

**Briefing Examines Public's Health Care Priorities for 2008
Presidential Candidates and the New Congress
and Details Congress' and the Administration's
Health Care Agenda for 2007:
Congress' and the Administration's Health Care Agenda for
2007
December 8, 2006**

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ED HOWARD, J.D.: Good morning. Welcome to topsy-turvy part two, or the second part of the double-header, or whatever metaphor this leads you to. I'm Ed Howard with the Alliance for Health Reform and I just want to take a second to thank Drew and Diane and the rest of the Kaiser team here for their constancy, not just in supporting their Alliance and the joint work we do in a variety of ways, but also, and I think more importantly in contributing generally to health care policy enlightenment over all these years. I'm very pleased to be here, especially in the Barbara Jordan Conference Center, one of the great places to talk about health policy and try to shape it.

I may not do a very good Cal Ripken imitation, but some say, at least in the context of Congress, that we have a whole new ball game, and at the very least the we know that at one end of Pennsylvania Avenue, we have a new pitching staff. Even before we know exactly where the 109th Congress and the president are going to leave health policy, and you've found on your chairs at least the best guess about part of that last minute action. We're going to look today at what the 110th Congress working with, at least working on the same issues as President Bush might do in the coming couple of years. Let me just say Diane Rowland, the executive vice president of the

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Kaiser Family Foundation, and I will be co-moderating this.

Diane, do you want to say a few words as we kick off here?

DIANE ROWLAND, SC.D.: I'm just pleased to have you all join part two. I will do no sports metaphors because part of the Kaiser Family Foundation avoids that, even though the other part leads with it. [LAUGHTER] I'm very glad to have you all here today and that we could do a double header in terms of having both the first panel look at the public expectations, but now we're going to really talk about the hard work of taking those expectations into policy, into reality and the challenges facing the next Congress. I'm just very pleased to be with everyone on the panel today but especially I wanted to say thank you to Liz Hall who has been a partner in helping us put together so many of these Alliance briefings over the last years and to wish her well in her new endeavors. Thank you and let's get on with the program.

ED HOWARD, J.D.: Thanks, Diane. I don't want to rush Julie Goon, who has managed to make it to our panel. Its part of the new just in time inventory system that the administration is installing, but we're very pleased that you were able to break away. It looks like the logistics of this are such that you should plan on speaking from where you are as opposed to coming to the podium, if that's okay.

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JULIE GOON: That's fine and if you want to have somebody else go first while I gather things for a minute, that's fine too.

ED HOWARD, J.D.: We can do that if that's all right. You can see we're making this up as we go. It's your choice. Either we will maybe have Kate talk about the Senate along with Liz, and then maybe you can interpose, then we'll have Wendell finish up. Is that all right?

JULIE GOON: Sure. However you want to do it.

ED HOWARD, J.D.: Is it all right with Kate and Liz? You can see we have this very well orchestrated. Let's do that then, if that's okay with you. Kate actually has to leave early, so it's only right that she should go first. I apologize for the introductions; we want to save more time for the actual remarks and insights that we're going to hear. Kate Leone is the senior health counsel to Senate Democratic Leader, soon to be Majority Leader, Harry Reid of Nevada. She also handled health issues for the previous Democratic leader, Tom Daschle. She's an attorney by training and we're very pleased that you made time for us today, Kate.

KATE LEONE, J.D.: Thanks very much for having me. This is a great occasion and I'm sorry that it comes during a week when everything is so frazzled still on the Hill, and running in and running out, because I would have liked to have spent more time

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here. Unfortunately, I guess we can start with the agenda for next year by saying that as a work in progress, we will probably know more about in the next two days. Right now, I don't know if people are aware of what's going on other than that the Extender's package is the big news. I can talk about that in a minute, but we have another set of unresolved issues. Liz and I have been spending quite a bit of time together over the past month trying to resolve a number of things and see if we can't make progress on a few items. There is a House-passed reauthorization of the National Institute of Health. It's unclear whether that's going to make it through the Senate. Tied into that is whether the Ryan White Care Act makes it through the House, and whether the bioterrorism reauthorization, which is combined with the Bardo Bill that a lot of people are very interested in in the biotech community – whether that makes it through all hinges on the NIH either way.

I guess what we're looking at right now are a lot of different people who want to see some changes to the Children's Health Insurance program so that we can address the shortfalls that a lot of states are going to experience in this fiscal year, so we have already started. All of that is hanging out there as unresolved at this point. I don't think we know where it's going to go. You'll notice that the Children's Health Insurance program shortfall issue did not make it into the

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Extender's package. It was a part of the Senate bipartisan package that the funds? [misspelled?] didn't come out of the Finance Committee, but the Finance Committee leaders put together. That was taken off the table during negotiations and I think for a lot of people in the Senate, certainly a lot of people in the House but on a bipartisan basis in the Senate that was a disappointment for us. More so probably for a number of Senate Democrats who are now saying, we're going to CHIP or nothing else is going to happen. I think we're worse in that position.

The House has taken the position that the Senate is going to do MIH or Ryan White and bioterrorism aren't going to happen, so we're butting heads. Hopefully we'll get to a resolution where we can do all of those things and make a lot of progress. I think that is all still hanging out there. Clearly for next year that leaves unanswered is if one of the first things we're going to be taking up is Ryan White, and one of the first things we're going to be taking up CHIP before it falls? [misspelled?], and whether the first things we're going to be taking up is bioterrorism. Clearly, if NIH doesn't get through right now, it's not going to be one of the first things that we do next year. There are just too many other moving pieces that are going to be needed to be done. That's all up in the air about whether that's immediate congressional agenda

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for January/February.

The Extender's package: Obviously, I won't say it's all done; we're going to pass. We're hopeful it will pass and that takes off the table for the immediate January period having to deal with the position [misspelled?] cut, which would be terrific with all the other things that are going to be on our plates. Clearly, if the moving pieces come together and let's put those aside and I can talk about what our agenda would be if we get all these things done in the next three days.

Obviously, the Senate Democrats and the House Democrats share the Six for '06 agenda that we put out. On that agenda are two health items: Medicare negotiation and stem cell research. Leader Pelosi has put out a 100 Hours agenda that I'm sure you're all familiar with, and Wendell can speak to you more.

Anyone who watches Congress knows that the 100 Hour agenda and the Senate means maybe one thing, maybe two things, so we're not going to be on the 100 Hour schedule, but we share these priorities and they are going to be the first things that we consider as we come back. I think stem cells have clearly seen the light of day. We've made a lot of progress on it. Wendell can probably speak more to it than I can because he has worked more closely on it in recent years than I have, but I think we can expect to consider stem cells, hopefully send it

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to the president, and see where we go from there. We went through this exercise this year and had gotten the veto. We'll see what happens with that one. On Medicare negotiation, again the House and Senate are on a little bit of a different timing track. We plan to see what our committee folks have to say about it and the Finance Committee and have them take a look at it. Senator Baucus has indicated he'd like to have hearings on the issue and figure out what the best way to go about it is. I know the House folks are proceeding along as well. I think we're on similar tracks. We're not as far apart as we often are and appears to be in this week as we look at all these other issues, but we're going to move along and see what we can get going through the Finance Committee in regular order and hopefully get something to the floor in the first few months. It's unclear what we're going to do when at this point. That has not been determined.

