ALLIANCE FOR HEALTH REFORM

Health Reform for New Health Reform Reporters
Alliance for Health Reform
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ED HOWARD: Hello. I'm Ed Howard. Let me welcome you from our leadership, Senators Rockefeller and Collins and our board of directors. Now this is not an event that is being cosponsored by anybody but I wanted to just acknowledge the fact that the Robert Wood Johnson Foundation has done an awful lot with our work with the press and to thank them for that.

One of the manifestations of that work is the sourcebook for reporters covering health issues that you got when you came in. And that leads me to make sure that you know that Bill Erwin who shepherded that sourcebook into existence, as our communications director, is available to help you with any stories you're wrestling with or you're searching for a source or you are worried about some obscure researcher who makes an assertion you don't like, Bill can help you.

By the way, there are about 18 different versions of that sourcebook available online. There is an HTML and a PDF as is a Spanish version if you have outlets that operate in that venue.

The other thing is I wanted to acknowledge Joanne Kenen's contribution, former Reuters reporter and now at the New America Foundation. You will see a little guide that she put together on covering this issue in your materials and she was the one who came to Bill and me and said you know, you really ought to do something to help smart people who haven't covered this to understand what the fight is all about, so that they can be a little more prepared. That is what this is all about and we hope that you will be able to build on this foundation.

I am sure you will be able to learn everything you need to know in an hour and 15 minutes. But it is a complex issue. It's got more jargon than anything I've run into since the Army and it's got presumptions about prior

understanding of issues that no one ever talks about. There is, by the way, in that sourcebook for reporters a section, a good glossary of terms, a good set of acronyms that lead you to the glossary that we hope will be of help.

Which brings us to today, and we are really pleased to have one of D.C.'s best health policy resources, Dean Rosen, to lay out the basics for you. There is some biographical information in the packets but just to hit the highlights of the highlights, Dean has worked in senior positions on the House and the Senate side on these issues. He was the main policy advisor on health care for then majority leader Bill Frist, when he was also the vice chairman of the Alliance for Health Reform.

Dean is now with the public affairs firm Mehlman Vogel Castagnetti and he served as one of our policy deans -- no pun intended -- when we ran what we called a health reform university for the

senior hill staff beginning last Labor Day and running through the last couple of months.

What we have asked Dean to do is to kind of hit the highlights as quickly as he can, introduce the characters and the main plot lines if you will, and then we will take as many questions as you have as long as you want to ask them.

Dean emphasized that this is much more of a Supreme Court argument than it is a lecture series. So if you have some question as he goes along, ask for the information you need to clarify it and he and I will try to respond to it.

You can see there is a webcast being prepared of this briefing, which will be available on the Kaiser Health News website Monday for sure, maybe sooner, and a few days later there will be a transcript available on our website, which is www.allhealth.org. So, Dean, thanks for coming and all you ever needed to know about health reform is about to be said.

DEAN ROSEN: In 15 minutes or less. Well, thank you very much for having me and thank you for inviting me, Ed. I really appreciate being here and I do want to underscore what Ed said. Please, I don't want this to be a lecture. Jump in and ask questions and Ed and I will try to respond as factually as we can on whatever you have.

I also want to say two quick things. One, I can't tell you over the years how many reporters that have called me and said "You know, I'm new to covering health care. I've been covering something else or I know about the White House and someone said I ought to talk to you." And I said "I'm happy to talk with you but the first thing you ought to do is get signed up on the Alliance for Health Reform website, because they do have information and Ed and his team over here are great." So I think it's really a public service that the Alliance does, and I believe it's really important, and this is a great event.

I noted, though, as Ed introduced this, he said that, described everyone here as smart people who have not covered health reform day to day. When Ed called me, he said something different. He said, "You know, I have the perfect event for you to do. It fits you to a tee. I'm kind of thinking about it as health reform for dummies [laughter]."

Now you shouldn't take offense at that. I didn't either. But I said, "Perfect, this is finally an alliance event that I'm qualified for." So in any event, I think that it is such a complex area. I'm just going to try to hit the highlights.

So, I'm going to go through stuff pretty quickly because I've got a lot of slides and you've got them all as background and some of these I think are just helpful in terms of setting.

Where are we? What are the drivers of reform? Who are the key players? And I think

that’s really important. As you know, as reporters, it’s the politics and the policy, but I find often in public policy that the personalities are equally, if not more, important to what actually happens and gets done.

(Let’s talk about) the timing and process and then some of the big issues that you’ve read about. I think there Ed and I can help to answer them a little bit more, and again probably (I have) more slides here than I’ll have a chance to go through today. I’ll go through them fairly quickly but you’ve got them in your materials.

So, let’s start with what we’ve done and where we are. The way I look at it, I think the president and Congress set out four big goals this year and they have already accomplished two of the big ones in terms of health care reform policy. They reauthorized the Children’s Health Insurance Program, (which) had been vetoed twice by the Bush Administration under the previous Congress.

This is a program that basically is targeted toward providing health coverage for kids and in some cases low-income families who don't get coverage at work or who can't get coverage at work, can't afford it but are too wealthy to qualify for Medicaid or some of the other low income programs. So, this was reauthorized, pretty big deal, a four and a half year extension of that program. It's typically done for five years at a time.

Then, as part of the stimulus bill, there were three or four major health reform provisions. But again if you pass any one of these on its own in any year, or at least two or three of these would have been a big deal. And in fact, health information technology, Congress had been trying to pass a framework for that for the last couple of Congresses and had not been able to reach agreement on it. So a substantial investment of about $20 billion was included in the stimulus act for health IT.

The president at the time said, in effect, that was a down payment on health reform, meant to make the system more efficient, set standards in place, provide funding to subsidize providers who would have to put in place these IT systems to plug into a more national network to share medical record information and other things. The enhanced Medicaid program is basically a combination state-federal program where the states put in a certain percentage based on the number of folks in poverty in that state and the federal government matches it.

So to deal with the recession, Congress increased the percentage of the federal matching rate for a temporary period. COBRA, some of you know, when you lose your job, leave your job you have access to, basically stay on your current employer's health insurance, but you have to pay the full amount for that coverage plus a 2 percent administration fee. Congress provided subsidies

to people who lost their job sort of as a result of the recession, so that was included.

So, they've already done a couple of big things. Those were done, as you can see, as of the first two months of the year. There's a couple of big "to do's", though. That's partly what we're here to talk about today. One is under Medicare. Because of the Medicare payment formula, physicians are going to face a 20 percent cut in Medicare payment beginning in January of 2010 unless Congress steps in.

They've sort of done it every year, every two years now, for the last couple of years. We can talk more about that formula if folks have questions. But, that's one major driver of reform. And the other is the big enchilada of health reform and that's the uninsured.

So, a lot of you know this, but a couple of moments on what's driving reform. First of all -- the president talks about this and policymakers talk about this -- the costs are going up rapidly.

