PANEL DISCUSSION:

"MEDICAID: WHAT'S DRIVING COSTS AND WHAT TO DO ABOUT IT"

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TERRI SHAW: Hello everyone. While you are all taking your seats, I also want to remind you to please, as I just did, turn off your cell phones and pagers and other devices just so that we don't have any unnecessary disruptions to the program. All right, well we'll go ahead and get started.

First of all, I want to welcome you all to the Center for American Progress. I'm Terri Shaw. I am the director of health policy here at the Center. And for those of you who don't know, the Center for American Progress is a nonpartisan research and educational institute dedicated to promoting a strong, just, and free America that ensures opportunity for all and we believe Americans are bound together by a common commitment to these values and we aspire to ensure that our national policies reflect those values.

And one of the clearest expressions of our values as a nation is our federal budget, and this year Medicaid has emerged as one of the most contentious issues in the budget. After being rejected in the Senate, a five-year $10 billion cut was included in the final budget resolution and the administration has announced plans to appoint a commission to identify cost reducing policies for Medicaid. That commission has already run into some stumbling blocks with members of Congress and governors from both parties refusing to participate.

So the stakes in this debate are high, particularly for the 50 million low-income families, persons with disabilities, and seniors who rely on Medicaid for their basic health and long-term care coverage. So to help inform this debate, we have brought together a panel of experts to talk about different Medicaid cost drivers. Note that in your packets you will find three papers being released today that will be discussed and you can also find copies of those papers as well as the slides and a transcript of the event on our website which is www.americanprogress.org.

And so without further ado let me introduce our panelists. First of all, we have Judy Feder, who is Professor and Dean of the Georgetown Public Policy Institute. She is one of the nation's leaders in health policy. She is a former principal deputy assistant secretary at Health and Human Services and she currently co-directs Georgetown University's long-term care financing project. I'm also pleased to note that she serves as a member of the board of the American Progress Action Fund.

Sitting next to Judy is Andy Schneider, who has over 30 years of experience with the Medicaid program as a consultant, as a congressional staffer, and as a public interest and legal services lawyer. Andy currently is a principal with Medicaid Policy, LLC, which he founded in January, 2000.

Kathleen Gifford is a principal with Health Management Associates. She specializes in Medicaid and other government-financed healthcare programs. Prior to

joining HMA in January, 2002, she directed the state of Indiana's Medicaid program and chaired the Indiana prescription drug advisory committee.

And Joy Johnson Wilson is federal affairs counsel and director of health policy at the National Conference of State Legislatures, NCSL, which is an organization that represents the legislatures of all 50 states and as well as those of the commonwealths, territories, and the District of Columbia.

And Jeanne Lambrew, finally, is a senior fellow at the Center for American Progress. She is also an associate professor at George Washington University. Among her prior positions – and there are many – Jeanne served as the program associate director for health at the Office of Management and Budget. And I should note that there are full bios for all of our panelists in your packets so you can learn more about them.

So without further ado I'll turn the podium over to Judy.

JUDY FEDER: Good afternoon everybody. It's a pleasure to be with you. It is not often in discussions of Medicaid that we start the conversation with long-term care, though given the importance of Medicaid to people who need long-term care and the significance of long-term care in Medicaid, it is a good place to start and I'm happy to do so. I want to very briefly, because other people seem to need to talk – (laughter) – I want to give you some background on who needs long-term care, how it's paid for, and why Medicaid is so important. And then in terms of looking forward to the future and what we ought to be doing, I want to focus on the importance of an expanded public or more specifically expanded federal role in long-term care financing indicating why it's so important and how we might develop one.

So let me start with the facts. Oops, that was my – this is not the facts, but this is the title. Now, just a clear picture of who – always start with the people. We have an estimated 10 million people of all ages who need long-term care, you can see from the slide that most of these people are not in institutions. What you can't see, but I want you to know, is that almost four in 10 of the 10 million are under the age of 65. And I also want you to keep in mind that nationally about one in five people who need long-term care report significant unmet needs for care and indicate that with that unmet need they are more likely to experience significant consequences like falling, being unable to bathe or eat, or soiling themselves. So our system is not doing what it should.

Next, I want – oops. No, that's exactly right. I wanted to go to the financing, how Medicaid – how long-term care is financed. I want to call your attention here to the big orange piece and the blue one next to it on the pie in terms of the distribution of spending – the big Medicaid and out-of-pocket role – because it tells you that we don't finance long-term care the way we do other catastrophic, unpredictable events. We can see that a minority of our long-term care financing comes through what we think of as traditional insurance. Private health insurance or private insurance about – pays about 10 percent of long-term care bills. In fact, much of that is not even about long-term care insurance, it is about nursing home or home health benefits after an acute illness.

Medicare pays close to 20 percent, but Medicare, too, is not providing primarily long-term personal care. It is also very post acute-care oriented. Given the limit to insurance coverage, what we see is a very sizeable role for out-of-pocket spending – about 21 percent – and then we find that the bulk of the long-term care financing comes from the Medicaid program. About half the total and even bigger if we were looking only at nursing home spending.

Now, this picture reflects the absence of insurance – the heavy reliance on Medicaid, which is where I now want to turn – reflects our failure to rely on traditional insurance protection. As I said, Medicare and private health insurance and private long-term care insurance play very limited roles and as a result, Medicaid becomes the nation's safety net for long-term care. Medicaid is invaluable in terms of providing services to people who could not otherwise afford them, but unlike traditional insurance, which protects people against financial catastrophe, Medicaid provides that protection only after catastrophe strikes. In order to get Medicaid – become eligible for Medicaid benefits, people give up virtually all their income and the bulk of their assets down to $2,000. So Medicaid is invaluable, but it does not operate to protect people against catastrophe.

Very briefly, more information on how long-term care is important to Medicaid. You can see here that Medicaid – that long-term care amounts to about a third of Medicaid. In fact, if we think about Medicaid we have to remember that, as I think we will hear today, those kids are cheap. What's expensive in Medicaid is long-term care for older and younger, as you see; people with disabilities. And what's not shown here is also health insurance for people with disabilities, which get us up to roughly two thirds of Medicaid.

Now, I want – I talked about the importance of Medicaid because it's coming about because people can't afford long-term care and there isn't insurance against that catastrophe. That is not a common view of Medicaid today as in its role on long-term care, so I next want to challenge some myths about Medicaid's role. The first is that Medicaid's nursing home coverage is really an asset shelter for the wealthy, providing benefits to people who could otherwise afford to take care of their nursing home care. Remember, nursing home care costs with somewhere between fifty (thousand) and $60,000 a year. That is far beyond the resources of most individuals who need long-term care and I would call attention to a paper by a colleague of mine, Ellen O'Brien (sp) on our site – our website, which is cited, that goes into detail on this issue. But the argument that essentially people are transferring assets and we could – they could be taking care of themselves is based far more on anecdote than on evidence, so let me give you just a little bit of a snapshot of the evidence.