One of the early health care issues on the floor also will not be something - that is something that is on our agenda. It's Small Business Health Care, but will not be coming from our side in this case because we are still going to look through and figure out where we want to be on Small Business Health Care. I do understand that as Democrats put minimum wage on the floor, which is one of our Six for '06 pieces that Senator Enzi's staff has indicated on in previous panels that

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they plan to offer the Enzi Small Business Health Plan to that piece of legislation. Whether that happens or not is a question for Senate Enzi and the Republican leadership. That could be an early health care issue that's on the floor that is not necessarily framed in a way that Democrats will support, but perhaps we can get something in for small businesses as part of that. I think that would be a hope that we could come to some kind of agreement that gets a number of votes in the Senate and gets us pass the thresholds we need, then send it over to the House.

Those are the early big-ticket items all hinging on today, I suppose, sadly to say, maybe tomorrow and the next day. We're keeping our fingers crossed for today still. Thanks very much.

ED HOWARD, J.D.: Have a nice weekend. [LAUGHTER] Thanks very much, Kate. Now let's hear from Liz Hall. She's the director for health policy for Senate Majority Leader Bill Frist, who also happens to be the vice-chair of the Alliance Health Reform in full disclosure mode. She's an expert in Medicare, Health IT and a bunch of other health care topics. She's here to help us understand how the Republicans in 2007 are going to deal with a whole range of issues and let me just echo and reiterate and magnify the remarks that Diane made about how much we have relied on and successfully relied on Liz

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Hall to handle an incredible array of onerous duties that we have heaped on her from the Alliance, and she has discharged them all beautifully. We're going to miss working with you directly in that way. We hope we can continue with the relationship in wherever else you go. Liz, thanks for being with us today.

ELIZABETH HALL: Thank you for having me, and thank you to everyone that has come out. I can tell that this is a topic of interest to the audience. It has been wonderful to work with the Alliance and with the Kaiser Family Foundation for a number of years. I too, will be very much miss participating as directly, but as the leader made clear at the last Alliance Board meeting, he will not be going far and he will not stop participating because he does feel that the Alliance does serve such an important role. I think that he and Senator Rockefeller will make sure that they continue to do everything that they can to make sure that there is a strong bipartisan dialogue on health issues. It's too important not to have that dialogue.

To a certain extent, I'm actually here to represent that perspective a little bit. When Ed mentioned that the Alliance was working with Kaiser on putting this together, one of the things that I mentioned is that the nature of the Senate and the nature of the margins in the Senate make it such that

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there will need to be strong bipartisan discussion and work to really accomplish some of the goals that I think that either Democrats or Republicans have for the future.

I'll start out my remarks by just talking about the nature of the Senate and reminding folks of the nature of the Senate. We try to keep it a collegial place. Absolutely on the floor the debates sometimes get a little bit less collegial, but the idea is to try and work towards agreement behind the scenes. The reality is it only takes one to try to stop and block something in the Senate, and it requires 60 to invoke closure and to end debate. So because of that it's important to remember that while 51 is a majority and I think the Democrats are very glad to have 51 as the majority, it's a diverse majority and I think that they will have a lot of Republicans to work with. There is a lot of common ground to be found, but there are going to be some significant differences.

Speaking from experience, and I think that's actually why I'm here today, it is a lot harder to try to put together agreement as Kate and I are experiencing right now as we try to close out the session, than it is to really foment fierce debate. We can challenge ideas, but it is very difficult to come together on ideas that we can move forward. With that said, Kate mentioned what is some of the Democratic agenda, and

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I'll just mention some areas where I think that there is great opportunity for bipartisan work and bipartisan agreement, as well as a few areas where I think there may be a little bit more fierce debate in the area of working together regardless of whether we are able to address SCHIP reallocation of some of the funds and re-addressing some of the shortfalls in the short term.

SCHIP reauthorization is due next year. I think that there will be a significant discussion and debate. There is a significant interest from the Republican perspective of trying to get that reauthorization done and done as quickly as possible. It just may be combined with some of the reallocation issues early on.

I would say that we have great relationships. One other thing I would say about just the Senate in general - we have great relationships between the chairmen on the two committees of jurisdiction. I think that will be very helpful. One of the priorities for Senators Enzi and Kennedy I know has been drug safety, and next year we happen to find ourselves on the Health Committee looking at reauthorization of several FDA related pieces of legislation. That will be a significant focus, and I think that is also a significant area for bipartisan agreement and work.

Health IT, unfortunately I think we've gotten to a

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stalemate with the House and the Senate on moving health information technology legislation forward. I think it's very likely that we'll be able to revive that and hopefully move that pretty quickly. There's been a lot of good work that's been done and a lot of ideas that have been very well developed that I think we can work on a bipartisan basis.

As Kate mentioned, Ryan White is another challenge that we are trying to face. Regardless of whether we are able to get the Senate compromise through, I think that early next year and the next Congress there will need to be continuing bipartisan discussions on the structure of that program and the future of that program. We absolutely want to make sure that we protect all of those who are affected by HIV/AIDS for the next three years. That's what the legislation on the compromise does, but we also need to think about the changing face of the epidemic and the future. There will be significant additional discussion on that one.

Where we may not find such consensus are a number of areas; a number of areas that we will have to work on very closely. We worked hard on the bipartisan basis to get the Medicare Modernization Act passed. There are some things, particularly on the Democratic agenda, that would make changes to that. I think that is one area where there will be some significant differences. There have been some discussions of

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some Medicare Advantage changes. The Medicare Advantage program, which offers private plans to Medicare beneficiaries, again an area where I think there are some significant difference and if you're hearing some of the discussion about Medicare Advantage base rates versus fee-for-service payment rates – those aren't apples to apples comparisons and I think there will be significant discussion about that in the future. I would say that the discussion of drug importation, clearly there are Republicans very supportive of drug importation, and there are Republicans who are very much opposed. There is a similar situation on the Democratic side where you have some difference in opinion amongst the Democratic caucus, so that's another area where there will be some debate.

Depending on what Democrats may or may not want to do on consumer-driven health care and health savings accounts, again something that Republicans worked very hard to establish consumer-driven options. They are not perfect, and we continue to work to try to enhance them and do things to facilitate the ease of use and the ability to make decisions through quality, which I should mention is an area where we can find some bipartisan support on the quality agenda. When it comes to exactly how consumer driven health plans work and health savings accounts again, I think that might be another area where there might be some differences.

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In short, I think it's going to be a very interesting - I will not be in the Senate next year. I am moving on to other places, but I hope to be able to provide some assistance and guidance to both Republicans and Democrats in my new role.

