Health Legislation 2007 - 2008: What's Possible?
Alliance for Health Reform
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ED HOWARD: We get started on time, we'll maximize the time for your own questions. So I know that's your motivating factor. I'm Ed Howard, with the Alliance for Health Reform. On behalf of our chairman, Jay Rockefeller; our departing vice-chairman, Bill Frist; and our soon-to-be co-chairman, Susan Collins; thank you very much for coming to this briefing on likely health care legislation in the 110th Congress. The 109th is now history, and I'm told that a lot will change come January.

You all know that this briefing is rescheduled from last week. A week ago today, as a matter of fact, we had the misfortune to schedule while the 109th Congress was still in the dying paroxysms of trying to bring forth the final adjournment, which they have done in fine fashion without having to spill over into the entire weekend, much to the pleasure of our panelists.

Our partner in today's program is the Robert Wood Johnson Foundation. I want to thank Risa Lavizzo-Mourey and David Colby and others at the Foundation for allowing us to do this program. David actually would have been here last week, but couldn't be here for this rescheduled event, so we're pleased to have their interest and support, and we'll be back

here doing this again sometime in the future, and I hope you can join us.

I'm not going to take any time either to give you a long spiel about the need to look at the legislative program for next year, you already know that, or about the bonafides of our panelists. Because those of you who have been around for a while know that as well, and I'm going to give them very brief introductions. We've asked them to be fairly brief in their presentations, and as I said, maximizing the time that you for interchange.

We're going to start right off with Kate Leone. She's the senior health counsel to soon-to-be Senate Majority Leader Harry Reid of Nevada. Previously, she was a principal health policy person for the Democratic Leader Tom Daschle, and at the Senate Democratic Policy committee. She's a lawyer by training, has put in some time at the Justice Department, and unlike some of us members of the bar, she actually talks in English. So we're absolutely delighted, Kate, that you could find time to be with us today.

KATE LEONE: Thank you. That's a lot of pressure, the speaking in English part, but I will try. After last week, it's a tall order. First, I just want to apologize for forcing the rescheduling. I think all of us were very sorry to have to do the last minute schedule change and we definitely waited too

long, and our sincerest apologies. As we tried to pull ourselves together, we realized there was really no way for us to get out of there, but I do want to thank the Alliance and Robert Wood Johnson Foundation for seeing to it that we got to reschedule, and hopefully make everything right by being here today.

I guess I will start by saying that I know we're looking at next Congress and the 110th, but it probably, based on the last Alliance panel I did last week, that a lot has changed since then in the last few hours of the 109th. We managed to get a few things off our place on the health agenda for the very beginning of the 110th congress.

We were able to pass, as part of the NIH reauthorization, some provisions to address CHIP shortfalls, the Children's Health Insurance Program, through May. So that's good news, because that was one of the things we were going to have to look at right away in January, and everyone at this table was instrumentally involved in making sure that happened.

We were able to send the Ryan White reauthorization to the president, which is also very good news, because that would have been something that we would have had to start right away in January, and now, while we are going to need to come back and take a good look at that program, the reauthorization was

shortened to three years from the original House-passed bill. So we are going to need to get to work right away in figuring out how to deal with Ryan White going forward, so that we don't have another - I guess it's inevitable that we will we have a formula fight, as we always do, but we hopefully will be able to lessen some of the problems that we had this year, going forward.

We were also able to pass the bioterrorism bill that included provisions to speed the access of medicine and bringing them to market, so that's also good news. So we have those things behind us. CHIP, obviously, just through May, Ryan White, obviously, for the next three years, but again, that's a complicated program, so those will be things we need to revisit. But the good news is they're off our plate for immediate January consideration on the floor, and are relegated to health staff figuring out where to go next. So that's the good news, coming out of the 109th from a health perspective.

How could I forget? The physician reimbursement cut was postponed, and that, again, would have been a big-ticket problem for us in the beginning of the 110th. It was just solved through next year, so again, something we're going to have to look at, hopefully starting earlier than we did this year, and figure out a way to prevent another scheduled cut and cuts going into the future. So we will be looking at those

things, but won't have to take up the floor time that we would have early on in the year.

Most of you have probably seen the Six for '06 agenda the House and Senate Democrats share and put together earlier this year. You probably also heard that Speaker-elect Pelosi has a 100-hours agenda for passing the items in the Six for '06 agenda. To be clear, the Six for '06 agenda are shared priorities for the House and Senate. The 100 hours promise is a House promise. If you watch the Senate at all, you know that 100 hours is not time to do the Six for '06 agenda. So we share those priorities and plan to consider them very early on, but we aren't limiting ourselves to 100 hours to do it. So included in that agenda are a couple of health care items. One is stem cell research, and we want to expand federal funding for stem cell research.

It's no surprise to anyone that that's one of our priorities. We did send a bill to the president this year, and he vetoed it. So I think we'll see the House considering a very similar bill this year, and the Senate also considering a similar bill, and we will hopefully get it to the president fairly early one. And our hope is that, over time, he has realized the need for expanded federal funding.

We haven't seen any guarantee of that, so we expect a veto, but we are still hopeful that we won't get one. People

are speculating quite a bit on whether we have veto proof majorities in the Senate and House, I guess time will tell on those fronts. But that's bound to be an early health care agenda item, and perhaps, fight. So look for that.

The other piece of the Six for '06 agenda that relates to health care is repealing the ban on Medicare negotiation for prescription drugs. The House of Budget [misspelled?] can probably speak to what the House's plans are on that front. In the Senate, we expect things to go through regular order, and so it probably gives you a good sense of what a bill will look like coming from the Finance Committee with soon-to-be Chairman Baucus. As you all know, in the Senate, we mostly need 60 votes for most legislation.

Senator McConnell has indicated that he plans to fight our efforts on the Medicare drug negotiation front, so we're planning with needing 60 votes in mind. The Snowe-Wyden approach has in the past garnered 54 votes. Obviously, we've picked up a few Democrats since then, and while we haven't canvassed them on this particular issue, some of them did speak about it on the campaign trail and we expect them to be with us on it.

And others we will be talking to as they arrive here in Washington. It's unclear whether we'll have the Snowe-Wyden approach or whether we'll do something different, and the

Finance Committee has begun talking to members and figuring out where they want to go with that. So again, that's sort of a work in progress, what it's going to look like, but we hope to have something on the floor in the early part of the year.

With respect to other Medicare items that are Democratic priorities for next year, I think that there's a shared interest among Republicans and Democrats in doing something to improve the low income subsidy in the prescription drug benefit. That's clearly the key part of the drug benefit, and so I think most people think that the administration hasn't done the best job finding those people and getting them enrolled. I think we'll see some oversight of the drug program generally, but hopefully also some improvements to the program, and specifically, I would guess, the low income pieces.