Most elderly are likely to have too limited income and assets to even warrant transfer, especially if they are disabled. People in poor health are more likely to conserve than exhaust assets, when you look at their experience prior to needing long-term care. Transfers among all the elderly that do occur are typically less than $2,000 and for those who are seeking Medicaid eligibility, the amounts are not significant contributors to

Medicaid costs. The fact is also that most elderly nursing home users pay full or all their cost when they go into nursing homes, so the myth that this is asset transfer as opposed to a safety net is simply not supported by the evidence.

Second myth: that Medicaid discourages the purchase of private long-term care insurance. Remember that long-term care insurance is expensive. It costs – you can think of that as the premiums even for a couple aged 60 for the median – a median-income couple aged 60, it could take back 10 percent of income to pay a long-term care insurance premium. What people would be buying with that premium, though potentially valuable, is also likely to have limited benefits. That's one way to keep the premiums even remotely affordable. As a result, even if they pay long-term care insurance premiums year after year, they are likely to find themselves without adequate benefits when they need care.

When we look at the evidence on people's choices about long-term care insurance, the evidence, though limited, tells us that the existence of Medicaid doesn't remotely begin to explain the low level of purchases of long-term care insurance by elderly or nearing elderly – that would be my group – nearing elderly people. It is the other factors – the cost and the limitations to the benefits – that are far more important.

Myth three: that improving and subsidizing private long-term care insurance will reduce public spending. That argument does exist and having better long-term care insurance policies with better benefits would be a good thing, but it would not make them cheaper; it would not make them for more affordable to people who are struggling to deal with retirement income, let alone long-term care needs. So, in fact, making these policies better is likely to increase their cost and reduce the likelihood of purchase or affordability, particularly for modest and low-income people.

Arguments that we ought to subsidize policies in order to spread long-term care insurance certainly won't save public money because we would be spending public money in order to subsidize them. We must remember that spending money through tax credit is spending money and those tax credits, we know from lots of experience, in health insurance are more likely to go first up the income scale to people who are even better able to pay for – pay the cost themselves, and are also likely to go to people who might have purchased the insurance anyway, so they are simply replacing private dollars with public dollars rather than reducing cost. So private long-term care insurance may be a fine strategy for somewhat affluent people who are – for whom the premiums are not burdensome and go along side other ability to save for retirement, but when we look at the bulk of the population likely to rely on Medicaid, both now and in the future, it is simply not reasonable to argue that that is a strategy for dealing with this problem.

So what should we do? The challenge is to build a better long-term caring system, one that spreads risks the way insurance typically does rather than simply sticking it to the unfortunate people who need long-term care. This strategy to exist in all states – if we are going to have a system that's going to exist in all states, that requires a

federal program and clearly requires federal money, so let me quickly throw out some ideas.

The first is that we could follow on a model of social insurance, which has worked and continues to work effectively in Medicare and Social Security. If you think about the Social Security model, it is a limited benefit. It is not everything for everybody. It has left room for private, personal responsibility and private insurance; as we think about Social Security, pensions wrap around Social Security. So we don't have to do everything, but we can provide a core and supplement that with private insurance for those who can afford it and with means-tested benefits better than we now have for those who don't. And if we look at what other nations are doing, European nations with populations - older populations - far larger than ours, that is precisely the direction they are moving, while still retaining a significant role for private resources and for family delivery of care.

A second option, somewhat more modest, is that we would provide a decent floor of protection for people who need long-term care; keep it means tested, but not require that people give up everything if they find themselves in the circumstance of needing long-term care. So a more generous safety net that would not only allow people to keep their life savings, but on a medium level for example, but would also provide people a greater choice of places in which you receive care, emphasizing care at home, which is now a modest portion of Medicaid rather than so emphasizing institutional care. We know that people would prefer to be at home and we should design a system that would make that possible.

A third option would be a federally funded home care benefit under Medicaid with uniform eligibility across states. We know, we hear a great deal from the governors about the cost of dual eligibles, Medicare/Medicaid eligibles in Medicaid. This would be a way to give state some relief as would, of course, the other options. This would be a more modest way to give relief and at the same time expand the kinds of services that are most lacking to people who need long-term care.

If you think about the way in which we provide income support at the federal level for low-income elderly people through the supplemental security income program and for people with disabilities - that is fully federally funded. We could do the same with homecare.

In any of these initiatives, it is important that we also pay attention to quality of care. The quality of care in our long-term care system is particularly lacking. As study after study shows, we can do better through provider regulation and payment strategies that reward providers for delivering quality care particularly for investing in staffing. We can – if we design those systems, we can get better value for the dollar and make our entire system better, even if we don't expand coverage.

So, in conclusion, many will say this is not something we can afford to do. That clearly is not my position. When we look at the situation, the choices we are making in

terms of both our current spending and the deficit that we are building with respect to the future, those are choices that we are making. I would argue we could make a very different set of choices to use our collective resources through the tax system to provide a better safety net in long-term care along with other services. I would point out what others have observed, which is that the Medicaid spend-down which requires people to give up everything in order to get long-term care from Medicaid – it looks like the last estate tax standing. It is time that we looked at a bit more – a broad estate tax or reexamine the broad estate tax as well as other revenues to spread risk in long-term care as we really should.

Thank you.

(Applause.)

ANDY SCHNEIDER: Good afternoon. I am Andy Schneider. I would like to thank the Center for commissioning this paper and for the opportunity to work with my coauthors, Yvette Shenouda and Jeanne Lambrew, that is, with Jennings Policy Strategies and, Yvette, would you please introduce yourself? Thank you. And Jeanne, you've already met. She is strategically positioned after me in order to keep me honest. It also gives her a chance when she was out voted on matters in the paper to make her case to you directly. (Laughter.)

Okay, so this is being done in the context of a lot of interest at the state and federal level in containing Medicaid costs, which I assume explains the presence of a lot of you here this afternoon. And the purpose of this paper is to inform the discussion of policy options around cost containment at both the federal and state level, just by reminding everyone that there are in the community high cost patients.

Now, these patients may be receiving long-term care in the community; they maybe be receiving acute care, but they are in the community. Nationally, roughly a quarter of all Medicaid spending is for services in nursing facilities and (immediate?) care facilities for the mentally retarded, psychiatric facilities, and we're not talking about that set of patients and institutions today; we're talking about patients in the community. Some of them may be getting long-term care in community; a lot of them getting acute care services.