ED HOWARD, J.D.: Terrific. Thanks very much, Liz. Now we're going to lead off with Julie Goon, who is the special assistant to President Bush for economic policy within the National Economic Counsel. Julie has responsibility for all the major health programs. She's been top advisor in HHS. She's spent many years in or representing the private health insurance sector and we're delighted to have you with us this morning.

JULIE GOON: Thank you very much. As you can tell from Ed's introduction of me, I never had the opportunity to work on the Hill through the time that I have been here in Washington, but have always both respected and enjoyed the process by which legislation gets made. I think that what we're seeing this week and over this weekend will continue to be very interesting. This is always the time of the year when you're getting close to a session being done where things actually can get accomplished. I know that both downtown at HHS and all over town I think people place bets on the likelihood of certain things happening, and to just track the ups and downs of who is ahead in the betting game has been one form of

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entertainment over the last week at least. It continues to not completely be clear who is going to prevail.

It's also the time of the year at the administration, which is something I am new to having only been there a couple of months where we are going through a significant process of figuring out what next year's budget proposal is going to look like. A lot of the policies that the administration puts forward are always expressed through our budget submission to Congress. In addition, folks are thinking ahead to the State of the Union, and all of the health care issues are always on the agenda as we go through both the budget and the State of the Union process, but clearly I think that this year, in part because of the election, people are far more aware that there is likely to be significant efforts on the Hill with respect to health care policies that we need to be determining.

As Liz says, where there are areas where we can work together very effectively, where there are areas that we will work together and may not end up in the same place. We'll see where that takes us and what health care policies are going to be. Things that are very obvious at the beginning are clear difference between Republicans and Democrats.

The administration's principles remain solid. We believe that keeping America competitive means requires affordable health care. Our government has a responsibility to

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provide health care to the poor and to the elderly. For all American's we must confront the rising cost of care in order to help people afford the insurance coverage they need. We believe in doing this by building on the private sector competitive models in order to ensure that government programs work well. We believe that health care has to be affordable, transparent, portable and efficient. I think you can see that running through a lot of the budget submissions that the Administration has put out over the last six years.

With respect to Medicare, I don't necessarily want to go all the way back and revisit all of the debates around the Medicare drug benefit, but there have been many years of conversation about the need to update the Medicare program and include a drug benefit in Medicare. As all of you are very well aware, that passed in 2003 and after several years of going through the implementation process, which is when I was at HHS as Ed mentioned, the Part D benefit had gotten up and running last January. Many of us probably don't stop and take enough time to reflect on what a big accomplishment and change that was in the Medicare program. Medicare had not been changed that radically since 1965 when it was enacted. In 1965, there were only about 20 million people who were eligible for Medicare. There were some 42-plus million people eligible in 2006. To add a drug benefit that was delivered through

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private sector models which is a different way of looking a benefit than typically beneficiaries were use to unless they were in Medicare Advantage plans, and educating them about their choices – given all the problems that could have happened, the place that we are right now is a tribute both to members of Congress who worked very hard on this to people in the Administration who worked very hard to get this implemented, and to all the people in the advocacy community who were, and I see Vicki right in front of me who was kind enough to always let us know where things were going off kilter a little bit. But I very much want to express to everybody in the audience how satisfying working on this program has been and how grateful people in the administration are to folks who spent a lot of time and effort learning about this program and helping beneficiaries learn about their options and get enrolled over the past year.

When the program was enacted, people didn't think we would have any plans and we would need to have a government fallback plan. Then there was a lot of worry that we had too many plans and people wouldn't be able to figure out what their choices were, that seniors wouldn't be able to make these choices, that there wouldn't be enough people available to help educate seniors and help enroll them in this program. There was a lot of worry that after low premiums the first year, that

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the drug plans were going to immediately raise their bids. Despite a lot of the implementation issues in the first couple of months of last year which I think folks are pretty well aware of – involved a lot of systems issues, involved the change of Medicaid beneficiaries onto a Medicare system, involved transition from drugs people were taking onto formularies, etc. I think we have come to the second open enrollment period in a pretty good position. Beneficiaries are saving on average \$1,200 a year. They could be spending less than half of what people without coverage would pay in the open market place according to Consumer's Union. If they join lower-cost plans, they can save even more. Taxpayers are saving too. I know there was a lot of controversy about what the original Medicare drug benefit estimates were when the bill passed. The costs have been significantly lower than what was estimated at the time. Part of that has to do with the number of people enrolled. While there are approximately 22 or 23 million people actually enrolled in Part D, there are another 10 or 11 million or so that are covered by credible coverage either through the retiree subsidy or through federal programs. There are still more people who have credible coverage who the folks who do all this estimating weren't completely aware of the extent of folks who already had drug coverage. Part of this is based on enrollment. Part is based on competition

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among the plans and part of it is based on lower drug price increases over the last couple of years.

The plan bids came in 10-percent lower in the second year in the second year than in the first year. That is almost unheard of in the private sector, and I know that CMS is watching over that very, very carefully and is working with the plans to ensure that hopefully is as successful as this year was in terms of plan bids. Beneficiaries have more choices this next year than they had previously with coverage in the gap in more states. Many beneficiaries chose plans this year or were provided the low income subsidy so we're not ever subject to the doughnut hole part of the standard benefit package.

Beneficiary's satisfaction has been high. I know the Kaiser Family Foundation has done a number of studies since the bill passed. Both the work that they have done and the work of others has been consistent over the last six months, especially JD Powers, which most of you probably know from the work that they do for new automobiles, has also taken on looking at the drug benefit. They have found that surprisingly the Medicare drug benefit has the third highest satisfaction rating of all the products that they survey. New automobiles being number one, and surprising to me, homeowners insurance being number two. If anybody ever asks me a question about homeowners

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insurance, I'm not sure how I would answer it, but there you have it. The issues surrounding the government non-interference language in the bill are more major than minor and we'll all be working very hard on those as we go into the next Congress. It's important to remember that language actually says that the government may not interfere in negotiations that are currently ongoing between plans and PBMs. It also says the government may not set a formulary. Part of the concern, I believe, with this provision which was actually originally a part of Democrats drug bill packages prior to the Medicare Modernization Act passing is a concern that the government would interfere in those kind of negotiations in a way that would skew the market place inappropriately and lead to problems with respect to research and development.

Frankly, the government doesn't particularly do a very good job in negotiation. I think if you take a look at the Part B Drug program and even with all due respect to my friends here on this panel, if you look at what's going on with the tax Extender's package, I think the amount of political pressure that comes for any particular piece of Medicare, Medicaid or other public programs as we go through putting legislation together is interesting. I think it would be a mistake to open up the political process to what particular prices are available for drugs.