CHIP reauthorization is also on the Finance Committee agenda. I'm sure both Bridgett and Mark can speak to that as well. Again, we have the shortfall deadline knocking on the door in May, so hopefully we'll see something earlier. With respect to Medicaid, I know that both Senators Grassley and Baucus share an interest in looking at what the administration has been doing with Medicaid waivers. I think we'll see some more oversight into that.

And in the Health Committee, just a few quick items. There's clearly still a problem for small businesses who are

looking to insure their employees, and they're having a hard time with costs. We're hopeful that we can start from a new place and figure out how we can merge Democratic and Republican ideas on this issue, and instead of having a partisan fight on the floor like we did last year, hopefully be able to start in the middle and work something out so we can get something done.

There's also some prescription drug items on the Health Committee agenda. The Prescription Drug User Fee Act is up for reauthorization. Senators Kennedy and Enzi share an interest in improving drug safety, and I think they plan to loop that into the PDUFA re-authorization. And again, in both the Finance and the Health committee, there is the health information technology legislation that didn't make it this year, and I think that that's going to be high on the agenda for both committees this year. So those are some of the priorities we have, and I'm sure these guys can speak more to most of them. Thanks.

ED HOWARD: Thank you, Kate. Let me just circle back before I introduce Mark Hayes, and mention a couple of housekeeping items that I didn't before. You had the opportunity to get an extra copy, if you haven't gotten it already, of the *Sourcebook for Journalists*, which took a great deal of effort for a small organization like ours. I hope you

can make good use of it. You may not know that there's also an electronic Find an Expert service.

When you're looking for a source on Sunday night, if you've registered and have your password, as a journalist you can search our database of several hundred experts with varied expertise with the ability to speak Spanish in some cases, the geographical spread that might be useful to those of you in different parts of the country, and get the contact information you need and hopefully make the contact that you need. If you want to pursue that or any other aspect that you think we can help you with, Bill Erwin, standing in the far corner, our communications director, would be delighted to help you. And Bill would kick me in the shins if I didn't note that there are in your packets materials on almost all of the topics Kate mentioned, along with some position descriptions that we have lifted from either news sources or websites connected to declared, or anticipated, or speculated about presidential candidates on both sides.

So with that, let me move to the other side of the aisle in the Senate. Mark Hayes is the health policy director for the Senate Finance Committee Republicans under Chairman Chuck Grassley. Anything you don't like about the Medicare Modernization Act in 2003, you can probably blame it on Mark, because he was in charge of that at least on the Senate side.

And after all, he is a pharmacist by training, so he's probably the only person who understood what was going on anyway. Mark, thank you for being with us, and I appreciate your taking the opportunity to look forward, as well as back.

MARK HAYES: Thank you very much. And just to clarify, we would say that anything you would complain about we would blame on the Ways and Means Committee.

I want to start off by echoing what Kate said about apologies for last week. The e-mail chain amongst all of us as we sort of collectively wrung our hands about how we were going to pull this off, and as it became more and more clear that there was no way we were going to be able leave the Hill. And finally coming to terms with that and admitting it, and the negotiation then over who was going to send the e-mail to Ed to say we were all going to have to do it, and thank you Kate for doing that.

KATE LEONE: It was a definite bipartisan negotiation.

MARK HAYES: Yes, it was a definite bipartisan negotiation at its finest. So my apologies as well that that worked out that way. Well, next year has a lot of things on its plate, I think, that are ahead of us. A lot of opportunities to make improvements in a lot of areas, and we're looking forward to working on a bipartisan basis on those things, both within the Finance Committee and the Senate. I

think Senator Grassley and Senator Baucus have had a very positive working relationship, I expect that to continue.

We are going to hit the 45-percent trigger next year on the percentage of entitlement spending coming from the General Fund. And the official sounding of that trigger, I think, will at least trigger its own discussion about entitlements and where we're going in this country with spending, because these are issues we will have to face up to at some point. And this trigger that was established in the MMA is a useful trigger to actually start that discussion, and to make sure that we all understand the long-term ramifications for the sustainability of Medicare and the choices that are going to ultimately have to be made about either restructuring benefits, raising taxes, or increasing beneficiary cost sharing in order to make the program sustainable over the really long term.

None of these decisions, of course, are easy ones to make, and much will probably happen on the discussion side. It will be a challenge to make anything happen in reality, but I think that will be an important discussion that will take place next year.

And, of course, layered in the middle of that is our physician update problem that continues. And in this bill last week, Congress addressed the update for '07. They addressed that through a bonus payment for '07 and a fund that is created

to help to address the '08 fix, so that when Congress revisits the position payment policy, that fund is waiting there to be available to address a longer term physician policy.

The work that needs to go into that longer term physician policy, putting just the money problem aside which is the context of entitlement reforms, it's $150 billion or so, or more, of its own spending. But there's really two issues here, and one is just the formula itself. What should be put in place of the volume performance standard? What kind of incentives would physicians have about utilization? Because the current formula really does not create the kind of incentives on physician behavior that really it was intended to create. And that's really the crux of the problem, that's what is driving the overspending in Part B that results in higher Part B premiums by beneficiaries and higher cost sharing for those services by beneficiaries. And yet, not an easy problem to fix.

So MedPAC has been doing a lot of work on this, and there's a report that is due to Congress at the first of the year with some options and some analysis of those options. And I think that will be a very important contribution to that discussion, but a lot of technical work has to go into exactly how CMS could implement any of those options.

But if any of you have had the opportunity to hear Elliott Fisher talk about the ramifications of the differences in geography, the differences in spending in different parts of the country, you understand the complexity, in part, that faces this volume problem when we look at physician utilization.

Besides that, which is by itself an enormous issue, I think there's a bundle of issues that I would put into kind of a quality bucket. We have started now a physician quality incentive system, a transitionary policy that starts for six months in 2007. And as part of the Physician Update, I think there'll be a desire to revisit that and really try to work out what is the long-term policy here, and in what other areas in Medicare can we begin to look at quality so that providers that provide better quality at some point in the future can look forward to a better payment for delivering that quality. And also that beneficiaries can compare providers and know if they are about to have an important surgery, that they might be able to look at different surgeons and find out which ones have a better track record.

Having had a family member myself have a heart procedure done just recently, it's very difficult because you can't find out, who is this surgeon that's about to operate on our loved one, and how good are they? How many procedures have they done, and how well have they gone? How long have the

patients lived after this surgeon operated on them? You want to know these things. And today, it's almost impossible to find those things out, and I think people want to know that.