Some of you may have seen the CBO study on Medicare high cost cases that were done last year and they looked at Medicare claims data. We did not have the luxury of looking at Medicaid claims data. We in fact based on survey on – based on study on the MEPS 2002 medical expenditure panel survey. This is nationally representative survey: non-institutionalized individuals, about 38,000 individuals in a sample that's done every year by the Agency for Healthcare Quality and Research. And of course, it's a national sample; it's nationally representative. There are going to be variations from state to state. If you've seen one state Medicaid program, you've seen one state Medicaid program.

Our findings: very briefly and I'm going to have to zip through this to stay within my allotted time, but all of it is in the – is in the paper that you've got before you or in the appendix. Basically what we found is that the high cost cases – and we'll talk about that a little and who they are – account for nearly three fourths of Medicaid spending in the community. And that most of the Medicaid spending for high-cost beneficiaries in the community is for hospital care and for home healthcare.

Among the conditions that we're able to determine from the survey, chronic illness is very common among these beneficiaries – these high-cost beneficiaries. And if you step back for a second and say, what kind of a role Medicaid play in the healthcare system – you know to qualify for Medicaid, it's a means-tested program. You fall into certain categories – aged, blind, disabled, family with dependent children – and you are poor or near poor and you have few assets. It does not matter how sick you are, so not surprisingly a lot of very sick people end up on Medicaid. That's its social role and this data bears it out.

So let's go through, quickly here, some of these findings in detail. High-cost Medicaid patients account for nearly three fourths of Medicaid spending in the community and there you will see that about 10 percent of the people, which is where we made the break for high cost, account for about 72 percent of Medicaid spending. Now, you could break it to 5 percent in which case you would find that the 5 percent of the high-cost Medicaid patients would account for about 57 percent of the spending in the community or you could break it to 20 percent and then you would find about 90 percent of your costs are accounted for by 20 percent of population. So it's skewed. We chose top 10 percent and our threshold there was total expense of about ($700 to $800?) annually.

So who are our high-cost Medicaid beneficiaries? And again, this is your nationally represented sample; you're going to see considerable variation from state to state. But if you look on – as you are looking at it on the right-hand column, that's the bottom 90 percent in terms of cost distribution and you will see that about two thirds of those are kids up to age 21 and then about a quarter or so are adults between 21 and 64 and then the elderly over 65, about 10 percent. But then when you look at the top 10 percent of the high-cost cases, you will see the distribution changes quite dramatically. It's not that there aren't high-cost children, there certainly are and some of them can be quite expensive, but in terms of the distribution of high-cost cases you'll see it's biased towards the elderly and adults 21 to 64.

Okay, one of the discussion points in the policy debate has been the role of dual-eligibles and we found, when we looked at that in this data, that in the high-cost Medicaid beneficiaries in the community they are more likely then the folks who are not high cost to have Medicare as well as Medicaid coverage, and of course that would be elderly as well as disabled Medicare beneficiaries. So some of the high-cost policy issues will have to be address with interactions with the Medicare program, and of course one of the moving parts here is the coming enrollment for drug coverage purposes of a lot of dual-eligibles in Medicaid Part D.

We also found that the – there is a higher proportion of women in the most – the top 10 percent, the high-cost population; roughly 70 percent as opposed to about 56 percent in the bottom 90 are women. In terms of racial and ethnic minority breakdown, we saw it turns out that there are more, on percentage terms, non-Hispanic whites in the high-cost Medicaid patient population than there are in the – both the low-cost patient population. Urban/rural: high-cost Medicaid patients are more likely to be rural.

In terms of income distribution – again, our poverty line here for a single individual was $9,600. It's about $800 a month. For a family of two, we're looking at $12,800 a year, about a $1,000 a month, and above-poverty is generally not very far above poverty. So we're not talking about a whole lot of income to deal with medical expenses and other living expenses in the community in any event, but you see a slightly higher percentage of people in – below the official poverty line in the top 10 percent high-cost patients.

So what are we buying for high cost patients? And again variation, variation, variation, not just among states but among the different age breaks. If you break this down, kids, adults, elderly, you are going to get some variations within state, but for the national representative population about 40 percent of the cost involved hospital care and about a quarter involved home healthcare. And it was interesting that in terms of the cost distribution that more was spend on home health services and than on prescription drugs for this population; not that prescription drugs spending was low by any means, but just in relative size the home health spending was greater.

So one way to look at who these populations might be – and again here you are also going to get variations by age – look at the conditions. These conditions, of course, can occur more than once in the same person, so people could have asthma as well as high blood pressure, arthritis as well as heart disease, and many of the high-cost patients do. Here you can see that heart disease, asthma, diabetes, high blood pressure account for – very common among the conditions of high-cost patients. The United Hospital Fund that we cite in the paper did a detailed breakdown of fee-for-service patients in New York looking at conditions by age, and you'll see the variations there. They found in their sample, for example, that much higher representation of mental retardation and cerebral palsy among the children they looked at than among the disabled adults. So, you know, this analysis is going to be very sensitive to age breaks and to state variation.

Okay, stepping back for a second, looking at Medicaid's role. In the greater social order, Medicaid's job is to cover low-income people regardless of medical condition and this shows how it steps up to the plate. If you look at the high-cost cases nationally, in 2002 some – Medicaid paid some or all the costs of 24 percent of those cases.

And then quickly the implications. So I think the data clearly show that Medicaid pays for many of the sickest Americans living in the community; that Medicaid spending for people in the community is concentrated in high-cost cases. Among the policy

changes under discussion right now at both the federal and state level are increasing cost sharing on various populations and reducing benefits in the form of better targeting of benefits and of course you have to think through the details of each of those proposals, but it's clear that there is going to be quite an impact on these high-cost beneficiaries depending on those details, and it's not entirely clear where they can go to avoid the impact of additional cost sharing or reduced benefits, and it's not entirely clear we are the providers to now treat these patients are going to go in the event of increased cost sharing and reduced benefits.

What's the alternative? Well, a number of states are experimenting with disease management, case management, lots of different models, lots of different names. We call it medical management of high cost cases. We weren't able to find any published data which was particularly compelling about the ability of these interventions to save federal and state dollars, but – again just speaking for myself – improving quality and improving health outcomes for this population doesn't seem like a bad way to go, even if doesn't save money.

Thank you.

(Applause.)

KATHLEEN GIFFORD: Hi. My name is Kathy Gifford and I am going to get a little bit in the weed's, I think, compared to our previous speaker talking about drugs and cost containment in drugs in Medicaid. There are a lot of acronyms that you have to learn to talk knowledgeably in this area, so I'll try not to confuse the issue too much in that way.

Now, first of all, I guess I probably don't have to tell all of you how significant drugs have become in help to delivery of healthcare and what a major cost driver they have been for public and private payers alike, including Medicaid. After years of double digit increases, states, after much effort and very aggressive cost containment measures, have made some success at getting the rate of growth to 7.1 percent in calender year 2004, which only looks good, mind you, if you compare it to the 17.5 percent growth that they had the year before. Now, keep in mind this came after great efforts across the country by virtually all states to do drug cost containment efforts; many multiple efforts at many times.