They are growing more rapidly than wages, which is outstripping the ability increasingly of the lower middle class and the middle class to afford health care.

And they are eating into other public programs because health programs are such a big part of the federal budget the prediction is that by 2018 health care costs are going to nearly double to about 20 percent of GDP. So, the numbers are going up.

MALE SPEAKER: Current dollars?

DEAN ROSEN: Yes. Those are national health expenditures in current dollars of percentage GDP.

FEMALE SPEAKER: I have a question. This isn't just federal spending, this is—

DEAN ROSEN: No. This is overall, this is an analysis that is done by the national Office of the Actuary, Centers for Medicare and Medicaid Services. But this is not just government program expenditures. That is a really good question.

This is overall projected national health expenditures, public programs and private.

I think that the federal government now pays about half of all health costs, if you look at things, give or take a couple of percentage points. So the federal programs are a big chunk of that. But these are overall expenditures.

So that number is going up. You will also hear a lot of talk about diabetes and chronic heart conditions and obesity and other things. Well, the reason there is so much focus on those particular diseases and on things that you'll hear in terms of acronyms in the debate about chronic care management is that if you look at that spending, basically three in every four dollars in health care are for patients with one or more of these chronic conditions.

So, it's a big piece of the pie and frankly it's an even bigger part of Medicare and Medicaid. About 80 percent of Medicaid and about

90 percent of Medicare are costs associated with people with chronic disease.

This is the other thing, other than costs, and I think you will hear policymakers talk about this as sort of a goal -- we want to reduce costs and we want to provide affordable access to everybody. We want to provide coverage to everyone. The words change a little bit but you have a growth in the number of uninsured.

This (seventh) slide is a little… it's accurate but at the same time it's a little misleading and it's in part because in 2004 they sort of changed the methodology by which they calculated the percentage and number of uninsured. But frankly there was a slight decrease in the number of uninsured in 2007.

In health care, we always are dealing with slightly outdated data, you know. It always amazes me that Target and Wal-Mart and all these stores can tell you how many widgets they sold last night but we can't tell you how much we spend on

Medicaid or how many uninsured there were until two years later.

So, the 2007 numbers are the most current numbers. We are expecting new numbers fairly soon, which will tell us about 2008. Everybody, because of the recession, is expecting that number 45 million is going to spike at least back to where it was back in 2006 and probably higher. But the fact is a large percentage of non-elderly population, the elderly 65 and older, have access to Medicare. But… 45 million out of 300 million Americans are without any kind of coverage at any point during the year.

And that is important as well. That drives up costs for other people. Those folks, some tend to go to emergency rooms. They don't have a usual source of care so they are not usually getting the best care available. They rely on the safety net program so that's been one of the arguments of the Administration and others have made in terms of being in favor of reform. Yes?

MALE SPEAKER: Is that 45 million a unified block—

DEAN ROSEN: I'll repeat your question. The question was the 45 million is not a unified block, it's not a monolithic group, and that's absolutely correct. I mean, you've got a percentage of people that you would think about as being uninsured. They are sort of the chronically uninsured. They are low income.

A lot of people don't realize this but the Medicaid program in general does not apply to single childless men. So you have a lot of uninsured, I mean people at 50 or 60 percent of the poverty level, who don't have any access to any kind of public program. So you've got people like that.

You've also got uninsured folks who have relatively high incomes but they choose not to get coverage. There is no requirement, at least not yet, that people buy insurance. So you've got a lot of people who are young and healthy or who

find that they don't want to pay the $5 (thousand) or $6 (thousand) or $8 (thousand) or $10,000 a year for insurance and say "I'm not going to do it."

So, you've got people who are sick and poor and can't get it. You've got people who are well off and choose not to get it. You've got a variety of different pockets of (uninsured) people. You've got college students and others. So part of the challenge in devising solutions to the uninsured is that they don't look the same.

Part of the challenge I think the policymakers have --and this came up in the debate about children's health insurance reform -- was how do you provide a public subsidy? This is a big thing, by the way, that's driving some of the cost estimates of reform into the trillions. When you put out a subsidy and say, okay everybody below 250 percent of poverty is eligible. You've got some people below 250 percent of poverty who

don’t have a job, who are not eligible for Medicaid and its new coverage for them.

You’ve got other people who are working and holding down full-time jobs at 250 percent of poverty whose employers are paying 75 or 85 or 90 percent of their coverage and they are insured.

So, you are substituting some potentially public coverage for some coverage that’s covered right now in the private sector. That’s part of the cost estimate too. So it’s a very good question and, like almost everything in health policy, leads to a very complicated and long answer, but that’s the point.

Let me… again I’m going to talk fast and I encourage you to keep interrupting. The Obama Administration, I want to talk about some of the key players in the administration on the Hill and in the stakeholder groups. I’m not going to go into a lot of the names here. I think you’ve known them, but the president has appointed some really key people.

If you look at the health care team who know a lot about health care, Kathleen Sebelius, obviously the secretary of HHS, former governor of Kansas, but also former insurance commissioner for a long time in the state of Kansas and knows a lot about health insurance issues.

Jeanne Lambrew was an academic who worked in the last Democratic administration with President Clinton at the Office of Management and Budget and in the White House. And Nancy Ann DeParle who ran what is now the Centers for Medicare and Medicaid services, what was then HCFA in the Clinton Administration, has been brought to head up the White House Office of Health Reform. Jeanne Lambrew is kind of her deputy and there are a lot of really smart people who work below them in HHS and at the White House. Ed may want to comment here.

The only other comment I'm going to make… we think about health care reform, in some ways, those of us who've spent our lives doing it, as

being sort of siloed. But the fact is when you go back and you look at President Obama's speeches on health reform, he talks about it as much as an economic issue as about a health care policy issue.

He talks about it as much in terms of the goal of slowing costs as he does in terms of expanding coverage. So the budget and economic teams, Tim Geithner and Peter Orszag and Zeke Emanuel, the brother of Rahm Emanuel, the chief of staff, are going to be sort of key players in sort of shaping the policy.

I think Peter Orszag, who is at the Office of Management and Budget, headed up the Congressional Budget Office before this, is really going to be one of the key players. And Rahm Emanuel, I mean he's a guy who knows how to get things done. He was on the Hill; I think learned a lot of lessons from serving in the Bush Administration.

So as you're looking at this -- as reporters and covering the issue and focusing on the personalities in the White House -- the health team is critically important but the chief of staff and the budget and the economic team, I think, is going to be critical, too. Ed, I don't know if you want to add anything on that?

ED HOWARD: No, I think you've got it nailed. What people might remember is that while he was at CBO, Peter Orszag sort of changed it into the congressional health budget office by hiring a whole bunch more expertise and analytical power in the area of health policy, because he knew that absent some kind of change, health care was going to eat both the federal budget and the U.S. economy.

