverage of women who are taking care of their children and this is the area where we see perhaps the most dramatic cutbacks in eligibility for women and the example I've listed here is Connecticut lowering it's eligibility cutoff for parents from 152% of poverty to 100% but this is a common strategy that we're seeing states feel like they need to take given the budget crisis. They're also increasing the cost sharing

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

obligations of women on Medicaid and cutting back on some of the benefits they receive.

Figure 10 which is the final figure I include it because I think when we talk about cuts and budget situations it's easy to lose sight of the people that rely on this program and so I'm not going to read the quote for you given the short time but I think it gives you a personal sense of some women who have really turned to Medicaid as a key source of health and these are the kind of people who will be very much affected by cutbacks. So with that as a little bit of overview of where things are I think I can (unintelligible).

**ELENA SALGANAKOFF:** Thank you, Jocelyn. We're now going to turn to hear from some voices from the states. We are delighted to have Sharon Green here with us today who's the Director of Women's Health in Illinois who's going to just discuss some of the challenges and some of the important improvements that Illinois has seen in women's health and then we're going to wrap up with Joan Henderberry (misspelled?) who's the Director of Health Policy at the National Governor's Association who has also personally had a lot of experience working on the state level on women's health and on maternal and child health issues and she's also going to share what she's been working on with the states in terms of women's health.

**SHARON GREEN:** Thank you, Elena and good afternoon

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

everybody it's certainly a pleasure to be here today. Let me begin by telling you a little bit about what's going on in my home state of Illinois.

The Illinois Office of Women's Health was established in 1990 (unintelligible) administrative action as one of six offices in the Illinois Department of Public Health as Deputy Director I report directly to the Director of Public Health who reports to the Governor.

The current budget for the Illinois Office of Women's Health is \$14 million dollars, \$8.2 million in federal monies and \$5.9 million in state funding. Next year's proposed budget includes an additional \$2 million dollars in state funds and if approved it will bring the FY04 budget for the Illinois Office of Women's Health to approximately \$16 million dollars. The Office currently has a staff of 16 and about 8 unfilled positions due to a statewide hiring freeze.

Thanks to the support of three governors in 6 years our office is now the most funded, most staffed and Office of Women's Health in the nation. So we have truly been blessed but we are the exception.

What about the other states? There is no single definition or model for the State Office of Women's Health and all states are unique. In some states there is a bureau or section within an office dedicated to women's health, other states there is legislation to create an office but no funds or

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

no staff.

States like Wisconsin and Michigan had initiatives started by their First Ladies that were never institutionalized and thus no longer exist in the majority of states there's someone called a Women's Health Coordinator who is actually employed by Maternal Health or Sexual Assault, Chronic Disease or other health programs and must carve out a niche for women's health within borrowed funds.

To date there are probably about a dozen states with an entity that we loosely can call an Office of Women's Health with dedicated staff and dedicated funding. That number fluctuates up and down monthly as some offices lose their funding and others are created. So why have we succeeded/

From my experience the key elements to sustain a State Office of Women's Health include a dedicated budget with specific line items, staff, and a direct reporting line to the host agency and there's one other issue that I believe that's unique to Illinois, prior to forming the office, the state went through a major reorganization where the Maternal and Child Health and WIC programs were moved out of public health and did not become part of our Office of Women's Health.

This allowed our office to have a much broader definition of women's health across the lifespan and not limit it to (unintelligible) to the traditional focus on reproductive and maternal health. Since we live two thirds of our life

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

outside those years, it's pretty important that we include those other (unintelligible).

One of the first things that my staff did was conduct a survey of all state agencies and what we found was interesting. Over 65 programs dealing with women's health in 11 government agencies, the two most funded areas for women were maternal and child health and domestic violence. Most of the other women's health issues received little or no funding compared to these two, breast cancer did not even come close, nor did heart disease the leading killer of women.

For a variety of (unintelligible) issues my office never had any expectations about taking over those 65 programs instead our role is to serve as the clearinghouse for programs housed in other agencies and help women navigate the complicated government system but let's move on to the discussion for today. There are several key points that I wanted to make and I'll divide them into state issues and federal issues.

First, on the state level, women's health outside of reproductive health is a relatively new priority area for the states and it is floundering as governors and legislators struggle to find new ways to cut their budgets women's health programs unless they are federally funded and institutionalized are vulnerable however women vote and efforts to (unintelligible) help keep this in check.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Second, more women, as mentioned earlier, more women are losing health benefits and are turning to the public health sector for help. These women are new to the public health community and need assistance navigating the system. We must improve customer service and do a better job of informing the public of available services. Public aid will no longer just be for the poorest of the poor.

Third, the Medicaid system will continue to be challenged. We are fortunate in Illinois that our new governor, Rob Blagojevich despite the \$5 billion dollar state deficit is not proposing any cuts in Medicaid and is actually recommending an increase in eligibility for Kid Care and Family Care.

While Illinois did not cut rates for doctors' services however the budget crisis has delayed the time it takes to get reimbursed and providers are beginning to refuse new patients. Small town pharmacies are shutting down.

