Programme OPERA – ENTRETIENS

Entretien – santé n°36

Pour citer cet entretien : Beaussier, Anne-Laure, Entretien santé n°36, Programme OPERA (*Operationalizing Programmatic Elite Research in America*), dirigé par W. Genieys (ANR-08-BLAN-0032) (*insérer hyperlien*).

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Interviewer: Oh, sorry. You were telling me that you are a lawyer.

Responder: I'm a lawyer and we-- you know, we have many types of professionals on our staff. We have doctors. We have masters of public health.

Okay.

We have masters in business administration. So, and-- but we all use this different expertise to advise the Members of Congress that we work for on health policy.

Okay. So, you mean your activity is more writing bills and not that much about policy (inaudible) analysis?

Well, in the process of writing bills, we do policy analysis. So, for example, you know, the health reform legislation that we are now writing, part of that is analyzing the problems that we face and looking at alternative solutions.

Okay.

Advising the Members on which solutions make the most sense--

Okay.

--and then writing those solutions into a statute, into a bill, that if the Congress enacts it and if the President signs it into law, that becomes a statute.

Okay.

So, it's a combination of policy analysis and advice and legislative drafting, actually converting the policy into a statute-- into a bill and then helping the Members enact the legislation.

Okay. How do you-- can you make the choice between solutions-- between the different solutions and these different options and choosing which one makes the most sense?

Well, so we are a partisan staff. We are all Democrats. There is a minority staff of Republicans and they work, you know, of course, they work for the Republican Members. We work for the Democratic Members and the Democratic members have different policy ideas than the Republican members.

Yes, sure.

So, we start with those policy ideas.

Okay.

So, for example, the Democratic members generally would like to see all people in this country have health insurance coverage. That is not the view of the Republican Members, okay?

Sure.

So, when we analyze a problem like there are 47 million people in the country who don't have health insurance coverage, we bring a different set of values to that policy analysis than, say, the Republican staff would. And our solutions will also be-- tend to be different.

Now-- so, one thing that informs what we do, what we at the staff level do, is where do our Members-- where do our Members think that policy should go.

Yes, because even in the Democratic Party, there is-- there are a lot of different views.

Yes, that was going to be-- that's exactly right. That was going to be my next point. There are differences.
And so, we call that the caucus, the Democratic caucus -- c-a-u-c-u-s -- and we have to try to resolve the differences within the Democratic caucus.

Okay.

And there are many of them. There are some members who would really like to see health reform legislation that does-- that has what we call the single payer--

Okay.

That there would be one-- there would be no more private health insurance. There would just be on public insurer. Everybody would have coverage through that public insurer and that would purchase the services.

Okay. That's the very liberal trend.

Yeah, so we have Members like that. And then we have Members who very strongly disagree with that, who would never, ever support--

Okay.

And they would be more conservative.

Okay.

And then there are Members in between.

The caucus-- the leadership is-- is the leadership between or trying to--?

Yeah, the leadership's job is to work out a consensus within the caucus.

Okay.

And it's less important-- what they think the right answer is. Their job is to make sure that we have most of the Democratic caucus agreeing on the legislation.

Okay.

Because in this case, a Democratic President has asked the Democratic Congress for this legislation.

Yes. So--

So, our job is to draft and enact such legislation.

Okay.

And, you know, the job of the Republicans in the House is to oppose us.

All the time?

Across the board.

Even if it's not in their interest to?

Their interest is to oppose us.

Okay.

And if you go to their-- you know, to their websites, you'll see in the House lots of information about why-- what the Democrats are doing is bad for America.

Okay.

No, of course, we haven't done anything yet, so it seems a little early, but--

Yes. You are working on it.

We are working on it and we will come out with something in the next month or so.

Okay.

And then the process of holding hearings on the legislation and having consideration of the legislation in subcommittee and full committee, that process will begin. And then eventually, the entire House will take up the bill.

Okay.

And a similar process is going on in the Senate.

Okay.

The Senate is a different body, though. You know, we have a bicameral legislature.

Yes.

And the Senate is quite different.

More--

Different procedures, but for the purposes of this discussion, the Republicans over there are part of the-- are part of the discussion. They're not saying no to everything. In the House, the Republicans are saying no to everything.

Okay.

So, and even-- so, even within the Republicans, there are differences in points of view.

Yes, okay. What kind? I am more aware of differences in the Democratic caucus, like the Blue Dogs, the Progressives.

Good, yes, yes.