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I don't want to spend all of my time on Medicare, but I did want to lay that out for people. Medicare Advantage as Liz said is also something that is a program that the Administration is very strongly supportive of. One of the other goals that the Medicare Modernization Act was to increase the number of choices available across the country. There are a number of policy decisions made after the Balance Budget Act of 1997 and also up through 2003 to ensure that those choices were more broadly available. There had been historically a lot of concern that plans in Iowa never had extra benefits while plans in Florida had zero premiums, lots of drug coverage and lots of additional benefits. That geographic variation has been significantly narrowed. We have seen the growth in those choices over the past three years and growth in enrollment in those plans as well. With the exception of very few counties, beneficiaries all across America now have the choice of a Medicare health plan option.

With respect to expansion of coverage to the uninsured; the position that the administration has taken historically has been to focus on the affordability of coverage. We have proposed through the budget, various ways to do that including association health plans, including medical liability reform, including making insurance more portable across states. All of those things are things we continue to talk about, look at and

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are supportive of. As Liz mentioned, the health savings accounts which are also part of the MMA have also been a strong part of the Administration's approach to providing more affordable health care coverage. The approach we took in last year's budget was to try and level the tax playing field between insurance that is purchased inside the employer based system and insurance that is purchased outside of that system, as well as health care services that you receive through insurance and health care services that you receive outside of your insurance system.

As Liz mentioned, those things need improvements and they don't work quite as well if there isn't information available, so the president signed an Executive Order this summer that is dedicated to working through the federal health care programs to make sure that we make information more transparent, both price information and quality information. That the quality information is centered around core performance measurement. That people in the provider community work to come to consensus on. That we work to get to more interoperable health IT systems and that we provide more incentives in the systems for both providers and consumers to care about the value of the health care services that they are purchasing. I received the two-minute warning and I'm sure I'm pretty close to the end of that.

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The last thing I would say though in the efforts to comply with the Executive Order, HHS and CMS have been very active in putting out on their website Medicare payments to providers. Last June, hospital DRGs went up. In August it was ambulatory surgery center prices. In November, it was hospital outpatient and physician fees. They will continue to do that. They continue to work with ambulatory quality alliance and the hospital quality alliance to get to consensus on core performance measures. The quality reporting that is presumably a part of what's going on, on the Hill is really important to the movement forward of those efforts. Thank you.

ED HOWARD, J.D.: Thank you, Julie. That was very informative. You can't mix a football metaphor, though, into the baseball one that Drew started. Now let's turn to the House. Wendell Primus is senior policy advisor to House Speaker-Elect Nancy Pelosi for budget and health issues. He's an economist. He's held a variety of posts in both the Executive Branch and on the Hill. A lot of us are forever grateful for his years of work at the Ways and Means Committee on a whole range of topics, but especially being the Editor of the Green Book, which those of you who know it, know it is a treasure trove of data for health policy wonks everywhere. We'll never outlive our gratefulness, as well as for showing up today. Thanks, Wendell.

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WENDELL PRIMUS, PH.D.: Good morning. It's a pleasure to be here and there really is a lot of excitement on our side of the aisle in Congress. I think the members are ready to get down to work and I think you will see right off the bat, especially on the House side that we're going to work starting on January 4th and work through the president's recess. It's also good to be batting clean up here this morning. I'll go back to the baseball analogy because I get a comment on what the other three speakers have said.

One of the first things I would say, which is very symbolic of the difference between the Republican priorities and the Democratic priorities, is this lame-duck session. They managed to find a billion dollars that didn't have to be paid for to improve health savings accounts, which the evidence shows primarily helps the wealthy and healthy among us. But there was not roughly \$400 million, a little less than that to take care of the SCHIP shortfall. I'd like to think that we could be proved wrong, but I don't think it's going to happen in this Congress and that really probably is the symbolic difference between Republicans and Democrats on health care. If I read these poll results right, I think the American public appreciates the Democratic priorities, because one of the highest things that we need to take care of in this country is getting more of the uninsured children with health insurance.

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Another thing I would say is one of the things that has made the Ryan White funding allocation difficult is the fact that over the last six years the funding per AIDS case has gone down by about one-third. I think it's time that reversed. During the 1993 period to 2000, funding per case went up substantially and that was a period when we had a Democratic president and mainly a Republican Congress. It also speaks to a lot of other funding priorities in the appropriation process. We've had 11-percent real cut in NIH funding over the last several years. We've had Title VII basically decimated, Ryan White and other discretionary programs. CDC and HRSA remain relatively flat. Those funding priorities in the appropriation process are going to start to change. I don't know how rapidly, but that will be another difference between the Republican Congress and what will happen in a Democratic Congress.

The other item that hasn't been mentioned today that is also part of the 100 Hour agenda in the House, and both leaderships are committed to this is a return to pay as you go budgeting. Over the last six years, we've seen an enormous - the largest fiscal turnaround in our nation's history. When President Bush took office there was six trillion dollars or 5.6 projected surpluses. That has turned into a three trillion dollar deficit. This president has borrowed more from foreign

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governors, foreign nations, foreign countries than all previous presidents combined. Actually the fastest-growing item in the budget is not Medicare; it's not Medicaid. It's interest payments to foreigners on our national debt. That is the fastest growing item. That is why I think the economy figured a lot larger in the poll results than most people would have expected. The other reason is that since early 2001 corporate profits went up about 3, 4, 5 percentage points of GDP. They are the highest level since 1950. Wages as a share of GDP actually went down substantially and that is why the first time in our nation's history, median income of non-elderly or working families went down while we had four years of economic growth, unprecedented. That is why another part of the 100 Hour agenda and increase in the minimum wage, as well as return to pay as you go budgeting, which will have some implications for the health care agenda is going to be high on the list. I think you will see all of those things pass before the State of the Union occurs on January 23.

Kate has already mentioned stem cell. We'll give the President another chance to veto the stem cell bill. We think that is very important research that ought to be taking place. Julie spent quite a bit of time talking about the prescription drug benefit. We think it is important that the secretary be given the authority to negotiate with drug companies on behalf

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of all those enrolled in prescription drug plans. Yes, the cost has not turned out to be as great, but that's primarily because enrollment is about \$7 million to \$8 million dollars less. Drug prices slowed down in 2004 and 2005, not because of the MMA but because of other trends. She also indicated that government wasn't a very good negotiator. I'm not so sure. If you look at what prices VA gets, they are substantially less. Really a very critical piece of information will be forthcoming. I hope it's forthcoming from the Administration by May or June, and we will find out when all of 2006 claims data is in how well the PDPs did in negotiating prices relative to the Medicaid programs. We have roughly 6.5 million dual-eligibles in this country and one can compare how well the PDPs did to the Medicaid program. I think that will be a very interesting piece of information that we will find out later this summer.

In the meantime, Democrats on both sides of the Hill are committed to giving the president negotiating authority. I think we're still vetting the language but the leading contender right now is to repeal and require. It will be very simple language. We do not think that Congress needs to hammer out all the details. There are a lot of smart people in the administration, including the secretary, that can look at how we're buying drugs, the Ryan White program, the Medicaid

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program, the Department of Defense, vaccines, et cetera, and figure out the best way of negotiating better prices with drug companies.