On the policy side, Illinois has been relatively progressive on many women's health issues however this does not seem to impact the health status of the state's women. Making the grade on women's health (unintelligible) report card prepared by the National Women's Law Center rates Illinois pretty high when it came to policies however we still ranked 36th in health status. I suspect that this has more to do with the demographics of the state than its policies. States that have large minority populations, under served rural areas and

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

poor urban centers will continue to influence the overall health status of a state no matter what the policies say.

Now I'd like to move on to federal issues. First of all who's taking the lead on women's health at the federal level? There are (unintelligible) agencies like the Public Health Service, Health Resources and Service Administration on (unintelligible), the FDA and the CDC have women's health offices and work together on a coordinating council but each agency comes with it's own agenda. The states that actually have Offices of Women's Health gravitate toward the Public Health Services Offices on Women's Health because they are viewed as having the most comprehensive approach to women's health but they have little money available to support what we're doing in the states.

The Center for Disease Control has a significant amount of categorical funding but most of their funding except for breast and cervical cancer is population based and it's difficult for the states to carve out pieces of these dollars to address specific gender issues.

The recent effort to consolidate grants into one application process have state program staff worried about turf and ownership issues. As states implement hiring increases that often include federal hiring it would be helpful if the CDC communicated directly with our governors on the importance of filling federal positions. This could help program staff avoid

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

being in the difficult position of having to justify unspent funds and go through the complicated carry over spending process to keep the funds available.

Third, HERSA has a large pool of funds available to the states through the MCH, the Maternal and Child Health block grant and (unintelligible) programs however we must be vigilant in monitoring its role in women's health. There has been some movement to take the C out of MCH and address the whole woman and that is the prodigal however HERSA relates to those state agencies that house MCH and many of these programs are not handling general women's health.

Any effort to expand women's health should be done in partnership with other women's health leaders at the federal and state level. We don't want to revert back to those days when we defined women's health by our ability to have babies. We have only come so far and we don't need to let that happen but thank you and waiting for your questions.

**JOAN HENDERBERRY:** Thank you very much and thanks for inviting me. I don't - I'm not a lobbyist for (unintelligible) so I don't come to the Hill very often and when I was the Director for Women's Health in Colorado of course one of our champions here on this side of the Hill was Pat Schroeder so it's very nice to meet some of the next generation champions for women here in Congress.

I absolutely concur with some Judy and Jocelyn's

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

remarks and the data that they presented in fact we rely at NGA very heavily on the data that's produced by Kaiser and their analysis so we really appreciate that.

Let me just give you a few more specifics so about what's going on and we touched a little bit - Jocelyn showed you a few slides on the revenue side and we're not going to talk - we haven't talked very much about the revenue problems that are driving a lot of the debate and the fiscal crisis in states but it's quite real and states as we speak it was just two weeks ago that we all had to file our tax returns. This is exactly - it's the month of May that states are paying very close attention to what the revenues - personal income revenues that are brought in by tax collection and they'll have a better sense by the end of May of what the picture for '04 looks like but it looks pretty grim, '04 looks worse than 3 and 2 and in addition to the healthcare cuts that 21 states - in addition to the healthcare cuts that have already been made, one of the things that you also will see that we haven't talked about are the cuts to education. If there is such a thing as a sacred cow in state government it usually is education and particularly K-12 but 21 states are cutting education, K-12 education and another 25 higher education so for those of you who are trying to get yourself through college or your parents are trying to pay for your children to go to college then you're feeling that pain as well.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Nineteen states expect their '04 budget cap to be 10% or higher meaning that the - as they're getting ready to start their fiscal year '04 which for most states is July 1st, they're already seeing that the gap between their revenues and their expenditures is going to be at least 10% and 13 states as they wind down '03 are expecting to get to the end of the fiscal year making last minute budget decisions because their gap is still 5% or higher and they only have two months left to figure out how to fill that gap because as was pointed out there's really only one state in the country that does not have to balance its budget and that's Vermont.

So we are talking about a \$70 billion dollar projected shortfall for '04 and 28 states specifically have Medicaid shortfalls and one other population that was just touched upon a little bit by Sharon that I don't like you to ignore. We're not here to advocate on behalf of state employees but the first thing that states always do and what they did a lot of in '02 and '03 affects state employees and I bring this to your attention in light of Sharon's remarks because the first thing that they do are hiring freezes, cutting back, layoffs.

And so what's happening in state government is really a loss of a lot of talent and particularly with programs like women's health and a lot of the service delivery programs that often fall under the umbrella of women's health, those are categorically funded they may be state only funds and they're

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

very vulnerable and when you lose the leadership of people within state government who have been behind those programs for a very long time or even new, young leaders it can place a really big hole in both the policy analysis, the advocacy that's done within a state government, so I don't want to ignore the impact that losing people and important people can definitely affect the priority that women's health programs get - I mean the attention that they get particularly in state legislatures.

