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Briefing: Healthcare in the New Congress: Insiders Look Ahead
December 10, 2004

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ED HOWARD: Good afternoon. Thank you for coming. I'm Ed Howard with the Alliance for Health Reform. On behalf of Senator Jay Rockefeller, our Chairman, Senator Bill Frist, our Vice-Chairman and the members of the Board of the Alliance, I want to welcome you to this session to look at how Congress might approach healthcare issues in the 109th Congress, which is just a few weeks away. My partner in today's program is the Kaiser Family Foundation whose good work on a whole range of policy issues is well known to most of you. We're grateful for their support, and we're pleased to have with us the Executive Vice-President of the Foundation, Diane Rowland, from whom you will hear in a moment.

We've just come through a campaign in which healthcare was an important issue, ranking behind the war, terrorism, that bundle of issues, and the general state of the economy, at least in the Presidential race. There was a good deal of evidence, and we heard some of it in a program we ran last week featuring some Democratic and Republican pollsters that healthcare was ever more important and occasionally even decisive in many of the congressional and gubernatorial and state legislative races.

Now, in real life, as opposed to politics, healthcare concerns are pretty easy to find, in America, because as Congress prepares to reconvene in January, healthcare news is

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just everywhere. You've got healthcare costs going up two or three times as fast as other prices and that is labeled as good news, because that's a lesser rate of increase than we've experienced over the last couple of years. You see legislators and governors in places like Maine and Massachusetts looking at ways to extend coverage to their uninsured residents and Tennessee, struggling to put a brake on the spending in their program for their uninsured in ways that do as little harm as possible. You've got a new Medicare Drug Law, enacted just about a year ago to go into full effect just about a year from now, and a lot of people who could sign up for the benefit don't even know it exists yet, so we've got to see how that's going to play out. And just as a final context setting note, the number and proportion of Americans with no coverage at all is going up again and the cost increases that we noted are promising to make the situation even worse. So, today's session, I guess, is a timely one. Lots of concerns, lots of problems, and the question is what are we going to do about it?

Before we get to the substance of the program, let me just deal with a couple of logistical items. You'll find a lot of background information in your packets, including, I hope, green question cards and blue evaluation cards. If you don't have those, you can hold your hand up, and we'll get you one. There were some kits that somehow escaped that particular stuffing. By the end of today, you'll be able to

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view a webcast of this event on www.kaisernetwork.org, where you can also find the various materials that are in your kits, and within a couple of days that you can consult to make sure that that incredibly insightful thing that was said was said the way that you copied it down in your notes. Let me just take that mention of kaisernetwork.org and turn it into the perfect opportunity to turn to Kaiser's Executive Vice-President, Diane Rowland, your cohost here today, and in her own right, one of America's leading health policy analysts. Diane?

DIANE ROWLAND: Thank you Ed, and thank you all for coming, and especially to our panelists for being with us today, and willing to share their insights into what the likely health agenda will be in the coming year. I think Ed's given you quite an impressive list of issues that could be dealt with, and we know that healthcare is always on the minds of the American public, and what we do about it matters greatly to millions of Americans, so as we look at the budget, as we look at the Medicare and Medicaid programs, at our public health programs and where we're going, I'm very pleased that we've got such a great panel to share with you their insights from both the House and the Senate, and look forward to both of your questions to them so that we can really begin to talk about what's going to happen in the 109th Congress, so thank you all for coming.

ED HOWARD: Thank you, Diane. As Diane said, we truly

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have an excellent lineup of speakers to help us to peer into this new session. We have senior congressional staff an each side of the aisle in each house. We'll hear brief presentations from our congressional experts and then get to your questions. Ultimately there was no Administration willing to intrude on priorities in this area, so I guess you can expect no interference in a setting of this agenda over the course of the next two years. We'll see how that works out. And some of you may remember that Dean Rosen's name was included as a panelist on this original announcement. Dean has decided to, in the face of some conflicting obligations that he had, to defer to the Finance Committee Staff, which he says does all the hard work, anyway.

And that brings us to our first speaker, Mark Hayes, who is the Health Policy Director for the Senate Finance Committee Majority Staff under Chuck Grassley. His fingerprints are all over that Medicare Modernization Act that I mentioned, especially the managed care and the prescription drug benefits. That's not surprising, it actually it's quite comforting, given his professional background, which is that of a pharmacist by training. He's also worked for several other Republican senators, and the Senate Health, Education and Labor Pensions Committee, and we are delighted to have him lead off our discussion panel. Mark?

MARK HAYES: Thank you very much. Thank you for the

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opportunity to be here, and I'll remember to thank Dean later for the endorsement. I appreciate that very much. Well, we have a very challenging year ahead of us, it certainly seems like, and this packet that has been assembled for you is an excellent one. In just looking through it, I would commend one article in particular to you, and that was one written by Sarah Leek, on December 3rd in the Wall Street Journal, entitled, *U.S. Health Plans Catch Fiscal Hawks' Eye*. It's an excellent overview of the whole situation, and pretty much tracks with a lot of what I'm about to say, so Sarah, you could just read her article, I think.

The budget is going to be a real backdrop to next year, as you might already expect, and I'm just going to start really quickly and provide context to some other things that I'm going to say by outlining the budget situation a little bit, and then I'll go through a few things after that.

When we look at the budget situation, we have growing Medicare and Medicaid spending, and we have a return to fiscal discipline, I think, beginning to occur. And if you watched, and if you were conscious in the last few months, listening to the Presidential campaign, you heard a lot of candidates talking about reducing the deficit by half over the next five years, and I want to just give you an idea what that means.

If you were to do that, at our current deficit, you assume the tax cut policies, and you assume indexing the AMT,

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the Alternative Minimum Tax, which is tax policy—not my realm; I'm not even going to go into—but if you assume that the savings you'd need to achieve come proportionally from Medicare and Medicaid, proportional from their spending in the federal budget, over five years, you would need to reduce Medicare spending by $55 billion, and you would need to reduce Medicaid spending by $27 billion, so that's $82 billion over five years.

A comparable ten-year number is hard to get to, but let's say if you continued that proportional policy all the way out, you would be at $239 billion over ten years, in total. That's a really rough assumption and there are a lot of caveats behind that, but just to give you a ballpark idea of the magnitude of dollars that we're talking about, $82 billion over five years is a lot of money. When we put that in context of the other items that are on the plate for next year, we have a physician formula problem that was temporarily addressed in the Medicare Modernization Act, but that temporary fix expires at the end of 2005. Now, fixing that problem costs tens of billions of dollars. For example, the CBO estimates that if you scrap one, the problematic part of the formula, and you replace it with an index update according to medical spending inflation, that costs $90 billion over ten years to implement. That's $25 billion over five years. So now you add that on top of the $82, now we're to $107 billion, because I'm assuming you'd want to pay for

the $25 billion physician payment fix, just to get back to a neutral starting point.

So if we're at $107 billion, there are also a couple of problems out there that need addressing. The S-Chip program. Maybe you all may have followed that there was $1.1 billion in spending that reverted back to the US Treasury out of the S-Chip program at the end of this last fiscal year, and there was a bipartisan effort to try to recapture those dollars and get them back into the S-Chip program. Well, that was unsuccessful, so that's still on our plates to get done next year. That alone has a cost of about half a billion dollars over the next ten years, you know, cheap by comparison with the physician payment fix, to be sure, but on top of that, we have a growing number of states beginning in '06 and '07 that are running out of money just to run their current programs, and maybe as many as 18 states by '07 that are running out of money. We also have a whole bunch of states that have more than twice the amount of money that they need to run their programs, so there needs to be a hard look at the S-Chip program. It's been a great success. We want to get more kids covered, but that's another challenge that awaits us that is something that will cost some money to fix, to fulfill shortfalls, to put the $1.1 billion back in the program, and by the way, we'd like to cover more kids, so you're probably north of a billion dollars to look at that.

There's also [inaudible] reauthorization that is

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still on our plates, and that has a cost associated with it. So let's say for argument's sake we're at $107 billion over five years in my happy little scenario. Just to give you some other comparisons, this is all out of the 2003 CBO Budget Options Book, which we all lovingly refer to as the Cookbook, so if you want to know where I got these from, you can go to the CBO Website, www.cbo.gov, and you can download this book full of creative ideas. You can, according to CBO, block grant the Medicaid program and that would save you $64 billion over 5 years. You could just block grand Medicaid dish payments and not the whole program, and that only saves you $10 billion over 5 years, or you could reduce payments to teaching hospitals and save 16 billion over five years.

My point is, that all these things are really difficult things for Congress to pass, and none of them get anywhere close to $107 in five years. So, that is just to share with you the kind of budget situation juxtaposed to some really big challenges that are on the health policy plate. Now, will we be able to do a permanent fix of the physician payment system as a result of its high price tag? Will Congress need to look at a temporary fix, and that makes the problem worse for fixing it down the road. All those questions have to be answered.