Now, in this context as we look forward to what the possibilities are in the future, I think we have to stop and remember what the impact or keep that in mind and I'll talk more abut that later about the impact of the new Medicare drug benefit and what impact it will have on states. In fact, it will cut direct spending by states for drugs almost in half, some estimates have been, but I would like to add that from a state perspective – if you come from a state Medicaid program, you're still going to be paying indirectly for the cost of drugs for dual-eligibles because of the clawback and by the clawback of course I think everyone by now understands that the clawback is an estimate of what the savings would have been to Medicaid from the drug benefit and it's a formula driven effort to

recoup those saving to help pay for the new Medicare drug benefit. So I'll come back to that later as far as options that the federal government might take to provide some fiscal relief to the states.

Now, I have mentioned that all states – virtually all states have moved aggressively to control drug cost containment. They use many tools and impacting all the moving parts of the program. Obviously, beneficiaries are impacted when states impose co-payments. Pharmacies are impacted when states cut the reimbursement rates that they pay for drugs at the retail level. States have taken many measures to help to control drugs utilization; that includes prior authorization programs, step therapy, preferred drug lists, limits on the number of scripts that you can have per month. Disease management and case management often have drug management components to them. States have tried to influence the prescribing patterns of physicians through provider profiling initiatives and counterdetailing activities. And of course states don't leave the manufacturers out. There have been many states – now over 30 – now also seek supplemental rebates from manufacturers to supplement the rebates they already get that are required under federal law.

Now, CMS – the federal government has been generally supportive of a number of state initiatives in the past. I mean, when states have gone out and kind of blazed a new trail with preferred drug lists or supplemental rebates initiatives, the CMS has been supportive and approved those initiatives. They've issued guidance on best practices and they have recently, last year and then again last week, approved multi-state purchasing pools to assist states in purchasing drugs more efficiently. But they have not been as proactive in my view as the states have done and I think there is more that they could do if their goal was to help mitigate the cost of spiraling drug costs for Medicaid programs, which of course would then benefit the federal treasury as well.

So I have focused on kind of – as I thought about this issue, I kind of divided it into four focus areas. First, there is the issue of what Medicaid pays at the drug store. So how do they decide what the reimbursement rate is going to be for particular product when someone shows up at the pharmacy? There are issues related to that. Then the area of how states maximize the rebates that they receive from manufactures that begin with the federally mandated rebates and then often states go further with supplemental rebates and through these – and also, now, more and more are joining multi-state purchasing pools.

As I said, I want to touch on the Medicare drug benefit and changes I think or issues that are important related to that that can be addressed that would also help states. And finally, perhaps the most important area is considering the evidence – considering how we could expand the research base to assist states in evaluating the alternative drug therapies so that they can be smarter and more prudent in their coverage decisions.

Now, generally speaking, all of these proposals touch one or more of these major components of drug costs and that's why you know this whole area gets a little complicated because some times you're dealing with, what am I – getting the best net

cost can be impacted by what you pay at retail level; the net cost is impacted by the rebates you get. Drug utilization of course impacts the mix of high-cost versus lower cost products. That all comes into play. So the various components that we will talk about address one or more of those components.

Now, first of all I am going to talk about prudent purchasing at the retail level. And there is been quite a lot of attention paid to this over recent years. Basically, states largely operate in the dark when they are setting their drug price reimbursement rates for what they pay at the pharmacy. For the most part, they rely on the average wholesale price and that's a figure that's reported by commercial publishers. They compile this pricing data and they base it on wholesale pricing data that they get from their manufacturers. It's also been called "ain't what's paid" because it's perceived and widely viewed as inflated and flawed. As I said, lots of attention paid to this. The HHS office of inspector general has reported on this more than once about the millions of dollars lost to states and the federal government from overpayments that result from relying on AWP. There of course has been litigation with manufactures over alleged artificial inflation of the AWP in order to increase that spread between what the AWP is and what the actual acquisition cost is – a much more discounted rate.

And, of course, even more recently now that the MMA has decided that Medicare Part B, and that's that part of Medicare that covers a small number of drugs – the MMA has now decided that we are going to move away from AWP as a pricing methodology for those drugs and to a new pricing methodology called average sales price. So with all that attention paid to AWP, I think it's clear that states that continue to rely on AWP because they have no other source of information to rely upon are at a disadvantage in trying to make prudent decisions at the retail level.

So basically as I thought through this issue, I kind of organized it – the first three bullets that you will see up there are basically alternatives, in my mind, that I think states need better data. So, one, we can start from scratch and I think the proposals relating to ASP, average sales price, that they are using now or will be using more of in Medicare Part B; in a sense that is starting from scratch because CMS is going to be collecting drug data. They are going to be calculating these ASP prices on a quarterly basis and setting the rates. We could do that for Medicaid. I don't want to pretend that that would be easy or cost-free, and it will be a massive job. I think for Medicare Part B, we are talking about maybe 5,700 national drug codes which would be the unit that you would pay that you would have to set a price for each national drug code, whereas for a typical Medicaid program you are talking more than 50,000 NDC codes. So the fact that we were doing ASP now for Medicare Part B does not mean that it would be an automatic simple thing to apply that to Medicaid, but if it can be done on a timely basis and accurately – and I guess I – those are two big ifs; that if it can be done timely and with accurate data, certainly it would be better for state Medicaid agencies to have better data and it would be better, I think, if that was done on the federal level. States are hardly in a position themselves to collect data for 50,000 NDC codes and develop their own ASP rates, so that's one alternative.

The second general alternative would be what if AWP was actually a reliable indicator of what the actual acquisition cost for drugs was? Maybe that would be a much better alternative because the systems are already out there and in place for reimbursement based on AWP. So if we could incentivize manufacturers to set more realistic AWPs, that might be a solution. And one possible way to incentivize manufactures would be to tie the drug rebate formula to AWP. Right now, and I will talk a little bit more about that later, the rebate is based on a different set of drug pricing data, not AWP. So that's an alternative.

And in fact the third alternative there relates to that different sets of drug pricing data called average manufacture's prices, and those are – that is drug pricing data that's confidential. It's collected by CMS. They use it in the Medicaid drug rebate formula. It's generally considered that it would likely be much more reliable as reflecting the real world than AWP does, so another alternative might be to release that data on a limited basis to states so that they could use it to develop their reimbursement rates. So those first three bullets I think are alternatives. You wouldn't all three. You would pick one of the three and do that.