One concern for - I was asked really to talk about now what are our concerns and now I'm also going to talk a little bit about what the governors are doing on Medicaid reform but I do want to remind everybody that one of my concerns especially having been with those people in state government running the (unintelligible) programs particularly programs with a focus on prevention is the vulnerability of prevention services that not only improve health but in the end really do save money and some of the best data that's been out there for a long time on the impact of savings on prevention programs comes from the data on family planning and on pre-natal care. The amount of money when you spend money you ultimately save money and it was those studies and those data that were - allowed us in states like Colorado and in many other states to expand healthcare for women because we had good information about prevention and the savings that that ultimately makes and I'm quite concerned

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

about the vulnerability of prevention efforts in all kinds of healthcare programs. They are hard to prove. It takes a long time to prove that prevention works. It's very hard to fund evaluation in state programs and state governments and it's very hard to get the money to fund evaluation but you need to do it so that you can justify continuing to fund those programs.

And I also do want to add my concern for older women. Although we talked a lot about them today as well but they're quite vulnerable particularly the dual eligible population and because the most frail, most elder population in this country are women, we're very concerned about them as well.

Let me just give you a couple of examples of the kinds of things that are on the table right now in these last two months of state fiscal year '03. The Missouri Senate Appropriations Committee wants to eliminate contraceptive coverage in their programs although I'm not quite sure how they're going to do that since it's mandatory but if anybody will try it's going to be Missouri.

Twenty one states have increased their cost sharing for prescription drugs, 15 states for other services, 14 states still decreasing reimbursements and the only reason that figure is so low is because they did so much reimbursement decreasing last year, 20 states changing benefits typically things like eyeglasses, podiatry, dental, physical therapy, occupational

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

therapy, again these aren't high (unintelligible) items necessarily but you pretty much can only cut optional services to optional populations and there just aren't many of those out there, 19 states changing eligibility, 40 states focusing once again on rationing down the prescription drug benefit and managing that benefit better. The state of Washington Senate wants to eliminate coverage for illegal immigrants and the medically indigent funding. The North Carolina House has put a proposal together that would make substantial cuts including decreasing eligibility from pregnant women in Medicaid from 185% of poverty to 150% and then also eliminating Medicaid coverage for 19 and 20 year olds. The Texas House has a proposal on the table to decrease eligibility for pregnant women from 185% to the mandatory level of 133% those things aren't decided yet they have again two more months for most states to make those decisions although some of these legislatures are full time but those are the kinds of things that are on the table that we need to pay a lot of attention to.

So for what's next? What do we see? The governors as you may know after their February meeting formed a Medicaid Reform Task Force it's made up of 10 governors, 5 Democrats, 5 Republicans and it is chaired by our NGA Chairman Governor Patton from Kentucky and our co-chair Governor Thorn from Idaho. I won't go into a lot of detail, the Task Force is

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

meeting about 3 times a week and they're hoping to propose something and present something to their colleagues, the rest of the governors who haven't been at all the Task Force meetings. They hope to do that by the end of May but basically what they've done is they've divided their conversations and their discussions about policy into six big areas. One is the dual eligible population as you heard these are the poorest and sickest of the folks who are on getting Medicare benefits but as we would say Medicare it desperately needs reform.

The governors consistently call for simultaneous Medicaid and Medicare reform because the two are very interrelated and the two things that are most broken - there's a lot broken in Medicare but the two things that are probably the most broken are the lack of nursing home and long term care benefits and outpatient prescription drugs. So we've had a lot of discussion about what to do and how to improve services in collaboration and coordination of services for the dual eligible.

Flexibility, there are now 2,500 approved Medicaid waivers in states. States and governors think this is cumbersome. They also feel that once something has been - a waiver has been adopted as a state of the art practice and it's what we all do why does everybody have to keep getting waivers to continue to do it? So they're looking for more flexibility.

Prescription drugs, particularly again, outpatient

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

prescription drugs for the Medicare population would bring a fair amount of fiscal relief in Medicaid to the states as also the right thing to do so governors are paying very close attention to the Administration's proposal on Medicare prescription drugs and other Congressional proposals as well.

Long term care, governors think that the time should come to an end when Medicaid is the only source of financing in this country for long term care and nursing care. We must encourage private and public sectors and family based programs and employer based programs. We have to fix the long-term care system and we can't continue to do that on the backs of the working poor and the Medicaid program.

Private sector coordination, we would like much better coordination when people do have access to employer based insurance but can't afford the premiums, better ability to coordinate public and private sector and then the financing piece is the current way that states and federal governments share in the financing of Medicaid. The best way for the 21st century or does that need to be improved?

So those are the things that the governors are looking at they will hopefully make an announcement within the next month and you'll know more about where they are. They are looking carefully and meeting regularly with Administration officials to look at the President's proposal and see how it aligns with the NGA policy. All of our policies on Medicaid, on

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

fiscal relief and everything we do is on our web site. So it's public information and I encourage you to take a look at it.

Our concerns will continue to feed the general economy. People losing coverage as you heard because they lose their full time job or they switch to part time jobs or they begin to work for small employers, the rising cost of coverage, nobody's really talking about that a whole lot why is everybody paying more for health insurance and healthcare services than we used to and what are we all going to do about that? And then the continued pressures on the public sector system and what can we do to improve that so that we relieve not just some of the Medicaid pressures but the fiscal pressures in general. Thank you.

[ END]