The other thing that hasn't been mentioned – I suspect there will be a lot of oversight by this Congress in terms of looking at ways we can save money, but also very important catastrophes that occurred; Katrina, is there anything that should be done there in terms of supporting health care, etc. Another issue that I think will be looming are the people that were affected in cleaning up the 9/11 pile, the New York City issue. Those workers are getting ill. I think it's the tip of the iceberg and despite all of our rhetoric about first responders and how important they were, their needs right now are being left unmet. I would expect to see some oversight hearings on that. I couldn't agree more, and I really hope that we can forge a compromise and that there will be bipartisan support for SCHIP reauthorization so that many more kids will become insured. That we can lower the number of kids who are uninsured. That actually went up again. The rate went up in this last census. We can lower that dramatically and I'm hoping we can work with the Republicans and the White House. In fact, I'm hoping that the president will have an SCHIP proposal in his budget that we can build on and proceed on.

The other things that Liz mentioned, the HIT bill,

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genetic non-discrimination, there are some other health agenda items that will be high on the Democratic list. With that, I'll end and be glad to take Q&A's.

ED HOWARD, J.D.: Terrific. Thank you, Wendell, and let me just say thanks to all the panelists. I know this is an extremely difficult time for you to free up time. It is very much appreciated. Let's try to get in a few questions. I would urge those of you who have a question for Kate to assert yourself early because she is going to escape and you will miss your chance. Depending on the question, she may escape sooner rather than later. I understand there are folks with microphones. You want to identify yourselves.

RALPH ROSENCRANS: Hi, Ralph Rosecrans with Inside CMS. I have two questions. One maybe for Julie Goon – are there any kind of initiatives that the president definitely wants to push next year or the next two years, maybe in a way that he has pushed health IT and transparency for the Executive Orders? Or maybe some other things that he definitely knows already that he does not want to push or prevent?

Secondly, I want to ask maybe the Democrats on the panel about the party reform. Structurally, I'm trying to figure out whether hearings are going to be first or whether legislation is going to be first, or at least are you thinking that you're going to finish a draft that's workable also with Senate Baucus

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before he even wants to do hearings.

ED HOWARD, J.D.: Pardon me. I don't want to be impolite, but if you can hold your answers to those questions, I would try to elicit a question or two from you for Kate before she has to leave. I believe the gentleman here indicated he was in such a position. Is that right? No? Well, maybe there are no questions for Kate. You were so clear.

MALE SPEAKER: Dallas Salsbury [misspelled?] with the Employee Benefit Research Institute. I do have a question, which I was going to have before the comments by Wendell but after that comment even more so. We released a survey on consumer driven health in HSAs yesterday. In the context of one of the discussions yesterday on the Hill that I was present for, the HSA provision was described as one could in fact; elicit a single senator to hold up the entire bill. Is that viewed as an issue in this bill of that level of import in the Senate, or are all the other issues you noted more likely to dominate?

KATE LEONE, J.D.: Do you mean the HSA provisions in the Extender's bill? Is that what we're talking about?

MALE SPEAKER: Correct.

KATE LEONE, J.D.: To be 100-percent honest, I have been so focused on the NIH problem we have, the Ryan White, bioterrorism, Bardo are not going to go through the House per

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Chairman Barton unless the Senate passes his NIH bill. There are people on our side who think CHIP has to be done right now, my boss included. We have some real problems coming our way. That's been the number one focus for us as we post putting together the Extender's bill. Obviously, the night the Extender's bill was put together, the Extender's bill was all we were thinking about. As we've looked through what ended up in the Extender's bill, which were broader HSA provisions than a lot of people were expecting, people are still assessing where they are going to be. I know that there are a number of people who are drafting amendments to the Extender's bill. I'll let Liz speak to the likelihood of those amendments in light of day, but I think that right now people are still looking at the package. It's a big bill and there is a lot of stuff in there that senators want. Democrats were pushing for - I don't know if it was months, I think it was months and the time before that we went out for the elections. There is a lot of stuff in there.

It's hard to know on balance where people will be. People want to help the physicians. We need to extend TMA. We need to extend the moratorium on therapy caps. The Extender's I can't really speak to because I don't work on those issues, but there is a lot of stuff in there that people want. Whether that has the weight to carry the HSA expansion? I don't know.

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Your study certainly informs people's judgment. Consumer satisfaction with those plans, the increasing evidence that those plans are not being coupled with contributions to the accounts that accompany them, the whole idea of shifting risks onto consumers is not something that Democrats are comfortable with. We need to do something with health care costs. The answer isn't just switching the cost to patients, so I think there is significant concern about it. I can't say whether it tears down this whole bill at this point. I think there is a lot of stuff in there that people really want to see, so I think we are waiting that out. We don't even have the bill in the Senate, so we'll see what happens in the house first.

ELIZABETH HALL: If I could jump in and, as I said in the beginning, it takes one to try and hold something up. It takes 60 to end debate, so I think every member is evaluating and trying to determine where they are going to be on the package. Admittedly it's a large package. There are a lot of really good things in there, including the HSA provisions from my perspective. The one thing that I would say also, to comment a little bit on something that Wendell mentioned, the HSA provisions are on the tax side of the ledger. Whereas many of the other provisions are on the spending side of the ledger. Again, this is where it comes down to – it's very good, it's very easy to come and make comments. It's difficult to

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actually legislate and find consensus, and I really am looking forward to watching Democrats operate under Paga once they reinstate it.

MARY AGNES CAREY: I'm Mary Agnes Carey with CQ. Kate, I just wanted to follow up with you a little bit about the SCHIP issue. I know you said people were still looking at the package, but how strong is the feeling from your perspective among Democrats that these shortfalls must be addressed now. Can they wait till January? If you're running the chamber, will you be able to move something? I'm just trying to figure out if it's strong enough to derail the current package we're talking about.

KATE LEONE, J.D.: We had hoped SCHIP was going to be included in the Extender's package. It was not. The Senate, in a bipartisan way, said this is what should be in here and we ended up not getting there, unfortunately. The question on SCHIP has become more about Chairman Barton who has jurisdiction over the SCHIP program and the Energy and Commerce Committee has indicated that his number one priority is NIH and he is going to let Ryan White reauthorization not go through. He's going to let bioterrorism Bardo not go through if he doesn't get NIH. I think right now the SCHIP debate is more linked up in that because that is his jurisdiction and Senator Grassley and Senator Baucus have both indicated that they would

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like to address the shortfall issue too. It's more tied into that the Extender debate at this point, but I could be wrong as we get to the period of time where NIH, Ryan White, BT-Bardo are falling either by the wayside and Extender's is the one thing left. That could shift. It is very important to a number of members of our caucus. It's very important to a number of Republicans. There have been bipartisan letters to my boss and to Liz's boss. Everyone recognizes how important it is. I think it's a significant issue.

