Transcript provided by the Kaiser Family Foundation[1]
*(Tip: Click on the binocular icon to search this document)*

# On the Edge: Healthcare Reform in a Recession
# Kaiser Family Foundation
# August 6, 2009

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

**DIANE ROWLAND:** Good morning, and welcome to the Barbara Jordan Conference Center for this session. I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation.

We're glad to have you here on this dreary morning to talk about a topic, which I wish I could say was going to be uplifting and leave you in a much happier mood, but I think it's an issue that instead is going to help us better understand the reality of what this recession has meant to so many Americans and the struggles that they continue to have, as well as those in our healthcare system are facing as they try to deal with this very deep recession that we're now experiencing.

I think it's particularly important to have this session today as the health reform debate seems to dominate all news and all issues of healthcare these days, when in fact, the healthcare reforms that we're talking about, if and when enacted, will take place

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

years from now as they are phased in while today there are millions of people who are out there trying to maintain coverage and deal with severe family budget issues as we weather this recession.

I think that one of the goals that we have as the Kaiser Family Foundation is to continue to really put the voice and the faces of the people who are affected by these issues out before you and out before the policymakers so that we can hopefully craft better solutions to the daily struggles that they're facing.

This program today continues the work that we've done to try and talk to people about their experiences in the economic downturn to meet with some of their providers of care and to try and shine a light on what is going on. Today, of course, is the day before the next round of unemployment statistics come out tomorrow when we can expect to see a continued struggle for families to maintain their employment and then to find health insurance coverage for themselves

and their families in the absence of job-based coverage.

This event today will be webcast and available at the end of the day on the Kaiser Family Foundation website kff.org. You used to go to Kaiser Network to try and find these things, but they're going to be available now through kff.org, the sponsor of today's briefing.

I think we have a very ambitious plan for you, but also some terrific speakers and a lot of good insights that we hope will come out about the struggles that are going on and some of the policy options and the effect of the stimulus bill on helping to maintain coverage for most vulnerable populations.

We're going to start today's session by asking Robin Rudowitz, the Principle Policy Analyst with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, to really go through some of our key findings on the rising health pressures, both from the focus groups we've done around the country, was well as

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

from discussions we've had with the Medicaid directors. Then we're going to turn to a video which will bring some of the voices and the faces of the people that we've interviewed onto our screen so that you can see more directly what they're experiences are.

Then following that, I want to really have an in-depth discussion from multiple perspectives about what's going on with the economic downturn and especially its impact on low-income families. We'll turn first to Barbara Edinberg, the Assistant Director of the Bridgeport Child Advocacy Coalition in Bridgeport, Connecticut to provide some of the perspective from those on the ground trying to connect people with their health insurance coverage.

Then we've going to turn to a distinguished member of our Medicaid commission, Art Kellermann, who's a physician and professor of emergency medicine at Emory University School of Medicine in Atlanta and co-chair of the Institute of Medicine's study of the uninsured and the consequences of lack of coverage to

provide some perspectives of the provider on the ground trying to deal with these issues at Grady and other public hospitals and safety net facilities around the country.

Finally, Joan Henneberry, who's the Executive Director of the Colorado Department of Healthcare Policy and Financing, is going to share with us the views of those trying to run the public programs that try and meet these needs in these economic times that are so difficult.

Then the new director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, our friend and colleague, Cindy Mann, will give some insight from her new role as the head of the Medicaid program and state operations on the issues facing the Medicaid program from both the federal perspective and certainly from everything she's hearing from the field.

So I think it promises to be not necessarily the most uplifting discussion you will have, but

certainly one that is very informative about the challenges and issues that are being faced by families today as we deal with this recession.

So we'll start with Robin Rudowitz who'll give you all the good news. In doing that, we would like to thank both Robin and Julia Paradise who's not here today but who helped contribute with Barbara Lyons to our report and to the Michael Perry team of Julia Cummings and Meredith Lewis from Lake Research Partners and especially their help in putting together the focus groups that led to our video that we'd like to thank Jackie Judd and her team for putting together and on the Donna Cohen Ross Center on budget and policy priorities always invaluable in helping us to find the families and the faces that go along with the video as well as with our focus group report. Our work with the Medicaid director lets us have a real insight into what goes on in the state.

We thank Vern Smith and his HMA colleagues for their continuing work with us on tracking what's going

on, but especially to NASMD [misspelled?] and the Medicaid directors themselves for their willing participation and helping us to understand the forces at the state level as well. So with that, we will now turn to Robin to give you some of our key findings.

**ROBIN RUDOWITZ**: Good morning and thank you all for coming today for this very important discussion about the ripple effects of the recession, rising unemployment, and the loss of health coverage on families, communities, states, and providers. I am going to provide a little bit of background and context and then as Diane said, go into the key findings from the major reports that we're releasing today.

If we look back to data from 2007, we know that about two-thirds of the non-elderly Americans had private coverage, mostly through their own or their family's employer. Another 16 percent had public coverage, mostly through Medicaid and the Children's Health Insurance Program, and 45 million people were left uninsured. Most of the uninsured were adults and

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

most of them have income at about less than twice the poverty level or about $44,000 for a family of four.

Since the end of 2007, which really marked the start of the recession, the national unemployment rate has climbed from 4.9-percent to 9.5-percent in June. As Diane said, we are expecting new unemployment figures out tomorrow. Over this period, six-and-a-half million people have lost their jobs and the unemployment figure is now at 14.7 million people. We know these numbers are in fact low, given that millions of Americans have accepted work or part-time work and many are not even counted in these figures because they have given up on looking for work.

Well nearly all states have been really affected by the recession. The impact really does vary across states. In June, 22 states had unemployment rates that were at or above nine-percent.

Higher unemployment rates are linked to major declines in personal income, corporate, and sales tax revenues for the states. For the first quarter for

2009, states experienced a decrease in overall state tax revenue of 11.8-percent from the same period in the last year.

This is the largest decline on record and early figures for the second quarter show a continued worsening in the fiscal situation for states. States are really facing dire budget circumstances and they could face shortfalls of over $160 billion for 2010 and in excess of $350 billion for 2011.

Loss in revenue make it difficult for states to pay their share of increasing Medicaid cost related to increases in enrollment and support care for the uninsured. We estimate that job losses since the end of 2007 have led to more than $11 million individuals who have lost coverage through the workplace. These declines in employer coverage have been related to expected increases of about four-and-a-half million in Medicaid and CHIP enrollment and expected nearly 5 million more people who are without insurance.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Most of the increase in the enrollment for public health programs is for children. Most states cover children at or above two times the poverty level. So Medicaid and CHIP are an effective safety net for children who would otherwise be uninsured when they lose their private coverage. However, Medicaid eligibility levels for parents is much more limited.

Twenty-nine states cover parents with incomes below half of the poverty level and the median eligibility level for parents is just 41-percent or about $7,500 for a family of three. Medicaid is generally not available for non-disabled adults without dependent children. So these childless adults really have virtually no options for affordable coverage.