I think the Information Age really has triggered that. We can find out so many things on the Internet now. If you want to compare products, if you want to buy a washer and a dryer, you can look up different consumers' experience with that washer and dryer, good and bad. But in our health care system, it's much more difficult to do that.

Also in the quality bucket, Kate mentioned health IT. I think that one is one where it is ripe for bipartisan action. We were very disappointed that it didn't happen this year, and it happened it was blocked because of reasons really not having anything to do with health IT. And so we hope we will be able to move forward on that, and on drug safety. I can't say anything about quality without saying something about drug safety. We have a big interest in that on the Finance Committee, because of Part D, and certainly in Part B, we can buy a lot of drugs as well.

And then the last thing I would say – well, I'll say two more things really quickly. One is that access to health care, we have SCHIP coming up for reauthorization, as you all know. And there's also a lingering debate about small businesses. And there's a lot of overlap here. I want to give

you three statistics about this. First, 69-percent of uninsured children are in families with either one or two full-time workers. Forty-nine percent of uninsured workers are either self-employed or in businesses with less than 25 workers, so mainly small businesses. And 75-percent of all uninsured children are eligible for Medicaid and SCHIP.

So really, we need to figure out a way how to connect these dots, how to maybe make it more possible for SCHIP to help people buy family coverage when they're working in a small business. And also to help small businesses make coverage more affordable and available to their workers. It's a big part of the uninsured equation and seems to logically fit in with the SCHIP discussion.

The last thing I'll say really quickly before my time is up, is on Part D. We will continue our Part D oversight work that we have been doing this year at hearings and a number of member meetings, and certainly, untold discussions with CMS and officials there about issues that were happening there. But there are also, I think, an opportunity next year to begin to look at some statutory changes to make some incremental improvements in Part D.

Pharmacy contracting, there's some problems with the open enrollment periods, where they don't really all align very well and there's policy ramifications there. We have Part B

and Part D drugs that overlap in the outpatient setting in nursing homes and pharmacies, that all needs to get untangled. And numerous other things that can be done to improve, say, medication therapy management is a benefit that was created in the MMA to help provide resources to beneficiaries so that beneficiaries that are taking a lot of different drugs that their physicians have prescribed for them, help them really maximize the clinical benefit there.

So we have a lot on our plates, and it looks to be the beginning of what I think will be a very busy year. With that, I will turn it back over to Ed.

ED HOWARD: Thank you very much, Mark. Those of you who are interested in pursuing Mark's mention of quality incentives, the Alliance is doing a briefing on Friday on pay-of-performance, which I bet Bill Erwin could slip you into just by the fact that our registration deadline is past.

Our final presentation will come from Bridgett Taylor. She's the main Democratic health staffer for the Energy and Commerce Committee in the House under soon to be Chairman John Dingell. She's an expert on Medicare and Medicaid and a bunch of other stuff, and has worked on it in the real world at both the state and national levels. Not only has she done it all, but she works for a man who has been described by *The Wall Street Journal* as a partisan investigative bulldog.

I don't know if that's a key to the activity agenda of the Energy and Commerce Committee or not. One thing I will absolve her of any responsibility to speak for our fourth panelist from last week's rescheduled briefing, Chuck Clapton, who had to cancel because of a meeting that the Speaker wanted him to be present at.

Of course, House procedures are less likely to present problems for a slim majority in getting things done, they don't really need 60 votes the way some other legislative bodies do, to get things done. But Bridgett assures me not to worry, that the Democrats are going to protect the rights of the Republicans in the House of Representatives. So she can speak for everybody. Bridgett, thanks for coming.

BRIDGETT TAYLOR: Thank you, Ed, and the Robert Wood Johnson Foundation for making this possible. I'm pleased to be here to speak with all of you today, and more importantly, to have the honor to be on this panel with my two wonderful colleagues who are not only brilliant, but very, very kind and gentle people and very fun to work with. So I feel honored to do that.

As Ed mentioned, I work for John Dingell, and I'm not going to comment as to whether or not he's a bulldog or not, I'll leave that to you to determine on your own. I'll just say

that I've worked for him for 12 years, so there is a kind side of him behind that bulldog.

He has not quit smiling since this happened, and I can't decide if my eyes are so wide because I'm a deer in the headlights or I just had Botox treatment, but I am looking at this as a new challenge, to say the least. I would like to say that the comments I'm going to make today are my own, for two reasons.

One, because our committee has not even organized yet and we don't know who our subcommittee chairman is, so I can speculate as to what we're going to be doing but I don't know that for sure. And secondly, it's my understanding, people tell me, that once we're in the majority that you all pay more attention to what I actually have to say. So I just want to make sure that I'm clear about that.

I guess my final request would be, if you do decide to write down what I'm saying, if you could not quote me as Bridgett Taylor. You can call me the Democratic female staffer who's worked for John Dingell for 12 years or whatever you like, but I'm not really fond of seeing my name in lights so if you could do that, I would appreciate it. But I understand that some of these caveats may not be able to be met. My colleagues have obviously covered a wide range of things, and many of those things we obviously share together.

So I will sort of skip a little bit of it, although the one comment I would make about the 100 hours in the House is that we clearly are going to try to work through these six areas as soon as possible. I don't know whether it will be possible for us to do regular order, in order to be able to do that, but for those of you who know Mr. Dingell, and I'm not saying anything he hasn't said publicly many, many times, but he is a firm believer in regular order.

If he has any influence over the caucus, we will have a very open process. We will have hearings. We won't move bills until we've had hearings, and we will allow amendments on the floor, at least as far as he's concerned. I can only speak in that particular instance for him.

One of the things that I didn't hear either of my colleagues mention - or, if I did, I was zoning out and I apologize for that - is the budget. And the budget, in my mind, is going to be probably the most important thing that's going to happen to us in this whole process, because all the things that my two colleagues mentioned, by and large, take money to happen. Kate mentioned the Children's Health Insurance Reauthorization Program, and we're going to be looking at doing physician payment. All those things cost money. And in the House, it's my understanding we're going to

have a pay-go rule, which means you cannot pass anything unless you pay for it.

I don't think even though people have accused the Democrats of wanting to raise taxes that you're going to see a lot of that to do with these different programs. So that means we have to find other ways to cut programs. And I'm not sure where that's going to happen, but we are going to spend some time trying to work with the budget committee so that in the resolution there is money set aside for the Children's Health Insurance Program or the physician payment – if I'm not naming it, it doesn't mean it's not on the list – but there are many, many things that we're going to have to do about that.