DEAN ROSEN: I'll make one other quick comment on it because I think it's really critical....We are going to talk about some of the strategy here in terms of timing and moving the bills. But in the Clinton Administration for those

of us who were around -- I was nine at the time. Just kidding. But my first job on the Hill was in 1993, and so it was just as reform was moving through and the economic folks at the time, Bob Bruman and Larry Summers who were there, I think made the argument.

Ed probably wears this painfully -- that we had to delay health reform because it was going to cost money and we had to focus on reducing the deficit and some of the economic issues. Now there have been a lot of lessons of the Clinton Administration internalized by this administration.

If you look at what the Obama Administration is going to do and you're trying to predict day to day, you should look at what the Clinton Administration did and just say it's going to be the opposite on health care reform, which is not quite true.

But one of the things that's really different this time around -- if you listen for

this in the president's speeches and in Kathleen Sebelius and others' speeches -- they are making the exact opposite (point).

They are making the argument that the key to economic reform and to coming out of the recession (is) to deal with health reform, to get some handle on health care costs. Again, they are making an economic argument for it as much as a health policy or equity or coverage argument.

ED HOWARD: Let me just add -- there is like a four- minute review course of lessons learned from '93-94 in your packets. It's a little four-page issue brief that we put together based on some briefings we did last year with some of the battle scared veterans coming back to tell those war stories, including Mr. Rosen here. And, he is absolutely on target with the process differences that he pointed out.

DEAN ROSEN: This is the one slide (#11) I have that is totally outdated [laughter] and you can tell that I finished this before yesterday

afternoon. But you'll give me some credit because I said including a likely 60 in the Senate. So I was prescient enough to know that the Minnesota Supreme Court would side with Al Franken and it is in fact they did yesterday.

So, the democrats now have 60 votes in the Senate, which is a big deal I think. The last time they had this number or higher was 1978 when I was nine, [laughter]. So they no longer have the one (Senate race) undecided -- and that's a magic number as you all know in the Senate. You don't have to cover health policy to know that you need 60 votes to get almost anything done in the Senate these days, outside of budget reconciliation which we will talk about in a moment. And the House has a majority, too.

The point being that these are really big majorities, and they are bigger in the Senate than they were the last time there was reform. I'd like to point out to some of my Democratic friends to tweak them, and some of my Republican friends

to give them hope, that in 1993 and ’94 in that Congress, there were actually 258 Democrats. There was one more than there is now, and health reform didn’t get a vote on the floor of the House or the Senate.

So, this is not necessarily a fait accompli. [laughter] But the numbers are big and there are a lot of things that are being done right this time, from the standpoint of the majority in Congress, that were not done right the last time around in my opinion. But these numbers are important and we will come back to them.

MALE SPEAKER: If you can go back to the previous slide, those heavy hitters that you described, are they going to write a clean bill for the people on this slide to deal with?

DEAN ROSEN: The administration people?

MALE SPEAKER: Right.

DEAN ROSEN: Well, that’s a good question. I mean, I think Ed mentioned these lessons learned. One of the lessons learned from the

Clinton Administration was… Among the first things the Clinton Administration did was to appoint Hillary to head up a task force to basically meet essentially behind closed doors, although it was big meetings, then present Congress with a bill, almost a year later or nine months later.

And you presented it to people on the Hill who had been writing health care legislation for 30 or 40 or 50 years and they said, “Well, this is great, but what do you want us to do with this?” And (the White House) said, “We want you to defend it and pass it” and they said, ”No, we are not going to do that.” Well, that’s one of the reasons it didn’t get a vote on the floor of the House.

Another reason related to that was, you had a fight between three committees of jurisdiction, which we will talk about. There are two committees of jurisdiction in the Senate and three committees of jurisdiction over health care reform in the House. And they had a fight in ’93

and ’94 about who would take the lead in Congress. It would take them two years to resolve that.

Now the difference is — there are two differences. One is in the House, they put out a draft bill about a week ago. It was a unified tri-committee bill, so they’ve internalized that lesson.

The other one they’ve learned -- and I think they learned this in part from Republicans with prescription drug reform -- is let the president outline the big principles but leave the details to Congress.

(There is) the question of how much the president is going to step in to enforce his priorities and keep the interest groups at the table. But the details of this are being written not by these people (in the administration). They are really sales and marketing in my view and technical support. It’s being written by these people (in Congress).

MALE SPEAKER: So that's a big strategic change.

DEAN ROSEN: It's a big strategic change.

ED HOWARD: Can I just give you a statistical verification of that? The bill that finally emerged from the Clinton Task Force ran to 1300+ pages. When President Obama sent his instructions to Congress about health care reform -- his eight principles as part of the budget message that he sent up in February -- it was 253 words long. Legislators legislate.

DEAN ROSEN: In the fall during the economic crisis in the Bush Administration, when Hank Paulson was looking for emergency authority, (the White House) I think sent up to Congress an eight-page bill or something like that, that said basically the Treasury Department shall have unreviewable authority to spend $7 trillion or whatever it was. I had some friends at the time in the Democratic Party in the House and the Senate that said "That's exactly the kind of health care

message we want from the next president. We just want to be given the broad outlines and tell us what to do."

… It's these people in the committees -- I put the leadership in because the leadership I think is going to be critically important. McConnell and Reed in the Senate are going to set the tone.

Kent Conrad and Judd Gregg are the Budget Committee. We'll come back to the importance of the budget process in a little bit, but (they) are going to help set the parameters for what's going to get passed. Plus Conrad is a member of the Finance Committee, senior member of the Finance Committee.

Gregg is a senior member of the HELP Committee. So those two guys, in and of themselves, are going to be critical. But it's the Finance Committee and the HELP Committee where (there's a) totally interesting dynamic. They are not actually working that closely together in the

Senate. They've shared documents and they are working on two different bills.

The HELP Committee started its markup two weeks ago, couldn't get it done, is going to continue after the recess. They started the markup of their bill even without some of the details around critical things like the government-run public plan, what does that look like? And they started to release that yesterday. They didn't have scores from the Congressional Budget Office on their bill.

Ted Kennedy -- I think a lot of people chalk it up to the fact that he hasn't been there. He's obviously probably the most or among the most formidable legislators but he hasn't been there. Chris Dodd has been doing it with Ted Kennedy's staff, so that process is pretty partisan in the HELP Committee. I think it's unlikely that there will be any Republicans that will vote for that bill.

The goal with the Finance Committee -- where Baucus and Grassley have been working very closely together -- when Grassley was chair, they worked very closely together. The hope is that they will come out with a bipartisan bill. They will vote on (it in) committee. The plan right now… is the second week in July, it will get merged with whatever comes out of HELP.

If it comes out and it's bipartisan, it may be mostly financed with a couple of sentences from the HELP bill. We will see. And then that will go to the floor. But these are where the key things are getting written and I'm going to come back when we talk about the issues to some of the dynamics in those committees. But you had a question here.

FEMALE SPEAKER: When you're talking about the Democratic majorities, could you speak to the influence or effect of particularly the Blue Dogs and or the moderate Republicans in those numbers and how that may shift things around?