I'll just mention a few more things before I run out of time, and that is, we have a really bipartisan desire here, too, to revisit and look at the problem of the

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uninsured, and that is going to get a lot more attention next year, and of course, by the way, also another spending item, just to keep that clear. But, a lot of importance attached to that. We have to look at how S-Chip and Medicaid fit in with that. We need to examine ways to help people afford health insurance. You know, there are tax credit ideas out there for purchasing healthcare insurance, and we'll be looking at those again.

Healthcare quality, I want to mention really quickly, in closing, too. There are a number of really good ideas on the sort of "bucket" of things around healthcare quality. There is a lot of work that Medpac and Leapfrog, Bridges to Excellence, private sector efforts to tie payments to quality, and of all the research that's being done on outcomes research, for years and years and years, and how long have we been talking about outcomes research? And the private sector is really leading the way here. It really looks like it's beginning to be an idea whose time has come, to figure out how can we tilt the system in Medicare so that it rewards quality providers, because many times our payment systems today are neutral to quality, or even can reward bad quality, which is obviously not helpful to our whole healthcare system and the quality that we expect to get as patients. We also, besides pay-for-performance, have healthcare IT proposals that fit in with that. We have nursing home quality that we're going to be taking a look at,

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and we have the joint commission, which has been a joint interest of Senator Grassley and Congressman Stark to look at JACO's role here in its relationship with CMS. I'm sure in Q&A we're going to get to many more things. We haven't even touched on drug importation or prescription drug costs, or the MMA, and I'll leave to my other colleagues.

ED HOWARD: That's a great jumping-off point, Mark. Thank you very much. Now let's hear from Alice Weiss, healthcare counsel for the Finance Committee Democrats. She's responsible for Medicaid, the Children's Health Insurance Program, implementing MMA, private insurance—that's quite a portfolio, Alice!—and as her title would indicate, she holds a law degree. She's one of those rarest of species of person who understands ARISA [misspelled?], so if she's talking in tongues, you'll know that it has to do with her prior experience. Alice, thank you for joining us.

ALICE WEISS: Thank you, and thanks for the introduction. I appreciate it. I often felt when I was speaking ARISA, especially on the Hill that it had the effect of glazing eyes over. I used to call it the glazed donut effect. But I'm glad to be here, and I thank you and Diane for inviting me, and the Alliance and Kaiser, for sponsoring this important forum.

You know, the weather outside if foggy, and I think that's fairly appropriate for this sort of conversation at this point in the year. You never really know what's coming

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ahead. I always appreciate the opportunity to talk more and clear up the fog. Also, I think the potential threat for the incoming storm may be an appropriate metaphor for this sort of conversation, because, as I think Mark has indicated, I think we are looking at a storm ahead, looking at the financing of important healthcare programs, and how they will be funded and structured in the years ahead.

So, I just want to offer a brief overview of some of the issues that will likely be coming up before the Finance Committee and in the Senate. I think the first issue I was going to touch on, I think Mark has done a great job of touching on already, which is the issue of deficit reduction and the role it will play. I'll just briefly mention that it sets the context for all of our discussions, any health program conversation necessarily involves funding in this environment and the President has promised to cut the deficit in half. I think we all have to be concerned about where those cuts are going to come from.

The President is also putting some very expensive programs on the table, potentially too, and there's not a whole lot of information about how those programs are going to be paid for. You know, tax cuts, I believe there was an article in the paper today about how there would be no new tax increases to offset those, and I think there are lots of questions about whether or not these new programs are going to be paid for on the backs of Medicaid and Medicare, and

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what impact that would have on those programs. That situation creates pressure on those programs, so we need to take a look at that. But if we're talking about a situation for Medicaid reform next year, I think it's clear that Senator Baucus and the Democrats are already gearing up for a fight, in that there is no support for any sort of movement towards block grant or even consideration to major cuts to the programs this time. There's a letter already circulating and hopefully already on its way to the Administration sometime soon that was signed by 48 Democratic Senators, basically stating their opposition to any sort of block grant proposal, and to the extent that the Administration or the leadership wants to go down this road, I think its going to be a pretty messy and a difficult fight. We know that the provider groups and the advocates are also gearing up for a major fight on this, and that it won't be easy, and that it will be fairly controversial. In addition, you know the states, you know, some of the last go-rounds and discussions around block grants have been supportive of the idea, are now looking again at that proposal and are starting to raise some serious concerns about whether they would support block grants. You know, another piece of this that's important is, you know, when you look at the agenda for the committee of jurisdiction, which would be the Finance Committee in the Senate, the Finance Committee conveniently enough has some of the other top priorities for the President, Social Security

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Reform, Tax reform, looking at Medicare implementation, and so it's going to be a busy time for the Finance committee, and it's going to be that there is a serious issue as to whether or not major reforms could be achieved, in part because there may not be enough time to do that.

But, in terms of talking about Medicaid reform, I guess I'd want to take a step back and provide a little bit of context. You know, Medicaid is the program that I think Allen Wilde said was "loved by few, denigrated by many and misunderstood by most." Whether you love or hate the program, it certainly is the workhorse of our healthcare system, and provides a critical [inaudible] amount of coverage for our populations in need and is really the backbone of our healthcare system at this point. In terms of what it does and its great successes in serving the vulnerable populations, it covers more than 50 million of the most needy individuals, pregnant women, kids and parents, elderly and disabled individuals. It covers one out of four children in our country—I don't think many people realize that—and it's a significant source of coverage, obviously for the elderly and disabled, but it also has a major economic impact on our health system, if you think about the fact that one out of every six healthcare dollars and personal spending is paid for by Medicaid, or the fact that one out of every 6 prescription drug dollars is paid for by Medicaid, or the fact that 50 cents of every dollar in long term care costs is

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paid by Medicaid. So any changes to the Medicaid program are necessarily going to have an impact, not only on access to care, but on economic livelihood of the providers who serve all of our population in terms of our healthcare needs, and that's something that needs to be looked at.

The other piece of this is, you know, Medicaid in the past few years, during the economic downturn, has provided an incredible—I don't know, I keep using the term safety net, but there's probably no better term for it—for the populations that have become uninsured because employers are dropping coverage, so Medicaid and S-CHIP have been picking up uninsured individuals, and provide a critical protection against uninsurance, and that's one of the reasons why the cost trends have been increasing. So any changes to the program have to keep that in mind and make sure that that flexibility and ability to respond will continue.

But obviously, Medicaid also faces some significant challenges, and I'm not going to be here and say that the program is perfect and doesn't need any changes. Obviously there are concerns about potential fraud in the system, and the need for change. Looking at the funding of the program, in states' budgets it's the top item now and has surpassed education for spending. And in federal spending, the combined state and federal spending now surpasses Medicare from a funding perspective, so I think that's something significant.

If reforms are needed for the program, Senator

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Baucus, and I believe other Democrats will feel that the program needs to be talked about in the proper legislative context. It shouldn't be reformed through an administrative waiver process and it shouldn't be reformed through the budget process. It really deserves an appropriate debate and discussion. We would be supportive of looking at that, and certainly I'd be happy to talk more in the Q&A about what types of issues we think could be constructive in looking at the program.

The other key issue I wanted to talk about is the implementation of the new Medicare law. Now, this is of serious concern to us. Senator Baucus and the Finance Committee held a hearing several months ago looking at the proposed rules and how the bill was being implemented administratively, and I think there are a number of concerns based on the proposed rules, and Senator Baucus said at that hearing, and I think he's reiterated a number of times that while he supported the bill and was a great advocate of the bill as the right alternative to provide prescription drugs to the elderly and disabled, but to the extent that the law wasn't implemented in accordance with Congressional intent, he would have very strong concerns about it and would withdraw his support. In terms of the problems that we see coming from the proposed ruling that may be coming up, there is significant problems with respect to the dual-eligible individuals and how they will transition to new coverage. As

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many of you may know, the dual-eligible individuals, individuals who are both eligible for Medicare and Medicaid will lose Medicaid coverage as of January 1, 2006 and transition to the new plans. And there are lots of logistical issues about how you're going to take that 6.6 million individuals and transition them within a six-week period to new coverage. A lot of unknowns about how it would work and great opportunities for problems, and when you're talking about a vulnerable population that's medically needy or disabled, you really do need to create a situation where they are going to have a smooth transition and that you're going to have a fallback plan to provide them access to coverage if there's a problem.

The second issue has to do with the subsidy and the planned enrollments of the low-income populations. Right now, under the proposed rule there is no automatic enrollment for this population and there are lots of concerns about whether or not these folks are going to get enrolled. The recent experience with the drug card provides a very telling example of how difficult it can be to reach out and find these folks and get them enrolled, even when you make it really easy. I think the Administration sent out mailings with a card where all the individual had to do was call the number and sign up, enroll and get the transitional assistance of $600 and they basically sent it out to 1 million individuals and only 100,000 individuals signed up, and that's of serious concern.

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And there are also issues about outreach enrollment and education. And certainly I think when you're looking at this population and how needy it is, you really want to make sure you get it right, so we're going to certainly encourage the Administration to do the right thing and do everything it can within its administrative authority to try to address these problems through the process.