That's, I think--

So, there's a classic example. That's what the leadership has to mediate. They have to be sure that most of the Progressives, most of the Blue Dogs, most of the New Democrats, most of the Black Caucus, most of the Hispanic Caucus, most of the caucuses are happy with and are willing to support the legislation.

Okay. Is there this kind of difference, also, in the Republican side?

You know, I don't know that there are that many caucuses over there. I just don't know.

Okay.

You'll have to talk to somebody over there.

Sure. I'm sorry.

You know, it's hard for us to see a difference.

Okay.

Because they-- they have a pretty consistent message, which is we're trying to enact socialized medicine and we're trying to get government between you and your doctor--

Yes.

So, I can't imagine they all think the same thing, but I-- it's hard for me to see where the differences are.

Okay. Is there such a difference between the Democrats in the Democratic Party inside this committee? Do you have members that are very different?

Oh, yeah. Yeah, yeah, yeah. If you look at the membership of this committee, and you line it up with the Blue Dogs and the Progressive Caucus and the Hispanic Caucus, you'll see we have 36 Democrats and we have lots of members from the Blue Dogs and the New Democrats.

Okay.

And the Progressives. More from the Blue Dogs and the New Democrats, although there's some overlap. But it's-- the committee's Democrats are pretty representative of the Democratic caucus in the whole House, the 283, I think, last time I counted, Democrats.

Okay.

So, it's pretty representative and whatever we can work out in this committee, my guess is that would be legislation that could pass the entire House.

Okay. Okay, because your committee is not liberal or conservative, like others maybe.

Well, we need 218 votes to pass the legislation in the House, out of the 435 members.

And in the House committee, is it the same? Are the people divided on the same proportion, the Members?

Um-hmm (affirmative).

Okay.

So, we know we will lose all the Republicans or almost all of the Republicans. So, we have to get at least 218 Democrats to vote for the legislation.

Sure. You won't have any-- okay, it's like really two different separate coalition parties. I have read some books about the new polarization--

It's more like-- the House is more like a parliament. It's more like--

Okay.

It's more like I understand your system to work. You know, the party makes a decision and that's it.

Okay.

Whoever's in power makes a decision and that's what happens. In the House, that's pretty much what goes on.

Okay.

In the Senate, there again, it's different. To make most decisions they need super majorities, not a regular majority.

Okay.

They need 60 votes out of 100.

So, they are more conservative?

Well, and the Democrats don't have 60 votes.

Yes, 59?

Right. So, they always need to negotiate--

Okay.

--with the Republicans. Here we don't need to do that.

Okay.

So, that's the long answer on what sort of political considerations we, at the staff level, have to work with.

Okay.

Another issue we have to worry about is cost to the federal government.

Okay.

Have you heard about the Congressional Budget Office?

Yes, of course. I haven't met anybody there, but I have heard that you made cost estimation of (inaudible) and that you-- there is a measure that impedes you to worsen the deficit, or something like-- the PAYGO process.

Yes, exactly. So, unfortunately, I had to move my office yesterday and so all my materials are not where they should be, but if I could show you this, it would make a lot of sense.
So, the rules we're operating under here for this health reform is in something called the budget resolution.

Yes.

Have you run into that? Okay, all right. So, in the budget resolution, which I think might be S.Con.Res13. I think it's S.Con.Res13.

Oh, can you repeat, please? I don't have this number.

Yeah, see, I want to-- I'll write this down for you.

Okay, thank you.

So, when you find this thing-- it's not hard to find if you know what you're looking for. No, you keep that--

Okay.

So, this is-- this is PAYGO -- you've heard that phrase, right?

Um-hmm (affirmative), yes.

PAYGO -- so, that means whatever we do can't increase the deficit. Right? All right. So, and the reason we have something called the budget resolution and that is-- I think it's S.Con.Res.13, I think. But it's the budget resolution for fiscal year 2010.

Okay.

All right. Which, for us, that starts October 1st of 2009.

Okay.

All right? And it ends September 30th, 2010.

2010, okay.

So, this is the budget resolution that covers this period and we are in this decision-making period now, okay, this calendar year.

So, in the budget resolution is a reserve fund.

Okay.

Something called the reserve fund for health reform and you'll see it as just a paragraph, all right? And in there, it says you can do health reform, but it must be budget neutral. It can't increase the deficit, okay? May not increase deficit.

Okay.

Okay? The other thing that's in there is what are called reconciliation instructions and we don't have time to go through all of this, but here's the bottom line. This says that instead of 60 votes in the Senate you only need 51.

Is the fast-track process, then?