In an effort to boost an ailing economy, Congress enacted and the President signed the American Recovery and Reinvestment Act or ARRA in February. One of the most significant pieces of ARRA was 87 billion related to a temporary increase in the federal share of

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Medicaid cost from October 2008 through the end of December 2010.

Similar to relief that was provided in 2003 during the last economic downturn; these funds are really designed to help support state Medicaid programs at a time when states are least able to afford their share. The relief includes a base increase in state matching rates for Medicaid as well as additional funds targeted to states who are experiencing extraordinarily high increases in unemployment.

To be eligible for the funds, states could not restrict their eligibility levels or their enrollment procedures. In addition, the ARRA included a 65-percent subsidy for individuals terminated from their jobs between September 2008 and December 2009 to help them pay and continue their employer-based coverage through COBRA; however, even with the subsidy, COBRA is still expensive and many are not eligible for that program.

One of the benefits of the Medicaid relief that was part of ARRA was that it reached the states

quickly. According to the GAO, 90-percent of the ARRA funds outlaid by mid-June that were directed for states and localities were related to the Medicaid Relief Funds.

With that in the way of background, I want to turn to some of the findings from our reports that we're releasing today. First, we have some insights from discussions with the leading Medicaid directors that took place in June. It will come as absolutely no surprise that the recession is having a major effect on Medicaid programs.

Enrollment and spending trends are up and well above original projections, which is contributing to severe state budget pressures. In fact, one director noted that enrollment in the previous three months had exceeded enrollment growth over the entire last year.

The ARRA funds for Medicaid have been critical for states and helping them to address budget shortfalls and also to avoid or soften any Medicaid cuts that otherwise would occur and also to help

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

preserve eligibility. However, even with the ARRA funds, states are still struggling and there is an intense focus on maintaining programs and controlling costs.

However, since states enacted so many cost-containment measures during the last economic measures during the last economic recession or downturn, it's been difficult to find reasonable options to help address costs and major cuts are on the table, including cuts to provider rates and to benefits. While most states are still struggling, some states are working hard to maintain the coverage that they have and also to advance coverage initiatives.

For an update of the recession and how that's affecting communities, we conducted focus groups and spoke to community organizations, providers, and employers in four cities across the country in California, Florida, New York, and Wisconsin.

We found that the financial crisis for family is severe and markedly worse than when we spoke to

families in November and December of last year. There are no jobs. Homes are in or at risk of being foreclosed. Individuals are depleted all savings that they had. They're incurring medical debt. They're having significant difficulty navigating assistance programs that they may be eligible for.

Employers are also struggling and they're facing difficulty cutting costs and decisions and trade-offs between having to do layoffs and also cut back on healthcare coverage. The recession has really highlighted these wide gaps in our healthcare system where children are often eligible for Medicaid and CHIP and we find their parents are extremely grateful for this coverage. But adults are generally not eligible for coverage and COBRA, even with the subsidy or non-group coverage, are out of reach.

Underinsured and uninsured people are delaying and foregoing important healthcare ranging from filling prescriptions for serious conditions like hypertension and seizures, delaying or not going to follow-up care

related to cancer screenings, and really putting off primary and preventive care as well as dental care.

The safety net has been critical but really cannot fill all the gaps in the health coverage system. There are long waits in the emergency rooms and very long waits to get appointments in the clinics. There aren't enough doctors and there are shrinking resources to support the safety net. These strains will be exacerbated as the number of uninsured increase and as we're predicting an aggressive return of the swine flu in the fall.

So to sum up, looking forward to states that we know that even when and if the economy starts to recover, unemployment and Medicaid will really lag behind and continue to rise. So budget pressures at the state level are likely to continue to persist. Many states are very concerned about the end of the ARRA funds at the beginning of 2011 because they really don't expect their economies to be fully recovered by that time.

As policy makers in Washington debate federal health reform, states see this as critical, but also have concerns about new fiscal responsibilities as well as administrative and provider capacity related to implementing potential new reforms related to expansions of Medicaid.

For individuals, it seems clear that more and better efforts could help connect families to existing assistance programs. It's also clear, as Diane said that even if health reform does pass, these individuals need immediate assistance and access to healthcare and coverage right now. But in the near term, if enacted, health reform could promise new options for affordable healthcare for these struggling families. With that, I will turn it over to the video.

**DIANE ROWLAND:** So the report that Robin has reviewed is in your packets, "Rising Health Pressures in an Economic Recession: A 360-degree look at Four Communities". One of those communities Barbara Edinberg is here to talk about as well. But we wanted to bring

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

the people from our focus groups to you, so now we're going to turn to the video that we have, "On the Edge: Healthcare in a Recession."

It is going to be available through the webcast so that you can view it on our kff.org website, but also, we do have some copies of the DVD for anyone who would like to take one home after you see the video. So with that, let's play video.

[Video played 00:17:11 to 00:25:53].

**DIANE ROWLAND:** I think that video clearly demonstrates the hard realities that many families are facing today and I think that our panel is going to help you to understand on the ground.

I'm going to turn first to Barbara Edinberg who's in the Bridgeport area where we did our focus groups earlier at the end of last year and I think she can really update us on whether Bridgeport has looked a little more today like the video we just saw. So

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Barbara, without further ado, open with some comments. Press the mike to start.

**BARBARA EDINBERG:** Thank you. I'm honored to be on this panel and to bring the grassroots perspective. I'm here today representing Bridgeport, Connecticut's children, parents, and any community organizations that serve families in our area. Our organization is a coalition that advocates for child well-being through policy change.

I live and work in what is commonly called the gold coast. Well, that gold coast is eroding. The recession is not just having a ripple effect where we live and it looks like elsewhere across the country. It feels more like a tidal wave to those of us on the ground, first the shock, then the aftershock, and then the long clean up.

Nonprofits like ours are facing a triple whammy: first, declining revenue streams for nonprofits forcing us to stretch our diminishing resources to the limit; second, a state budget deficit in the billions

of dollars resulting in drastic cuts in services which puts more of a burden on nonprofits; and then third, increased community need as you've seen in this most powerful video.

As a nonprofit, we depend upon funding from private foundations, in fact more than two-thirds of our budget. In the current economy, our funders report declining endowments by as much as 30-percent and donations from individuals donors are down.

So if this past year was bad, we anticipate the next year will be even worse. We've cut our budget to the bone. We have frozen a vacant position, and there's only six of us. So there's not much left. Last spring we had staff furloughs. The only thing that's not declining is community need.

Our mission, we feel, is more important than ever before. One of our initiatives is to find outreach and help families apply for Medicaid and CHIP. In so doing, we systematically address and identify barriers to enrollment.

In June, Bridgeport's official unemployment rate was 11.9-percent. We just completed a survey of 2,000 families and we found closer to 30-percent had been laid off, two-out-of-three in the last six months. So you ask if our conditions in Bridgeport reflect what we've seen in the video—absolutely and then some.

Last year we started to see not only increasing numbers of families who lost coverage, but also families representing all socioeconomic demographics. We're not alone. Many of our coalition members are social service agencies, community health centers, hospitals are all seeing more families without insurance, families not only from the city, but from the surrounding suburbs as well. Any of those, as you've heard in the video, have never needed assistance as well. They're overwhelmed.

