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Health Care Reform Newsmaker Series: Nancy-Ann DeParle, Director, White House Office of Health Reform
Kaiser Family Foundation
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DREW ALTMAN: – and I'm not the least bit surprised that there is so much interest in her appearance here today. Next up, just so you know, is Senator Dodd and that will be on April 28th and then Senator Hatch and that will be on May 7th. As you know, the hosts, the three of us don't say very much at these events because they are for our guests.

I will simply introduce this morning's event by saying two things. One is as a health policy person, I just can't resist saying that whatever happens with health reform this year, there is just no question but that Nancy-Ann is one of the most respected people in our field and I don't know a single major player who wasn't happy if not thrilled when they learned the news that she had taken on this critical post.

The second thing I want to do is just to underscore the importance of the debate that we will have this year and of the assignment that Nancy-Ann has taken on by showing you this semi-serious chart I've been working on for some upcoming speeches that I've been doing in about two seconds.

This shows you in the yellow that there have been four major moments of opportunity for health reform since Harry Truman, including Wilbur Mills and Fannie Fox falling in the reflecting pool and here is my take home number, hold on a second.

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MALE SPEAKER: You could have added Roosevelt.

DREW ALTMAN: I could have, yes, but you will see why I didn't in a moment. And here is my take home number for today, not to put any pressure on Nancy-Ann but simply to underscore the importance of the moment and also the importance of the assignment that she has taken on for the president.

The average time between major national health reform windows since Truman, 19.7 years, so if it doesn't happen now we may have to wait awhile. With that, let me turn the program over to one of our two partners here, to Dan and then to Ron who will introduce Nancy-Ann and she will make whatever remarks she chooses to make and we will open it up for your questions.

We also have, I should mention, a good many journalists on the phone here today who are in listen mode only and you remember how this works. The reporters in the room will ask the questions. So, that is our plan.

DAN DANNER: I'm Dan Danner with NFIB. Let me say a couple of things before Ron is going to officially introduce Nancy-Ann. As we have mentioned at each of these, we do think that small business is key to the health care debate. Small business is about half of all the jobs in America, about half of GDP, but there also, small business owners, their employees and families are about half of all the uninsured. So, we

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really believe that small business is a key component of any health care reform.

I did have the great pleasure of meeting the other day with Nancy-Ann and do want to say we really look forward to working together to find a solution that works for small business.

RON POLLACK: Hi. I'm Ron Pollack, executive director, Families USA, the national organization for health care consumers. I was going to go launch right into the introduction of Nancy-Ann but with Drew's slide, it does remind me of something. I am an optimist. We are going to pass meaningful health care reform and I'm looking forward to all of us being in the Rose Garden when the president signs it. There are some cynics in this town. Of course, nobody in this room is a cynic. And, one cynic likens health care reform to a cicada. It comes out every 17 years or so, it makes a lot of noise and then goes away. I think we are going to see a very different phenomenon with Nancy-Ann's leadership.

For those of you that don't know Nancy-Ann, you are in for a real treat. All of us who care about health care reform truly rejoiced when Nancy-Ann was selected by the president to be counselor and director of the White House Office of Health Care Reform. She has an illustrious history and background in health care. She served in 1997 to 2000 as the administrator

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of the Health Care Financing Administration. Many of you now know it as the Centers for Medicare and Medicaid Services, where she ran Medicare, Medicaid, and the CHIP program for children.

She served as the associate director for health and personnel at the White House Office of Management and Budget. She served in the cabinet of Tennessee Governor Ned McWhorter as commissioner of health services. She's been a commissioner of the Medicare Payment Advisory Commission. And she's had a distinguished career in the private sector as well. She was a fellow at the Institute of Politics at Harvard's John F. Kennedy School of Government, a senior fellow at the Wharton School.

She's a board member of the Robert Wood-Johnson Foundation. Nancy-Ann really brings a lot of background and knowledge to her tasks so we are all thrilled that she was willing to join us here today.