So I think that's an important thing to look at. And as you know, we always have the budget hearings in our committees, Secretary Leavitt is going to come before the Congress committee, I'm sure he's coming before Finance and we'll go before Ways and Means, and we'll be interested to see what the President puts on the table so we can see where our parameters are, in terms of working with him.

We obviously are interested in Medicare, Part D, Part C, part whatever you can think of. The low-income subsidies are of keen interest to us. As many of you know, our committee has jurisdiction over the low-income health programs, Medicaid and SCHIP, so we obviously pay attention keenly to those areas

and are going to want to see what we can do to improve the ability for these people to get their subsidy and then also to get enrolled in the proper program, which I know Chairman Grassley has shared a lot of interest in that as well as soon to be Chairman Baucus.

In addition to SCHIP, we care a lot about Medicaid on our committee, and we're disturbed by many of the things that were put into the DRA. And some of these things were fixed in the technicals bill that just went through in the tax extenders. But we're still concerned, for example, on the citizenship area.

The administration decided to be expansive in their interpretation of the statute, and decided that newborns who are born in hospitals in the United States of America may or may not be citizens. So they have asked that these newborns have to put forward information that shows that they actually belong here and get therefore eligible for Medicaid before they can get it.

And for those of you who have not been getting birth certificates recently, it sometimes can take as much as two or three months to get your birth certificate. So it seems to us like this is not a very smart provision that was regulated on, and I think there's going to be some desire to try to look at taking care of that.

One of the other areas in the citizenship, which, as a staff person, we are concerned about that they were not able to do in the technicals is, to allow people to have some time to collect their data and information to present it before they are – this is for people who are on the program and who have to recertify themselves to be allowed to have a reasonable amount of time to go and collect their information before they're actually cut off. And that, as much as I know my colleagues at this table tried to work to get that, just didn't happen in the context of the technicals.

So we're glad that we're going to be able to try to do something about that. And Mr. Dingell and several of our other members have written multiple letters to the administration on the benefits package for children that seems to not be – the administration's interpretation, again, of the rules are not giving children at low income levels the benefits that they have been entitled to for many, many years. Which essentially, allowed them to get – if they are determined to have medically necessary – if they have medically necessary benefits, they should get them. If they have needs, then they should get those medically necessary benefits.

And also, if they are chronically ill, which is not necessarily – they might be born with a birth defect. It's not necessarily that they have medical needs, but they should get

their physical therapy, because there are some interpretations that if you're not brought back to normal health, you can't get enough of the services. And in the case of a child that was born with a birth defect, they can never get back to normal health. So we want to make sure that they get the adequate physical therapy, other things they might need to keep their muscles from atrophying and things like that.

We are clearly going to be looking at the uninsured. I know that there will be a gazillion flowers blooming among the members of the Democratic Party who have had all this pent up desire for the uninsured, so we will be trying to determine which ones of those do hearings and things like that, and meet the budgetary targets we'll be able to move forward.

And then, I guess I would just close, for those of you who just want to look these are some public documents, there are many letters that have been sent, like six that have been sent over to the administration since May, actually, by Mr. Dingell, Mr. Wax and Mr. Rangel, Mr. Brown and Mr. Stark, identifying several things that they would like to see done. They're all on our website, or if you can't find them on the website, just let me know, I'll get them to you.

But they range from questions regarding – in August, President Bush signed the Executive Order about transparency, but yet the administration's been holding back on giving

information regarding that, Medicare, and made plans in the Part D plans that might help us to just understand what's going on there.

There is some concern about – and I think, can't remember now, somebody in this room wrote a story about the marketing practices going on with the Part D plans in some of the states, and the fact that the administration is allowing these plans to not have to meet the licensure and solvency requirements at the state level. Or, in the instances where they do, they don't require them to meet the marketing standards, and there's been some concerns about that.

And then, obviously, the citizenship one that I've also mentioned, and the regulations they put out regarding provider payments and Medicaid, which, that was signed by all the entire Democratic Caucus. So anyway, I'm happy to answer your questions, and it's a pleasure to be here with you, and thank you very much.

ED HOWARD: Thank you, Bridgett. We have ample time for questions. If you would identify yourself before you ask a question, and wait for somebody to come with a microphone so that the rest of us can hear you, that would be much appreciated. Yes, go ahead.

FEMALE SPEAKER 1: What do you expect from PDUFA, and what we might expect regarding generics and other things that could be attached?

BRIDGETT TAYLOR: Call John for it. [misspelled?]

FEMALE SPEAKER 1: Okay.

ED HOWARD: There. That was the crispest exchange that you're going to get. Yes.

DAVE POSTAL: My name is Dave Postal. I'm with the National Underwriter, Washington Bureau Chief. Representative Starr recently said that what they're going to do is direct Mr. Leavitt to establish a government price, and that would be the ceiling and people would negotiate it under. Is that what you would support, and do you think, because odds makers say it will not happen, that the current system will remain, including Karen Ignagni of AHIP? What are you precisely looking for on that ban issue? Can you explain it to us? And where do you think it's going to go? Ms. Leone?

KATE LEONE: As I said, we expect to go through regular order, and the Finance Committee has not done hearings or taken a good look at that issue yet, and Senator Box has indicated that his initial move is going to be to have some hearings on the subject. So I think that what we're going to have coming out of the Senate remains to be seen. We're talking about it, we're trying to survey everybody in the Caucus.

As you know, there are some Republican leaders on this issue. Senator Snowe has been a very strong supporter of Medicare negotiation. We're going to need to talk to her and her staff. I think that we're still in the early stages of figuring out exactly what a bill is going to look like coming out of the Senate. Obviously, the House folks have their process to go through too, and I'm sure Mr. Stark is intimately involved in that, as the incoming Chairman of the Health Subcommittee.

So we expect probably to talk to the House at some point about what they're doing, and probably all get together. And perhaps that'll be in a conference, but I think that right now in the Senate, we are still in the process of going through our options and taking a look at the program. And hopefully, we're going to have some hearings so that we can figure out how best to do it.

NANCY FARRIS: Hi, I'm Nancy Farris from Government Health IT. I wanted to ask Ms. Taylor what she thinks the key elements of the health IT legislation might be in the House.

BRIDGETT TAYLOR: That's an area where we're going to have to have some hearings, there's no doubt about it. Because there was not a lot of open process last year on the health information technology legislation, and quite frankly, the Democrats were in one position and the Republicans were in

another, and it didn't seem like there was much middle ground, in terms of where we were going.

We were much closer to being in the same camp as where the Senate had been than we were in the place of the House. But I think that there's no question in my mind that we have to do more to ensure that there is the ability for a physician offices to be able to access information and have the technology necessary to do that.