Right. So-- and basically, I think it's October 1st, if no health reform by October 1st, then in the Senate you would only need 51.

51 votes.

Now, if there are 59 Democrats then you do not have to negotiate with the Republicans, right?

I see.

So, the Republicans, of course, were very upset about this.

It's a matter of, if you want to compromise, you will not need to be--

Exactly. That's exactly right. So, that's what will play out.

Okay.

Over the next couple of months. And we don't know whether these will be necessary, whether it will be necessary to do this. Perhaps there will be an agreement with the Senate Republicans that we would agree to.

Okay.

We're a little early to know that yet. We'll know that in a couple months and so that's-- that's sort of the overall ground rule and then what you need to look at if you're going to follow this issue, in particular, is the Congressional Budget Office has done in December up on their website, which is cbo.gov, they did options for health reform.

Okay.

In December-- it's a--

Okay.

Maybe it's considered-- anyway, it's right up on the main page. You'll see a link to it and it's a large--

Oh, my cookie. I just dropped--

So, you'll see a large-- you know, it's a book about this thick.

Okay.

And it sort of explains, from their point of view, what, generally, it's going to cost to do this and generally where we could find offsetting savings to reduce the costs so that we would not increase the deficit.

Okay.

Because we know spending is going to go up, right? But if we can also get some offsetting savings, then the deficit, you know, the difference between spending and revenues, the deficit wouldn't increase.

Okay.

But over-- over 10 years.

This is your framework?

That's the framework, 10-year framework. Okay? It has to be budget neutral and, technically also, over five years. It wouldn't have to happen in each individual year, but over the 10-year period for sure and over five years. So, this is pretty heroic, 10 years. I mean, honestly, who knows what's going to happen-- what the world's going to look like in 10 years. But they have to--

Especially in health.

Right, exactly. So, they-- but that's their job and so we're going to get 10-year estimates. But what'll have to happen is, all the spending-- the spending must be offset by savings and by new revenues.

Yes, we have this same disposition in our constitution in France.

Right.
So, what this volume tells you is this the way the Congressional Budget Office will be looking at the legislation we develop.

Okay.

Okay? And they are really-- they're the referees. They're like the soccer referee. They can hold up the yellow cards. They can hold up the red cards. They can throw a bill out. Oh, yeah.

Oh, they have this power?

Well, because-- they have this power because it's their judgment, it's their professional judgment about what's in the piece of legislation and what effect it will have on spending or on revenues. That's what counts. even if we disagree with it.

Yes. There must be other numbers.

Right. There are other numbers. So, you know, you'll see in this options book, for example, a lot of people feel that if we-- if we spent more money on primary care, if we paid primary care physicians better and if we had more primary care physicians, that over time that would save money.

Yes.

They don't agree. So, we're going to spend more money on primary care in our bill because we think it's the right thing to do, but it's going to cost us money, right? So, we will have to find offsetting savings or offsetting revenues.
And, of course, well, you're a student of politics, so you understand every time you have to reduce government spending, somebody is unhappy, that somebody being who is getting the spending now. And every time you have to raise revenues, somebody is unhappy.

Is unhappy too.

That somebody whose taxes are being raised. So, it very much complicates the enactment of legislation and the finding of a consensus, because maybe we could all agree on how to reform the health system, but now we also have to agree on how to pay for all that.

Yeah. Yes, I was reading about something like that, about, like, suppressing the Bush tax cuts on higher incomes or taxing products. So, you have taxed, for SCHIP, cigarettes.

Exactly. Exactly. So, that's a good example. When the House-- you know, there's a long history on that particular-- on the CHIP legislation. And the first time it went through the House, this was before it was vetoed in the summer of 2007, before it was vetoed twice, the first time it went through the House, it was paid for by savings from Medicare Advantage plans, Medicare HMOs.

Okay.

Insurers, private insurers in Medicare who were being overpaid. The Medicare program was overpaying them by about $170 billion over 10 years.

Okay.

That's a lot of money. We're just paying-- and everybody knows it. And so this was an obvious place to go for the money to pay for CHIP.

Sure.

CHIP was going to cost-- I can't remember the exact numbers, but something in the range of $60 billion and, again, the Congressional Budget Office, you know, they had an estimate. So, and it had to be budget neutral. So, that's exactly the way this health reform is going to work, too. They're going to have an estimate and they have to show over 10 years it won't increase the deficit.