Many of the families were working low-wage jobs to begin with and with no assets to fall back on, no bank account, they have no money squirreled away for a rainy day, and let me assure you, they don't get any

severance packages. On the other hand, we are also seeing parents coming in who had been earning six-figure incomes. They might have gotten a severance package, but that's rapidly coming to an end. They've never been in this situation before. They don't know where to turn. They feel shame. They are humiliated.

So our outreach efforts are more challenging. One-on-one outreach we find is very critical. It's very labor intensive. We are debunking myths. We are reassuring parents that it's okay to apply for Medicaid. The state is not going to take their house. It's not going to seize their assets.

At the same time, we have to often give adults the bad news that they don't qualify. We find that sometimes their unemployment puts them over income. In one of the mom's cases in the focus group we did death benefits. She was a young widow. It put her over income. They are single or they don't have children living at home, so they don't qualify for Medicaid programs.

So with all of this, those of us in the helping professions are feeling very much in the middle. We're living with more stress and we're at high risk of burnout and fear of losing our own jobs. Now add to the mix, a state budget deficit in the billions of dollars.

There is debate going on even as I speak on how to bridge that gap. We don't have a state budget yet. Among the proposed cuts, no surprise, Medicaid. The federal stimulus funding through ARRA has given Connecticut and other states like ours a lifeline. Of the $3 billion that Connecticut is going to receive in federal stimulus dollars, $1.3 billion is going to be for Medicaid.

But many of the advocates feel that as importantly as the increase in dollars, are the requirements placed on states to access those funds. Our state is threatening to eliminate simplified application processes that help big families get on Medicaid more quickly and access needed care sooner.

Other budget cutting proposals include requirements for premiums for low-income parents on Medicaid, shortening the renewal process, both of which would result in a loss of coverage.

If enacted, these cuts would reduce health services for over 450,000 low income children, families, seniors, and persons with disabilities who are now on Medicaid. So maintenance of effort requirements under the federal stimulus program has given us the leverage we need to maintain these critically needed services.

But I have to say, if there are any positives coming out of the recession, it has helped us in Connecticut build public will for healthcare reform. We're finding the newly unemployed and uninsured are angry. They have worked all their lives and over night, they have lost it all. People who have never given healthcare a second thought are now faced with no coverage.

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So we have been able to turn that anger into a powerful voice for change. Along with other advocates across the state, we have mobilized tens of thousands of Connecticut residents and small business owners in the fight for healthcare reform.

As a result of this collective advocacy, Connecticut state legislators in Hartford, the insurance capital of the country, overturned the governor's veto and just passed landmark legislation that will put Connecticut on the direct path to affordable comprehensive healthcare, including a public health plan alternative by July 2012.

But we are not nearly out of the woods. Results from healthcare reform are more than two years away. So in the interim, state funds for outreach when we need it the most are gone. Eliminating Medicaid services for new legal immigrant parents, restricting adult Medicaid dental to emergency visits, increases in premiums for children on CHIP are but of the few programs that are on the chopping block.

I wish I could say that Bridgeport, Connecticut is unique, but we are not. You have seen in this powerful video. So I want to thank the Kaiser Family Foundation for inviting me, but also for this most compelling video for helping shed a light on what parents are experiencing every day. We are seeing the repercussions of the recession day in and day out, and it is very grim out there. Thank you.

**ART KELLERMANN:** I'm an emergency physician. I practice in Atlanta in the only Level 1 Trauma Center serving a metro area of 5 million people. I want to tell you a true story because it is important that we understand that this is not about abstract concepts. The consequences of this recession and its impacts on the healthcare system are affecting the lives of real people.

It took them two hours to reach Atlanta from the North Georgia Mountains. I faced them across the outstretched body of their son. It was two o'clock in the morning. The sounds, noise of the emergency

department diminished as the nurse closed the heavy leaded doors to the trauma bay behind her so that I could have a private conversation with them. The ventilator hissed rhythmically 10 breaths a minute. His chest tube bubbles constantly. He had an intracranial pressure monitor poking out of the young man's head.

Mom and dad were on one side of bed. I was on the other. The father stared straight down at the floor. Mom looked deep into my eyes searching for a summit. I spoke first. I said, your son was in a terrible crash.

His truck left the road at high speed. The paramedics could see that he was critically injured and they called a helicopter. That's why they brought him here. He arrived about three hours ago. He has several injuries; a collapsed lung, internal bleeding, but those aren't his most severe problem. His brain injury worries us the most.

That's when mom interrupted. She said, and this is as best I recall a direct quote, "Doctor, I

don’t know how to say this, but I must. My husband lost his job six weeks ago. I work, but my employer doesn’t offer health insurance. Is my son going to get the care he needs?” Then she started to cry.

I was taken aback, but then I looked at her and I said ma’am, you’re at Grady hospital, one of the finest trauma centers in the south. I promise you, we will do everything in our power to save your son. I meant what I said that night, but I didn’t tell her the whole truth. She wasn’t prepared to hear it, and I was in no shape to say it. I didn’t tell her that our best might not be good enough and that if her son survived, that he’d probably be disabled for the rest of his life.

I didn’t tell her that although she and every American is entitled to emergency care without regard for their ability to pay, they would be billed for the helicopter flight, for the emergency department treatment, and for the days and weeks to come in the intensive care unit.

And that that bill would likely be well over a $100,000 maybe many hundreds of thousands of dollars. I didn't tell her that because of the people she and her husband are, they would do everything in their power to try to pay that bill—mortgage their house, empty their savings, scrape all the money they could together, and it wouldn't be nearly enough. The coins and the bills left in the coffee can in the local diner wouldn't come close to covering the difference.

I didn't tell her that that unpaid balance of their son's bill would push Grady Memorial Hospital closer to insolvency, closer to its own crash. If Grady were to close, metro-Atlanta, the economic engine of Georgia and a leading center for economic activity in the Southeast United States would lose it's only Level 1 Trauma Center, it's only burn unit, the state's only poison control center, the only comprehensive sickle cell center in the region, and 700,000 inpatient beds. If you took Grady out of the mix, the private hospitals

in the metro-Atlanta area would fall one after another like dominoes.

This story illustrates the personal, the family, the community, and the national consequences of having tens of millions of Americans without health insurance. We now, as you've already heard have probably five million more since this recession started. This problem is not limited to the inner-city or to metro areas like Atlanta. It's nationwide.

Back in January when things were a little better than now, the American College of Emergency Physicians surveyed its members; 1,700 doctors responded. Three-quarters of them said they regularly see patients who have because they delayed or put off or because they ignored symptoms out of fear of the cost, have ended up in the emergency department with severe or life-threatening problems.

Nearly 90-percent of the docs in that survey said that they'd seen patients who had been turned away from doctor's offices or clinics because they were now

uninsured. That was in January. The situation is more grim today.

In 2004, a committee I co-chaired for the Institute of Medicine systematically analyzed the data on the individual, the family, the community, and the national consequences of uninsurance. We issued six reports that documented the enormous harm that this does to our great country.