DEAN ROSEN: Yes, the question about the influence of centrist Democrats or moderate Republicans… I think the impact is a little different in the House and the Senate on health care. I will let Ed talk about the different visions in the Democratic Party of reform or different elements of the party, but clearly the Blue Dogs in the House.

Centrists in the Senate like Kent Conrad are important because what they have said is that, essentially, they want health care reform to be paid for and in fact they are trying to pay for it all. So it might cost a trillion dollars or $1.5 or $1.6 trillion, but they are going to have to find offsets for it under the budget rules.

And I think the Blue Dogs, in my view, will essentially say “Well, as long as it’s paid for.” They may not like certain elements of it, but as long as it’s paid for, that’s a pretty big deal.

Now there are other things, a number of Democratic senators have come out against a public plan. We haven't talked yet about that, but we will. So, there are clearly going to be elements where, even though you've got 60 in the Senate, it's important on procedural votes but it's not dispositive because even if Republicans aren't there.

There are Democrats like Mary Landrieu, Louisiana, and others, who have said that they have got real concerns about some of the key elements of reform. So, they are going to hold sway. But if you look at the climate bill, what happened in the House, I think it's an interesting lesson. Henry Waxman sort of started off with something, but he gave away a number of provisions to moderates to get the bill done. My own sense is that's what they will do in the House.

Republicans aren't at the table at all in the House. In the Senate, I guess I'd like to pause on your question about Republicans and come

back to that in a couple of slides. Ed, do you want to comment at all on the Democratic factions?

ED HOWARD: Only to add to the complications raised for the leadership by the Blue Dogs. There are other complications raised by, say, the progressive caucus which has 30 more members than the Blue Dogs (and) as a matter of fact (has) sent a letter to the leadership and the president, I believe. It may just have been (to) the leadership, last week, saying "No strong public plan, we will vote against it." Not "We will try to shape it in as best a fashion we can and then vote with the majority."

DEAN ROSEN: It's pretty clear to me, in the House, that the speaker has made the decision that their bill is going to be -- how do I say this -- fairly consistent with the president's principles or fairly far to the left. I mean, if you look at their plan, it's got an individual mandate. It's got an employer mandate. We don't know the extent of it yet but it has to have

pretty significant tax increases to finance it if it's going to be paid for.

So, they have made that calculation (that) they can afford to lose 20 or 25 votes and still pass the bill, and I think that's what they will do. There will be some people, the Bobby Brights of the world, possibly the Heath Shulers of the world -- I mean, there are about 30 Democrats in the House that are sitting in districts that John McCain won, you know.

So those folks on health reform are going to have to calculate, you know, "Do I want to vote for a public plan, do I want to vote for tax increases, do I want to vote for Medicare cuts, all rolled into one, or do I want to vote for an alternative and then vote for it?"

So, my sense is at the end of the day this is why climate is instructive. I think this is too important politically for this not to go through the House. The Senate is a bit of a

different matter, but I think in the House it's critical.

Again, there are three committees in the House -- Energy and Commerce, Ways and Means, Education and Labor. I put the budget folks up there, but these guys are all working together as well.

The other critical thing, this time around -- I think we've seen this just yesterday with Wal-Mart coming out and endorsing an employer mandate -- is that unlike 1993 and '94, the stakeholders are at the table trying to shape reform rather than trying to stop reform. That frankly was true in the early days of '93 as well, but I think now it's even more pronounced. I mean, you saw this announcement from Wal-Mart yesterday as an example.

You saw last week an announcement from the pharmaceutical industry that they are going to agree to $80 billion in cuts or in savings that would come out of pharma. We are expecting that

there will be a kind of similar announcement from the hospitals. There may be an announcement from health plans.

So these are folks who, not only are they contributing funding toward reform, but they are offering substantive ideas and I think that they have concluded, as I have said in other forums, that they'd rather be at the table than on the menu.

Now having said that, I think there are some waves out there in what looks like maybe a relatively smooth sea. Look, for example, at the testimony that the Chamber of Commerce gave last week before a House committee -- very, very sharply critical of the House bill.

And I think it's one of the reasons that the interest groups -- interest groups and stakeholders that I would put on sort of the health industry side -- have staked so much in the bipartisan bill potentially emerging from the Finance Committee, because there are elements of

the House bill, there are elements of the Kennedy bill that they are against…

So I think things could turn negative on this bill, particularly if it hangs out there for a long time, if you don't a bipartisan Finance bill that's maybe more moderate in its scope and sweep. But for now, this is a really big difference between 15 years ago and now.

FEMALE SPEAKER: Are you using Wal-Mart as… sort of a model employer coverage plan? Because Wal-Mart has not been good about covering their employees. I don't know if they have changed recently.

DEAN ROSEN: Yes, it's really very interesting. I mean, actually in full disclosure, we do some work for Wal-Mart, so you can take that into your consideration. But I mean, Wal-Mart yesterday endorsed an employer mandate and I think their argument was that "we would rather have something equitably applied because we do provide

health insurance for people." It's a level playing field kind of argument.

Now they would have almost never – it would have been hard to imagine 15 years ago or even five years ago that they would have made that announcement.

There have been a couple of interesting articles out there in the press in the last couple of months about the fact that Wal-Mart -- I think in part as a response to criticism -- not only has kind of worked inside the beltway with the Service Employees' International Union and others on common ground on policy, but has taking a number of changes frankly in their benefit plans to make them more generous, to make them more widely available, to focus more on wellness and prevention. And I kind of encourage folks to look into that.

So, I am certainly not holding them up as a model. I was citing them as a group that you wouldn't have expected to be in favor of reform

the last time around. But I think you should definitely do your own homework on it -- look at some of the changes objectively that they've made over the last few years in their health plan.

FEMALE SPEAKER: I'm hoping that is not a model, because I just came out of Milwaukee Health Department and we know in Wisconsin that they really routinely …they didn't cover their employees. It's a matter of semantics of how do you cover? If most employees are not full-time employees, they don't get coverage, so the majority of their hiring practice is not hiring –

DEAN ROSEN: My understanding is that they have got -- even compared to some other retailers -- they have got a larger number of full-time folks who do have coverage, a larger percentage than others. I don't know, Ed?

They have made a number of changes. I think it's worth looking into. I'm not -- again, I didn't cite them as an example of "let's hold everyone up to the Wal-Mart benefit standard,"

although again you should definitely look at what different employers are offering.

I think one of the key reform questions is what standard of benefits are going to be required or going to be subsidized -- but the question of whether employers ought to have some responsibility to provide coverage or pay for it -- again, I was citing that that's something that they stepped up and said they were for yesterday. Others have as well.

ED HOWARD: I would just add that you need to be aware of the sharp difference between large employers and at least the associations that speak -- purport to speak, and sometimes do speak -- for small employers.

In some of the same stories that carried the Wal-Mart announcement, there was an observation by the head of the National Business Group on Health -- which is very large corporations -- to the effect that many of her members actually favored a mandate as well on

employers so as to level the playing field between those who already do it and their competitors.