The last bullet relates to a pricing mechanism that applies to generic drugs and generic equivalence. There is already a system in place where the federal government sets upper limit prices for certain generic drugs that meet certain criteria. This is another area that has come under scrutiny where the office of inspector general has observed that this process could be done better, and one key aspect of it is the timeliness of placing drugs on this list. When a high-cost drug goes off patent, the faster you can get that on the upper payment limit list and get a maximum allowable cost on that, the sooner the savings would start accruing, so that's another area that can be tightened up and that would result in savings to both the federal government and the states.

Now, this area I am going to talk just a moment or two about manufacture rebates and again this is a statutory formula, but it's been in place virtually unchanged for over 12 years. It's based on proprietary data. That average manufacture price data is proprietary. It's not generally public information. The generics – they pay just the flat percentage. For brand names, there is a best price component meaning that if your best price that you give – with certain exceptions, if the best price that you offer to anyone is lower then the rebate will be based off of that. And then there is also – for brands, there is also a penalty if you increase the cost of your drug in excess inflation over time.

So some of these recommendations – again, none of these are really that new, but some of them are more technical than others. The first one relates to increasing the federally minimum required rebate and this is something that the governors have talked about doing. Obviously, we have seen a run up in drug costs over the last decade even as the rebate formula has state the same. There is also been a lot of concern that with the implementation of the drug benefit – the Part D drug benefit that states' leverage – their leverage to negotiate higher rebates will be diminished. So now will be an opportune time to help make up for that by reconsidering what that federal minimum ought to be and maybe moving that up.

The next two alternatives are kind of mechanical adjustments to the rebate that address price inflation; one for brands and one for generics. And I think this has even become more of an issue that has been highlighted, I think, by other organizations that have been tracking drug cost price inflation as we – since the passage of the MMA. So I think it's entirely appropriate to make sure that the rebate properly accounts for that component of drug pricing that is been more prominent in the last couple of years in particular.

The fourth bullet there addresses, again, more of a process issue. That means that the process were currently using for rebates – again, another area of federal focus, another area where – you know, where the office of inspector general has focused in on how the process for calculating those rebates has gone and seen that there are weaknesses in that system and weaknesses in the oversight when the manufactures report their data – limited follow-up to verify that the data is accurate. So the federal government could be more proactive and take greater steps to ensure the accuracy of the rebate system that the currently have and that could mean more revenues for states in the form of the rebates.

And the final recommendation there is more of a defensive position on my part and that is the current administration's budget proposal includes eliminating the best price component of the rebate formula and I think it's – I don't really think anyone knows what the long-term impact of that would be to Medicaid programs because of course all this data is proprietary, so it's not like that they could give it to you and you could model it. So in light of the fact that we don't really know exactly how that would play out over time, I think one thing that we – would happen is that it would undermine existing preferred drug list programs that states have because it would change all the relative cost effective – cost effectiveness calculations. And because I think that could be very disruptive, I really think we ought to think twice before we eliminate that, especially when we don't really know what we do in the long run.

Now, I said I also wanted to talk a minute or two about the Medicare drug benefit, the clawback which we – which I mentioned earlier is a formula and the one point about that formula I wanted to draw your attention to is that in the future there is an adjustment in that formula, which is based on growth in the Part D expenditures. It's more complicated than that, but just for purposes of these first couple of recommendations here – just to understand that if there is high cost growth in the Part D plan, that means the clawback obligation for a state would be larger. If they really – if they handle it more cost effectively and keep cost growths down, that's good for states.

So my first two recommendations relate to, well, since states have a direct interest, therefore, in the cost-effective administration of this Part D program in Medicare, it's in the states' interest then that – I believe to eliminate the prohibition in the MMA that prevents CMS from negotiating better pharmaceutical pricing that – (applause) – and I realize that there is differences of opinion as to whether CMS would actually – whether the federal government can actually negotiate. I appreciate all of that. And I am not saying they actually have to go out and negotiate. I just think if the

provision weren't there that that would change the context itself and that maybe it's an overbroad area and that, you know, it eliminates the possibility of even doing anything targeted or minimal if you found the problem areas. So without advocating that they go out and aggressively negotiate everything, you know, I think they should at least take this across-the-board ban out.

The second recommendation is a little bit more nuanced and I don't know how I would exactly write the legislation on this, but my point here is that we all know that over time benefits – advocacy groups – I'm sure there are a few here – advocate for expansions and improvements in benefit programs. Then if in the future the Part D benefit is made richer, you know, that's going to affect the growth trend. And by richer – and in many ways that means that the state could be paying twice for the same thing. And an example of that would be many states today have open access to certain classes of drugs. I mean, mental health drugs is a good example where they are not on PDLs or they are not subject to prior authorization programs, so it's pretty much open access.

So the current cost of the clawback has – it takes that into account. The cost of that open access is subsumed in that calculation. If, for example, down the road there was a law that passed that says, you know, in the Medicare Part D benefit there may be no restrictions placed of any kind on mental health drugs. I mean, and plug in your favorite drug class for that. There would probably be a cost to that that would impact the growth rate of that drug benefit that would then pass through to states and impact the clawback. So that's a very rough kind of example of the general point that states are already on the hook for the clawback based on a comprehensive Medicaid benefit that they have today and if future enhancements to the Part D benefit occur, that should not affect their future obligations.

And then in general, also of course states would love it if we got rid of the clawback entirely, so I had to throw that in of course. And then there is also an issue with certain excluded drug classes that are a problem for states; that states will have to cover, benzodiazepine is an example of that, and barbiturates.

The last point is comparative effectiveness, and I am sorry that I am running out of time because I really think it's the most important area that has the most potential for long-term cost savings. With the advancements in biotech drugs that are often very expensive coming down the line, states need help in picking the best drug at the best time and the best drug therapy, and so I think that is an area where the federal government could be particularly helpful. They are in the best position to finance that kind of research to fill in the drug – to synthesize the research that we currently have and to fill in the gaps for the research that we don't have completed yet. And in that vein, and the MMA even contemplates greater funding that we've currently committed to that, and so my last recommendation is to fully fund the commitment in the MMA and, of course, ideally the more we invest in that area, I think the bigger the payoff will ultimately be down the road.

Thank you.

(Applause.)

MS. SHAW: We are going to turn now to responses from Joy and from Jeanne.

JOY WILSON: Well, the first thing I would want to say is that it's a pleasure to be here and I am particularly happy to receive these papers because I found them very informative and helpful and I will be sharing them with the people that I work for because I think they will be interested in what's in there. And Judy and Andy may be surprised, but I agree with much of what they said. It happens on occasions. (Laughter.)