At the end of all that work, we came out with two recommendations, only two, unusual for the IOM. One of them was that until we achieve universal coverage, that we should not dismantle SCHIP or Medicaid. But the central recommendation of that committee in 2004 was that the President and Congress should commit themselves to an unequivocal goal of covering every one in this country, providing them with health insurance, and achieving that goal by 2010.

Well, by my watch folks, we've got about four months to go. We have got to get beyond the politics of nope and solve this problem in a sustainable,

effective, and fair way so that no mother need never ask again, will my son get the care he needs.

**JOAN HENNEBERRY:** Thank you. Good morning. The findings of these reports and the stories that you've heard are really very consistent with what's going on in Colorado as well. Although we are much better off in many ways than other states and other communities in terms of our unemployment rate and our economy. We have, though, had the largest Medicaid enrollment in the history of Medicaid in Colorado, 14-percent growth last year and we're expected this calendar year to see, again, double digit growth in our enrollments.

Without the stimulus money, without the ARRA funds, we would very likely have had to completely eliminate our Children's Health Insurance Program, over 65,000 children and pregnant women that we serve in that program. The other thing I think is really important for people to know, and the report alludes to this a little bit, if I had shown you a PowerPoint, I have this great graph that my budget staff did that

show the direct relationship between unemployment rates and then the rising enrollments in our public health insurance programs.

But what's more telling about this graph is that it takes about a year after the economy turns around and employment begins to rise again, there's a nine to 12 month lag time before we start to see a leveling off or even a decrease in the need for and enrollment in these programs.

So when we made budget cuts over the past three months to fill our $400 million budget gap in Colorado, we were instructed and had to carry those cuts through, not just this particular fiscal year that just began a month ago, the '09/'10 fiscal year, but those cuts have to carry over into 2011 because of the expected but similar budget cuts in the '10/'11 year.

Frankly, we are looking at those as permanent cuts. SO whatever we are giving up right now in our public insurance programs, whatever benefits, whatever special programs, and we don't have very many optional

programs or benefits in Colorado, but we are seeing those as permanent cuts.

Now, not to make light of this conversation, but as I was coming here last night, you know you get on the plane and you're trudging down the aisle toward the back of the plane and most of the seats are still empty.

I'm walking down the aisle and I'm walking down the aisle and it occurred to me we are never going to get those pillows and blankets back again. They are gone from the aircraft and they're gone forever.

There will be no reason in this economy for them to ever give us those little benefits back again. That's how we're beginning to feel about our Medicaid programs and our public insurance programs. We gave a lot up in the last recession in terms of optional programs and optional benefits and innovative ideas. Now we're doing that again and this time, I just don't think we're going to get them back. So that's sort of

the mood among states and Medicaid directors at this point.

Colorado has some unique challenges, as do a few other states around constitutional restrictions against raising additional revenue and taxing. We also have some restrictions around caps on spending. So this, for us, is very much a revenue problem, as is true in most states. We have some additional constraints against that.

We also have this interesting little thing in Colorado, a constitutional amendment that guarantees K through 12 education spending. So when we took that 40-percent of our state general revenue, 40-percent of the budget, the expenditures are off the table for reductions. So there are only three departments left in the state of Colorado where the bulk of the general fund goes.

It's healthcare policy and financing for public health insurance, human services for all of the other social services that these same families and same

communities use, and Department of Corrections. So we get the most money, we're going to take the most hit on general fund shortfalls.

In spite of that, we've seen 90,000 new people enroll in our programs in the past two years and we passed the largest health reform bill in the history, in 40 years since Medicaid began, our Healthcare Affordability Act.

So through a provider fee—we don't call them taxes in Colorado—but through a provider fee assessment, we will raise another $1 billion and we will cover another hundred thousand uninsured people in Colorado. That's fabulous. That'll make a huge dent in the need that we have. But we still have 800,000 people without coverage. We have administrative challenges.

It's important to remember that almost every state still uses big, old, clunky legacy systems to do all of the payments and eligibility and enrollments. These are not nimble systems that can accommodate these

huge caseload growths and claims growths that we're paying out.

So those are challenging. We have lots of new requirements around program integrity and contract management enrollment. States, you hear people often say well Medicaid is such an efficient program. Administrative costs are below five-percent. Our admin costs, we have about a $4 billion Medicaid program, and our admin expenditures are about 3.3-percent.

I do not brag about that. That is not enough money and not enough effort to be managing such a huge program when you're trying to do all of the oversight and the quality and the auditing and the program integrity that we are expected to provide, not just by our federal partners, but by our state auditors.

So, it's great to say that's efficient, but there are things that don't get done that should be getting done when you're running such a huge healthcare enterprise that we can't do because of these financial constraints.

So our focus, like most states, has really been on efficiencies and trying to drive down per capita cost and bring as much efficiencies to our programs as we possibly can without sacrificing the quality of care that the most vulnerable populations need. Frankly, we're not going to do this on the backs of our providers. We think that's the wrong way to go. We have had to cut some provider rates.

We've done it in a very targeted way. We've done it in collaboration with our providers. We went to the provider communities and we said look, you know the budget reality. You know what we're faced with. You serve our clients every day. You see waste. You see things you could do better.

So you come to us and tell us what you could do around utilization and better management of the benefits and if you come up with some good ideas, we'll score those. We'll put them forward toward our budget cuts, and we'll spare you a two-percent or a three-percent or a four-percent cut.

So the providers who came up with great ideas that saved us money were spared cuts. Those who didn't, took two and three and four-percent cuts. So that's how we want to continue working with our provider community, but I do fear that as the economic situation worsens, we won't have quite that flexibility.

So I'll just close by sharing some of Art's thoughts here. It's just sort of a funny comment coming from a state official, but we absolutely need some national solutions. We need national framework, we need national policies, national standards, and you can do all that.

I absolutely believe you can do that without sacrificing the need for state and frankly local customization of how you actually deliver services. But states can do a lot and we are doing a lot, but we cannot continue to do this without major national reform. Thank you.

**CINDY MANN:** Thank you. It's hard to follow such a gripping sett of presentations, frankly. So I'm

here as the fed who's here to help, huh? It's been a very moving set of presentation, and mostly we've been focusing, as we should, about challenges and hardships.

But it's important, I think, to step back and appreciate in the midst of this hardship and the difficulties created, particularly by the recession, of Medicaid's invaluable role in maintaining coverage and in fact filling in so many of the gaps created by the hardships that people are facing.

If you think about it, Medicaid is the only source of insurance that continues. In fact, naturally sort of by its nature expands when all other sources of coverage are contracting. It really underscores the vital role that Medicaid plays daily and particularly in downturns. That having been said, of course the presentations today underscore some of the very difficult challenges that families, providers, states, communities are facing.

So let me review a little bit some of those challenges as we've been seeing it across the nation

from the federal level. First of all, of course running the Medicaid program, the fundamental mission is to ensure that all eligible people get the coverage to which they are entitled. Then that coverage is quality care. Lots of new individuals are now eligible for Medicaid, but as the presentations demonstrate, many of them are new to the system.