DEAN ROSEN: And this is, I should say -- this is symbolic for every one of these organizations, there are probably 50 behind it -- there are a lot of stakeholders in health care reform, and again, most of them have concluded that at least for now they want to be trying to work and shape reform.

MALE SPEAKER: Is this a good time to talk about the public plan option? Or is that later in your presentation?

DEAN ROSEN: Let me talk about the public plan in one minute. Let me just fill out what Ed was talking about earlier in terms of the process, and then let’s come back to the public plan and some of the other issues.

We have really already talked about this, but this is sort of my point I made earlier about the lessons learned from 1993 and ’94. You look at what’s happening here in terms of the

Democrats' reform strategy -- they've adopted and internalized lessons from '93 and '94.

They are trying to move rapidly. The congressional committees are working closely together. They are drafting legislation with the White House's support. They are engaging stakeholders instead of shutting out stakeholders. And at least for now in the Senate, they are trying to drive toward bipartisan consensus.

I know the Republican side pretty well and Ed may want to comment on the Democratic side. You asked the question earlier about how Republicans who were moderates were sort of shaking out. I sort of put the Republicans into four kind of concentric circles. And in the House -- I'm not intending this to be a partisan comment but effectual comment -- the bill that we saw emerge so far from the House was written by the Democratic chairmen.

I think they would say, as would the Republicans say, that (Republicans) had no hand in

it. So I think at the end of the day, there may be a couple of Republicans that vote for the House bill because maybe they conclude it's better to be for something. But I think the vast majority of the House Republicans are going to be against reform.

In the Senate, it's a little bit different and there are clearly attempts -- we talked about it earlier in the Finance Committee and some members of the HELP Committee and others -- to try to work together on reform. There are a couple of moderates in the Senate -- Olympia Snow, Susan Collins. There are fewer Republican moderates today than there were in '93 and '94, but that are working to reform.

But I kind of put them into these four camps. There are kind of the reformers that will say "we are totally in favor of reform." Senator Burr and Senator Coburn have a bill, Representative Ryan has a bill that would really be a very different vision of sort of a more

competitive market place -- individual choice, reduction in some regulations, insurance reform and subsidies -- but with a much more individual choice model as opposed to building on an employer-based system.

So there's a group of folks that are for pretty aggressive reform in the Republican Party but it's a very different direction than the one that the Democrats and the majority are moving toward.

You have a group of undecided. You have a group of moderates…who are willing to compromise and work off of some of these ideas that the Democrats have put on the table and try to give and take. And you have budget hawks and sort of fiscal conservatives, and again, these are all overlapping.

I actually think this is sort of more representative of where things are, if you look at things proportionately in terms of size. I mean, in 1993 and '94, there were a lot of moderates in

the Senate that I think now may find themselves more comfortable in the Democratic Party in the Senate -- you know, people like John Chafee, people like David Durenburger, people like Bob Packwood and others, you know, Jack Danforth.

I mean these are folks who sat on the Finance Committee at the time, and it's really hard to find that many of those. So the fact is that just the number of what we would call moderate Republicans has shrunk, so there are few targets beyond those 60 Democratic senators.

Senator Grassley is one who is at the table. I don't know whether he's moderate or not, but he's at the table. Senator Enzi I talked about -- Senator Collins, Senator Snow, and a few others, Senator Corker maybe, but there are not that many. There are not 20 Republican moderates to get. There may be three or four or five or six on sort of a good day.

MALE SPEAKER: Dean, why don't you put your circles in each corner of your slide instead of overlapping them?

DEAN ROSEN: I should. I should. Well, because here's actually why, because I think that – well, first of all I'm always open to graphic assistance but –

MALE SPEAKER: My question is, do they really overlap?

DEAN ROSEN: Yes, and I'll tell you why I think they do to an extent. I think that the moderate camp is a good one and this goes to the point of "can you get to 70 votes in the Senate?" I mean, if you think about people who are -- again the term moderate is a little bit of a misnomer – but…if you think about people who are in the problem solving caucus in the Republican Party, you put somebody like John McCain in that category. You put somebody like Judd Gregg I think in that category, Lamar Alexander in that category. You put someone like Kit Bond sometimes

in that category. But…a lot of those people are… also budget hawks.

It's hard for me to see a John McCain -- or Warren Hatch is another one -- at the end of the day go along with the bill, not because they don't want to solve the problem but because they are not going to be for a one-point-something-trillion dollar bill that raises taxes or that's not fully paid for.

So, that's why I do think they do sort of overlap to an extent, although it's not perfect. These are the fault lines we talked about earlier.

The public plan -- this would probably be a good point to talk about it. The individual mandate -- some Republicans, the majority of them, clearly (are) opposed, although I think increasingly the Republicans who are at the table recognize that having some kind of an individual requirement or at least strong incentive to buy insurance is preferable to having a public plan

because it would help make the private insurance market work.

The theory being --like right now we talked about the uninsured not being monolithic and you've got your 25 year old, kind of bullet proof, healthy, who aren't going to see a value in buying an insurance policy -- the feeling is if you keep all the healthy low-cost people out of the system, it's going to raise costs for everyone else. So that's why they are talking about an individual mandate. That is one of the issues.

The employer mandate, this is taking various forms. There is the employer mandate that… Wal-Mart and others (are) supporting which would basically be like they have in Massachusetts, kind of a pay-or-play model where you are going to cover your employees with a certain level of benefits, or if you're not going to cover them, you're going to pay some kind of a penalty.

There are some other things they are talking about which would basically tax or assess employers if they've got a certain percentage of their folks enrolled in public programs. These are all ways to both make sure that employers don't shift people from their private coverage to government programs, but also to help finance reform -- again a sticking point with Republicans.

There has been talk about expanding Medicare down to people below 65. That hasn't really shown up yet in any of the bills, but could at some point. Medicaid expansions or SCHIP expansions -- Republicans prefer to have those programs targeted to low-income folks. In the House bill, Ed, what is the level of subsidy, it's up to?

ED HOWARD: Is it 150 (percent of the federal poverty level)?

DEAN ROSEN: 150 for everyone, so there is not necessarily opposition to that level, but the higher you get up (there is). Comparative

effectiveness research, another one -- these are, I should say, not only hot button issues with some Republicans but (also)hot button issues that the Democrats are going to have to grapple with, between the sort of more liberal elements of the Democratic Party that are for some of these and more conservative Democrats who are against it.

Government-funded studies to compare the relative effectiveness, clinical effectiveness of different interventions -- it might be studying a class of new drugs versus a class of older drugs.

It might be studying the effectiveness of a surgical intervention compared to non-surgical intervention. There are, again, some of the stakeholder groups that are for this, some of the stakeholder groups that are against it or against some forms of it.

For example, some of the folks in the device industry are concerned: “You could show that a high-cost device may not always be effective but it might be very effective for an

individual patient and we don't want the government making that decision."