And I think it's a key component of – Mark was talking about pay-for-performance. You really need to have that ability for there to be interaction between the institutions and the physician community to even be able to report. The one area, though, where there was controversy was whether or not we actually provide new funding, which I think is where the Democrats would like to be, versus allowing there to be an exemption from the Stark provision, which basically prohibits the ability of there being some sort of quid pro quo, as you might call it, between-

Let's say we allowed one hospital to give only to the physicians they picked to give it to, that there might be some question as to whether or not that was a legal matter that should go on that way. Or, more importantly, if the hospital picked out a physician and gave him that, would the physician have the ability to communicate interelectronically with

another institution? Which was another key component that I think we need to have, which is interoperability.

So if, for example, you did get equipment from one institution, that you could have the ability to communicate with another institution, even if they had different software. I could go on, but I think those are probably the major elements. Does that help you, what you needed?

ED HOWARD: Several questions over there after this one.

BILL SALGANIK: Bill Salganik from the *Baltimore Sun*. On SCHIP extension, are we looking at something pretty much like the status quo, going forward, or, there was mention of including family coverage somehow. Are we looking at somehow reconfiguring the program?

MARK HAYES: Since I was the one that brought up families, let me clarify what I'm talking about. SCHIP is a program for children, and that's the priority there. You have a lot of kids in this country who are uninsured but they're eligible for Medicaid and SCHIP already. The issue about the family, where the Family comes in, is that many of these kids are dependent of full-time workers. And many of those workers are employed in small businesses, or they're self-employed.

And so there's a connection between these two problems, in terms of families and small businesses, and the children and

SCHIP. And what I was suggesting is that on the SCHIP side, that we should look at keeping the priority on children, but making the program more flexible, so that SCHIP can help provide some assistance to families to cover the portion of family premium that they're getting to add the child to their family coverage. I just think about our own family. It's complicated enough to navigate our health care system. And if the parents are in one plan and the child is in another plan, that's making it that much more difficult. And we need to find a better way to coordinate these programs.

So if SCHIP – and I think there's one state in particular that is beginning to test this to provide some resources so that SCHIP can help buy that family coverage for the child. But at the same time, separate from that, we have had this debate last year, or this year, about how to help small businesses generally. And there were competing proposals in the Senate between a group of Republicans, and then there was a group of Democrats led by Senator Lincoln, and they had a tax credit proposal. And this is an important priority.

In small businesses, a lot of the uninsured are those dependents of workers in small businesses, and we need to figure out how to connect the dots here so that we can get some synergy, I think, between how these two policy challenges, really, the solutions around them, should be identified. Just

to clarify, that's what I was referring to, not necessarily expanding SCHIP for families.

BRIDGETT TAYLOR: Can I just add one quick thing to that? Because I think there are a lot of elements of SCHIP that we probably need to look at in reauthorization, but the one that I think is the most important is that right now SCHIP is funded at $50 billion over a year into perpetuity, and it doesn't take a very smart person to figure – over five years, I'm sorry. I'm sorry, I meant five. I apologize. Thank you for correcting me. I wouldn't want them to think I was willing to spend all that much money on children - into perpetuity.

The problem with that is, that that's not even enough money to cover kids who are today on the program. It doesn't even current – if kids who are currently, I mean, if the eligibility level is 100-percent of poverty, and in addition to that, eligible kids who are not enrolled want to come in, there's not enough money for that.

So I think what you're going to see a lot of us trying to do is, if nothing else, just make it so that it's a program that grows. So that even if they're not expanding coverage, like going to 200-percent of poverty, or 300-percent of poverty, that there's at least enough money to cover the kids who are in the program now, or who could be in the program if

they could find their way to an eligibility station, so stay tuned.

BART JANSEN: I'm Bart Jansen from a Maine newspaper called the *Portland Press Herald*. My question, basically, extends from what she was just saying. If 70-percent of all uninsured children are already qualified for Medicaid or SCHIP, and you already can't afford the kids who are showing up, do you really expect reauthorization by May, or are you expecting another band aid beyond what they've got now?

BRIDGETT TAYLOR: I will say that the best intentions are to have it done as soon as possible.

ED HOWARD: All right.

DOUG TURNER: Doug Turner from *The Buffalo News*, Washington Bureau. About a dozen or so years ago, Harris Wofford won a big Senate election on universal health care. We had a new president, Democrat, and as Mrs. Clinton began her studies, Paul Sompol [misspelled?] showed that up to two-thirds of the Americans wanted universal health care.

That plunged down to about a third, about 35-percent-37-percent after all the fighting was over. Now you have industries – this is a two part question, for Mr. Howard also – you have industries now wanting to unload their defined benefits, or go out of business, or outsource their factories.

In Canada, which is right across there, my neighbors in Canada, elderly people who pay $100 premium, and they get all their drugs for nothing, out of OHIP. What are the prospects, just not as policy makers, but as observers – what are the prospects that universal health care is going to become a big issue in the 2008 presidential election? Mrs. Clinton has been avoiding the question, but irrespective of what she does or doesn't do, how likely do you think this is going to be a question in the 2008 presidential election?

And the second part of the question is, why won't it be? [Laughter]

ED HOWARD: I'm going to give you a chance to collect your thoughts by quoting Senator Frist's principal health advisor until about 18 months ago, Dean Rosen, who predicted that the last time we had this conversation that health care would be the number one domestic issue in the 2008 presidential election. And that's something I've heard Senator Frist say himself. I'm going to stop right there. That's the factual part. And my colleagues, who are much more into the interstities [misspelled?] of this issue can respond. Kate?

KATE LEONE: I think that clearly it pulls at the top of peoples' minds, in terms of domestic concerns, and I guess the question is, when do we reach a tipping point for people to decide if this is something we need to do. I note that we're

now in the sixth year of President Bush's term, and he has yet to propose in his budget any kind of comprehensive health care program, so maybe that's a sign.

The other question is, paying for it. Bridgett mentioned in her comments, and I should have mentioned in mine, the pay-as-you-go rule in the Senate and in the House, which, obviously, any presidential candidate is going to have that in mind too. How do you get there and where's the money? I'm used to doing all my panels these days with Wendell Primus from Speaker like [misspelled?] Pelosi's office, so you'll understand why I leave the pay-go discussion to him, if you know Wendell. But I think it's when do you reach a tipping point? And I would say that I think it's going to be a very high concern.

I don't see how any presidential candidate gets away with not talking about at least providing access to affordable coverage for all Americans, at this point. It's a growing crisis. It's 46 million people now who are uninsured, and even for those who are insured, many of them are underinsured. And for those who aren't, they're still having trouble paying for it.