So, they said-- and the numbers aren't quite right. They said, okay, over five years CHIP will cost $60 billion or whatever and over five years we can reduce excess payments to Medicare insurers and we can save $60 billion. So, over five years there won't be any increase in the deficit.

When it got to the Senate, the Senate said we can't do that. We want to keep overpaying the insurers. So, we said, okay, how else do we offset the $60 billion. And, again, these numbers aren't the right ones, you understand, but-- and so we eventually got to a tobacco tax. In the Senate, we could find the votes to increase.
So, how much would we have to raise the tobacco tax to get the $60 billion? And it turned out to be $0.62 a pack. Maybe then it was $0.61 a pack.

So, that's what we ended up doing. But that was a whole separate set of negotiations just for the pay for. Nobody was disagreeing about how much money to spend on CHIP, or how much--

Okay, it's a specific issue. It's totally different.

And it makes things very complicated. For example, again, there are different points of view in the Democratic caucus. The members from states that produce tobacco did not want to see an increase in taxes on cigarettes.

Okay.

So, it made it more complicated for us.

Yes and the insurers.

And, similarly, there were some members who were from states where the insurers that are making all the money off of Medicare are located or where they do a lot of business, and so they didn't really want to see us go after the insurers. So, there's never a policy that satisfies everybody. You just need to find a majority.

Okay. And what is the best options--

And our job is, we have to work with the Congressional Budget Office and come up with something that works.

Okay.

Where the spending and the offsets are, over 10 years, equal so that there is no increase in the deficit. And then, we have to do that in a way that we think is going to be acceptable from a political standpoint for our members and that is good policy for the country.

Okay.

And-- well, you can see how-- you know from the SCHIP experience how difficult that was. That was an example where you actually had conservative Republicans in the Senate trying to persuade conservative Republicans in the House to override a veto by a conservative Republican president. And so, the Democratic strategy, then, was, well, let's make concessions to the conservative Republicans in the Senate so that they will be supporting the legislation and then they will go to the conservative Republicans in the House and try to get them to overturn the president's veto, because the conservative Republicans in the Senate had tried to talk the president down and he refused to accept the legislation, for all sorts of reasons, including there was a tobacco tax increase.

Okay and he's--

But even if we had done the other, even if we had gone after the insurers under Medicare, he opposed that, too. He didn't want the bill.

Yes, I know.

So, you can see how the institutional dynamics can really be affected by the different cultures. You know, the House is a parliament. The Senate is more of a bipartisan.

Okay.

It only matters in the House when the president vetoes legislation and we have to get a super majority.

Okay.

Then we need a couple of Republican votes over here. But now, of course, we have a Democratic president and, hopefully, we're smart enough not to send him any legislation he's going to veto. That would really be a waste of time, right? I mean, we'd embarrass all of us.

And he's-- the White House is working on a draft, too.

Yes, right, right.

So, you must work very closely with the people that--

Yes, right. So, but in terms of your thinking of the differences between the two countries, the CHIP example is a very good example of how our system is set up in a way that can prevent something from happening that most people want.

Oh, yes. That's--

I mean, that's what happened there. Because this was not a lot of money. It was just health insurance for low-income kids who did not otherwise have health insurance and-- now, low-income children don't vote.

Sure. There are lots--

That's considered, but this was not a controversial bill. You know, most members in the Senate could support it, Republican or Democrat. Most members in the House -- 65% of the members in the House could support it, but not 66%.

And so our system is set up in a way that if a president really digs in his heels and in either House, either the Senate or the House, he can find enough members of his party to stand with him to oppose-- to oppose overriding the veto, that's it.

So, it's really-- it's a system that's designed so that if a small, organized minority wants to stop something that's really popular, they can do it.

Okay.

And then-- and CHIP is a classic example of that. Now, you're not going to have that situation with health reform.

No?

Obama, obviously it's one of his top priorities.

Yes.

He wants a piece of legislation and so it'll be a different-- different dynamic.

Yes, but there can be-- there may be internal gridlocks.

Yes. But you still have-- you have to solve the problem in the Senate of the 60 votes and that's why this was important. There was no reconciliation option with CHIP. There wasn't an option to go from 60 votes to 50.

Okay.

We had to get 60 and we didn't have a problem in the Senate. We had the 60, because, again, some conservative Republican senators supported it and they thought they could actually persuade their House counterparts to say yes. But, as I explained, they say no.

And now there are less of them than there were then. In my view, partly because they looked terrible opposing this legislation, but who knows? And they-- so there are less of them now and now the ones that remain are even more adamant that we not enact any health reform legislation. But there are fewer of them.