So the idea is that the government would provide the information around research, but the payers would still make a decision as to what to cover. But it's a very controversial idea among some Republicans, particularly (if) you use it to actually make coverage decisions in these public programs.

ED HOWARD: That's worth emphasizing. Hardly anyone will assert that they are against comparative effectiveness research.

DEAN ROSEN: Right.

ED HOWARD: And that government should even pay for it or at least make sure that it's paid for -- there are a lot of people, particularly on the Republican side, (who) object. And the people whose comparative effectiveness is being assessed believe you ought not to allow the person who does the research to make the decisions

about what you pay… That has been a really big sticking point.

The other thing to emphasize is that there is a billion dollars already put into the till to fund that research. You saw yesterday the Institute of Medicine issuing a report on what ought to happen with one big chunk of that money -- the kinds of research that are being done so that you get the most bang for your buck.

DEAN ROSEN: Let me tick through a couple of these other ones and then…

MALE SPEAKER: Just a quick question, do any of the pieces of legislation actually make that connection at this point between comparative effectiveness and deciding what will be paid for?

DEAN ROSEN: No, they don't. In fact, Senator Baucus and Senator Conrad in the Senate have introduced a bill that…there was a feeling by Baucus and Conrad and others that there wasn't enough definition around that, that there wasn't a structure that would provide funding or sort of

analysis going into the future of how you go about these studies.

So they explicitly, in that bill, say that at least for now they won't be used for cost effectiveness. But the fact is the information is going to be out there, so a payer can look at the information and use it. And so some people do object to just the very idea that it's going to be there, but there are no bills so far.

I would say the fear was made real for some opponents because earlier this year, in the stimulus bill, the language didn't say that it could be used for cost effectiveness, but the House folks attached some report language that talked about using the information to assess the cost effectiveness of things and that it would help in terms of making coverage decisions.

So there is that thought that once you have it out there, it's kind of a foot in the door, but nothing right now…

ED HOWARD: By the way, there is a lot of comparative effectiveness research going on right now, both in the United States and elsewhere, and no where that I know of is it not tied somewhere to getting better value out of what you purchase.

We had a roundtable a few weeks ago in which we brought in the people who run the agencies in Great Britain, France, Germany and Australia. They all started out with a straight comparative effectiveness mandate and all ended up with a very strong cost conscious value orientation and some with a very direct connection to the nation's health insurance system.

DEAN ROSEN: Peter Orszag, who is now at OMB, has written a lot about this when he was at CBO -- that this holds a lot of promise, he says, to control cost down the road, at least providing this information.

I think that some of the groups that would have their interventions compared are the ones that fear that we might move to a system like

Great Britain's…for those of you who are interested in story ideas or other things. I mean there has been a lot written, but they would say "Well, we don't want some government body in the United States saying that cancer patients who don't show progress after a certain number of months can't get this treatment."

And you saw, those of you who watched the ABC News special the other night, you saw this question posed by a physician to President Obama, who asked him about his own mother's experience. He said, "Would you want your mother to be in a public plan that denied this?"

So, it's a big issue. It's a little different in the United States, I would say, than in Great Britain but that's why this has become such a hot button debate, whatever side you come out on.

MALE SPEAKER: You mentioned that you saw waves on the placid waters. And I assume this is a list of potential waves?

DEAN ROSEN: This is the list of waves.

MALE SPEAKER: Talk to us, would you please, about tax increases. What will be the political fallout when the sponsors of, say, the House bill put the tax increase on the table and what kind of tax increase would that be?

DEAN ROSEN: Let me answer the tax increase question and then I'll come back to your question about public plan and then we can talk about the process… So the politics of it…I'm not sure I'm in the best position to assess, but my own view is that there is a real risk here for the Democrats, particularly if they have a bill that doesn't have any Republican support.

Because if you ask some people, why did the Democrats lose control of congress in 1994, they will say, "Well, it was the health care plan that symbolized everything that Democrats were for and Republicans were against and (Republicans) won… they ran against the health care plan."

If you ask other people, they will say “It wasn’t that at all. It was the tax increase that President Clinton passed, coupled with the crime bill in ’93 that made it very hard for conservative Democrats to hold onto those districts against Republican support.”

So, I think there’s a lot of risk. The two things -- and I have some polling data in the slides that you can look at too --that I think folks are at risk for is really two things. One is the president made very clear during the campaign -- by many accounts, spent about 70-percent of his advertising dollars in the last few months of his campaign around health care reform -- made it a big issue, and was very, very critical of Senator McCain.

Senator McCain’s plan -- the central feature of it was to get rid of the tax exclusion that people enjoy if they have employer-provided insurance. (Now) if you get your insurance from Politico [laughter] and Politico says the value to

you is $5,000, that $5,000 is not included in your income. Senator McCain would have basically converted that into a tax credit, treated that as income and converted that to a more equitable tax credit.

A lot of health economists support that notion because they think that the exclusion not only costs money but is inflationary and is regressive because it benefits high-income workers and it benefits sort of richer plans. The richer the plan or the more expensive your plan, the higher the tax benefit.

But, one of the key ideas that's being talked about in the Senate, not in the House, is to at least cap that exclusion. So I think there is risk. If you look at some of the polling…, the American people support paying for reform by kind of taxing the rich, people above $250,000, however you define that. But they are strongly opposed to the idea of taxing benefits.

I think in part -- my own theory, because you had a president who raised and spent more money than any presidential candidate in history and ran 70 percent of his ads in the last three months, talking about how this was a bad idea -- I think there is risk. And I think it's one of the reasons the Democrats are trying so hard in the Senate to get some Republican support, because you can raise an awful lot of money. The value of that exclusion is about $300 billion a year, $280 billion or something a year in foregone tax revenue.

Now, they wouldn't tax all of it or treat all of it as income. But if you start to cap it – in the House bill, I mean… The other things that have been talked about are -- Ed can probably add to this list -- but they've talked about raising taxes again of people (making)over $250,000. The president has proposed to eliminate the charitable deduction for people over $250,000.

The president has talked about capping the amount that can be deducted from income taxes for mortgage payments, for people above $250,000. I think all those things are sort of on the list, and all those things are tremendously unpopular with charitable organizations or the housing industry and others…

I think the risk is compounded because there's a new poll out today, I think a CNN Poll, and there's also some polling I have in here from the *ABC/Washington Post* which is consistent with that.

There's a theory when you ask people -- anything the government touches is going to be really expensive and it's going to cost a lot of money. So I think that the Republicans politically will tag some of the conservative Democrats who are in these districts with the idea of you are raising taxes. I think they are potentially vulnerable on that.

On the other side of the ledger, to be fair, there is support for change. There is support for financing that with some tax increases. It will be a huge fight as to how those are portrayed, I think.

MALE SPEAKER: Can I make two quick points? One is nobody in this fight that you've mentioned so far is critically disadvantaged when it comes to health care, not the Senate, not the House, not the people with the little icons. They're all taken care of. The people they want to help are not. But when you have a battle where all of the so-called stakeholders or all the decision makers already are on the good side of the line, it skewers it.