So I think it's not just a small business problem, it's not just a kids' problem, but those are the areas where I think Congress is looking to effect some kind of incremental change

by biting off some piece of this problem. It's a huge one, and I think what we really do need is leadership from a president on it. And so I hope that it's going to be an issue in the campaigns because I think that's what you need. We're going to need a president to come in and say, "Here's how we need to do this."

MARK HAYES: It's really a complicated mess, isn't it? I think the fact that people will say, yeah, we want everyone to be covered is understandable. Everybody wants everyone to be covered, I think. It really is the devil's in the details, and I think that's what the lesson was in the Clinton health plan era, is that the more people found out about what was being discussed, the more people had questions and concerns.

Politically, the reverberations, the aftershocks of what happened in '93 and '94 still reverberate today. And I think politicians are very wary about repeating those mistakes, and that is why I think you hear a lot more about looking at components of this issue and not trying to solve everything all at once. Our health care system is a complicated thing, and everything is interrelated.

And you can't stop the machine in order to change it and then put something out there. The machine keeps running and you're trying to fix the machine while it's running inside,

you know you can lose fingers doing that. It's not a good thing.

I also think that on the money side of this, speaking of pay-go, this is something you've seen presidential candidates run into trouble on too. If you're a candidate, you start talking really big about what you want to do, you're going to very quickly get questions about, how exactly do you plan to finance that endeavor?

And is that going to involve taxes to pay for that, or exactly what is the financing mechanism? No easy answer there either. So it is probably the best example of the devil's in the details that I can think of at the moment, although probably on the next question I'll say, "Well, that's a good one too." But it is an issue, though, that like entitlement spending, that we are going to have to face.

Because there was a very, very interesting article posted on the Health Affairs Web site about a month ago now, that was a comparison of access issues in seven countries. And you mentioned Canada. Really, when it turned out to looking at use of health IT, e-prescribing, availability of care after hours, it turned out the only country that was really rated as poorly as the United States was Canada.

And you looked in New Zealand, Australia, the Netherlands, all doing very well on the use of health IT and e-

prescribing and access to preventive services and things like that. They've clearly figured out something that we haven't yet, and the Canadians haven't either. So those are the kinds of issues that we really – those are the fundamental drivers of a lot of the problems that we have to address first, I think, as we try to march through exactly what a longer-term solution might be.

ED HOWARD: Let me just add, by the way, if you haven't seen the Kaiser Family Foundation poll that was released last Friday it's precisely on that point, about peoples' attitudes toward this as an issue both for Congress and for the presidential candidates. So I commend that to you. If you have any trouble finding it, let us know. Yes.

DONNA SMITH: I'm Donna Smith with Reuters. Mark, you mentioned earlier about a 45-percent mark triggering a discussion on entitlement spending. Do you anticipate any congressional action or anything more than discussion between now and the 2008 presidential election?

MARK HAYES: A few weeks ago, I would have said we were going to have hearings on the 45-percent trigger. I don't know whether we will now. There's a response required on the bill and in the MMA, and one of my sort of favorite things in law is to look at that language and think, well, it's just so

interestingly worded to say that a response is required by the President. And it could be anything, right?

I think you will see it will trigger a discussion. I don't know whether that's going to be a discussion in the form of hearings, or what form that discussion is going to take. But I do hope that it will serve as a jumping-off point for the public to understand better what is really at stake, what is really happening when it comes to entitlement spending and the threat that that poses to these programs. The trigger is about Medicare, but I think a lot of the same things apply to Medicaid as well, in terms of the long-term sustainability, the ability of states to be able to finance their share of the program as well.

So these are hard questions, and it certainly fits in with the health care reform discussion as well, in terms of the relationship between public programs and private health insurance and financing private health insurance as well. And these are big issues, and I think we face a really big challenge in explaining this to the public so that it is understandable and real for people in the near-term too.

JILL WEXLER: Jill Wexler with *Managed Health Care Executive* magazine. Mark, you didn't mention Medicare Advantage rate issues on your short list of incremental changes for Medicare. I know a lot of Democrats are interested in that

issue. Does that panel think that that's going to be a real target for cuts and for providing money to beef up the drug benefit plan, or is it going to be more just talk?

MARK HAYES: Well, if I can jump in here first, I know what they're going to say, I think. [Laughter] Here's what I would want to add to this discussion, and that is that I think you could make a lot of improvements in how the Medicare Advantage rate setting mechanism, the formulas, work. And what I would say there is really, Part D provides a much better example for how it should work.

In Part D, the federal subsidy is based entirely on the bids. The companies bid on a set of benefits, they're competing. The bids went down, it probably never, ever happened in the history of entitlement spending anywhere. There is a lot of competition happening between plans about how to provide this, how to provide Part D, and I think the competition between the fee-for-service side and the Medicare Advantage side in Part D, I think provides an interesting model to look at.

Medicare Advantage, of course, is completely different. It's competing against a fee-for-service program where you have the Part B premium really frozen in place across the country. And I understand how controversial the idea of premium support or anything like that is, of course, and CBO just came out with

an interesting report about premium support. But really, stepping back about Medicare Advantage, the way that Medicare Advantage payment rates are set is built on top of the fee-for-service spending, which, by itself is not really distributed evenly at all.

And so if you look at Elliott Fisher's work again – I'll mention his name a second time – and fee-for-service spending, and then you're layering Medicare Advantage rates on top of that, it's no wonder that you're going to see odd numbers showing up across the country. Because Medicare Advantage doesn't get to use Medicare payment rates when it pays providers, it has to come up with its own payment rates.

So it's a long way of saying there are improvements that can be made. I think that the Part D bidding mechanism would provide a better way for Medicare Advantage to work in this sort of artificial benchmark that we had to do in [inaudible]. But now, you all can talk about Medicare Advantage rates if you'd like to.

BRIDGETT TAYLOR: I guess what I would say is that there is going to be some desire among our members to look at the Medicare Advantage payment rates. And I'm not saying where they're going to go, but I think they really want to look at. MedPAC has made some recommendations about this. The one that always comes to my mind, and is the most obvious to me, is that

teaching hospitals get a payment called Indirect Medical Education. And in the past, they've always gotten it. And the managed care industry was concerned, because they were having a difficult time getting the teaching hospitals to participate in their plans.

So Congress, in its great wisdom, decided to quit paying the teaching hospitals the IME payments, and then to pay it to the managed care industry. And then, there didn't seem to be any improvement in the relationship between the teaching hospitals and managed care plans. The teaching hospitals got upset. And so, instead of us taking it away back form the managed care industry and paying it back to the teaching hospitals, we're now paying it to both.