Finally, I'll just talk a little bit about S-CHIP. Certainly, I think Mark rightly said that we were very concerned and interested in trying to find a deal on extending the availability of the 1.1 billion that expired in the fall. We're certainly hopeful that that work can continue, and think certainly that it's best to try to look at a fix that takes care of this problem in the context of the existing program. Trying to take on a restructuring of the S-CHIP program, especially in the context of any discussions about Medicaid reform would be a white-hot controversial issue and something I think we'd probably want to avoid. And finally I think on the uninsured, I think Mark mentioned opportunities for finding common ground, and certainly we see those as well. It seems as though, from a variety of perspectives, ranging from the President to Majority Leader Frist, to Senator Kerry as a candidate, everyone has been proposing looking at the low-income folks first, looking at low-income kids and parents, and childless adults, and certainly we would be supportive of moving

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forward on that front. With respect to a tax-credits approach, I certainly would caution those looking at that to take a page out of the book that we're now reading on the experience with the TAA bill, and some of the problems that have been had, both in terms of implementation and in terms of the costs of providing insurance coverage through an individual tax credit.

So finally, I just want to close and thank you very much for the invitation to speak, and I hope that this conversation and the Question and Answer session, especially, can provide a beacon in our fogs going forward. Thank you.

ED HOWARD: Thank you, Alice. Chuck Clapton's the Chief Health Policy Counsel for the House Energy and Commerce Committee for the Republican Staff under Chairman Joe Barton. While he's been at the Committee he's done a lot of work on the Medicare Modernization Act, including the new drug benefit, and on how Medicare pays for existing Part B prescription drug coverage. He's been the lead majority staffer looking at possible changes in the Medicaid program, as well, so we may hear a little more about that, and before that he'd worked on fraud and abuse issues for the Committee. He also happens to be one of those pesky lawyers, so we'll see how he handles ARISA-speak or Medicare-speak. Chuck, thank you for being with us.

CHARLES CLAPTON: Thanks Ed, thank you Diane. I guess, probably, let me start with a disclaimer. As Ed

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mentioned, I'm the Chief Health Counsel at Energy and Commerce. It's a great job. I enjoy it a lot and I really hope to be able to retain the position, so what I would ask is that everyone keep in mind that any remarks I may make today are strictly speaking on behalf of myself, not as the representative of the Energy and Commerce Committee or Senator Joe Barton.

Unfortunately, I have to start at the same place Mark did, which is talking about the overall picture fiscally, with budgets and deficits. Given where we are right now with regard to deficits, I think it is likely that we will be talking budget reconciliation next year. Let me take a step back from that. Right now the Administration is working to develop their internal budget that will eventually be released as the President's budget for sometime next year. At the same time, both the House and Senate Budget Committees are going through, looking at the numbers and preparing for next year and preparing for what very well could be a reconciliation package.

Now, for those of you who have not been around for the past few years, if past is every prologue, I think it would be fair to expect that the committees of jurisdiction in the House Energy and Commerce, and Ways and Means in the Senate Finance, could very well be facing significant reconciliation [inaudible] next year to have to reduce entitlement spending, principally. And unfortunately for

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those of you who have been following the Medpac meetings in town this week, the news is not particularly good. Typically when Congress has been called upon to reduce entitlement spending, one of the first places historically we've always looked has been hospitals. What the Medpac Commissioners heard yesterday was that there's a great deal of instability currently with regard to hospital Medicare margins. As recently as two to three years ago margins were positive in the order of magnitude about four percent. They've been decreasing. It's been projected they're going to be negative for this year. For 2005 Medpac estimates that they will be negative 1.5. In that context I think it will be extremely difficult both from a policy and a political perspective to advocate reductions in hospital payments. Similarly, Mark had talked about physicians. I think this is one of the more stark examples of exactly how bleak the budget picture is that we're going to have to face next year. Mark had described some of the options for fixing the problem but I want to go into a little greater detail to talk about the problem itself. As Mark mentioned, we fixed the problem for physicians for this year and next, however starting in 2006 physicians are facing a cut of 5.2 percent. For the next five years thereafter they are looking at similar cuts of equal size and magnitude. I think everyone agrees that that is unsustainable in the long run. That's not going to be able to guarantee Medicare beneficiaries access to high quality

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physician care and it needs to be fixed. The difficulty, as Mark described, however is that there are no cheap easy fixes. The range of proposals we've seen has ranged anywhere from 90 billion up to 115 billion, and that's off the baseline. That's not putting new money into this—or sorry—to make those changes will require new money. If nothing else were to happen, the physicians will take those cuts, and if we don't – in order to fix them we're going to have to put in somewhere in the order of $100 billion over the next ten years to fix that.

Looking at other providers where typically reductions have been proposed, skilled nursing facilities, home health, certainly have better margins than hospitals, or physicians, for that matter. But again, on the order of magnitude of paying for the numbers we might be looking at, doesn't even begin to get you close to where you would need to be if reconciliation instructions are going to $10 billion or more. Similarly, much of what I'll describe as the low-hanging fruit, those easily fixable problems that produce savings, we actually have already taken care of. Ed had alluded to the fact that when I was a counsel working with MMA, we tackled the problems with Medicare physician-administered drugs. We were able to recoup $15 billion in savings. Similarly, we made changes to how Medicare pays for durable medical equipment. All of those were good policies. We tried to get an appropriate balance of paying for providers and also

making sure Medicare pays appropriately for these services, but there aren't a whole lot of easy proposals out there to achieve the savings. Mark went through and described some of the options that CBO has identified. I think all of those we recognize carry very heavy political cost. That is at least the deficit and the offset scenario that we face. It's worthwhile also to get a picture of the larger scene that we in Congress are going to face in the next few years looking at entitlement spending. I think most disturbingly, the most recent estimates I'm seeing are that Medicare Part A Trust Fund—which as an aside, I must mention, I have no jurisdiction over, it's exclusively Cybele, so she can talk in greater detail about that—but actual expenditures are expected to exceed revenue this year, which in turn is also going to lead to the bankruptcy of the Trust Fund that much sooner. In addition, this year total Medicare spending, close to $300 million. For the first time, Medicaid, which Alice spoke at great length about, spending there will actually exceed, when you look at federal and state spending combined, Medicaid will now be the largest single medical entitlement program in the nation. If you take the two programs combined together over the next ten years, you're talking about $7 trillion in mandatory entitlement expenditures. Given the difficulties that poses for, I think all of us as a nation, in terms of where we are with overall entitlement spending, it will be very difficult for us in Congress to come up with

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appropriate policy solutions that balance the need for providing for the healthcare needs of our sickest, most vulnerable and elderly populations while at the same time trying to rein in overall government spending.

I'm going to talk very briefly about a couple of important topics, the first being Medicaid. By doing that I'm going to co-opt one of the phrases that a colleague of mine has used. We've often talked about Medicaid reform. That's been seen by many as being very pejorative and having a whole set of concepts and ideas that comes with it. So, I'll give her credit, Brigitte Taylor, my counterpart on the Energy and Commerce Staff likes to talk about Medicaid Miracles. And I don't mean that facetiously. I think all of us recognize how important Medicaid is with regarding coverage for the 40 million individuals who currently rely on Medicaid to receive their healthcare coverage. At the same time, I think that many of us recognize that Medicaid could be made significantly better. One of the things that the Energy and Commerce Committee has spent a lot of time looking at is some of the financing mechanisms that are used by various states to draw down additional federal dollars. One example I was looking at this morning, two comparative southern states, each with approximately equal populations, each with very close approximations of what the per capita incomes are, which is obviously the basis for Medicaid match rates. One had total Medicaid expenditures for programs like Dish of

approximately $115 billion. The other state had $70 billion. For two states that are so similar, that seems to point out a basic inequity that exists within the Medicaid program. Recognizing I get myself in a great deal of trouble by identifying the states, I'm going to refrain from that, but for those of us who've been around the Medicaid program for a while, you can probably guess who some of those states are.

At the end of the day, I think my Chairman's perspective is that Medicaid dollars should certainly be used appropriately to pay for healthcare services for the low-income beneficiaries. I don't think anyone can justify diverting those dollars for other state expenditures, or even basically violating the underlying compact that states and the federal government agreed to when the original Medicaid match rates were set up. So certainly financing would be something that can be looked at.

Another topic would certainly be different populations and having different rules. Currently Medicaid applies a one-size-fits-all set of rules for all populations. Many of us, as we've started to look at the Medicaid program have started to realize that a case can be made for why different rules may be very applicable for various populations. I think cost sharing is a very good example. While it may only be appropriate to apply minimal or no cost sharing for someone who's at 87 percent of poverty in Arkansas, I don't think anyone can say that those same rules

should apply to someone who's living at 200 percent of poverty in New Jersey. And of course, the difficulty as it's been pointed out will be determining what the break point will be and how you have those differential sets of rules. But that seems to be a common sense reform that you could implement that might have significant changes for reforming Medicaid.