So, in the House, because the president is not going to veto anything, we don't have to worry about them.

Okay.

You see? We just have to get a majority within our own caucus.

Yes, that's the--

The Senate is still-- Right now we're working on the assumption we need 60 votes in the Senate, so we need a couple of Republicans. And we'll see what happens. We'll see what comes out of that. That's what will play out in the next couple of months.

Okay. Are you working here on this current date very closely with Senate committee?

No.

No. Like, Senate Finance.

That's the right committee and then the Senate Health Committee.

Yes,

So, they have their own discussions. Here we have three committees and we spend all or time in meetings, except for lunch, when we do interviews.

Okay.

Right. So, there's no time. Once we get a bill out of the House, then we can sit down and talk with the Senate. They have to figure out how they can get a bill to us.

Okay.

We have to figure out how we can get a bill to them.

Okay.

And then, once that's happened, we'll figure out whether there's a compromise that can go back through the House after the Senate and get to the president's desk.

And are you working with the Ways and Means Committee and--

Education and Labor.

Yes. Are you working closely?

Yes.

Because you are a very senior staffer and there are also other senior staffers, I think.

Yes.

I guess it must be very important to have like very experienced-- people who have a lot of background in House. I read some of your biography. You have a big background in Medicaid policy, so what is--

Well, Medicaid is going to be a piece of health reform. You know, we have 60 million Americans, roughly, covered by the program and the program has its problems. But, again, we're not-- we're generally taking an incremental approach. We have things that work -- not as well as we'd like -- but they work.

Okay.

Medicare, Medicaid, employer-sponsored insurance. But there's a large group of people that are not in any of those. So, we need to have an answer for that large group of people, 47 million, who have nothing. And we need to do that in a way that doesn't disrupt Medicaid, doesn't disrupt Medicare, doesn't disrupt the employer group insurance coverage now.

The people who are well insured.

Yeah. But over time, we have to make some changes to the system overall, because, as you know, it costs too much money.

Yes, sure.

We're not getting good value. So, at the same time as we're bringing coverage to the 47 million who don't have it, we have to make some changes overall. For example, we need more primary care physicians. We need to pay them better. So, it's, obviously, a very complicated--

Yes. You have to put all this--

Together.

--together.

And we have to do in a way that doesn't increase the deficit and that gets a majority of the House Democrats.

Okay.

A large majority of the House Democrats--

Okay.

--virtually all of the Senate Democrats and a couple of the Republicans to agree.

Okay. So, that means you--

On both the spending and the offsets.

Okay.

So, for example, the Medicare insurer piece that was really unpopular in the Senate, that will be part of ours. It's too much money. We can't keep paying these plans more than they need to provide the services we're asking of them.

Is that primarily the drug benefits?

No, this is-- yeah, this is not the drug benefit.

Overall.

This is the managed care plans, the insurers, where people enroll instead of going into Medicare Part A and B on fee-for-service, they go to Part C. It's the Part C plans. And, actually, somebody at George Washington yesterday, Brian Biles, B-i-l-e-s, Dr. Brian Biles, some of his colleagues just published a report on how much we are overpaying these plans. It was published by the Commonwealth-- I just saw a little note on it, the Commonwealth Fund.

So, that will give you an example of just one year how much-- so, we have to go and get that money and apply it to paying for care for people who don't have it now.

Sure.

Well, you say sure, but, you know, we'll see what the Senate has to say. But you can see the problem.

So, we know last-- just two years ago, the Senate said forget it.

Okay.

Well, we can't have that answer this time, because it's too much money. We need a lot of those offsets or we will not be able to cover all the people that the Members want to cover.

Okay.

So, we'll be having this conversation sometime this summer or fall with the Senate, because I assume that, you know, they haven't changed their position. We'll see. They have the same problem. You know, they have to pay for what they do. Where are they going to find it?

You mean offsets.

Right. So, that's why it makes it very complicated. And a lot of this is-- right now, this is not transparent, because it's just going on within-- among the staffs and the Members on the Democratic side. But soon, once a bill is introduced, everybody will see it and when we actually consider the legislation, that will all be public. People can see it on the Internet. Everybody's vote-- you'll have the legislation. You'll see what amendments are being offered to modify the legislation. There will be votes.

So, for example, we will probably have something in there about our insurers, our health insurers' overpayments. Somebody may come along and offer an amendment to say take that out.

Okay.

There will be a vote on that?

Depending on the rule? Oh, you mean, in the committee.