There is serious concern about what's going to happen in some states right away if we don't do it and they can't wait until CHIP reauthorization is finalized. We clearly want to do CHIP reauthorization early. We think it's an important thing and it's really an opportunity for us to do something to improve a program that's near and dear to Democrats and Republicans' hearts. I would agree with Liz. That is an opportunity to work together. There are people who think we can't wait for the CHIP shortfalls to be addressed until that happens. It's a significant issue. It's going to tie us up for a little bit. The people who are from states that going to experience the shortfalls and have children with their coverage in jeopardy, that's their obligation as members who are representing those states and those children. [Inaudible] has estimated that over 600,000 children have their coverage in

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jeopardy. How do you go home and say, "I didn't fight for that"? It's a significant issue. I don't know what the likelihood is that we're going to be able to prevail on getting that done.

It's a heavy lift at this point and that's especially true with the House closing down the rule on the Extender's package. It's especially true with them and their suspension calendar. Not to say anything bad about the House but they tend to just send stuff over and leave town. We would do that to but for our members who keep us in, I'm sure, but we don't have that luxury. We'll see whether there is anyway to get it done, but it is going to tie things up. I think it's going to be a big issue. Whether we can get anything done on shortfalls and if we can come to some kind of an agreement that Chairman Barton can live with from his Texas perspective, and that's the state that he represents, and saying we're trying to work with him, trying to get it done. I'm not maligning anyone but he's decided to hold Ryan White hostage to the NIH bill. A lot of people on our side think NIH can be reauthorized next year and they want CHIP now. It's the classic who is going to blink and I don't know who that is at this point.

ELIZABETH HALL: If I could – just one additional comment on that. I would agree with Kate to the extent that there is a little bit of blinksmanship going on right now, which is

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unfortunate. It is one of the things that can happen as we get towards the end of the year. I would say, in all fairness to where CHIP is or is not in the Extender's package, that on the Senate side, the Extender's package is not only a bicameral agreement, but it's a bipartisan agreement. So there was a lot of discussion about SCHIP and whether to include it or not. I understand greatly the disappointment that it's not included and I think that I can appreciate that.

The other thing we have to think about though, and this will be part of why the reauthorization discussion is so important, is that some of the states that are in shortfalls are covering many more than children. They are covering childless adults up to a significant percentage of the poverty level. There are going to be serious policy debates. Clearly we do not want anyone to be dropped from coverage and that is why from the Senate perspective on a bipartisan basis. We have been saying that we will act as quickly as we possibly can on SCHIP when it comes to reallocation and to addressing the shortfalls, but there are some policy issues that need to be addresses as well. It is unfortunate that there is some holding up going on. It's going on, on both sides of the aisle.

DIANE ROWLAND, SC.D.: For those that may be having some difficulty following this – there are two children's health

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insurance issues here. The first, which is part of what's being considered right now in what they call the Extender's, is a series of legislative additions that are really meant to be short term fixes or appropriations issues, is the issue of whether states that have hit the cap on their federal funding for SCHIP can get a bump up in that cap so that they continue to receive federal matching funds and cover children. But next year, 2007, the entire state children's health insurance - SCHIP legislation is up to be reauthorized by the Congress and will - as Molly noted in her overview of public opinion support - be the major vehicle by which we look at how we cover children through public programs in this country.

So there are two issues. One immediate about the funding levels and the second will come up in the 110th Congress is how they deal with children. Similarly there are a number of Medicare provisions here that are extending or changing provisions, but it is not a major piece of legislation. That is redoing Part D. That will wait to see if anyone wants to propose that. The public wasn't supportive of that. They wanted minor fixes in our public opinion work. But just to keep the field a little clearer here.

ED HOWARD, J.D.: Wendell would like to comment.

WENDELL PRIMUS, PH.D.: Just one last comment on this SCHIP/HSA thing. I want to be very clear. The reason we had

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so much difficulty getting to cover the SCHIP shortfall was because of the demand that it had to be paid for. We could have done like we did last year and put \$350 million or \$380 million on the table and there would have been no problem. We wouldn't have had to hurt Texas or any other state that still has some SCHIP surpluses, so because one had to be paid for and the HSAs didn't have to be paid for is why we're in the bind we're in.

ELIZABETH HALL: Just on that point, though, if I can, and I know you don't want to get on the back and forth. One of the things again about the difficulty of governing budget rules is that just adding additional funding, it's not like we can just throw a couple hundred million dollars into this program even if we had a couple hundred million dollars to throw into it. Because of CBO scoring rules, where they actually build that into the baseline and so what seems like \$300 million or \$200 million actually is billions. Again, difficult of governing presents itself and rears its ugly head on a regular basis. CBO rules are CBO rules.

JIM BURN: Hi, I'm Jim Burn. I'm editor of *Health Care Disparities Report*. A narrow question for you, Miss Hall.

ED HOWARD, J.D.: Just a second. Can you hear him in the back? No? Why don't we try another one?

JIM BURN: Yes, there we go. I assume that the bipartisan

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Disparities bill that Senate Frist and the three Democrats introduced probably is not going anywhere the rest of the session. It's not going to be tossed on anything.

ELIZABETH HALL: As much as we'd love to get that bill done, because we worked well over two years on that bipartisan agreement - I think what I would say is that our Democratic co-sponsors and ourselves pushed the envelope on both the Republican and the Democratic sides as far as we could to get agreement, a bipartisan agreement. We're going to have to spend a lot of time with our colleagues trying to make sure that they understand the policy and are comfortable with the policy. Unfortunately, because it took us as long as it did to get that legislation drafted and reach that agreement, we have not had as much time as we've liked to make sure that all of our colleagues are educated. My guess on the prospect - it's not going to be added on to anything last minute because most of what we can do is either in the Extender's package developed or are stand alone bills that we can pass by unanimous consent or on the suspension calendar in the House.

Unfortunately, I don't think that it's going to go, but that is not a reflection on the commitment on the leader. In his new capacity, I expect that he will continue and probably have a little more time to devote to it.

JIM BURN: I have a broader question that I'm interested in

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the views from the Hill and the administration. On Monday, the National Academy of Social Insurance came out with a very carefully worked out proposal to use Medicare as an engine of going directly after disparities. It involves things that can be done in the Executive Branch by CMS and the like, but it includes some legislative proposals too. If that's not a super costly proposal, I haven't cost it out yet – is that something that the Hill and the Administration would be very sympathetic to looking at?