I guess the other thing I would say is that I consider Medicaid kind of a cross between Cinderella and Rodney Dangerfield. You know, she picks up after everybody else and can't get no respect. (Laughter.) But that's kind of where we are. And to the extent that there seems to be not much – nobody wants to give Medicaid any more money; that puts us in a very difficult place. At least those who have the purse strings in their hands they are not being very generous at the moment and so for states that have to balance their budgets on a year-to-year basis, they don't get to do what the federal government gets to do. This becomes – the instability in funding for the program is particularly troublesome. In most states now, Medicaid is running somewhere between 15 percent and 20 percent of the state budget. Fifty percent goes to education; everything else has squeezed in between that. So it's a very challenging mix in terms of funding.

Long-term care, of course, is now on everybody's radar screen because I think after all of these years everyone has figured out that that is the third rail for Medicaid. The demographics are not working in our favor and nursing home costs are high, and we have an institutional bias. And I think that if there is anything that legislators agree to across the board regardless of party, regardless of state, is that under the current funding mechanism we can't continue Medicaid as it exists and so this whole issue of Medicaid reform becomes very important.

And unfortunately in looking at long-term care, we have not been able to identify that silver bullet that's going to get us where we need to go. And I think legislators will be the first ones to tell you that long-term care insurance is not the silver bullet, but they do believe it's going to have to be part of the future of Medicaid; that we have got to somehow get insurance as part of the infrastructure for long-term care and recognizing that it's going to do nothing in the budget window, which of course is always important. Long-term care insurance is a long-term investment in terms of putting together a long-term care infrastructure that doesn't exist now and I think that that's very important and I think legislators are very clear on that.

The other thing that is often talked about, and I think Judy did a great job of talking about home health and how important a component it is, and everybody wants to do more home health and somehow they connect savings with home health and they will not necessarily go hand in hand and I think that's important to note, but it's also important to know that we got to do something to make home and community-based care

in the broadest sense available on a broader basis. And we have to figure out a financing mechanism for the continuum of care in long-term care and I think that's critical and we have not identified how we are going to pay for that.

Certainly, the high-cost people – legislators are very clear on that. You know, there is the optional categories and unfortunately, optional services, optional categories that get treated like racing stripes on cars; you know, like it's an option. You know, what color do you want? You know, wheel size or something like that. And optional eligibility categories and optional services in Medicaid just aren't like that. Those are real services; they are real people who need real healthcare and I think that it's very important that all of us in the Medicaid, who care about Medicaid, do what we can to inform people that Medicaid options are not like car options. It's much more serious than that. And I think that, not well understood by the press, we have got to work with the press to get that across because when you eliminate an option it sounds like, oh, you know, it's not core; it's an option. You eliminate an optional service – oh, you know, it was a choice you could make.

And unfortunately for legislators they have to make those choices. They have to provide the core services and everything that's an option is on the table. It's not a fun game that the people I work for have to do, but they have to find – they have to balance their budget and balance all programs, not just Medicaid.

Finally, on the prescription drug issue, let me just say we really hate the clawback and we wish somehow we could get rid of it, but of course to eliminate it we would have to find an offset out of probably the same program, so that it creates a problem for us. But clearly clawback is a maintenance of effort requirement that is significant and I think, the treacherous piece of that is the only part of the clawback formula that a state can control is number of dual-eligibles, so if push were to come to shove, controlling number of dual-eligibles would have to be on the table. I think that's fair to say.

We have been trying to get transparency in the Medicaid rebate program for as long as I can remember and much to the chagrin of my pharmaceutical friends, we have policy saying there should be transparency. We've not been able to get that, but that certainly is important to legislators who find it very frustrating that they can find prices for almost everything else that they have to deal with, but for something as important as the prescription drug program in Medicaid, they are not permitted by law to know what those prices are.

MMA did great damage to the Medicaid drug program. I don't think we know – we won't know until it's in place how great the damage was, but it certainly compromises our ability to receive supplemental rebates, and also not much talked about is this impact on best price where all the prices negotiated under MMA – and this includes those negotiated under the retiree health benefits, so these are private companies as well as anyone who's negotiated prices under MMA – is eliminated from the calculation of the Medicaid best price. So it seems to me, then, that Medicaid best price is not really best price at all, and so we'll have to see how that plays out because it's very complicated

formula but certainly off the top of my head it sounds like we've been compromised there. And we don't know what the impact of going to a flat rebate and eliminating best prices altogether – we don't know if that's better or worse because we don't know what the flat rebate would be. But all of those things are under discussion.

We believe that we're going to be very challenged in the prescription drug side of things. Even for the states that have the multi-state pooling, most of them feel that the savings that they have predicted they would receive under those programs are going to be less due to things that have happened under MMA.

So I'd say that we're very challenged. It's a struggle and I think that next year is going to be a very difficult year for states because I don't think that most states have probably put aside sufficient funds to offset the cost of implementing the MMA Prescription Drug Program because there are substantial Medicaid costs that I think will accrue the states between September and January when they go into session.

JEANNE LAMBREW: Thank you, Joy. And I have to start by saying that I agree with everything that Joy said, not necessarily because I agree with most of what she said, but all she needs to do is give me one hip check and I fall off the stage. (Laughter.) So all of you on the left side of the room, hopefully you can hear me because I'm kind of in danger here.

I would like to start by commending the authors for doing what Deep Throat, recently unveiled as Mark Felt, said to Woodward and Bernstein which is, "Follow the money." These papers do that; they kind of try to cut through all that information and misinformation on Medicaid cost to really look at where is this money.

What we learned from Judy is that Medicaid is not the problem in the long-term care system. The long-term care system, or lack thereof, is a problem for Medicaid. What does that mean? That we really need to address this long-term, long-run problem with something like a social insurance program; broadly financed and not just financed by states. In the short run, we should consider improving our home and community-based care system, really looking at some sort of nationwide (asset or?) but in this current Congress we shouldn't risk taking away Medicaid eligibility with nothing in place or potentially spend precious resources or taxpayer dollars and tax subsidies for questionable private long-term care insurance.

You learned from Andy and Yvette that the vast majority of Medicaid spending is for a few very vulnerable people, even when you take out those people in nursing homes, which we know are primarily financed by Medicaid. So this really does cast doubt on whether you can really generate large savings from policies like benefit reductions or cost sharing. If most of your money is associated with few very sick people, your opportunities for cost and payment are potentially limited.

And Kathy's paper, I think, is quite useful to policymakers in really boring down into the federal policy related to prescription drugs and offering a number of options that

should be considered in this current Congress for addressing prescription drug cost, but as a (unintelligible) which haven't been considered for decades primarily because of the special interest politics around this.

So taken as a whole, what we see is there could be some savings in prescription drugs and Medicaid, but most of the costs in Medicaid are associated with these few high-cost cases and even those costs are primarily for hospital services and for home health services. And if we really are talking about Medicaid reform and preparing Medicaid to meet its challenges, as Judy remarked, we need more federal resources, not less.