The last thing I'll talk about is long-term care. Unfortunately, as I sit here I don't have an easy proposal or an easy solution that would take care of long-term care. Certainly one of the greatest single cost drivers in the Medicaid program, approximately one-third of the Medicaid population is in long-term care, consuming approximately two-thirds of overall Medicaid expenditures. That's something that has to be tackled, and we're willing to look at things like incenting insurance for people to pay for long-term care and other options to keep people out of long-term care for as long as possible to allow them to stay in the home, where they have actually better clinical outcomes and where they have greater levels of satisfaction.

Mark and Alice also talked extensively about S-CHIP so I'll skip over that. MMA implementation, the one highlight that's been a real success, the Medicare prescription drug card. As of the most recent numbers, we currently have 5.8 million Medicare beneficiaries who are enrolled. We now are actually getting close to or possibly even exceeding the

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targets the Administration had set for enrollment. I think most importantly, because all of us, when we were drafting MMA were most focused on what does this do for low-income beneficiaries? One point five million low-income beneficiaries below 135 percent of poverty are currently and are receiving the $600 transitional assistance. Wrapping up on the uninsured and other issues, Mark had mentioned quality, health information technology, will certainly be an area of great interest. It holds both the potential for lowering costs, but most importantly, reducing medical errors and improving clinical outcomes, which I think is important to all members. On a related note, patient safety. Unfortunately the conference on that important legislation was held up in last minute negotiations at the end of this year. We fully expect that we will back working again at patient safety for next year, and that's our hope, that we can get a patient safety bill passed sometime early in the New Year.

Additionally, the one point I'll wrap up on, looking at the question of the uninsured, Ed talked about the numbers that we're facing. Something very clearly has to be done. Some of the things that have been identified as issues that may be raised in the next Congress, looking at high risk pools, that legislation that had passed the Senate, unfortunately we were unable to get to that by the end of the session of the House, but I expect that that will be

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something that once again will be on the table for next year, and then also looking at the overall insurance market. What are the barriers that currently exist for providing healthcare insurance for populations—it could be low-income populations who currently aren't getting access. There have been a lot of innovative ideas that people have discussed. Certainly AHPs have been around for a long time, but additionally there have been proposals for federal charters providing very clear safeguards and other interesting ideas that I expect many members of Congress will want to explore in the coming year. So again, with that I want to wrap up, but that you for the opportunity to come up this afternoon and speak to you. I look forward to answering any questions you might have.

ED HOWARD: Thank you very much, Chuck, and don't worry, the folks at C-SPAN have assured me that this entire session is off the record. [LAUGHTER.] Lastly we're going to hear from Cybele Bjorklund, the Democratic Staff Director for the House Ways and Means Health Subcommittee, chaired by Congressman Pete Stark. So I guess if we're going to look for stark examples, this is the place we ought to look. Cybele was a senior Health Staffer for Senator Tom Daschle in a prior life, and then for Senator Kennedy, and the Health Committee Democrats. She has Executive Branch experience. She's got a Master's Degree concentrating on health policy and an undergraduate degree in journalism, so she knows a lot

and she knows how to tell you what she knows, which is why we're happy to have here on the panel. Cybele?

CYBELE BJORKLUND: Blew my cover, Ed. Most people don't know about my Bachelor's. Thank you, again for having me here today. You guys always put on informative and interesting forums. I'm always thrilled to come to something like this, because it's my first glimpse also at what we're going to do next year. [LAUGHTER.] And at the advantage of going last—mind you, I often like to be last. That's my lot in life on the House side; I'm accustomed to it. It's a comfortable position—but it also means that my colleagues have generally said a lot of the things that I was going to say. But I've got a few more back there, and I won't go into quite some of the budget details or some of the other things that I had that these guys have actually covered to some degree.

And then I have to actually compliment Ed and Diane at putting Mark and Chuck up here, because they are not only smart, but also very likable, pleasant guys, and it's really hard to talk about the hard lines that their party often takes with respect to health, and you have such pleasant guys up here, who we've actually managed to work bipartisanly with on a number of issues through the years. So, I hate to be so negative, but it's my role to be the skunk at the garden party. And I have to say that with some important exceptions where I think there's a prospect of some bipartisanship

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around really important core healthcare issues, quality, IT, patient safety, some things like that, in my personal point of view is that if this Congress is passing health legislation it's probably bad. Most of the so-called coverage initiatives that have been promoted, at least by the Administration actually would erode existing public and private coverage. The one exception to an erosion might be their tax-credit. We have other concerns about that program. Think it probably would have done little good, but it might not have done too much harm, but last year the Administration failed to fund it in their budget and most of the Republicans up here have had either different tax proposals for, in any event, not taking up the Administrations, and when you look, as Alice alluded, to the early view on the trade adjustment assistance healthcare tax credit implementation, it's not promising, despite actually really good efforts from folks to get people identified and enrolled. There are lots and lots of logistical problems. I have no idea whether the Administration will put their tax proposal on the table next year, and if so, whether they'll fund it, but I'm a little less optimistic of the prospect of moving forward on coverage initiatives bipartisanly next year, especially in light of the budget situation.

As for association health plans—now it's my turn to concede to Chuck, not in my jurisdiction at all, but I can't resist a swipe at them—even CBO has said it will raise costs

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for four out of five people covered by small businesses. If you look at how they've done other analysis that means that some people might lose coverage instead of gaining coverage as a result of that policy. And while at one point they had said a few hundred thousand previously uninsured small business folks might get coverage, it comes at the expense of about 20 million people already in that market, and that doesn't sound like an equitable or effective solution to me. I'd say that's an old idea that should be left in the dust of old congresses.

Health savings accounts, which started out primarily as a tax shelter for the healthy and wealthy, and which Treasury admitted as much last year in testifying before our committee, "Oh, no that's not our coverage initiative," they said. So, we're pleased that people might start to recognize it for what it is, that it's really not something for the uninsured. They, we believe, have the potential to wreak havoc in our system, as health insurers and employers move toward them. After all, it lowers their costs tremendously, as they offload expensive comprehensive coverage. What's not to like? We may see more and more middle and low-income families pushed out of traditional coverage and into high deductible health plans or just out of coverage all together. It won't be a matter of choice; it won't be a matter of their choice, and as a colleague of mine said—I wish I could take credit; it's a nice little quip—as she was saying, this thing

about this ownership society is it means your own your own, and I think that that's something that can be said for a lot of the policies that we're seeing from the Administration and from some of the folks up here. And putting a low or a moderate-income person into a plan they can't afford to access does essentially leave them uncovered, so HSAs as a solution for the lower-income uninsured are economically irrational. Why would someone spend premiums for a policy they can't afford to access? And if you want to turn the most jaundiced eye to it, you could say in the worst-case scenario, where hit by a bus, they are going to make it to a hospital and be treated, but if they're paying premiums for a policy they can't access on the day-to-day, it just doesn't make sense.

So I think we need to be talking about coverage that helps people get the care they need in a timely fashion. We all have a pretty good sense of the profile of the uninsured, and there are some pretty straightforward things we can do to help them, but the all cost money, and they cost a lot of money. That's another clue for anybody looking from the outside in. If a proposal to cover the uninsured doesn't cost a lot of money it's probably not doing very much, that's just the facts.

Also, in the name of flexibility and possibly, as our colleagues have talked about, to meet deficit reduction targets, Medicaid is likely to be on the chopping block.

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Again, something I have no jurisdiction over. I think Alice wrapped it up so nicely that I'll not go into the details there, but that makes us very alarmed, very worried. I think that people have to mount a strong dissent against the program, not only for the people it serves, first and foremost, but also for the providers who serve those folks, who serve all of us, who are often the economic engine in various communities as major employers, and they'll swear, when you combine, for example, with hospitals, the already low Medicaid payments with what we're seeing on the Medicare margin, it's spelled devastation. For some reason Congress doesn't act, HHS is making ample headway toward destroying the program by approving questionable waivers and CHIP may be under assault as well, so that's, as in medicine, it's my great hope next year that Congress first does not harm.

Last year, conventional wisdom held that we would have a Medicare bill this year, at least for drug coverage, technicals, and to address the already discussed physician issue. I had recently heard that even that might not happen. Of course, all bets are off if we get reconciliation instruction. Then I think it's Katie, bar the door, I can't imagine what will be stuffed into this bill. And if the President does make good on his campaign promise to cut the deficit in half and if the Republicans up here follow his lead or do so on their own and put it into the budget—that's assuming we have a budget. They've had some troubles agreeing

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with themselves in the past—then Medicare and Medicaid are front and center. The simple fact is that you cannot accomplish serious debt reduction without major cuts to one or both of these critical programs.