ELIZABETH HALL: I'm not aware of what exactly the National Academy for Social Insurance proposed, but I would point out that a number of the items that were in the MMA were very specifically directed or can have very specific impacts on this disparities issue. Number one: All of the preventive screening benefits that were added to the Medicare program are in many cases related to diseases that disproportionately affect people in minority communities. Number two: The drug benefit has seen higher rates of enrollment among African-Americans, Hispanic-Americans, and Asian-Americans as opposed to Caucasians. In part that is more than likely because many Caucasians have access to retiree drug coverage. At least, that's the belief over at CMS that has caused the difference in the percentages, but as people get access to drug coverage in combination with those preventive screenings, there is definitely an expectation

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at CMS that this is going to have a very positive effect on health disparities. I know that as we went into this open enrollment period, they were spending a lot of time actually trying to promote the Welcome to Medicare physical as well as the preventive screenings that are now available as part of the Medicare program.

FEMALE SPEAKER: I'm Susan Dunser [misspelled?] from the "NewsHour with Jim Lehrer" and I have a question for Wendell and then I would love to hear Julie's response. Wendell, you mentioned on the question of government negotiation the emerging idea was repeal and require as distinct from some of the other things under discussion like creating a separate government sponsored plan. Could you elaborate on why that course as opposed to others and, Julie, would the president veto a law that specifically repealed the non-interference provision and required him or the Secretary to negotiate?

WENDELL PRIMUS, PH.D.: In the first 100 Hours, we are not going through regular order, so there are no hearings. It's not going through the committee process. Therefore, a decision was made that any proposal here has to be quite simple. In fact, if you look at all of them, minimum wage, student loans, they are all pretty simple but they send a very clear message that the Democrats can govern and we care about the American people in the middle class. Really, the two leading contenders

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here were just repealed a non-interference language, but given the Administration's opposition to doing anything, I think there was a feeling that we had to do a little bit further and go to repealed and non-interference as well as require the Secretary to actually negotiate.

The other proposal that was on the table for awhile, and that is creating Medicare Part D may eventually come with hearings, et cetera. It was not something that we were comfortable legislating in the first 100 Hours because it takes time to develop that kind of legislation. That kind of legislation needed to go through the committee process.

JULIE GOON: I appreciate the insight into the Democratic leaderships thinking on what they would like to do in the first 100 Hours. I would say I think that it is not clear to me what repeal and require would actually mean or do. It's not clear how that would work. Would it work with the current private sector plans? Does that mean that the government would have to get in there and figure out by plan how many drugs were covered of each particular drug on formulary? What would they then end up doing with respect to interfering between the process between the PBMs and the drug companies, between the PBMs and the pharmacists? Just saying you're going to repeal and require something doesn't really tell you how something would work, and so it's difficult to actually respond operationally

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to that. I think that the philosophical objections we have to getting rid of the non-interference clause and to requiring any kind of negotiations stand. There certainly would be advice that would go forward that would reflect all both the intellectual and operational thinking inside the Administration about this issue.

FEMALE SPEAKER: Vicki Gottlich [misspelled?], Center for Medicare Advocacy. I have two separate questions that affect low income people primarily. The first, for Wendell, is what's going to happen with Medicaid? In particular, some of the issues around documentation of citizenship which seems to be a real burden for people.

Then the second one is really for Julie. This is a policy question. We saw in the polling that was released earlier that people don't want to put more co-payments onto Medicare beneficiaries as a way to save Medicare costs. It's very likely that the trustee report is going to come out in March and show that more than 45-percent of Medicare monies will come from general revenue within the timeframe of the MMA. I was wondering whether the administration had begun to think about how they want to change the Medicare package in order to have some cost savings in Medicare in response to those reports.

The third thing I want to say is if we could answer Rob's question, because I was interested in the answer.

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ED HOWARD, J.D.: About Medicaid.

WENDELL PRIMUS, PH.D.: As you know, every Democrat in the House opposed the Deficit Reduction Act changes. Particularly the primary reason for that opposition was the Medicaid changes, including the citizen thing you referenced. There is a package of Deficit Reduction Act technical's that are in the Extender package that I think, improve the situation a bit. I don't know if it goes as far as you'd like to have, but we think that those technicals are important and they've been worked on, on a bipartisan basis. They take the rough edges off of that documentation requirement.

JULIE GOON: I thought – and maybe Liz can answer this – I thought there was maybe something that was going on in here that was even – maybe that's what you were referring to, Wendell, that took the rough edges off of this. I thought there was a little tweak. With respect to not wanting to require seniors to pay more cost of out pocket, the other thing that I thought was very interesting about this very same question was high requiring higher income seniors to pay higher premiums was. Given that we're starting into the transition period where as a result of another one of the provisions of MMA, higher income seniors will be beginning to pay a higher Part B premium next year. It's a three-year transition period, but there has been a lot of concern about that, that has been

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expressed as well. A lot of not knowing what was going to go on as seniors began to see that reflected in their Social Security payments. It's going to be very interesting to see how that plays out as well. As we get to the Trustees report and what it in fact is going to say, people are very aware of that. We're talking about how to address some of those issues beyond even just that particular trigger. As many of you know, there have been a lot of conversations inside the Administration about the whole issue of entitlement's reform and how to slow the growth in entitlement's programs including Social Security, Medicare, Medicaid and those conversations continue. More will be forthcoming at appropriate points in time when people more important than me get to make news, which is basically by answer to Bob's question as well.

ED HOWARD, J.D.: To parallel what Drew Altman said earlier; we have time for one or two more questions. We have two on the aisle, so to speak.

JUDY RIGGS: Yes, I'm Judy Riggs. I'm a health policy person with the Alzheimer's Association. Wendell, to follow up on the Pago issue and thinking now about the longer-term issues that we discussed earlier today; it seems like if we're ever going to address these broader health care issues of cost and coverage, we're going to have to do something about the budget rules. And the way the budget rules work in terms how you cost

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changes in one program, and considering the impact of those changes on other programs and tax expenditures. Or looking beyond the immediate cost to long-term savings, are there any ways that Democrats can start thinking about that? Can you really do health care reform – major changes in health care and in the entitlement programs without doing something about the budget rules?

ED HOWARD, J.D.: Could I just add a little footnote to that question? You might just explain what Pago is and what the Democrats are planning to propose as changes to the current rules.

WENDELL PRIMUS, PH.D.: Pago rules basically mean that anytime you want to spend more, you have to offset it by spending cuts or revenue increases. Or any time you want to grant a tax cut, that has to be paid for either by spending reductions or tax increases so that you don't increase the deficit. That is something that we have been about for the last six years and we think it affects economic growth, and a lot of other things and why we need to restore fiscal discipline. Yes, it does make it tougher, but there are things in health care – the commonwealth issued a report a couple days ago that suggested that managed care providers were getting a 12-percent additional subsidy rather than the fee for service world. We think there is no reason that playing field should

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be so unlevel. There are some offsets that can be gone about. I think the idea of an entitlement commission on Medicare is premature. There are lots of ideas out there, including HIT, including better chronic care management, maybe cost effectiveness. But you are right. The savings from those are going to be very difficult, and it's not clear.