Many of them have not been receiving Medicaid coverage before, are unfamiliar with the fact that they may be eligible or that their children may be eligible or unfamiliar with the methods of applying or have notions in their head that they can't be eligible if they have a home or if they have a car.

So one of the things that you really need to do in these times is to do some new kinds of outreach, to go to unemployment offices, to go to employers, to go to different places to be able to reach out to families and let them know about the eligibility and the simplified ways that most states now allow people to apply for Medicaid.

But, of course, in a downturn, that's exactly not the time when we have those resources available. We have some struggling community organizations doing that but for the most part, states aren't doing that. They aren't in the position of putting outreach dollars on the table. Some of them are actively hoping that that outreach doesn't happen because it means additional enrollment, which is additional fiscal pressure on the states.

So that's one of the challenges is how do we make sure we reach all these newly eligible people and get them enrolled. In addition to not even having outreach dollars, we know from states around the country that they're facing significant administrative cutbacks. So we're seeing cutbacks in staffing all around the country and real concerns about timeliness of processing applications and re-determinations.

So we need to make sure that infrastructure is there to support the eligibility that is available for people. We need to support that in the community. We

need to support that at the state and the local level. I think many people can be part of that solution.

States are obviously a part of that but there's really many actors, I think, that can jump in. we have a long history of pulling together and doing some of this work for kids' outreach and enrollment and we can really think about what are the new opportunities and new challenges of doing it during a time of recession.

Beyond the enrollment, we have clearly seeing some issues around access as some states are moving to lower their rates of payment to providers, in some cases, rates that have already been threatening access to care. So that's an area that I know states are concerned about, providers are concerned about, and certainly we at the federal level are concerned about.

We've seen some of the less benefit restrictions being adopted but as Joan identified, those are areas that some states are going to be forced to continue considering. The ARRA funding, of course

has been an essential ingredient of the positive part of the success story, the positive part of Medicaid being that critical, countercyclical health insurance program.

As Robin's report identifies, there's been an 11.7-percent decline in state revenues in the budget period of March through June and that's only getting worse. So what ARRA did is recognize that you have, in a time of recession, this wonderful role of Medicaid as being the countercyclical program that is there to expand coverage.

But, at the same time, states' budgets are in most difficult circumstances and their revenues are down and so ARRA recognizes that reality by pumping a significant amount of new federal dollars into the Medicaid program through an increase in the federal share of Medicaid costs as estimated to be about $87 billion over nine quarters that end in December 2010.

There's a number of provisions around ARRA. One is the direct increase in the FMAP. There's also an

assurance that no state loses, has their FMAP declined during this period. The across the board increase is 6.25-percent. Then states get an extra bump up if they have higher unemployment rates and that bump up is tiered based on the level of their increased in unemployment rates. There's 38 states right now that are getting that extra bump up because of the increase in the unemployment and we expect that to grow.

Along with the funding, as we've heard, there was a commitment written into the law that states that accept the increase in federal matching payments not roll back their eligibility levels and not change, make other changes in their program that would significantly reduce eligibility and enrollment.

So that has meant, in fact, that a lot of states have either rolled back some changes that they took after July 1, 2008. They had until July 1, 2009 to change their procedures so that their procedures and their eligibility levels were at least where they had been in July 1, 2008.

Some states were considering taking further steps in the legislature this past session and they decided to stop taking those steps around eligibility changes because of the ARRA maintenance of that for provisions in some states that would otherwise have put some of those changes on the table have refrained from doing that.

We've spent a lot of time, over the last several months, working with states, working with state legislators, working with governors, and other organizations on working through those maintenance of effort provisions.

It's meant that, in some cases, states have not increased premiums, that they have not adopted more stringent levels of care determination, not reduce the waiver slots that would have been available for people in home and community-based services or increase the number of re-determinations that would have occurred or made other changes that we know, thanks to so much of the work that the Kaiser Commission has done and

others, that we know has a direct impact on reducing eligibility and enrollment.

Those have been very important parts of keeping that critical countercyclical role of Medicaid together. We have heard, as we've heard today, from governors, from Medicaid directors, from legislators, from providers, and certainly from others in community organizations that the funding and the provisions in ARRA have really been critical.

The provision, the recovery act that gave the states the money was really one of the first set of dollars that was on the streets into state coffers. It provided an enormous stimulus value in terms of being available quickly and unfettered. It was truly shovel-ready, maybe even before the shovel was already before the dollars were there. Of course, it played a critical role in maintaining coverage.

I want to also note the enactment of CHIPRA as another source of additional federal dollars to support health care coverage during this time. in this case,

particularly of course for kids and pregnant women, CHIPRA, the new dollars for the reauthorization of the Children's Health Insurance Program doesn't do what ARRA did.

It doesn't reduce the state share of the cost going forward in terms of covering kids or in some instances, also covering pregnant women but it does provide stable and predictable and much more ample, pay it, federal dollars for state coverage initiatives.

It's hard to remember but with all the things that are going on now, but think back a year or so ago when we were faced with threats to coverage for children because states could not be assured that the federal funding was going to be there in a predictable way. We had some states, Georgia for example, on the brink of closing down enrollment because they didn't have a guarantee of adequate, predictable federal funding.

So CHIPRA has allowed states to, at least, move forward and keep their programs in tact without

worrying that, at the end of the fiscal year or two-thirds down the way of the fiscal year, they may run out of federal dollars and then be stuck with that coverage with state-only dollars in a time when they can't afford those state-only funds.

So the value of that stable and more adequate funding shouldn't be overlooked in terms of the network of coverage that we do have in place, shattered though it is in many other regards. There's also an often forgotten provision in CHIPRA that provides a performance bonus or so it was described but it may have other functions as we move forward.

It recognized that states that increased their enrollment of CHIP kids and get the enhanced match that CHIP generally provides often have increased costs in the Medicaid program. So CHIPRA provided some additional federal dollars to states for their Medicaid enrollment should they succeed in bringing their Medicaid enrollment of kids above certain pretty ambitious enrollment levels given the recession as well

as a lot of states continuing to move forward like Colorado.

With improvements in children's coverage, we anticipate that a fair number of states will actually benefit from that performance bonus and get some additional help on the Medicaid side for their kids.

So while all these measures are incredibly important, I think it's the lesson and I think the striking message from the presentations today is that what's really important is that we move ahead with health reform. We need clearly a recession-proof coverage system for everybody.

ARRA did a lot of good things but it didn't create Medicaid eligibility for some of the parents and the childless adults who simply are not eligible for state Medicaid programs and of course, it didn't help the small business owner who had to cut back on his health insurance that we saw in the video and his worker who, with breast cancer, who now has no way of affording care.

While the recession is pushing forward new interests in cost containment measures and I think a lot of interesting discussion is going on at the federal level and certainly at the state level around different ways to think about getting more value for our dollars, I think what is extraordinarily clear is that unless and until and Dr. Kellermann probably said this most pointedly, unless and until we have everybody covered, we really cannot be efficient about doing our cost containment.