Chuck hit some points I was going to hit around Medpac and what their data are showing. The easy pots of money are not available. The one easy pot that I think is available technically is probably not available politically, and that's the Medicare Advantage plans. We've got a $10 billion slush fund. Excuse me, I believe it's called the Retention and Stabilization Fund, which was in the MMA. There is questionable support even among some Republicans for it. It doesn't start until 2006 so it hasn't hit the streets yet, so my taking it away, we're not taking it from anybody who's currently getting it. My understanding is that there is, or should be retention in the plan communities because a number of plans have persevered through what they might call the "lean years". We might disagree with them. And they don't want the $10 billion to entice their competitors who stayed out during the "lean years", so I'd hoped the $10 billion was essentially gone, but even that doesn't get us very far toward the targets that Mark had talked about.

So, we've all heard about the challenges that we're facing. I do think if we get reconciliation instructions, then there will be a lot of action up here. I think if we don't get reconciliation instructions, it's hard for me to

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believe much will happen on health. Certainly our Committee's going to be taken up with Social Security reform and potentially tax reform and other non-health related issues. But if we have instructions, you might see a renewed interest from our Republican colleagues in the House and some bipartisanship after they turned the biggest surplus in history to the biggest deficits as far as the eye can see. After conducting a thoroughly partisan conference on Medicare, I suspect we could be invited into the room to provide cover as we cut providers and benefits and potentially balance the budget on the backs of poor people. So, it could yet be an interesting year, and I look forward to hearing what people have to say.

ED HOWARD: Thank you, Cybele. It's nice to sense the consensus that has formed as the panel discussion has gone forward. At this point, you want to get a chance to raise your question. If you want to be seen by hundreds of thousands of people on kaisernetwork.org or C-SPAN, you're going to have to come to the front where the microphones are and ask your question. If you want to be subversive about it, fill out the green card and hold your hand up and someone will pluck it from your hand and bring it forward. And while we're doing that and give you the chance to get started, let me just ask a technical question, and if our folks aren't comfortable answering a budget process question, then maybe we have some budget experts who can. If there is no agreement

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on a budget resolution as there was this year, is it still possible to generate reconciliation instructions to the respective committees? It's not.

MARK HAYES: The reconciliation instructions would come out of the budget process and the way that could potentially work is if you have a budget reconciliation instruction that goes to multiple committees. The resolution will tell the committee, they'll give the Finance Committee a number, say you have to achieve this number, in legislation you report out by a date certain. It then goes to the Budget Committee and they put it all in one package from all the Committees. It goes to the floor and in the Senate it's got some procedural protections, 50 hours of debate, no filibusters, no problem with needing to get cloture, and there's procedural rules on the floor about amendments and so on. But if the Committee were to fail to produce a bill by that date certain, then it's vulnerable to a motion to recommit on the floor, and that would mean it would go back to the Budget Committee. So let's say for example the Finance Committee failed to produce a bill, it would then go back to the Budget Committee who would then be tasked with taking on the Finance Committee's role in reporting out what the Finance Committee in that scenario wasn't able to report out. I can tell you that's never happened, and I am confident it will not happen this time.

ED HOWARD: We have some question cards, which you

can bring up if you'd like. And let me just make sure that I understand you perfectly. I may be the only person who doesn't understand this. If the House passes a budget resolution and the Senate passes a budget resolution, but they can't, pardon the expression, reconcile those two versions, can there still be reconciliation instructions? No? Okay.

ALICE WEISS: I think theoretically they can ask, but there's no power behind it.

ED HOWARD: Very good. We did get a question or two in advance that I should take advantage of to give Diane a chance to sift through the ones that you've sent forward. There are some recent estimates by Republican Linda Devow that say—and I kind of alluded to this—that only half of the Medicare beneficiaries know that there is a new Medicare drug benefit, and only a third say that they'll sign up for it. If that's true, what would that do to the sort of adverse selection problem that has been alluded to a couple of times, or for the help for low-income residents that several of you've made reference to?

MARK HAYES: I'll jump in and at least start the ball rolling on that one. First of all, it's not a big surprise that Medicare beneficiaries are unaware of the drug benefit right now. There hasn't been any outreach program on the drug benefit. There isn't an enrollment campaign; the options aren't out there. You can't make a decision about whether you

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want to enroll yet, or not, because you don't know what your plan choices are going to be. You don't know what the premiums are going to be. You don't know what the drug benefits that will be available to you will look like. So no one should be asked to make a decision right now. That will happen beginning in November of next year, and there's a lot that CMS has on its plate and is planning to do to do an outreach program, and it's really important that we get very good and accurate information out to beneficiaries. CMS has been doing a great job, and I think you'll see a very powerful campaign that CMS will be doing to make sure that beneficiaries have the information they need to make good choices, and a voluntary drug benefit program that no one is forced to enroll in. Everyone can make that individual choice, and so, we have a long ways to go. Those early polling data are just like any early polling data for any—if you're thinking about a political campaign, you wouldn't want to bet your money on polls in a presidential race two years from now. You wouldn't want to plan your bets around this now, either, I don't think.

CYBELE BJORKLUND: Yeah actually, the one thing I would actually like to quibble with her findings are that only a third will sign up, because probably more than a third will be pushed into it involuntarily without a choice. You've got the millions of Medicaid beneficiaries who do not have a choice to stay behind. They will be automatically—well, not

automatically, but they will be enrolled. You've got probably up to three million people with employer-sponsored coverage losing it, who if they want to have any drug coverage will need to buy in. You'll have folks in the Medicare Advantage plans also going in that way, and also new beneficiaries unable to [inaudible] that gap. So, you know, there are some [inaudible] in here that actually force participation, even though it's theoretically voluntary for a lot of folks.

And as for education, I cannot agree more with Mark that it is very important to get accurate, unbiased materials out there to people. We are actually deeply concerned, and will be trying to monitor this next year, because of the Administrations materials on the drug card, where deemed by GAO in some instances to be propaganda and in other instances to not be quite propaganda, but be so misleading as to contain false and misleading statements. So we're actually very worried about the ability to get people accurate information and we'll be playing a watchdog role and hope that that gets out there, because it does need to get out there. The benefit is rolling into place. People are going to have to make these coverage decisions, so hopefully we can work together to make that information useful.

CHARLES CLAPTON: I guess just a couple of quick points. What you're seeing now with the drug card enrollment is nothing new or unusual. I think if you look at S-CHIP was a great example. Typically these new federal healthcare

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programs providing a new benefit take a while before you can do the outreach to beneficiaries and get them signed up. And I think that one thing that we all agree on is education and the absolute necessity for it. CMS should be commended that they really have done yeoman's work in the extremely short timelines they were given to go out and educate beneficiaries. And they're doing more and more, and I think that's part of the reason that you're seeing drug card enrollment up to six million beneficiaries almost now, and they're going to do more of that now. They're contracting with state health insurance programs and various other stakeholders are out there working with seniors now. I thought the recent Kaiser report was illustrative, that when you look when Medicare beneficiaries have more information about the new benefit, their views actually improve, and I can speak, having gone out and done multiple town hall meetings for various members of the Energy and Commerce Committee, typically when you speak to seniors, their initial impression has been shaped, unfortunately, by some of the rhetoric that we saw at the end of last year, but when you start talking about the actual benefits and particularly for low-income seniors, the $1200 over the next now approximately year, the wrap-around benefits many manufacturers are providing, this is a great benefit. And it really would be unfortunate if at the end of the day, people who could really stand to lower their prescription drug costs don't enroll in

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it. I think that is one thing that all of us share an interest in, is getting people enrolled and getting information out there to them to do that.

ALICE WEISS: Great. Well, I spoke a little bit about this in my comments, so I'm going to keep it very short, but I think one of the key issues I would want to raise is that, when we're talking about it being a slow take-up rate or acknowledging that it may be a problem as it was in CHIP and as it was in the drug enrollment card, I think we have to start looking at the cliff that the dual-eligibles are going to be facing at the end of the year and going into next year, losing Medicaid coverage and having to transition to these plans, and whether or not it's feasible to do it as a cliff, and whether or not the Administration should look at its administrative authority to try to implement some sort of a transition period whereby individuals could remain eligible for Medicaid for a certain period of time and therefore you would ensure that there wasn't any gap in coverage. That's one piece. Another piece is obviously looking at educational resources for the one-on-one counseling that the CHIP programs and others are providing.

ED HOWARD: Thank you all. We have some people lined up at the microphones and we have a number of questions here we want to try to get to as well. So if you would, try to keep your questions short. If you have somebody specific to ask them of, please do that, and identify yourself, if you

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would.

MARY AGNES CAREY: I'm Mary Agnes Carey with Congressional Quarterly. The panelists have made it pretty clear that budgeteers are going to look to health programs for cuts to help balance the budget, and I think as Chuck noted, some of the Medpac staff recommendations have complicated the picture, especially as it comes to hospitals.

Some of you have addressed this, but I wonder if each of the panelists could answer a question. If your boss came to you today and said, where do I cut to make this reconciliation instruction, which you all seem to feel you're going to have, where would you go? What would you cut? Thank you.

MARK HAYES: I went first last time!

ED HOWARD: Chuck volunteered.