And people can talk about the government and what the government does and the government shouldn't do things that are inefficient and whatever, and to me paying the same payment for the same thing to two different entities is ridiculous. So MedPAC brings that one forward. So I think that's something we're going to look into and see what the situation is there.

And while I, to some extent, appreciate my brilliant colleague next to me in his comments about the managed care industry, MedPAC – again, you can look at MedPAC, Mark mentioned MedPAC – says that we are overpaying them to approximately 110-percent. In some cases, we're paying them as

much as 119-percent, and that's not just HMOs. I mean, the 119-percent is to the private fee-for-service plans, which some of us are pretty concerned about where they're going, as well as some of the regional PPOs.

So we just need to understand exactly why this is happening, and some of what Mark said is probably the reason. Because Mark brought up the 45-percent trigger. Part of the reason we are getting to that 45-percent trigger faster is because – some of us, in some of our minds – are overpaying the managed care industry.

So I think it's fair game, given you've heard two sort of slightly conflicting, but not completely conflicting opinions, for us to have a hearing to look at this and to see, because there is a lot of pent up need for financing of other things like SCHIP and the Part D drug benefit or whatever. So I think that this is an area where people want to see is this something that we should continue to do.

Should we ratchet it back in small increments? Should we change it, like Mark said, and pay them like Part D? What is the solution? I don't think any of us – I certainly don't know what the answer is, until I hear from some witnesses. And clearly our members, since they are the ones who do the voting, deserve the right to hear from witnesses and determine what they want to do here.

MARK HAYES: Can I add 60 more seconds full of commentary about that? Because I think Bridgett raised some very good points. The only other thing I want to add is, just to remember that Medicare Advantage, if it's overpayments to Medicare Advantage, Medicare Advantage is then paying providers. And in many cases, Medicare Advantage plans pay providers more in Medicare than Medicare fee-for-service pays. So a lot of physicians, for example, are paid better by Medicare Advantage plans than they are paid in fee-for-service.

So at the end of the day, I think if you boil this all away, it is a question of how do you set payments to providers as well? Should it be administered pricing, the way traditional fee-for-service works, or should it be a little bit more of a give and take between the provider, as it is in Medicare Advantage?

MICHAEL EMILIO: Michael Emilio [misspelled?] with the "NewsHour with Jim Lehrer." The first is kind of a more specific question for Kate and Bridgett. You've mentioned with Part D looking at price negotiations and subsidies for low income, but is getting rid of the doughnut hole at all on the radar for either of your sides, that you're thinking about pushing?

BRIDGETT TAYLOR: All I'd refer you to is every political campaign that just about all of the Democrats that

got reelected had. I think the word "doughnut holes" become a family word. So there's no question in my mind we're going to look at what components of the donut hole we can deal with, or whatever. It does cost an awful lot of money to completely get rid of it, but I think the members will want to look at what we can do about that.

KATE LEONE: Certainly, it's on the radar showing for just about every member, and they want to do what we can to alleviate that burden on beneficiaries when they're in the donut hole and paying premiums and not getting any drug coverage. I think, obviously with pay-go in place, that's an expensive proposition. And there are ways to do it slowly, there are ways that we need to look at.

And I think that's something we'll be doing and there are other things we can do with respect to the donut hole that aren't necessarily filling the doughnut hole but are improvements that beneficiaries will see. There's the Prescription Drug Assistance programs that the drug companies have in place to help people deal with their prescription costs, and there are some pinks in there that I know that Mark's definitely more expert than I am, in terms of what could be done in that respect.

There are the AIDS drug assistance program, Indian Health Service, that are not functioning properly from our

perspective in the doughnut hole. And I think that there are improvements we can make that are less expensive propositions than filling the doughnut hole, though I think filling the donut hole is certainly a goal for, I would say every one of our – if cost weren't an option, I would say all of our members would want to fill the donut hole. Weren't an issue, I should say. But with the cost constraints, obviously, we can do some smaller things and have our goal to be to fill the donut hole.

MALE SPEAKER 1: More along the lines of health IT, how do you guys see Wal-Mart's recent push of getting into this and really focusing on health care in general, shaping policy as the Congress moves forward in the next couple years? Do you think that's going to have any type of impact on your members' decisions, and how they shift their positions at this point?

KATE LEONE: Health IT or generic cost sharing?

BRIDGETT TAYLOR: I know a lot about Wal-Mart, but I'm not sure I know what you're mentioning about Wal-Mart.

MALE SPEAKER 1: They're going to be doing electronic records and having it available to all their employees, and having those open. And there seems to be a push amongst other employers that are teaming up with Intel to get health records to a larger number of Americans than have it currently, and how that will change the debate.

MARK HAYES: You've obviously caught us off guard on the Wal-Mart brand [misspelled?], so we'll have to go and look at that as well. The private sector all over the place are way ahead of Medicare and the federal government in terms of health IT on incentivizing providers to provide better care on lots of things, where employers have been experimenting successfully with better ways to finance and deliver on health care.

I think there's a lot of good examples we can draw from, so Wal-Mart has figured out a good way. I think, to the extent everybody thinks it's a good way, it'll influence the discussion. And people always welcome that, I think the more ideas the better, to add to the debate.

BRIDGETT TAYLOR: I'm sorry, I don't know about the Wal-Mart thing either, and I apologize. I try to read the business section, but I don't always get there. But the one thing I would add, and I don't know whether Wal-Mart's doing this or not, but it came up in the debate that we had on the floor of the House about IT, which is privacy. And I think people are concerned the more and more their electronic health records are made available, whether or not there is adequate privacy protections in the law as it exists today.

Many people, at least in the House on the Democratic side, don't think there are enough. I know that there is an opposite opinion about that, but I think that as they look at

what Wal-Mart has done, as Mark mentioned, and other companies are ahead of the game in terms of the government, I think privacy is an issue.

Plus, I think one of the things that was in the Senate bill and was in the House Democrats' bill, was having the government take a lead for setting some standards for the way this all operates, so that there isn't all this, different companies doing this without their ability to communicate, like with federal government programs and things like that. So one of the things that I think we will want to look at is for the federal government to initiate and actually set some standards at the federal level to help make it work.

ED HOWARD: We have time for, I think, two more questions, I'm afraid. And by the way, there are some blue evaluation forms in your folders. If you could fill them out, we'd be very grateful, because it'll help us improve these briefings from time to time, and you can suggest topics that we might want to do them on. Yes.