So it is both obviously an enormously compelling reason to go forward morally but also for all of the reasons in terms of making the system a system that actually works. It appears that in all the proposals before us on health reform, Medicaid is a critical piece of the puzzle moving forward and we're anxious to see how it will all turn out and hope we will get a bill by that four-month deadline.

We certainly look forward to working with everybody here, with research or community, the states,

and the provider and community groups to making sure it really is the best system it can be as we go forward. Thank you.

**DIANE ROWLAND:** Thank you. I think our panelists have clearly given us the additional 360 view of what is going on, on the ground, the importance of health reform, and how all of these issues hang together, the immediacy of the needs that people are facing today, the importance of ARRA, and of the Medicaid program, and that these programs are actually working to try and help people but the challenges exceed some of the capacity that's out there.

I think looming for many is the fact that the ARRA funds will, themselves, run out in 2011. So beyond that, how far will we be out of the recession and how long will the lag be before the states and the Medicaid program catch up and when will health reform, if and when enacted, kick in to provide assistance.

So there's never anything easy about health care either health care reform or health care as it's

delivered today but you've been very patient in hearing our gritty and grim tale of what is going on today but I think there's always a lot of hope that we will use this as a way of understanding how to better provide the health care that Americans need.

With that, we're going to open the program up to your patient audience participation. So if you would identify yourself when you ask a question, raise your hand, we'll get a mic to you and then just tell the panel who you are so that we know who's posing the question. Thank you.

**LINDA BERGOFSKY:** Hi. Good morning, Linda Bergofsky from the Veteran's Health Administration. One of the things that we always ask when we're talking to veterans is what other coverage do you have and just curious how you in the field see VA as the other public funding. We hear a lot about Medicaid.

We hear a lot about Medicaid coverage but VA and Veteran's Health Administration services in particular may be one service that could be open to

childless adults who have served in the military and particularly who are challenged financially. So I would like to get some insight from those of you out in the field what the perspective is about VA as a gap filling service.

**DIANE ROWLAND:** Let's start with Joan.

**JOAN HENNEBERRY:** Thank you. We don't see it as a gap filling service. We see it as a critical part of our health care system in Colorado and of course, we're a large military state and we have many, many folks coming back from the wars and going back into their communities and it's putting quite a strain on the safety net system and the provider networks. We just entered into what we're hoping will be a long-term and excellent relationship with our VA health care system in Colorado.

They actually came to us and said we think that there are a lot of veterans that you're serving in the Medicaid program that really should be coming to us first. We should be their primary medical home and

first place to come. We think we could actually save you, Medicaid, some money if we did a better job to coordinate these benefits.

So we actually, one of our budget saving ideas in our '09, '10 budget is to do better data matching and better coordination with the VA so that they go there first and then will wrap around those services if they need us to. So we came at it from a little bit different perspective but we see the VA services and the system as instrumental in helping us make sure everybody has access.

**DIANE ROWLAND:** And Barbara, can you comment on the role you see?

**BARBARA EDINBERG:** Well I made a note to make sure that we do ask that when we come across adults. Our VA system is about three towns over. So it's a good hour and many of the parents that we've been seeing don't have transportation. So for them to get to the VA system is going to be particularly challenging but I made a note to make sure that that's one of the issues

that we start to look into to see how we can bridge that gap and make that system work more smoothly because I don't think we're probably asking that. Thank you.

**DAN HENDERSON:** Hi. Dan Henderson, I'm from the American Medical Student Association and Barbara, I'm actually from Connecticut. I've worked in a lot of the towns you were mentioning there. So Medicaid and Medicaid patients tend to be the ones, as we saw, most affected by this problem.

I was just wondering if you could comment on how the Medicaid system, which already does a lot of rationing because the providers who take Medicaid are few and frankly very generous, are there signs that Medicaid is going to stop really offering coverage in response to these huge growth in the people on it or by coverage, really what I mean is access in that, if there's one doctor in a town who will take Medicaid and 1,000 more patients, you've got a problem. Thank you.

**BARBARA EDINBERG:** That's why we need national health reforms that that doesn't happen for sure. What we're seeing, at least in Connecticut, that I've come across when we're looking at cuts are barriers to enrollment.

I think because of maintenance of effort, our hope is that we won't cut back on our simplification processes. We have few physicians now that take Medicaid, very few, in fact if you have a need for a specialist, if you need a neurologist and you live in Bridgeport, you need to go to Yale New Haven Hospital in New Haven, which is a good hour to two hours if you don't have transportation and you're lucky if you can see someone within three months. It is really quite scary for parents.

So I think we're going to start to see more road blocks. Connecticut just changed, about a year ago, its' health plans that were participating in the Medicaid program. So that added a further road block

because we have even fewer physicians now accepting that.

So our role, in addition to working with parents, is really to do outreach with the medical community to try to encourage them to participate while we are trying to reduce some of the administrative hassles frankly that the state puts on even the providers who want to participate. I have a friend who is a doctor and he said they came at me with a 20-page application. He said I can't do it. So I just see people for free.

So your question is certainly a good one and one that we struggle with is how do we ensure that we have access to care. So I think we have to approach it while we're working on national health reform is to go out to the medical community and to talk to them about participating. At the same time, we're looking at hopefully increasing reimbursement rates and reducing the administrative hassles. I don't know if that answered your questions.

**DIANE ROWLAND:** I think Art has a comment and then Cindy, I'm sure, has a comment.

**ART KELLERMANN:** Yes. I just wanted to say, really emphasize we're seeing a lot of people now that are coming to public hospitals like Grady that had not previously been our clientele. My doctor just said they can't take care of me anymore or I lost my coverage or I can't pay the co-pay every time I come in. Then the other area that hasn't come up and I just want to get it out there is local government is getting hit hard too.

Counties are a critical part of preserving the safety net particularly in larger communities. Grady Memorial is just a mirror of what we see across the country. Grady is supported by two county governments and largely by the state of Georgia through Medicaid and various other programs like our indigent care trust fund, our DISH program but the surrounding suburban counties have never supported Grady and aren't going to

now although we're seeing more and more of their citizens.

The two core counties have progressively restricted their funding. Last spring, Fulton County government eliminated all public funding for Grady's ambulance service, which is the 911 responder for the entire city of Atlanta and basically dared the hospital to shut down 911 ambulance service to the city. The hospital didn't do it. It has preserved that service but it's running a deficit of over $30 million this year.

The state of Georgia has reminded them that they kind of got an advance a few years back on Medicaid and they owe Georgia $20 million in cash, which it doesn't have. So it just keeps running up the deficit that it owes. Emory Medical School and Moore House Medical School as the lenders of last resorts. It's a very, very precarious situation.

I can assure you that's being mirrored in Chicago and Los Angeles and in large cities across the

country and in many respects, even tougher in smaller communities that don't have the economic backing. So it is a very dicey situation. We don't have a margin of error here. I'm telling everybody this time around don't think about Harry and Louise. Think about Thelma and Louise. We have to change the direction. If we keep going straight ahead, a nation of 300 million people's going over the cliff.