CHARLES CLAPTON: In fairness to Mark, since he went first, I have to tell you, I can't give you any easy answer. As I sit here right now, that this is going to be one of those difficult situations. I know in the House there are lots of members who are very interested in reducing entitlement expenditures. There are a lot of difficult choices out there, and again, I'm going to reiterate my caveat that I put at the front. These are not the views of the Energy and Commerce Committee nor or Chairman Joe Barton, because I really like my job! [Laughter] But people have talked about, we had a hearing just last week looking at

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Medicaid drug pricing, what could be done to reform that. Just looking through the laundry list of issues that were raised at least during the MMA, Medpac has had some very interesting comments looking at what are some of the drivers that underlie the physician SGR and having reforms that could get at that, imaging and overutilization potentially of imaging services and how that drives the overall payments for physicians. Just thinking of all the providers I will alienate by even mentioning their names. Another area that has at least been identified has been clinical labs, and the need to look at clinical labs and whether Medicare is paying appropriately for that. And with that I'd like to share this opportunity with some of my colleagues. [Laughter]

CYBELE BJORKLUND: All right, I'll jump in, because I have an easy target, and a predictable target. I should also caveat, as Chuck did, that I do like my job as well, and I haven't talked to either Mr. Rangel or Mr. Stark about reconciliation instructions and what that might mean, so this is my thought. But if you brought managed care payments in tandem down to fee-for service rates, I believe, coupled with a couple of other reforms including risk adjustment and stuff, I think we've seen a letter from CBO that that gives us on the order of $40 billion. That's a good start. That's the easiest money that I can think of that's out there that follows Medpac recommendations of a payment neutral system between fee-for-service and Medicare Advantage. Give the

plans what fee-for-service is getting as opposed to 107 percent more plus the selection factor. That would be a great start. It's predictable, I can say it, because they expect me to say it, but that to me would be a great start.

MARK HAYES: I'll jump in and I will also give the same caveat that I haven't talked to Senator Grassley and this wouldn't represent his view. These are just my thoughts as well. You know, we had a sort of cycle of creative financing in the states, and it certainly looks like we're back on the upswing of that. We've got IGTs. That has been a big part of discussion this last year. I hear about provider tax arrangements that are going on beneath a six percent safe harbor that's in regulation and wasn't part of congressional intent around provider tax arrangements. There are probably other Medicaid scams that the GAO has provided a lot of analysis on just recently in a report. In the fraud and abuse area we have—it seems like healthcare is a target-rich environment, when you talk about the ability to scam the system sometimes, and those are the kinds of things that are easier pickings sometimes when we talk about ways to reduce spending. And I'll say what I said, again, though, at the beginning of this, is that there are a number of sort of cats and dogs that we can look at, and even in Medpac's recommendations, besides their caution flag that they're showing us about hospital margins, there are other areas where they are recommending some restraint. But all these

things are small nickel and dime things compared to the perhaps more aggressive deficit reduction things that we may need to accomplish to accomplish the reductions in deficits that I think we all agree probably need.

ED HOWARD: Mark, tell us what an IGT is, in case we don't know.

MARK HAYES: IGT is one of the bad things about healthcare. You know, we cloud all these things in numerous acronyms and it's all just about job security. Like, so no one will know what we're talking about, and we really don't work that hard. IGTs are intergovernmental transfers and they are a mechanism where a local tax maybe is transferred to a state of to a healthcare institution and is used as the state's share in the Medicaid program to draw down federal dollars.

ED HOWARD: Thank you.

ALICE WEISS: I feel as though being very new to my job in the Senate, I need to make the same disclaimer that my colleagues have made, because I like my job too, even though I haven't been here that long. So, in terms of the sorts of cuts that could be considered, I think generally the stabilization funds that Cybele was referencing in the Medicare law apparently is something that might be an option. But in terms of Medicaid I'd rather not frame it in terms of cuts, but perhaps sort of rethinking and opportunities for savings. There are a couple of items and then maybe I can

throw in the other items that we think in terms for form and get back to that issue, which was, so on the front of long-term care costs. I know we talked about the fact that long-term care costs are a leading driver in the growth of Medicaid spending. As Chuck mentioned, I think that looking at some constructive solutions for harnessing private dollars into the long-term care program for the Medicaid program would be a way to go. Another way of saving money in the long-term care front might be encouraging greater flexibility for home and community-based services while protecting access to institutional care. Another point I think Mark has raised, about state financing mechanisms. I think a number of those state financing mechanisms that are so well maligned are need to help protect the safety net, so we have to look carefully at what we do there, but I think certainly there's an opportunity there to tighten up some of the current situations that are going on. And certainly there might be an opportunity to encourage states to curtail fraud and abuse in the Medicaid system to the extent that it exists by passing their own laws. And then, finally looking at the drug rebate requirements and making sure that they're appropriately enforced as they stand and that they're enforced fairly and implemented to the greatest extent possible. And then in terms of the constructive reforms that we see for the Medicaid program, addressing the counter-cyclical funding nature of the Medicaid program is something that we'd like to

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see, certainly allowing greater flexibility for the states and expanding coverage through the Family Planning waivers and HIV services waivers is something that we'd like to look at. And then, finally making sure that it's clear what can and can't be waived through the waiver process is something that we'd want to look at.

DIANE ROWLAND: Speaking of big items and how to reduce the deficit, a question from the field says that there have been rumors that the tax-free status of employer-sponsored health insurance might be eliminated as a way to reduce the deficit. How likely is that from a political point of view, and what would the impact be on the overall provision of healthcare?

MARK HAYES: Well, I'll jump in here and tell you right off the bat that I don't do tax policy. I think it's a really good question and it's one you'd need to address to one of my tax colleagues on the Committee, but that's certainly one that's been mentioned in the past. It was examined during the healthcare reform efforts in the 90s. It does generate a lot of revenue, and you know it has been one that people have been discussing as a sort of way to realign revenues in healthcare so that you could help other folks at the other end, use the tax credits to buy into the system for health insurance. But as to predicting its political feasibility, it's extremely controversial and there's a lot of employers and union health plans that I think are very

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concerned about what that might mean for them, and that's where I'll stop.

CYBELE BJORKLUND: It seems to me that the quickest route to a Democratic majority. [Laughter]

MARK HAYES: Do you support it?

CYBELE BJORKLUND: No, but that's how much I love getting people healthcare, that I would still rather they not do that. But it strikes me that collectively the bosses like their jobs a lot and hopefully not go there, but who knows?

JULIE RAVNER: Hi. Julie Ravner from Congress Daily and NPR. I have a question for Mark. I notice you were all deferential about other committee's jurisdictions. Although your boss hasn't been quite so deferential in recent weeks. He spent a lot of time on the FDA, so I'm wondering as you point out, given the limited time for health policy making at the Finance Committee—you have to do taxes and Social Security— how much time do you expect that you're going to spend trying to wrest the FDA jurisdiction from the Health Committee?

MARK HAYES: Well very timely question. Thank you for that. Listen Senator Grassley takes very seriously his job at oversight and something that he has done throughout his career, since before he was chairman of a committee, certainly as he was Chairman of the Special Committee on Aging and now as Chairman of the Finance Committee. We do oversight to look for tax scams, to look for how non-profit

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status is determined, when you look at the FBI. We pretty much will look anywhere in the federal government where it looks like we could do a better job for taxpayers and our constituents, and we will not fall back from that. Now, having said that, of course the Finance Committee doesn't have jurisdiction over the Food, Drug and Cosmetic Act, but we do certainly have a big concern about federal spending on drugs and dug safety. We have a really big new commitment on prescription drug expenditures and I think a serious investment into the safety of the use of those drugs, the information in terms of clinical trials, and clinical trials' registries being available as formulary decisions are being made and prescribing decisions are being made within that system. So, there is an important look that we need to have here about the FDA's role and which drugs come on the market, and how that influences Medicaid and Medicare expenditures and the safety of that system. So, but when it comes to moving legislation, we're also going to respect committee jurisdiction, something that we feel takes great umbrage when appropriators put things in omnibus appropriations bills, like tax items that are in the Finance Committee's jurisdiction with our new Chairman coming in, Senator Enzy with the help committee, I'm certain we will want to do the same there.

CHARLES CLAPTON: I'd be remiss if I didn't weigh in as the only representative up here of a committee with

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jurisdiction over FDA now. My Chairman has also been very active looking at FDA. We've had several hearings, most recently the hearing looking at SSRIs and FDA's approval and labeling of them. In addition we've done some letters on Vioxx as well, and some of the problems associated with that, so I would fully expect moving into next year that the committees of jurisdiction will be spending time looking at what FDA is doing, and hopefully also getting a permanent FDA Commissioner appointed, as well, which hopefully, I think will go a long way towards addressing some of the institutional problems that may have led to the issues you've seen arise now.

DIANE ROWLAND: One of the issues that's gotten a lot of attention, especially during the recent presidential election was medical malpractice, medical liability, so we've got several questions coming from the audience about the likelihood of Congress passing caps and other restrictions, any chance of doing insurance regulation as an alternative? Any action possibly on nationwide alternative dispute resolution? Where is malpractice going?