My second point is I'm old enough to have covered the Medicare fight in the Senate in 1968, with Hubert Humphrey and friends. And the numbers they projected on what Medicare would cost Americans were no where near anything -- I mean not even by exponentially -- what Medicare has

cost. So why, when we're having this fight, should I believe that without seeing a repeat of 1968?

ED HOWARD: Let me try a couple of those. One is that you were, I think, partially right when you talked about the people who are having this debate all having insurance. But not everybody who has insurance feels good about it. There was the front page story that Reed Abelson had today in *The New York Times* about people who have insurance and are going bankrupt. And Elizabeth Warren is an academic who has done a lot of work in that area showing that there are real holes in the coverage that a lot of people have.

MALE SPEAKER: I'm just saying that the people who are legislating are not people who are going bankrupt, okay?

ED HOWARD: Well, we hope. That's right. Historically, on the projections of Medicare costs, Marilyn Moon at the American Institutes for Research has done a lot of work on this, and one of the things we often overlook when we make those

comparisons is that the Medicare that was signed into law in 1965 is not the Medicare of today.

The coverage is much broader and now covers people with total and permanent disabilities. It covers end-stage renal disease. It has a benefit package that now includes prescription drugs and other things that weren't in the original package. So I mean the projections really aren't comparable.

Did (costs) go higher? Of course they did. Look at any estimates of a private insurance company's expenditures 20 years out from that point and you will find that, as Dean pointed out, health care costs have not gone up only in government programs. They've gone up in every kind of public and private plan. Some believe slightly less rapidly in public programs, but comparably in any event.

DEAN ROSEN: The one government program I know and I worked on… that came in underestimated

was the prescription drug benefit, which has come in under the projections.

But anyway, let me talk about the public plan and then the process in the last couple of minutes and then we can take whatever questions.

The public plan is the other debate that I think you hear out there. In fact, I think a lot of this can be simplified. I mean, all these kind of versatile issues into… how expensive is this and how are we going to pay for it. That's one big debate because (of) the factors that are going to shape the outcome.

The budget bill that passed really did two things, really important, and I think will dictate the outcome. One is it said that any reform, give or take a billion dollars -- which is nothing -- has to be budget neutral, has to be paid for by tax increases or by program cuts in some other areas. And most of those program cuts are going to come from health care itself. So the

political question about the tax increases is a good one.

The other one is providers are going to see more patients, potentially, but a lot of them are going to get their Medicare payments cut to help finance this. And that is going to be controversial as well. So, they have got to pay for a trillion dollars plus, or whatever the final cost of this bill is.

The other thing is budget reconciliation, which I will talk about in a minute, but one issue is how much is this going to cost and how is it going to be paid for?

The other issue of the public plan, I think, sort of symbolizes and has become a proxy for a bigger war over what is the role of the government versus what is the role of the private sector.

In some ways, we fight this war over and over again in every health bill. In the prescription drug bill, it clearly was much more

on the side of the private. Now, the significant government rules around the prescription drug benefit -- it's got to meet a certain value, you know, the plans have oversight.

They have to meet certain metrics. They have to disclose their benefits. They have got to renew their coverage. They have got to issue their coverage.

They can't deny people, but essentially the risk for that program is passed onto private insurers under a government oversight scheme and they get a payment per month per beneficiary that they cover. They've got to manage within these rules -- how much they provide to meet those rules and how much they earn as a result of how well they manage it. Is it a good system? Is it a bad system? It depends on your perspective.

On the other hand, you have other programs -- and this is the public plan -- where the argument is that we can't somehow trust the private insurers to do it even when it's highly

regulated. We need a government entity there to deliver it.

I think the public plan in some ways is a political reality check (showing) that there's not enough support for a single payer system. But we want to have a government role out there to compete, to offer assurance, to maybe help hold down costs, whatever the arguments are.

So the debate over the public plan, and I won't even characterize it as Republicans or Democrats, but I'll just say people in favor of the public plan -- their arguments are that we need to keep insurers honest. We need to ensure real competition. We need to have a safety net for people who are out there and we need to make sure that costs are under control.

The people who are opposed...say this is maybe a slow track or maybe a fast track, but is a track toward single payer because if the government is going to set the rules and the

government is going to compete, it can never be a fair competition.

Some of the private estimates out there show that large numbers of people would enroll in the public plan and the private market simply won't be able to compete. They won't have the size, they won't have the clout…

So, they believe that the public plan will be able to more effectively hold down costs not by negotiating, but by setting prices, that their premiums will be lower and that more people will go into the public plan. That's essentially the debate. It's between the people who want to have a more role for the government and people who want to have more of a role for the free market.

And I think that where that comes out in the House will clearly be more on the strong public plan side. Where that comes out in the Senate will depend on who is at the table at the end of the day, but will probably be less rigorous.

They are talking about two compromises. One would be to basically not have a national public plan, but to have a cooperative. A lot of people from rural states -- I grew up in Minnesota -- we had a lot of electric cooperatives and others. And it was just known the shareholders were essentially the public, it was run by an elected board. That's the model that provides some funding and have these public plans, but they are more of a co-op model. There are Republicans like Senator Grassley and Enzi that under the right circumstances would support that.

The other option which Senator Snow and Senator Schumer of New York have been kind of working on would be…a fallback or a trigger. That's kind of what was done in the Medicare prescription drug bill, which was to say if you don't have a certain number of plans out there, you don't meet a certain level of competition, then the government can step in and offer a plan.

Now, to give equal time on those two, people who oppose it, they would say “Well, the fallback is different in prescription drugs because you didn’t have any experience with these stand-alone drug plans. This is very different.” But in any event, those would be the two compromises, I think, in the Senate bill, if Republicans are at the table at the end of the day.

The other big, and let me then stop…

ED HOWARD: Let me just say one more word about the public plan. There are a number of shadings at both ends of the spectrum and one of the real dangers that the opponents point to is the Trojan horse notion.

That has been addressed by some of the proponents of public plans by backing off of the immediate tying of the rates that this plan would (pay) to the Medicare rates, (avoiding saying) to doctors and hospitals “unless you take our payment that is tied to Medicare, you can’t participate in

Medicare," so that participation in one is tied to the other.

If you sever the two, then presumably low rates (paid by) a public plan would generate less revenue, less satisfactory service, and presumably in an open market, fewer people enrolling. So there are gradations in these alternatives that almost make you think that whatever they pass will have something in it that is a non-insurance company option that people will be able to get into.

MALE SPEAKER: If you make it too draconian, aren't doctors going to opt out?

ED HOWARD: Sure. I mean, that is the point. At least the proponents of the public plan would say if doctors opt out, there is no threat to private insurance and so be it.

MALE SPEAKER: But doctors are also opting out of private insurances and (are saying)pay me (directly).