**DIANE ROWLAND:** Cindy, would you like to respond?

**CINDY MANN:** I'm not going to go after Art anymore [laughter]. Well I just want to say something about the comment on Medicaid rationing. I'm struck first by the fact that my insurance, my doctors don't take my insurance, my private insurance.

So we're seeing problems all throughout the system. I mean I can decide to front the money for my primary care and take the risk that some day the insurance company will pay me back but lots of people who work for my employer can't.

So we've got problems all across the board in terms of how our system works and what rationing looks like for different people. It's not just an issue in the Medicaid program. There clearly are some issues around Medicaid rates and access particularly for certain specialties and in certain parts of the country.

I just wanted to remind people that in the CHIPRA legislation, there was a new commission that was developed and that the GAO is putting together that specifically looking at the question of access and the question of rates. It's an area we're certainly going to be looking at and are looking at more closely as we go forward.

So it's very much on the table and with respect to the health reform bills but there's activity going on now and before we have a health reform implemented, I think to look carefully at this to see what we can do.

**DIANE ROWLAND:** In the pink?

**PEGGY EASTMAN:** I'm Peggy Eastman with *Oncology Times Newspaper*. I have a question related to health reform because virtually all of you have said that's really going to be the answer.

So what you've seen so far with the House bill, we don't yet have a Senate bill, but from what you've seen so far and particularly with the discussion about a public option, are you all confident that we will have something that passes and goes to the President's desk by the end of this year and do you think that that will really help as you have suggested, this is the only way to go? Do you think that will really solve some of these problems that you've mentioned today?

**DIANE ROWLAND:** Cindy?

**CINDY MANN:** Yes. I heard a quote from a physician. In fact, it was an oncologist just two days ago and he said well anybody can predict the future, just don't be dumb enough to put a date on it. He used the word stupid but I wouldn't dare do that in this

town these days [laughter] but we absolutely do need some help.

Yes, I do think we are going to see some reforms. the Medicaid portion of it, the bill that I mentioned, the Health Care Affordability act for Colorado takes basically does what the national proposal is, doesn't go quite as far but it will take our Medicaid population to 100-percent of the federal poverty level for parents and for childless adults. So we obviously very much support that policy. There's just no question in our minds.

Now people who are poor in Colorado do not look the same as people who are poor in California or people who are poor in Connecticut. There are some differences based on your workforce and economy but we know that in Colorado for families living with that level of income, they just are never going to be able to buy their own insurance and they're not likely to have jobs, the kind of employment mix that we have in Colorado. They're not likely to have a job that will

offer insurance or a job where they can afford their portion of the premium.

So we believe very strongly that government has to help them. So that's a policy that's very consistent that we were going toward anyway. So we're optimistic at least about that portion of the bill. We are not frightened by this public plan notion. Although we haven't seen a lot of detail on it, we think there are a number of ways you can look at that. You could look at state employee plan as something you could buy into. You could look at Medicaid.

You could look at your safety net plan. Most states have very good safety net insurance plans where the traditional safety net providers and FQHCs are a big part of that provider network. So we're not afraid of that as an option in our market place.

**DIANE ROWLAND:** And I think if anything, this panel has showed that the status quo was not exactly a good option for the future. Do you have a question in the back?

**CLAUDINE SCHWARTZ:** Good morning. My name is Claudine Schwartz. I'm with the National Association of Public Hospitals. I'm so glad that Kaiser is paying special attention to this issue. I'm glad that Dr. Kellermann, a long time friend of our organization, was able to be here today and give thoughtful remarks.

I'm wondering if the panel could reflect on the ongoing role of the safety net post reform in keeping with the earlier gentleman's questions. I'm concerned that some folks may view that national health reform would obviate the need for a strong safety net. So if you could reflect on what appropriate investments may be made in the health reform legislation to ensure a viable safety net, I'd greatly appreciate it.

**DIANE ROWLAND:** Cindy?

**ART KELLERMANN:** Everybody's looking at me. I'm just a doctor. I'm sorry.

**DIANE ROWLAND:** I was going to let Cindy go before Art.

**CINDY MANN:** Well it's an important question and demands a multifaceted answer I think. There's no question in my mind that the safety net as the safety net needs to be not only continued but strengthened in health reform. There's a lot of roles that this so-called safety net plays and people have different definitions of what that safety net is. In some communities, it is the source of insurance for people who have no other insurance.

In the world of health reform, we'd like to think that everybody will have insurance, but as you can look at some of the legislation you realize that not everybody will have insurance even under the strongest versions of the legislation that we've seen emerge from Congress. And particularly people who are new to the country and hopefully, there'll be less administrative barriers for people but people who also, just getting through all the hoops but not everybody's going to be eligible under anybody's design.

But beyond that, as we know that safety net hospitals and community health centers are also often critical places that do business in communities where other providers aren't doing business.

They provide those services in a very mission-oriented way with a very close connection and understanding of the communities that they serve. That's not going to go away in any system. What we hope is under a new system that those facilities will have adequate support and financing and a seat at the table.

**ART KELLERMANN:** One angle that I don't think we've adequately thought about is how important safety net hospitals are to preparedness and to homeland security and national security and disasters in a potential terrorist attack and just in the large scale and day-to-day life-threatening emergencies that happen at a community level is level one trauma centers, is burn units, and is disaster resource hospitals.

A few months ago, Mike Spivey and I wrote a perspective piece in *The New England Journal of*

*Medicine* about this and I would commend it to your attention and suggested that some fairly straightforward modifications of the current statute regarding DSH might be a vehicle even as DSH perhaps goes down in a post-reform era. I think having targeted dollars for preparedness will be very important for the country.

I co-chaired a roundtable for the Institute of Medicine a couple of months ago on emergency and disaster care and a very thoughtful federal official said by law, we pay for the delivery of care. We aren't allowed to pay for preparedness.

I think everyone in this room wants to know that if the bad one happens or if there's a disaster in the District of Columbia or in a major community in this country that the system will be ready and able to respond. That requires preparedness investments. That also keeps a safety net strong and functioning.

**BARBARA EDINBERG:** If I can just add, from the community, just to follow up, the safety net services,

at least in our community, the federally qualified health centers, FQHCs and the hospitals, play a critical role for many families in the inner city. They are their primary source of care. That's not going to change.

So if anything, they need to be strengthened. We're not going to get private pediatric or internal practices in the inner city. So let's hope that that's strengthened and just to follow up on the question about a public health plan alternative, as an advocate, I would say we better have something. Thanks.

**DIANE ROWLAND:** I have one question here.

**JOHN KANE:** Hello. My name is John Kane. I'm with the National Coalition on Health Care. I actually grew up in Bethpage, Long Island, which is one town over from Levittown, so that was somewhat chilling to see that in the video.

My question is about the more I speak with individuals, I find that there's a certain amount of contempt for government programs. we've all heard the

statement that's ironic as it is to keep the government out of my Medicare and I find that it's particularly with Medicaid, there's a particular amount of shame that's felt as you pointed out Ms. Edinberg.

I was wondering if you can comment on how to get people passed that amount of contempt or shame that they feel and the stigma that's attached to public programs and to try and get people to understand that enrollment in the public program is not somehow a detriment to themselves or a detriment to who they are as people.