Not our jurisdiction, but I think that the main thing—unless as somebody said, "Hey maybe Ways and Means ought to raise revenue by taxing awards." That's not a suggestion. I sure hope they're not going down that road. But the bottom-line is that the rhetoric around that issue is so blown out f proportion. There's clearly a problem with

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physicians affording malpractice insurance. We're led to believe it's much more because of the underwriting cycle, investments and other issues, not the damage awards payouts. In fact I think CBO shares that belief because they've said that even if you were to dramatically cap awards, so the things along the lines of the House passed bill, you would end up with less than one half of one percent premiums savings, so it's not a cost-containment mechanism. Something certainly that needs to be done on it, but I'd hope that Congress would look at other things. My argued belief, unfortunately, is that it will at least fly through the House, and what happens in the Senate?

MARK HAYES: I'll speak to the Senate. Also, it's not the Finance Committee's jurisdiction, and whether Congress passes it or not is certainly above my pay grade, but I would say that the prospect of passage in the Senate while we have a stronger majority on the Republican side, we still are short of the 60 votes necessary, probably, to pass major malpractice reforms, and we'll see how that plays out, but I would differ with my good friend Cybele, and say that I think that as we think about cost growth in healthcare and the ways that those costs are driven, defensive medicine can't be completely discounted out of this equation, that there are unnecessary tests that are run because doctors and providers are looking over their shoulders, worrying about lawsuits and running unnecessary tests. And we also have a disconnect when

it comes to IT, because the medical records don't follow you and you wind up running the tests again anyway, so we probably have multiple defensive medicine happening as a result of that, so it's something that we really need to take a look at as we're looking at healthcare costs and where our system's headed.

CHARLES CLAPTON: I guess as always, hope springs eternal in the House of Representatives with regard to the United States Senate. I think Cybele is right, that there's still a great deal of interest, at least amongst House members in getting liability reform enacted next year, certainly looking at the crisis that you have seen in several states, most recently Pennsylvania; Nevada's been in the news with regard to specialties who are simply no longer providing care in various areas because of, in the physicians own words, liability issues. I think many acknowledge that it's a very real problem that needs to be addressed, and in terms of the impact, I think you don't need to look any further than the CBO estimate in terms of what some of the savings are, and please don't quote me, but I recall the number as being $16 billion associated with liability reform, HR 5 that passed the House. So clearly there is an impact there by having meaningful real reforms enacted. We will look forward to continue to work with our colleagues in the Senate and hopefully get legislation enacted next year.

ALICE WEISS: Well, I probably should reiterate that

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it's not our jurisdiction so I probably shouldn't be commenting, and I also hope to dash Chuck's hopes about hope springing eternal with action in the Senate, but I would say and reiterate what Mark said about the problem of getting cloture. I just don't think you have the votes at this point. But beyond that I think the underlying bill that's being supported, there are a number of problems with it. First and foremost, perhaps the idea that it proposes caps as a solution to the problem. Senator Baucus has had significant experience with caps in the State of Montana, and unfortunately, our premiums are as high as anyone's, and we're very much concerned about the fact that caps may not be the solution and don't seem to work on a national basis. The second problem I think, is that the bill that's being discussed is very broad, it's not just targeted at medical malpractice, it's looking at a lot of other issues in terms of health plan liability and product device manufacturer liability, and I think our recent experience with the hearing on Vioxx, although certainly I don't want to say anything about whether or not Vioxx has done anything wrong here, but I think concerns about making sure that you have oversight and accountability when something goes wrong with a drug manufacturer is something that should be protected. I also think that there are opportunities for common ground. It's clear, as Cybele has said, that there is a problem here, and that there is a need for some policy solution, and certainly,

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I think alternatives should be considered, and I think also it should be considered in the context of a larger discussion around patient safety and medical errors, because I think the two should go hand in hand.

ED HOWARD: Let's take a question from the microphone. Yes?

Al WIEDA [misspelled?]**:** Hi. My name is Al Wieda, and I'm with Guide Consulting Services, here representing the community mental health centers today. I wanted to ask a question with regard to the dual-eligibles that Alice brought up a few moments ago. In their letter to CMS, the state Medicaid directors recently raised the prospect of a six-month coverage gap for dual-eligibles as they make the transition from Medicaid coverage to the Medicare prescription drug coverage, and that's scary because there are a lot of people with chronic illnesses who are dual eligible. We're particularly concerned about people with Alzheimer's disease and severe, persistent mental illness. And I'm wondering whether there's an opportunity to provide through legislation or through the inherent authority within this CMS, and expanded educational opportunity for those specific populations, individuals with cognitive disabilities as they attempt to make selections among what we hope will be a rich array of options under MMA for their prescription drug coverage. I just wonder if there might be some opportunity to implement something like that?

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MARK HAYES: Well, I'll weigh in first on this one. I mean, this is, the dual-eligibles are, as everyone is aware, a very complex population, and already their benefits straddle Medicare and Medicaid, and how anyone can keep track of who covers what and how you coordinate that care when it interacts that way, I think is something we should continue to look into, not just in drug coverage but in other areas as well. When it comes to drug coverage, I'm forced to remind everyone—I think this is what I want to do—that in the bipartisan Senate bill that passed 76 to 21, we kept the dual-eligibles drug coverage within the Medicaid program so that these transition issues were not going to be something that we had to consider. Now, that was a battle that went out in conference. The House took the other position and so we are in the spot where we are now. We have the dual eligibles going into the Medicare drug benefit. Now, they're going to have a program, or CMS has already signaled that they're going to provide a very stringent review of formularies and formulary decision making to make sure that the drugs that are medically necessary are available to everyone who enrolls in that benefit, and when it comes to that gap in coverage, I know that CMS is looking at this very seriously. I don't have anything to tell you. I don't speak for them as far as what they might be doing, but I hope they will address this in the final rule when it comes out, and I think it's something that we will continue to be looking at.

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I'd just add that this issue actually was raised at the hearing that the Energy and Commerce Committee held on Tuesday. The question was posed to Dennis Smith, the CMS Medicaid Director in the context of the story that had run in the New York Times over the weekend, and Dennis very clearly articulated that the Administration is working right now on a plan to assure that beneficiaries, particularly low-income or dual-beneficiaries on Medicaid are going to be able to transition, especially in the context of long-term care. I think everyone recognizes that long-term care poses several unique and discreet problems that are completely different than providing a drug benefit for beneficiaries who are going to be getting their drugs through an outpatient setting. It's one of the reasons we had said in the drug card that CMS has to have at least one card that will interact with long-term care to help CMS get the experience with how to interact with that type of entity, and we were certainly assured hearing Dennis that, I think he made it very clear that when the final reg is published it will take into account and will lay out exactly what the Administration is planning to do to make sure that those beneficiaries continue to get access to their drugs.

I think this issue, just briefly, goes to the heart of the concerns and problems we have with the entire system upon which Part D is based. When you're out there with private coverage where all the important decisions,

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virtually, are left to the private companies in terms of which drugs to cover and how much to charge—now the duals, of course, they're got the cost-sharing filled in—but in terms of the formularies, it's a problem. Before we were kicked out, excused from the Medicare conference, we had had some discussions around formulary issues, and we had really wanted there to be a uniform formulary and class used so that at the very least there would be an ability to have an apples-to-apples comparison when you're trying to evaluate what's going on. I'm sorry, in uniform classes and definitions so that even if the formularies were different, you would make sure that you would do an apples-to-apples comparison, and we lost, not surprisingly. So, you know, we're now going to have a real mishmash. It's going to be real hard for people to see what's going on and where we go, and how to pick a plan and then how to move to another plan if your drugs aren't covered, and how to do the appeals system. People complain about Medicaid to some degree now, but I think the appeal systems in Medicaid will look like cake compared to what we're going to see in the class plans.

ED HOWARD: Mark, do you have a quick comment?

Yeah, I just wanted to say a quick followup, I want to make clear that the decisions aren't left completely to the plans, there are significant beneficiary protections that were enacted as part of the Medicare Modernization Act, and the plans will go through a very comprehensive and stringent

review at CMS when they submit their bids to make sure that they're not discriminating against populations and that their formularies look like the best practice in formularies that are out in real life today and that people have selected and enrolled in. I think it's important for people to understand that those protections were put in place.

ALICE WEISS: If I can just add on that point, I think that certainly the law and hopefully the rules will include those sorts of protections and ensure that there is no discrimination, but I think that the question remains as to how it will be enforced and what sort of resources will be brought to bear to ensure that this is going to happen, and really how this can be done, technically, from CMS to protect beneficiaries. I think that there are a lot of questions, and I would just echo Cybele's concern about the appeals process, and I think that really gets at some of the core of these issues, because when you look whether a benefit is going to be forthcoming, you have to look at what happens if its denied, and what the safeguards are to ensure that there's a fair and reasonable process for making that decision.

ED HOWARD: We have about ten minutes left. Diane has a couple of representative questions that have come through with cards and we want to make sure that everybody standing at the microphones has a chance to get to his or her question, so we'll ask everybody to be brief, both in asking and in responding.