ED HOWARD: That's fair enough. That's fair enough.

DEAN ROSEN: I think we are out of time. I have got a lot on the back end on polling which you can look at. Just to say, I think to maybe conclude with this.

I think we have talked about some of the hot buttons. The timing of this is a little bit up in the air for those of you who are doing it. I think the House is pretty clearly going to mark up in July and try to get on and off the floor in July, although that may change, depending on what happens in the Senate, but that's the plan.

The Senate, I presume that at some point the HELP Committee is going to finish their markup in early July. Right now, I think the plan is that Senator Baucus and the Finance Committee would go to markup sometime the week of July 13th, which would presumably give them enough time to pass that bill out of committee, merge it with the HELP Committee (bill), get to the floor.

Remember, I live in a siloed world of health care reform, but the other big thing that has to be done according to leadership in the Senate is to vote on the Sotomayor nomination in July, early August. So you look at the timing. I think there is at least a chance that the (reform) debate in the Senate gets pushed off until September.

And if it does and if Republicans -– the Democrats have a huge option out there, which is the other piece of the budget that we talked about, (not) budget neutrality but budget reconciliation. What they've said is that if there's not an agreement on health reform by October 15th, by mid-October, then the reconciliation instructions would kick in.

And that's essentially a fast track procedure in the Senate of 20 hours of debate on the floor and 51 votes, as opposed to 60. There is some fallout from that because there are some substantive things that you can't do under

reconciliation, but it certainly gives the Democrats a huge opportunity that they didn't have in '93 and '94 procedurally, to get at least something done if they can't get to 60 votes, either with all Democrats or with mostly Democrats and some Republicans.

So, I think that is where we are going. You guys can read the rest of these slides in terms of the numbers and those kinds of things. But I think that where this is going to end up is anyone's bet.

If anyone asks me, I think the chances that something gets passed are a lot closer to 100 percent than zero, because the Democrats have done a lot of things right as opposed to everything they did wrong in '93 and '94 procedurally, or most of what they did wrong in '93 and '94.

And I think that they have got reconciliation. And I think, most importantly, a political lesson that I learned in my time is that the president is so far out there politically in

favor of getting something done… I think Senator Daschle gave an interview the other day and (was asked) what is going to happen on the public plan, is there any alternative?

I think Senator Daschle said in effect -- and I agree with this -- that there is a lot of flexibility on the public plan. He thinks (what)the administration is not really willing to compromise on is their ability to get something passed.

And I think that's right. I think failure here, however you define that, is not an option, given politically how far out the president, the Democratic leadership is.

I will leave you with that and I am happy to answer questions or to follow up with you all.

MALE SPEAKER: The final stage, which you didn't put up there, is those White House meetings that are going to take place around the conference report, which is when the deal is going to get made.

DEAN ROSEN: There are a lot of people that think that this will get written, the details will get worked out in conferences.

ED HOWARD: There are also a lot of people who think that looking at a conference committee deliberation is optimistic. [Laughter]

MALE SPEAKER: They'll take it into the White House.

FEMALE SPEAKER: Thank you very much, Dean. I have a question, now that this is all looming, there are a number of states that are trying preemptive moves, like Arizona which just passed I believe a bill to opt out of the, whatever goes on here but states rights, will they have a leg to stand on?

I mean, (considering) how states want to do their own thing and the pass their own legislation…what's going to happen? And a number of the Republican states may, like Arizona is trying to do is opt out of anything that goes on here.

ED HOWARD: Don’t forget that Arizona has a history of opting out of federal programs. They only had a Medicaid program in, what, the last 15 years and one can imagine… Medicaid is a voluntary program, so if states choose not to, at least under current rules, they would be within their rights to do that.

FEMALE SPEAKER: [Inaudible] for matching funds or anything, this is [inaudible].

ED HOWARD: It’s only partially true -- at least in some of the graphs, the extension of Medicaid to a given percentage of poverty and to a whole new group of people who don’t qualify now at current incomes would impose substantial new burdens on some states, (concerns)which were voiced by the governors who met with the president last week.

DEAN ROSEN: I think that is right and I think that it is probably unlikely that the states would opt out of all this, because even in the House bill, it’s not really set up as just a

government program where the states are implementers. But there are aspects of this where Ed mentioned, one with Medicaid where the states are going to have a role to play including a funding role.

Also with the insurance reforms, in a lot of states, the current drafts would have the states enforce a lot of the insurance roles around solvency and pre-existing condition, but the federal government could act as a fallback enforcer if the states don't do it.

So, it's going to be hard for the states to opt out. But the states are going to retain a pretty significant role and I think, in a lot of cases, would have their authorities increased by this federal law -- so in some cases, having to put up some of their own money, in some cases getting some funding.

FEMALE SPEAKER: Dean, you talked about July being a date in the House. How do you see it playing out, particularly since the Republicans

have come out with this broad outline of a plan. Do you see them getting any amendments through, do you see no chance?

DEAN ROSEN: I really don't think there is going to be, I mean, again I could be wrong, but look at the climate bill as an example where there is very little Republican support -- and I think a good example of Henry Waxman being politically pragmatic on what it would take to get something done in a committee that's got a number of Blue Dogs and conservative Democrats on it.

I think this, I think Republicans will offer amendments. But I think they are going to be really more setting the tone of debate as opposed to being successful, and there may be some bipartisan amendments that are adopted. Look, there are some Democrats in the House who are not supportive of the public plan as it's drafted.

There are some Democrats in the House who won't like the way this is funded. There are some Democrats in the House, for example, one thing we

didn't talk about, which may be included or may not be included in the House bill, is follow on biologics, providing a regulatory pathway for generic or follow-on biologic drugs.

Henry Waxman has a bill that has a couple of cosponsors. There is an alternative bill that Anna Eshoo has, that has the majority of Democrats on that committee. So he's going to have a fight on some of these issues with Democrats but I think Republicans at the end of the day, I would be surprised if more than two or three or four or five voted for the bill on the floor.

I would be surprised frankly if that many voted for it. And I think, like everything that goes to the floor and the House, there may be one opportunity to recommit the bill back to committee but I think there won't be a lot of open amendment opportunity in the House.

The Senate is going to be different, but I think depending on what happens in the next two or three weeks in the Finance Committee, you know,

and maybe they delay that into September. But depending on what happens over the next either two to three weeks or two to three months, you could also see a bill come out of the Senate that is partisan as well.

I think by any stretch, at the end of the day, there won't be a majority of Republicans in the Senate supporting the bill. That is my guess as of right now.

So, I think there will be potentially a few Republicans in the Senat,e but by and large this is going to be a bill that reflects the imprimatur of the president and of the majority party and that's what happens when you win elections.

ED HOWARD: And we have run out of time. Thank you for an enlightening presentation and enlightened participation. This will be continued, I have no doubt, over the next few months.

DEAN ROSEN: Thank you all very much and I'm happy to follow up with anyone if you've got questions.

[END RECORDING]