For us, a lot of it is that one-on-one outreach and it's establishing a trusting relationship with the family that we're working with and to say that Medicaid is available for them as their health insurance plan. What is difficult, as many do have to then change their doctors and so until we have national health care reform and universal coverage so that everyone goes to, doesn't matter.

I remember and it's quite chilling. A parent said to me I wish it didn't matter when I went to the doctor, this is a mom on Medicaid, the color of my skin, the language that I spoke, or the card that I carry.

So until we get to that point where it doesn't matter what card you carry, it's still going to have that stigma. So it falls upon us in the community to reassure parents that it is okay, that it's not shameful, that this is something that they are entitled to, they're eligible for. They're entitled to it. It is their right to have health care. So I think we all can do a better job at really trying to assure parents that it is okay and it's just going to take a long time in that trust.

**DIANE ROWLAND:** Joan?

**JOAN HENNEBERRY:** I think that's a really important question because you heard Cindy use the words Medicaid as a countercyclical program and we say those words all the time at the state level but the

discussion we're having now at the national level really changes that. We're saying that families and people who are burning a certain amount of income, we will become their insurance plan.

I think we have to think of that very differently then. It means that this is going to be the way you get your insurance. Very few states have Medicaid doctors, Medicaid clinics. This has always been a public/private partnership.

Yes, we have a four billion dollar health care enterprise with 275 employees. You find another insurance plan in the country that has that much money and runs programs with so few people. we have to rely on the private sector, the health plans, the health care systems, the docs, the hospitals, the clinics. It's always been that way and I think we just have to start using different language and think about it very differently as an insurance program for people. It's the floor. It's where we start.

Even the safety net providers, the FQHCs, people have, there are a lot of myths about them and believe me, at least in Colorado, we have a very robust clinic system, Some of the best health care you could get in Colorado takes place in a federally qualified health center. So this notion that they are just for poor people or just for immigrants when that's where you can get some of the best health care including chronic care management that you could find anywhere in the state.

**DIANE ROWLAND:** Robin?

**ROBIN RUDOWITZ:** I'll just echo Barbara's comments about doing specific outreach and I think we found in New York and on Long Island and other communities as well that had dedicated enrollment assistors to help people through the application process and work with the state eligibility offices, those were invaluable assistance. There are other communities doing outreach specifically in the clinics and the emergency department. So as people are coming

in for care letting them know what their options are in terms of coverage are valuable as well.

**DIANE ROWLAND:** I think it's also been true when people are uninsured, they tend to value coverage regardless of where it comes from. I think that's one of the issues that we really need to build on. parents in surveys that we've done that have uninsured children have gladly wanted to enroll them and just want to know how to do it and how to get them more quickly enrolled in Medicaid and CHIP.

So insurance matters for families. I think that's what we're seeing here. We've kind of come to the close but I know there's one more question over here and then we're going to have to wrap up.

**ADAM DOUGHERTY:** Hi. My name's Adam Dougherty. I represent Insure the Uninsured Project out of Los Angeles. We look for dynamic ways to expand health insurance to the seven million uninsured Californians. As you know, California's facing a significant budget crisis right now though the budget balance, our

governor has line item vetoed a number of health services. So my question is in regard to the health reform proposals currently on the table.

We're seeing Medicaid proposed to expand to 133-percent, even 150-percent of federal poverty level and of course, Medicaid reimbursement rates being increased eventually to Medicare levels. So I was wondering what the panel thought about how and if states would be supportive of such an effort if they had to contribute financially to this and how we could do this without basically seeing a state level revolt from a number of states. So that's my question.

**DIANE ROWLAND:** It's a pretty compelling final question.

**JOAN HENNEBERRY:** Well we, meaning Colorado, are very supportive of the national proposals. We think we need a national solution and we think that the President's principals are on the right track. I don't believe that, based on conversations that I've listened in on and been part of, I don't believe the governors

per say, have come to consensus among themselves about what exactly they feel they can handle and can't handle. States are always concerned about unfunded mandates and the pressure.

You've heard from states, from communities, from counties that expecting us to continue with these cyclical things and the unique budget constraints that we have, the fact that we have to balance our budgets within 12-month periods every year, we just can't keep doing this by ourselves. As good as we are doing and as hard as everybody's working and as many people as we're serving, we have to have some national solutions.

**CINDY MANN:** Yes and I would just add our experience is very similar. We've been working with the governors and speaking with them regularly on it and clearly governors and this is the time to make it most emphatic is don't want to sustain new obligations that they can't afford.

That having been said, I think there's broad agreement and certainly NGA policy to support health

care reform and there is a lot of aspects of the legislation that can bring some very significant relief to states and to state budgets and obviously to state residents if you look broadly across the legislation in addition to some of the actually fairly generous provisions around the Medicaid financing that's in the House bill.

So I think looking at the bill, as a whole, is what a lot of states are doing and what they need to do going forward, if not now, when and if there's no solution now, what will the situation be like for states going forward as well as for people.

**ART KELLERMANN:** I hope that everybody, as you leave today that you don't leave depressed. I hope you leave determined. This is crunch time, this month and the next few months in terms of what's going to happen if we're going to have any major action on a federal level. I would appeal, as we go forward, that we seek balance because I think what a theme today is how out

of balance the current system is in this country and what a price people pay.

Ambulances and emergency departments are about two-percent of our country's health care spending. We're staffed by about four-percent of America's doctors. We provide over half of all the acute care visits by the uninsured in the United States more than the other 96-percent of doctors combined. That's not balance.

The Congress is struggling right now with health reform legislation and they're trying to find as many dollars as they can to cover Americans. That is a good thing but my colleagues and I, the providers, who all say we need to control costs are all for cost control provided it's not my cost, my piece of the $2.3 trillion a year we're spending on health care.

That won't work. That dog won't hunt. We have got to find realistic savings and they're out there in fraud, in waste, abuse, and inefficiency but no part of the health care industry, pharma, hospitals,

physicians, medical technology thinks they're part of that savings piece. That's got to change.

We have to have a balance of cost reductions in the right places and fair and proper coverage for every American. It is within our grasp if we don't fall apart and turn on each other. So I hope in the next few months, we'll see the greatness of America, which is when we pull together to do something good and right and not become petty and self-serving once again. That drama will play out. So let's leave more determined than ever to make this work.

**DIANE ROWLAND:** Now Art just used crunch time and I thought that this was worse than a crunch. It was a crisis. So we took the word crunch out of our, we were headed for a crunch in our last round on the recession and this time, we thought that it was really much more dire and the needs are much more immediate.

I hope that we have not left you too depressed but determined, as Art said, to at least try and provide some immediate help now for the families that

are struggling but also to be sure that in health reform, we preserve the base on which so much coverage has been built and be able to move forward to get better coverage for everyone.

I want to thank all of the panelists as well as the staff that worked on the video and the reports for helping to bring all these issues together today. I hope it's been a useful and informational session for you all. Thank you very much [applause].

[END RECORDING]

[1] The Kaiser Family Foundation makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.