In the committee. The Republicans will have an opportunity to offer an amendment to say we are standing with you, the health insurers. We want you to continue to have overpayments.

I see.

They won't exactly say it that way, right? And then our Members will have to vote to say, yes.

Okay.

And then, then in the elections, you know, the Republicans will go after some of our Members saying, they wanted to take away your Medicare Part C benefits.

Okay, yeah. It's going public.

Right. So it'll be all public and everybody will have to vote and take a stand on each issue. And there are many, many of them.

Is it possible to assist in the-- to go this meeting or is it private?

They're public.

Okay.

Oh, yeah, they're--

It would be very interesting to--

Of course, there will be millions of lobbyists who will also want to get in, so it will be very hard to get in, because there's just not enough space. And all the lobbyists for all the interests that will be affected by this--

Okay.

They will all be standing in line, also, to want to get in. But you'll be able to watch it on TV.

Okay, if I get up early? If I'm here very early?

Well, you know, what they do is they hire people to stand in line for them?

Really?

Right.

Okay.

So, if you get here very early you'll find a long line of people being paid to stand in line. I mean, you're welcome to do it, it's just bring a sleeping bag. You know? I'm serious.

Okay. I will try.

So that-- and that's all public and when we have those markups. And, of course, the other committees will be doing the same thing.

Okay.

The two other committees will also be having markups. My guess is, right now, that will happen right after our 4th of July recess.

Okay.

Before that, sometime before that, maybe two weeks before then, we will be having hearings. You would be more likely to get into the hearings. That's where the different groups will testify what they like about the bill, what they do not like about the bill. There will be many people testifying. It will go on and on and on.

And so, usually in the afternoon it's easier to get in, but it can be very boring.

Okay. Okay.

But for you it might be interesting.

Yes, definitely.

So, there will be hearings and then markup and the markup is when amendments are offered and voted.

I think will be back to France in July, so maybe I won't--

Yeah, I doubt we are going to mark up before-- before early July.

Before not--

I don't think so. I don't think so. But if you just wanted to see a markup on any bill, you know, there will be markups on other bills and you could go to any one of the committees, whether it's Ways and Means or Education and Labor, and just--

Okay.

--sit through one of those and see what happens.

Sure, okay.

As a process. And then, I don't know what the timing is on the Senate side. It's possible on the Senate side there will be-- they will mark up earlier. It's possible, either in Health or in Finance. I don't know if they plan to mark up in June.

But you'll have the same problem there. There's not enough physical space and the lobbyists-- and there'll be very long lines.

So, I think your best bet would be to watch them on TV.

Oh, yes.

C-SPAN will definitely be covering that, definitely.

Okay, I will. I'm not sure if you have a meeting now--

I have about five more minutes.

I just wanted to ask you a question about yourself and your expertise and because I have seen that you were in Medicare Policy--

That was a consulting firm. Right, that was just a small consulting firm.

You had like options that you personally-- ideas that you personally want to be enacted, or you're trained to support solutions on Medicare-- Medicaid, sorry.

I'm not a single-payer person or a market competition. I'm not an ideologue like that. I would just like to see everybody have health insurance coverage and that buys, in a sensible way, so it's smart coverage.

Okay.

It doesn't overpay health insurance plans, you know? It's smarter than that, but it's fair to the plans and to the providers.

Okay.

So, for example, I don't think we're paying primary care physicians enough. I think they are way, way underpaid.

Yes.

So-- and so-- you know, you could sort of go down a list of issues like that where I have views, but not on sort of the broad ideological-- I think people ought to be treated with due process. So maybe the closest ideology I have is that. And what that means in this country is

if you are denied eligibility for a benefit or, say, you are denied eligibility for Medicaid, that you have an opportunity to challenge the decision to make sure that it's not incorrect. Okay?

Okay.

Unidentified Participant:Hi. Can I speak--

No, I was going to go in and out, but I need to speak with you for just a second.

Okay, what I think-- it's possible that--

Unidentified Participant:You can stay right there and you can come with me.

All right, because we're almost done.

(Off mic conversation).

Do you need--?

No, it's okay. She's going off to (inaudible).

Okay. I just don't want--

Okay, well, actually, since the other table is open, why don't we--

Okay.

Right here.

Yes.

So, we were-- (inaudible).

And then-- so, we were talking about due process, right?

Yes.

And are you on?

Yeah, I'm on.

Okay. So, we were talking about due process and somebody, say, applies for Medicaid or Medicare, is told no, you're not eligible--

Unidentified Participant:(Inaudible).

Yep. Hold on. Yep.