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DIANE ROWLAND: Okay, in the context of Medicaid reform, the question is, has any thought been given to establishing some type of pay-for-performance quality measures, much like Medicare is considering?

ALICE WEISS: I'll jump in and say that that's a great idea. I know that the state Medicaid directors have actually been leaders on this issue and trying to sort of look at this issue of quality and how you measure it for the Medicaid program. I'm sure that there's a lot more work that we can do at the federal level, and certainly that would be an area that would be worth looking at, especially if there were opportunities for savings.

BRETT COCKLAND: Hi. Brett Cockland, Part B News, and my question has to do with physician payment reform and what maybe the baseline proposals are, aside from what Medpac has recommended. What's out there? What are the reforms that are do-able? Thank you.

CHARLES CLAPTON: I guess I can describe one idea that's been suggested, which would be to look at the impact that drug utilization has on the SGR, and take that out of the SGR formula. There's even been a suggestion of attempting to apply that retroactively back to a specified date which would further minimize the potential cuts that would result in the out years. However, that still has to come off of someone's baseline, however it be, Congress, if it's done through legislation or the Administration, if they were to

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take administrative action, but that's certainly one idea.

MARK HAYES: I would just say that we've heard a lot and seen a lot of evidence that the volume performance standard system just really is not working as intended, and I think that, you know we're going to get a lot of proposals here from Medpac about how to look at that system and restructure it. It's a really complex thing, and whether there is sort of a half-a-loaf policy that costs less money, I don't know, but it's complex and beyond the de-boggling of the mind, but certainly issues like this one that Chuck's raised are a possibility, but I think it will be really hard to tinker around the edges. I think we've got to really fix it for the long haul and get it over with so that there's stability here, or the costs of some of the short-term things are high enough, will end up doing a short-term thing, kind of kick–the-can down the field for another year, I'm not sure.

ED HOWARD: Yes, sir, and as you respond, let me take the ten seconds to ask everybody as we finish up here to please fill out those blue evaluation forms so we can try to make these programs even better for you. Yes, sir.

RODNEY REVLOC [misspelled?]: Rodney Revloc, Congressman Charlie Norwood. See, Mark, I'll just direct it at you. I was listening to my friend Alice and I didn't hear where she was willing to play ball on Medicaid at all. For us on the House side, if we're thinking about serious

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significant structural reform to Medicaid and having to deal with the singular pleasure of having to put up with Cybele and Brigitte, who at the mere mention of Medicaid slather their faces with blue paint and scream, "Cry freedom!" that we should take on Medicaid if you guys don't have the wherewithal to do so, and I'd like for you to take a shot at convincing me that you guys over on Senate Finance are really ready to talk about Medicaid.

MARK HAYES: Well, I thank you for the question. I appreciate—

RODNEY REVLOC: I had it planned for Dean, but he blew off, so you can blame him for that.

MARK HAYES: I also appreciate the sort of colorful descriptions, too, because that's just really fun! But, [LAUGHTER] as you know, the politics in the Senate around these issues are really different than they are in the House. In the Senate, when you really want to get things done, many times that requires a bipartisan approach, and if you look in the Finance Committee and think about counting noses for things about block granting the program, or some of the more far-reaching things that have been discussed, I think you very well might come up short. Now, I think there are some things that are very significant modernization of the Medicaid program that can be done. The Medicaid program, other than coverage expansion, hasn't really been changed since its enactment. It has not kept pace with the advance of

medicine and medical delivery. States have been forced to run their programs through waivers in order to make them work in the way that healthcare is delivered today, and there have to be some things that we can do to make this program work better, to make the financing of it work better, not force states to skim money off of the federal government in order to make ends meet, and really make the program move into the 21st Century. So it may not be the kinds of things that you're talking about that the House would like to address, but I think that on the Senate side we're going to take a serious look at Medicaid and there are some important improvements in the program that I think we can entertain.

ALICE WEISS: I'm going to have to take umbrage with Rodney's characterization of me as not being willing to play ball, because I think he said

RODNEY REVLOC: I know enough to know that was that.

ALICE WEISS: So, in any case, I think I outlined a variety of ways in which we're willing to sort of look at ways in which the Medicaid program needs to evolve and become current, but one piece of this that I think we just really need to keep in mind as we talk about this is, you know, the primary cost drivers in the growth of the Medicaid program have less to do with states' creative state financing and so much more to do with the fact that Medicaid has been the primary source of coverage for long-term care and for prescription drugs for the most vulnerable populations in our

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country, and I think the problem here is that, you know, from a federal policy perspective, yes, we haven't substantially reformed the Medicaid program since it was passed in '65, but also the growth of the population in need of long-term care services, because our population is getting older, and the growth of the reliance on prescription drugs has meant that these state and federal joint programs have had to bear the cost of what arguably could be a federal responsibility in ensuring that the predominantly elderly and disabled populations are getting what they need, arguably out of the Medicare program. So I think, you know, we need to start looking at what purpose is this program serving, and what are the real problems? And I think that's one of the key issues that's going to have to come into play as we look at potential reforms. We need to agree on the problem, and I don't know if I see that yet, that consensus as to what the problems are and therefore moving on to solutions.

SHARON CANTOR: Sharon Cantor with E-Health Initiative. Just pulling together some of the threads of the discussion that we heard today about pay-for-performance, and IT, and savings, and I would ask us for instance, to look at the E-Medical record, and there are some good data to show, for instance, that all the duplicate lab testing that would certainly be substantially down if you had and E-medical record. So, your question really deals with scoring on the top possible savings and using the health IT. Any comments?

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CYBELE BJORKLUND: Yeah, this is an area, I think, where there's probably lots of room for bipartisanship, I'd even venture to say in both chambers to look at some of these issues. As Stark has long said, look they know when I use my Visa Card in China in that currency in real time. My bank has it out of my account. Why can't our health records be following? And I think that we're making a lot of strides. First, as you know, we've got to get interoperability standards down and get some agreement among the proprietary standards out there for that to become a more prevalent reality. Kaiser Permanente has made great strides in their organization. There are lots of good leaders to look at, but I think we're a long way from the place where CBO at least would give us scorable savings. But we'd like to see movement in that direction toward a more interoperable system that relies extensively on IT. I will say though, from my HIPPA days that you have got to have really strong privacy protections then, and Mr. Stark might say, right of action, to scare people into following those standards and those rights so that if privacy is transgressed, people have redress.

MARK HAYES: I just want to add one thing. I think Cybele's exactly right. I think there's a great opportunity for bipartisanship here on IT policy. I just want to say, though, that I don't think we'll ever achieve our goals and adoption of IT until we make it part of the business model

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for healthcare financing, and that means looking at some of those pay-for-performance ideas. You know, we've got to reward the quality that we want to result. We had some folks come in and tell us that without that, what IT could do is just make you do the wrong thing faster, which won't help us at all, but I hope we can look at that side of the equation as well.

CHARLES CLAPTON: I guess I just want to follow up on a point Cybele made, that I think while all of us sitting here will tell you that intuitively health IT and quality are great things, the difficulty, as Cybele correctly identified is going to be the Congressional Budget Office, that there are lots of programs that we looked at intuitively that make sense, result in better clinical outcomes and could save money, disease management being a classic example of that, where, because CBO, for a variety of reasons, first and foremost because they don't have sufficient data, has viewed that as a score, and given everything that we talked about today, it makes it that much more difficult. So, I think the challenge, and the challenge I propose to all the providers of health IT is to really go out and develop good data sets that we can use when we go in to talk to CBO to go in and show, this is something that provides value, both from an economic and also a clinical perspective.

And I guess I would be remiss if I didn't chime in and say that Senator Baucus supports movement on quality

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improvement, IT and so I would just echo a lot of what my colleagues have already said. Thanks.

ED HOWARD: And we shouldn't draw any lessons from the fact that there was no money included in the omnibus appropriations bill for Dr. Braler's [misspelled?] new office as Information Technologies are?

MARK HAYES: You know, I was looking to see if anyone else was going to jump in on that one first, but I think you've got a good downpayment there. There was a designer and a requirement there to restrain domestic discretionary funding, and you really, I think, have a sense that we've got to connect all the dots on an IT policy as it fits into pay-for-performance, or P-for-P, as the other is too hard to say sometimes, and once that plan is really cemented and we make it part of the business model and we march forward, then I think you'll see a much greater investment there.

DIANE ROWLAND: I apologize to the half of the people in the audience whose questions we didn't get to. I think it speaks, though, to what a stimulating discussion we've had here, and we did think we should end, maybe on a bipartisan note, so the last question seems like a good one to end on. Ed?

ED HOWARD: Thank you Diane. [APPLAUSE.] Yes, please do. This has been a wonderful discussion. [APPLAUSE CONTINUES.] Let me just ask you to fill out those blue evaluation forms, and stay tuned. We'll pick this up again

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after the Congress reconvenes, or convenes.

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