MARILYN SERAFINI: Marilyn Serafini with National Journal. Mark has come back a couple times to the 45-percent Medicare trigger, and I'd like to hear a little more from our Democrats about how Democrats are going to address this when it does come down. It looks like it's going to come down the road this year. What can and might Democrats do?

ED HOWARD: By the way, are there very many people who aren't familiar with the 45-percent trigger? We're okay.

BRIDGETT TAYLOR: Well, I think it's an area that many of the Democrats are concerned about, because of the impact that it has on fee-for-service, particularly. But whether or not we're going to immediately repeal it, how we're going to deal with it is not clear, because as Mark pointed out, we have many members in the Democratic party who are fiscal conservatives – and we affectionately call some of them the Blue Dogs – and the Budget Committee, who is going to want to look at entitlement spending. And I don't think removing the 45-percent trigger is going to come easily.

Having said that, I think it is something that people are concerned about, the impact that it might have on the program. And so we'll want to deal with it. Mark mentioned it, it is kind of interesting. I thought that the language that basically, the administration had to do something, and then Congress was supposed to look at it and hold hearings on it, but then it didn't say whether we were supposed to do anything with it at that point.

There are some people that believe it doesn't have a whole lot of teeth in what it is, but I personally believe if they send up something and Congress is supposed to look at it,

it's going to be kind of hard for us to look at it and then set it by the wayside and not move forward on it.

KATE LEONE: I think that certainly part of the goal of the 45-percent trigger is to look at Medicare and have a legitimate debate about spending on health care and that program. I think another piece of the 45-percent trigger is to create a crisis, which sort of seems to be the way the administration likes to go with respect to entitlement programs. So I think that we're looking at Medicare in a vacuum when we talk about the 45-percent trigger. I mean, businesses are facing the same problems. They're facing the same costs escalating unchecked, and it's sort of a larger problem.

And I think that we're certainly interested in, and want to take a look at what the 45-percent trigger report, should it come, what their proposals are, what their ideas are. But I think that the 45-percent trigger generating any kind of hysteria is probably misplaced. I think that the hysteria should be about what we're not doing on health care generally.

And I think that that's what we also need to keep in mind here, is that we have a crisis in this country. It's health care. Medicare is part of our health care system, but until we deal with the elements that are creating the crisis,

generally, we're not going to really solve anybody's problems with entitlement spending.

MARK HAYES: But I think the purpose of the 45-percent trigger really is not necessarily to create a crisis or certainly not to invoke a hysteria, but just to make people aware of the issue, because it is there, and we can't ignore it. The fact that entitlement spending is going to outpace what the federal government is taking in over time and that some hard decisions have to be made is just a reality, and people need to be aware of it. The whole spending discussion and pay-go, all of these things are going to be the biggest challenge, I think, next year. Four hundred billion dollars-plus to fill the doughnut, can you imagine what it would take in a pay-go situation to offset that spending? Just to move forward on some of the ideas around SCHIP and the physician update alone are really heavy lifts for this year. And I think it'll be very interesting.

I think that this is one of the areas where I'm trying to adapt to the idea of being in the minority. That we've taken so many arrows about the doughnut on the Republican side about the fact that it's there, and why is it there, and it doesn't make any sense.

The priority was about low-income people, and the low-income beneficiaries don't have a donut. And we have

improvements that we do need to make in low-income subsidy. The Senate bill didn't have, one prong of that eligibility didn't have an asset test. And at the beginning of this, I think I said all the bad ideas we were going to blame on the Ways and Means committee. So, there you have that.

FEMALE VOICE: They were responsible. [Laughter]

MARK HAYES: They were responsible, over the acid test. The Senate bill didn't have an acid test, so a lot of people who are deserving of that additional coverage and shouldn't be in a doughnut, are in a donut as a result. There are improvements like that, that we can make, but $400 billion-plus to fill the entire doughnut is a big challenge, and I think you're going to continue to hear that from everybody.

ED HOWARD: We have time for one last question. And you have the microphone.

CHRIS LEE: Chris Lee with *The Washington Post*. I don't think anyone mentioned the issue of the importation of drugs from Canada. Do you see any movement on that front this summer? [misspelled?]

KATE LEONE: That's a John Ford question and I [inaudible] as well, so I guess I'll take that. Clearly, that's been a priority for a number of both Republican and Democratic members in both the House and the Senate. I think that it's not in the Six for '06 agenda, not for any reason

that I know of, but we have six things. So you're limited by – maybe when we're in 2012, we can have Twelve for 12.

[Laughter]

But right now, it is a priority for some of our key members in leadership. I think that we'll probably be looking at it, and I think in the House as well, I know it's a bipartisan issue. It has bipartisan support. I understand Senator Grassley is a co-sponsor of Senator Dorgan's bill. In the Senate, there's a bill that Senator Vitter has, and he's pursued some action in the past year on the Homeland Security appropriations with respect to customs enforcement. I think that we're bound to see it. I think there are a lot of people who are interested in it.

I don't know what happens when a bill like that, if it gets through the House and Senate and it's the same bill, or if it's conferenced and it goes to the President. I don't know what the administration does. They've been pretty resistant to the idea. Senator Vitter even had a hold on Mr. von Eschenbach over it, at the FDA.

So I think that it is something that's going to be on the radar screen, and it's going to be a priority. We have a lot of priorities, and in the Senate, at least, we don't get through them as quickly as we would like usually. So I think we'll be looking at it and hopefully see some action.

MARK HAYES: I wouldn't add much to that except to thank Kate for mentioning that Senator Grassley is a part of the Dorgan and Snowe effort, along with Senator Kennedy on the Senate side. Senator Grassley had his own bill a Congress ago, and we worked very hard to combine the Grassley effort with the Dorgan effort so that we have a combined and unified front.

We have to pay very close attention to the drug safety issues here, and that's one of the things that Senator Grassley also cares a lot about. So really, what we have now is a completely unregulated permissive reimport system that's happening all over the place every day. And what we have to do is find a legal pathway for this to happen in which we can ensure the safety of the drug delivery system, but Senator Grassley looks at this as a trade issue. We have global trade in agricultural products and lots of other things, and why not in prescription drugs? So I hope it's something, on behalf of Senator Grassley, that will be high on the agenda.

ED HOWARD: And that's the last word. I want to thank you for showing up and asking such really good questions. We got an awful lot of information out in a lot less than 100 hours. We did leave a bunch of unanswered questions, and if you'll help us by suggesting topics, we'll try to address them in future briefings. Thanks to the Robert Wood Johnson Foundation, and I ask you to join me in thanking our panelists

for helping to spread some information that's about

[misspelled?] the misinformation.

[END RECORDING]