Unidentified Participant:Sorry. Sorry for this.

That's okay.

(Off mic conversation).

So, due process. So, you know, my personal conviction and this comes from my legal training and just when I grew up, if somebody is told, well, you're not eligible, then they should have an opportunity to go to someone else, not the person who said you're not eligible, right, someone else impartial and say a mistake was made here, I am.

And then if a mistake was made, then the impartial person can say so and tell the initial decision maker to change his or her position.

Like mediation.

Yeah, a mediation, sure. It could be that. Technically, it's not quite the same. This is just an opportunity to appeal a decision and have what I would call a fair hearing so that you have an opportunity to make your case to someone else.

Okay.

To make sure that it's right. And the same would apply to, say, a health insurer denies you coverage for a particular benefit. And you read the rules or-- you know, and the rules say, the physician has to say it's got to be necessary and it has to have this or that characteristic and you think you've met all the rules and the insurer says, no, we're not paying.

So, now the issue is, what happens, right? And due process would say, well, you have-- you can go some place independent, some place impartial and question the decision.

And if the impartial person agrees with you, then the decision is changed. If the impartial person doesn't agree with you, then it stands and you lose, but at least it's not just one person saying, this is the way it is and I don't care if I'm wrong.

Okay.

And it's different than asking the person who initially said no, say, would you please reconsider and then the person says, I reconsidered and the answer is no, right? So, that's a very crude, a very oversimplified explanation of a due process approach.

Process.

D-u-e p-r-o-c-e-s-s.

Okay.

Very inefficient. You have to pay somebody to be the impartial person.

Now it is familiar

It takes time and then for the people who are trying to manage--

Okay.

--it creates uncertainty, right?

For the agency or the insurer--

Yeah, because the agency, that's right, because now they're not so sure their decisions will be upheld.

Sure.

So, that-- anyway, that's my personal view on it.

And do you have an opportunity here to make-- to push this option or maybe to--

Well, I have an opportunity because the person I work for, Mr. Waxman, he agrees with me on this.

So, he wanted to work with you on this particular issue.

Yes. He would be concerned that people have an opportunity to challenge incorrect or arbitrary decisions.

Okay. If there are just other people who are your allies who help you pushing, like--

Well, of course, I-- he is the chairman of this committee.

Um-hmm (affirmative), yes.

So, I work for him. If he's unhappy with me, I'm gone.

Yes, but I mean, is there also representatives--

Other representatives on the committee who share this?

Yeah.

I think most of the Democrats-- on this issue, I think most of the Democrats on the committee would be sympathetic.

Okay. Okay.

Okay? You know, and, of course, on the Medicaid-- I mean, I spent a lot of my career on Medicaid, so I know what the good parts of the program are and what the bad parts of the program are. And I think the Members are generally supportive, but they would-- you know, we could have disagreements on particular issues within the program. And they're too

complicated to get into, but it at the level of health reform you're not going to see any of the Democrats saying let's end the Medicaid program.

When this budget resolution-- when this was going through in the last couple of months, the Republican alternative was, essentially, to end the Medicaid program.

To end it? I thought it was just to turn it into a block grant, and not an entitlement.

Well, to turn it into a block grant and take a lot of money out of it, yes.

Okay. Like the (inaudible) program.

Yes, but with a lot less money.

Okay.

A lot less money than Medicaid has now. And, yes, that would end it. That would end the program.

Okay.

Because at that point, if the state doesn't have the money and you have no individual entitlement to a defined benefit--

On Medicaid--

Well, right now you do.

Yes.

If you're on Medicaid, you have a-- and that's part of due process. You know, you have-- there's a set of rules as to what people are entitled to. If you're low income and you have a medical need for a service that Medicaid covers, you should receive the service.

In a block grant--

Okay, it depends on the state.

There's no entitlement. There is no individual entitlement. The state can say, one, you're not eligible, or, two, we are not covering this service, or, three, even if we cover it, you're not getting it.

And I read somewhere that Newt Gingrich in 1994--

Yes, he did.

--tried to--

Yes, he did.

--but he wasn't successful.

Well, he got the bill to the president's desk and Mr. Clinton vetoed the bill and that was it.

Okay. And after this first try, they just tried to focus on Medicare and left behind Medicaid?

Yes. And the CHIP in 1997, the CHIP legislation, was sort of the end of that conversation, because the question at that time was, we have a lot of uninsured children, what can we do about this?

Okay.