So taking a broader view on this here at the Center for American Progress, we actually think that Medicaid challenges are the system's challenges. They are the healthcare cost challenges, not Medicaid cost challenges. They are general coverage challenges, not just Medicaid eligibility questions. And we actually have a health reform proposal that we think would address many of these issues that have been raised about Medicaid today.

Our plan would create a simple nationwide floor for Medicaid eligibility, giving states the flexibility and have them deliver those services, but fully federally financing coverage for low-income people recognizing states like Louisiana are hard pressed to come up with resources within their states to do that. We'd create a new national pool for private insurers for the working population subsidized through tax credits and re-insurance, trying to take the pressure of Medicaid to care for the sickest people or those losing their employer-based coverage. We would invest in wellness to try to prevent people from becoming high-cost cases. We'd invested in information technology so when we have those high-cost cases, you could go ahead and manage their cost well. And we would invest in comparative effectiveness research. We agree with Kathy: if we are actually going to think through -cost(.82501 Tw 12.36 0 Td (h)Tj0.0002 Tc -0.00Td(f W)16.0003 T(th Katsick rem)vestedith Kvent

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MS. SHAW: I want to thank again all our panelists and open it up for discussion. I know that we have a very packed room. I'm sure there are plenty of questions to be had, so I won't take up time from that discussion. I do want to ask everyone to please, when you're asking a question, stand up, identify yourself, and use the microphone that will be coming around. Theo will bring a microphone to you. Please speak into that so we can be sure and capture all of the discussion for the transcripts.

With that, questions?

Q: Hi. I'm Daniel Davis with the National Council on Independent Living. And I was really pleased – our organization is a big supporter of expanded investment in home and community-based services and I was very pleased to hear the panelists discussing the importance of that. I wanted to ask if any of the proposals that are currently on the table such as "money follows the person" are what you would view as a step in the right direction or if some outside-the-box thinking is necessary?

MS. FEDER (?): I think that we obviously have a share. I can't see you. There, okay. We have a shared belief that people ought to be able to get services where they live rather than in institutions, and the value of providing people the opportunity to purchase those services is that it gives them an opportunity to have a service package that fits with their kind of lifestyle, long-term care being part of people's lives.

The concern that I have with some of the proposals on the table is that one has to be particularly concerned that the money being provided is adequate, that it is not a way of essentially reducing service benefits, so, for example, cashing out the – what is now in a service package for, say, various kinds of equipment and turning that into insufficient cash that actually leaves people with fewer choices and fewer resources than does a service benefit. There are other concerns with respect to adequate protections for workers and adequate protections for the purchasers. So I think that while the concept is good, one has to look very carefully at specific proposals to see if what is being proposed is a plus more than a minus.

MS. WILSON (?): On that topic, I would just say that our biggest concern is that we're not convinced that there are sufficient resources or that individuals would know necessarily what resources are available, and I guess our thought is that there really needs to be some effort to help people identify – you know, choice is about knowing what your choices are and if you don't have sufficient information then you should choose whatever comes your way, which may or may not be a good use of the funding that you receive. And given that it is limited funding, we're very much interested in making sure that there is some support for people who – you know, we just don't think throwing a check at somebody and say, "Go find your care," is sufficient so we really think that there needs to be more to it than that and I think that's our biggest concern. But we're supportive of efforts to expand home and community-based care and give people more choice.

Q: Hi, my name is Ed Sheehy with Volunteers of America and I think I'm directing my question first to Mr. Schneider. Florida Governor Bush has proposed a

Medicaid reform package – I think it's called "empowered care" – which includes a tiered benefit package for different populations, co-pays, I think there's premiums – sort of a market-based approach. In looking at your paper, it seems to incorporate some of the things that you're proposing, or some of the policies implication of how to deal with high-cost cases. I'm just wondering, do you sort of see that – I know it has yet to be implemented, but do you sort of see this model that is being proposed in Florida as the bellwether for where Medicaid reform needs to go?

MR. SCHNEIDER: I'm not familiar with the details of the Florida proposal, but from what you've explained about it, high cost sharing will affect people who use lots of services and that would be the high-cost populations that we looks at. We know that cost sharing – the imposition of cost sharing – whether it's in the form of high deductibles or co-payments, we know that it would reduce utilization of services. It's very effective at doing that, especially among low-income populations. Some of the services that get reduced are unnecessary, but some of the services that get reduced are necessary.

And of course, then at the lower income levels you get a major financial burden associated with having to pay high out-of-the-pocket deductibles and high co-payments. Now, if you're in a situation where you are a high-cost beneficiary and you have a chronic disease or an acute illness that basically you can't avoid using services for, then all that's going on with cost sharing is it drains whatever remaining income you have or forcing you into a set of negotiations with your providers about waiving the cost sharing and deductible obligations. I don't think that's a good situation to put people in and if that's what the Florida proposal would do, I don't think it's a good idea.

MS. LAMBREW: And actually I just would add – because I also am not so familiar with the proposal, but I've heard elements of it that my understanding is Florida was also thinking about doing some sort of voucher for private insurance for this population. And when you think about it, the high-cost cases really beg the question of, if we have a few people accounting for three fourths of the cost and a ton of people – 90 percent of the people – accounting for very little cost, how do you figure out what that voucher should be? So for some people it may be – and you can do some (risk?) adjustment, but it's never perfect. For some people it would be too much, and for those people who account for most of the cost it would be too little. And that's, I think, some anxiety that people have about kind of this idea of moving towards some sort of voucher system in Medicaid.

Q: My name is Deborah Shuman (sp). I've been a member of Physicians for a National Health Program for many years. I was really interested in Jeanne Lambrew's comments that this is not just about Medicaid; this is about the entire system in the United States. And we spend $6,000 per capita per year in this country on medical care and healthcare for people and roughly 30 percent of that spending goes to something other than healthcare – you know, to corporate profits in drug companies and to administrative costs. And we hear about this vast network of complicated everything, you know: drugs and long-term care and all these stuff. And I just think our country needs a different paradigm to approach this problem. Insurance is a risk pool issue. The

more people you have in the risk pool, the better the system is going to work. We're looking at these statistics how three quarters of the Medicaid dollars are going to take care of 10 percent of the people and this is cost shipping onto Medicaid. This is cost shipping from the general population. We should all be paying for this and I'd just like to hear people's comments.

MS. LAMBREW: I would agree that we all should be paying for it and that's why we have developed a plan. I would say the Center for American Progress plan is not necessarily a single payer plan because we were trying to produce a plan that we think could cover everybody by the year 2010, very specifically saying the Institute of Medicine challenged the nation to say, "How can we get from here to there?" We developed a plan that builds on the existing system, pays for it, and lowers cost, but gets everybody there quickly. I mean there are certainly other people who propose going further and trying to get everybody into a single risk pool. We do think that this is a financing question. And I'll go back to Medicaid: I think it's unrealistic to assume that some states that don't have the tax basis can do it themselves. This really is a federal issue.