I'll give you one factoid, and that is 23-percent of the Medicare beneficiaries have five or more chronic conditions. They see 13 doctors on average and they consume about 68-percent of the Medicare dollar. Can we both improve the quality of care as well as slow down cost if those doctors talked to one another, coordinated the care, et cetera? The answer is that we don't really know. That's why there is not a set of well-developed policy choices that we can turn to, to slow down Medicare's growth rate. Medicare's growth rate is less than what's been happening in the private sector. It will make life difficult, but life has to be made more difficult because we can't keep increasing the deficit as we have done.

CHRIS LEE: I'm Chris Lee with *The Washington Post*. Everyone sort of alluded to, in one way or another, the problem of the uninsured. I guess it's something like 46 million people and it's going up now and the number of children who are uninsured are going up. I was going to ask if you could talk about what specifically the Congress might look at to address

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that and, Miss Goon, how that might square with the principles you laid out before about expanding health insurance coverage.

ELIZABETH HALL: I'll start the answer and others can jump in. I'd say one thing about the number of 46 million uninsured. Yes, it's a census number that we get every year. That's uninsured at one point during the year. The reasons that they are uninsured, if you start to delve into the numbers and we should probably pose the question to Dallas because he's done a lot of that, are very, very diverse. Some of it has to do with does the employer offer. Some of it has to do with the premiums by which an employer offers. Some of it has to do with just personal choice and not wanting to – for a lot of young people – not wanting to spend money on health coverage. So trying to address the uninsured from my perspective, from the Republican perspective is very much multi-faceted. There is no one answer to that question. I think that a number of the proposals that we have tried to present are lower cost options, are additional choices, and really if you look at some of the things that we proposed particularly on the tax side are true incentives. Trying to create some parity between those who have access to employer sponsored coverage and those who don't, who would purchase individually. That's just a few. There is a whole spectrum and I think Julie can talk about what the president has proposed. There is a whole spectrum of ways

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that you can deal with that. Ultimately though, from at least my boss' perspective, the only way that we truly start to address the problem is to look at cost. That is through transparency and through information, and as consumers taking responsibility for figuring out and working with your providers. In health care, it's very difficult. There are a lot of difficult choices we're talking about; in many circumstances, life-and-death choices, but taking some responsibility, taking some time to learn the options that are available. Again, we clearly need to provide much more information to really make that possible and provide that information in a way that individuals can really understand process and use it.

JULIE GOON: Just to follow up on Liz, very quickly. Dallas, I'm sorry. I haven't seen the results of the survey work that you did. In the conversations that are in the speeches that I've heard the people that I work with give, in part on consumer directed health plans and HSAs, one of the things that we do feel very strongly is that employers should be contributing to the funds of folks who are moving into consumer directed health plans. If consumer-directed health plans are going to cost employers less, a smart employer is going to take at least a significant chunk of that savings, apply it to the HSA impart as an incentive for employees to

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look at this as a particular option. It's not necessarily about shifting risk onto the employee. It is about shifting responsibility for thinking about things. If you have a plumbing problem that is a minor plumbing problem, you do have a chance to search around for somebody that might provide the best and most cost effective plumbing system. If you have a flood in your basement, you're probably going to call the first person who actually picks up the phone and says they can get to your house in 20 minutes. It's not necessarily different in other sectors of the economy as well.

To the parity issue, I think it's important that we ask ourselves why people who are purchasing insurance coverage outside the employment system don't have the same tax advantage that people who purchase it inside the employer system do. With respect to the concern that people in consumer directed health plans and HSAs tend to be healthier than others, if that is getting uninsured people into the insurance risk pool, that is not a bad thing. If what happens as a result of consumer directed health plans is that insurance companies who have this as part of their product, their range of products are actually getting people who have by choice, chosen not to purchase insurance because they are healthy, they are young and they don't think they need it. I think at the end of the day that helps throughout the system as we're looking at the uninsured,

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because it's important to get those people insured as well. With respect to government run programs, I think that we'll probably all have a lot to talk about with SCHIP reauthorization coming up in particular.

I also think it's important to ask the question about whether having all kids covered, including higher-income children, is a more important policy priority than actually looking at more of the lower-income adults who are currently uninsured. If you move to a system that covers all kids, what crowd-out factor does that have in coverage that children currently have through the employment system and with their families?

WENDELL PRIMUS, PH.D.: I'll re-emphasize that I think this will be a healthy debate within the Democratic caucus, but my sense of where the Democratic caucus is that where we want to use the SCHIP reauthorization to take a large step forward in reducing the number of uninsured, basically the number of uninsured children. It's not to say that there won't be other proposals, but my sense again, of where the Democrats and my boss is at, is that we can use SCHIP and also your polling results add fuel to that, if you will or confirm that might be the right choice. That's where I expect to go. I just heard this administration argument; maybe we shouldn't cover higher-income kids. The truth is that one of the uninsured numbers

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here is that there are a lot of children that are eligible for SCHIP and Medicaid that currently aren't enrolled. We need to do something about that as well. I look forward to a proposal from the Administration that truly reduces the number of uninsured. It's gone up by six million over the last six years and if they really want to put more emphasis on lower income other adults, we'd like to work with that and see that proposal. I don't think that's an argument against not doing a very good job in SCHIP.

The last thing I'll say is that there has been a lot of talk about consumer-driven health care and that if we just make the consumer more knowledgeable, all knowing, somehow the health care system will come into balance, etc. I think that is just completely false. Yes, we ought to have informed consumers, but the key decision making in our health care deliveries system is the doctor. Once you've been diagnosed with cancer, diabetes or heart problems, you're on a course of care where you're going to be spending a lot more money than any other consumer. Cost constraint is not the primary factor. It's the quality of care that Americans want. I will bet that the cardiac surgeons in this town know what hospital is the best in terms of infection, et cetera. American consumers are going to put a lot of trust in their physician to get the best care, so I think if we want to do something about both the

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quality of care and expenditures, we have to give the doctors – align the incentives right. We also have to figure out whether the new device, the new drug or the new procedure is better than the old. Not mandating it, necessarily, but finding out whether the new drug is better than the existing drug. That means that we have to develop more evidence so that the doctor, the key decision-maker can make better decisions on behalf of the consumer.

ELIZABETH HALL: I think we would definitely agree with strengthening the role in the relationship between the doctor and the patient.

JULIE GOON: I would also just put in a plug. There is a great Frist-Bingaman bill that was built on an Administration proposal to make sure that those kids who are not enrolled get enrolled. We'd love to see that enacted next year.

DIANE ROWLAND, SC.D.: We clearly saw this morning that the public expects action on coverage, action on cost and health care and gave the priority if you had to make some choices at covering kids. We know that this has been a long morning but we hope it has been an insightful morning in term of both the public expectations and the difficult that Congress is going to face as it tries to meet those public expectations, especially around a more active government role.

We have come to the end of our program and we have

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lunch outside for those of you who can pick up the box lunch. Others watching on TV are not here to do so. I want to thank Ed and the panel for being here today with us, and also for our morning panel for setting us off on this course. Thank you.

[APPLAUSE]

[END RECORDING]