And, of course, there were two proposals. One was to expand the Medicaid program to cover more uninsured children, which had some logic, because Medicaid was already covering over a quarter of the children in the country. It's the largest single insurer of children in this country. So, if you're going to try and reach the rest of the low-income uninsured children, maybe it would make sense to use that program, since it's already there.

But there was strong ideological opposition to that and that ideological opposition was to having an individual entitlement for children.

Okay.

So, the other option was a block grant, without an individual entitlement for the child. And that is what SCHIP is.

Okay. And there were like a compromise because SCHIP can be a part of Medicaid, but it doesn't work.

Yeah, that gets a little complicated. Yes, a state can take its SCHIP dollars and not set up a separate program, but take its Medicaid program, and take the children who are eligible for CHIP and enroll them in Medicaid.

Okay.

And, of course, the state gets paid more under CHIP than under Medicaid. But a state only gets paid more up to a certain amount, right?

Okay.

Because it's a block grant. So, that's the key and that was the ideological divide. The individual entitlement-- if you have an individual entitlement, you have to have the federal government saying we are in-- we will match these costs on an open-ended basis. We're not going to decide in advance we're only spending this amount of money. We're going to have what's called an open-ended entitlement.

And that's what in 1997 the Congress didn't want to do. Instead, they decided we'll spend so-and-so much money on lower-income children and we're going to do this in a way that we're just going to divide the money up among the states and then each state can decide whether it wants to spend the money or not and, if so, who's going to qualify and what the benefits will be. But no child in that state will have an individual entitlement to CHIP coverage, because the federal government is only going to match so-and-so much, right?

So, that is a totally different approach than Medicaid, which says, okay, children that are poor and near-poor, they have an individual entitlement to very broad benefits.

Okay.

And we will match the costs of those services, regardless of how many children come in and regardless of what the costs of those services are.

Okay.

So, that's different. You can see that's a totally different approach.

Yes.

And if a state denies a child entry into Medicaid or denies a covered service, then the child has a due process right to go to an impartial person and ask them to look at that decision.

Because isn't it an option to change SCHIP into an entitlement?

Yes, it is. It is an option.

Okay.

Not under current CHIP law. We could do it. Congress could do it. The president could sign it, and we would have to change CHIP law. But what just got enacted in February--

Yes, I see that.

That is just a block grant. That was the deal. We're going to extend the block grant for another five years. But we could always come back and in the context of health reform, we could revisit that.

Okay. And I just another question, what would have been the solution of Republicans who just wanted to end Medicaid, as you said.

That was just-- the block grant. The block grant.

What would be their next step?

What would be the next step if they had won the vote? Instead of-- this committee would have been instructed to report $600 billion in savings over the next 10 years in Medicaid and the

only way we could have done that was to go into the current law and change it from an individual entitlement to a block grant. That's the only way to get those savings.

But people-- it's pretty nice, but people need this benefit, so it's not just possible to stop it right now.

Well, we don't think so. They did, because they voted for it.

Okay.

I mean, I don't know what they're thinking, honestly, so you should go talk to them and ask them about it.

I will.

I mean, they wrote it-- you can go to their website and you'll see that was their plan and they explained their reasons. I--

I will try to--

I don't understand it, but, yeah, that would have been our first question. So, where are all these people going?

Yes.

Who's going to care for them?

Work?

Well, but again, most of these people are earning less than $22,000 a year for a family of four, which I know is hard for you to understand, but around here, you can't raise a family of four on $22,000. You can't do it.

So, I mean, people obviously do--

You can't have--

It's just extremely, extremely hard.

Okay.

And when you start taking that much money out of Medicaid, that's who you're going after and it's not just people with families, you know? It's people with disabilities and elderly who are not working any more, who can't work.

It's Medicare--

Well, some of them will have Medicare. Yeah, some will.

People too poor to have Medicare, they just get Medicaid?

Yeah, it's a little more complicated than that.

Okay.

So, it's always more complicated. But you get the general idea. If you take a look-- a lot of the questions you have will be answered by this health reform thing. It's a little dense, but it's worth you going through it. I mean, if you're ever going to get to this level of detail, you should read this.

Sure I will and I have a found book there.

And there are two options books. There's a detailed options book, which is probably too technical for you, which sort of goes into each of these programs and picks out little pieces and says, here's how much-- I'm not talking about this. I'm talking about sort of general issues. I think it's called "Issues in Health Reform." Maybe it's not options.

Okay.

If I have my-- are-- this all used to be organized, right here.

Okay.

Now I need to take it all out and look, but anyway you'll see.

Thank you.