MS. FEDER (?): Just a quick observation. Long-term care, one could argue, given the aging of the population, is we're at the beginning of long-term care, and a problem we some of the proposals that are on the table and (a desire to bet on?) private long-term care insurances is once we start – that's a little market right now. We start investing in that kind of system, which all we have to do is look at the health insurance system and know that is not a way to get folks. We start investing in it; over time we get stuck with it, we get entrenched, there are people who are invested in it, providers are invested in it. Well, we start now – we know it won't work that – there we can build the social insurance system and that's the right way to go for the future.

Q: Marilyn Serafini with *National Journal*. I've a question for Judy. In your strategies for long term care financing, you were talking about providing – the possibility of providing everyone with the core benefit and then having some kind of supplemental private insurance. I'm having a hard time understanding what would be a supplemental benefit. I mean, when you talk about nursing homes it seems that you either you need the care or you don't. Can you be more specific about how you define core and the supplemental?

MS. FEDER: Sure. I'm confident there are many ways we could do it, Marilyn, but I think a simple way to think about it, and you do see this in systems around the world, is that a core benefit could require significant cost sharing. And so you can think of the supplementation in terms of the out-of-the-pocket payment side rather than essentially in the division of benefits. It's quite a simple way to do it. You can even think about that with respect to the way the Medicare benefit is designed. It's got holes and people have had to fill those holes in different ways.

MR. : This will be the last question.

Q: Thank you. My name is Annabelle Fisher. I have been one of those Medicaid/Medicare welfare recipients a while back. I am employed. I am well educated and needed that system way back when. My question – and in some respects it does work and in some respects it doesn't work, and I've also worked in the system and in healthcare.

I'm not sure who to direct this question to, but I think I'm going to direct this to Joy and Jeanne and maybe Judy or whomever. Do you think because the Medicaid system is both federal and state, and the state governors are saying we don't have the money to cover our Medicaid patients – the Medicaid system is abused, there's no question about that; we all know that. Do you think that the feds should be the only ones who run the Medicaid system, which would then dictate how much money each state gets and they'd have to do it on a means test depending on the number of people who require Medicaid because it's run by both state and feds? It's very confusing, and the same thing with the Medicare.

And then with regard to Medicaid long-term care, having worked in healthcare, Medicaid Part B covers some long-term care in-home services as long as the patient is homebound and the doctors sign a note saying you're homebound and we can provide a visiting nurse and social work and PT and all that good stuff. So since long-term care insurance, which has been out there for a while now, has gotten to the point of being unaffordable and rejecting patients who have a history of Alzheimer's, mental illness, diabetes – you no longer qualify for the long-term care insurance – wouldn't you rather increase the Medicare Part B which includes that already for homebound patients to include some long term care coverage for those folks and then you'd increase the revenue because obviously some premiums would have to be increased to pay for it? I know when I get to Medicare I'm not going for the drug supplement and I'm not going to take that.

Thank you.

MS. LAMBREW: I'll just say a quick word on the financing. We actually – the states are really primarily helping to design the Medicaid program and deliver it. They kind of can respond to local circumstances. We maintain the shared role of Medicaid – state and federal financing in our health plan. That said, to really fill in the gaps in the program – you know, we have – you know, the median poverty threshold for childless adults in Medicaid is about 57 percent of poverty and we have huge gaps. In some states it's as low as 12 or 17 percent of poverty in terms of what the eligibility limits are. We think that that needs to be financed by the federal government because the states with those low levels typically can't afford to go higher. So we would maintain a shared responsibility, but recognize that we need to change our formula and have greater federal responsibility to fill in those gaps.

(Also?), on the Medicare front, I'm sure Judy will want to talk about that as well. Just on the financing side, Medicare has potentially a broader based financing than states, but there also still is some regressive elements of Medicare financing through the payroll

tax, so I think that you can think about the broad financing – that Medicare is probably better than Medicaid, but I think we also should think through kind of if we're doing a major long-term care expansion should it be financed the same way that Medicare is.

MS. FEDER (?): I would just add to that in terms of expanding Medicare, if you adjust, as Jeanne said, for a progressive financing base, then you can – that is a basis for a social insurance program. It can be. And so that is consistent with one of the options I put forward. Building on what we have in Medicare is fine. The Medicare benefits, though, remember, it's both, as you said, homebound – and I've forgotten what the other one you mentioned, but the piece that is also true of Medicare is that it's dependent on need for skilled care and, well, we have a difference of opinion. The Medicare benefits provided tend to be tied to an acute illness and not long-term personal care and you get the personal care only as long as you need the skilled care, and that's why it's limited now and one could certainly go beyond that.

MR. SCHNEIDER: Just real quickly. One of the unfortunate things about the current congressional debate in terms of the federal/state financing share is the federal government wants to take money away. Right now, they're looking for a $10 billion reduction over four years, and of course this comes in the context of in the normal operation of things about 21 states over the next two years are going to find their federal matching rates dropping, plus we have our clawback complications, et cetera. So that's not really quite the direction for the federal partner to be moving in, from my own point of view, particularly if the way the federal partner decides to get those savings is to reduce benefits or to increase cost sharing because it can. And that's just going to come down on the high-cost cases; that's also (really?) where it's all going to fall and everybody should be real clear about that. And whether it's people with mental retardation, cerebral palsy, or congestive heart failure – I mean, we can walk down the list – they need to think – everybody needs to think through very clearly what the implications of this reduction in federal financial assistance is going to mean.

MS. WILSON (?): And I would just like to add lastly another note on MMA that's gotten very little attention but is very important to us is that the clawback payment that states make us a line item in the Medicare budget, so we are now financiers of Medicare, which is new for us. The kicker is that if the Medicare budget goes over a certain amount – a certain percent of the federal expenditures, it calls for action at the federal level to ratchet that down, which since we are a line item could mean that the clawback could be increased to help fix the federal overage.

So this whole notion of more federal payments, given this new construct, is just difficult to comprehend, but I think it's very important for everyone to know that we are now a line item and we're therefore very interested in how Medicare expenditures occur because we have a vested interest in the not going over that 45 percent – I think is the percent – and we have seen predictions that it will occur in my lifetime and in possibly in the budget window. So I just think – throw that out there is something for you all to chew on.

MS. SHAW: Well, and on that note, we clearly are in the environment of extreme uncertainty in the budget context for Medicaid and going forward on healthcare generally, so I want to thank all of the panelists very much for being here to help flesh out some of these issues and focus the debate, and all of you for being here. Thank you for joining us, and I'm sure people would be sticking around a little bit for some additional questions. Thank you all, and join me in thanking the panelists.

(Applause.)

(END)