NANCY-ANN DEPARLE: Thank you. Well I don't know about cicada's and Fannie Fox, but I am here to tell you that we are making a lot of progress in realizing the president's goal of getting health reform enacted this year. One reason I think is that all the groups who were on different sides of the table 15 years ago are now at the same table, working together and talking about how we can reach these goals. We have got not

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only NFIB and I am happy that Dan is here this morning. He's been very open and willing to work with us but also the unions, Federation of American Hospitals, the AHA, Families USA, Ron, and what I found remarkable is that no one wants the status quo. They don't start off taking about their position. They talk about how do we get everyone covered? How do we lower costs for businesses and families? And that is coming not only from the groups that are – like Ron's group, Families USA, which is more of a consumer group, but it is coming from the providers themselves. They understand that health care costs are out of control and something that we have to get ahold of.

The president has made clear and you all have heard him that he intends to get health care reform done this year. And unlike the effort 15 years ago, Congress has put its money where its mouth is and its already enacted a budget resolution that has health care reform, the health care reserve fund in the budget. So if you look back, I think Drew's chart this morning was instructive, if you look back 15 years ago at where we were at this exact time in the Clinton Administration, we are in a very different place.

The administration is vigorously engaged with members of congress as they work to draft legislation that is consistent with the president's blueprint and principles. And remember they are starting, in both the House and the Senate,

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from the president's blueprint, that he set out in the campaign and talked about for two years.

Since I've been there, which is about a month now, I have met one on one with more than 40 members of Congress, both Democrats and Republicans. I have worked with many of them before in the past in my career and I have found that on both sides of the aisle, they are in agreement with the president's principles. While they don't agree on every single point in his plan, they are all saying that they want to work with us constructively and my experience in working with them has been that that's the case, that they have been more than willing to meet me halfway in the past and I am sure they are going to be able to this time as well.

That is another way I think in which the process this year is very different from 15 years ago. That time, by the late summer, by early fall of '93, there were probably a dozen or more bills in the Congress, health care reform bills of one sort or another, but there wasn't really the kind of engagement that we see this year on the part of the committee chairs or staff working on a bill. It just wasn't the same thing.

In fact, as you will recall in the Senate finance committee, which is a lead committee of jurisdiction here, the chairman did not agree that health care reform was a priority and he wasn't particularly interested in moving forward on it,

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wanted to work on welfare reform and some other issues. By the time President Clinton sent a fully written bill, 1400 pages or so, up to congress, it was I think October or so of 1993.

This time around, it's only April and the difference is that the cicadas from our committee staff are busily working away and engaged in the mechanics of sorting through technical aspects of bills and drafting specs and actual bill language. You may think this is a congressional recess, this last two weeks, and that folks are on Spring Break, but in fact if you have been up to the Congress you know that the committee staff members who work on these issues are meeting, they are working in their offices, they are very engaged in drafting specifications and looking at numbers and things like that, and the administration is providing them with what I will call active technical assistance and guidance. We are meeting with them virtually every day, we are talking with them on the phone, they are working on the weekends, I mean this is very active work that is going on.

In the Senate, there are two committees of jurisdiction, the HELP committee and finance, and they both are on track and I think they expect to be on the floor with bills by the summer. In the House, there are three committees of jurisdiction and we are seeing something that we have never seen before which is that those three committees are working to

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report very similar or the same chairman's marks soon after the Senate acts, and I expect that to be around the August recess.

It has been so far a remarkably harmonious process for that many committees and that many staffs to work together. They are deeply steeped in the details. You know that Senator Baucus has held more than 20 hearings in the last couple of years on various aspects of reform. You know that Senator Kennedy has for the past year been convening in his office meetings of stakeholders.

I know Dan has participated in those, as has Ron. They have devoted a lot of time to meeting twice a week for hours with some strange bedfellows to working through, towards a consensus on some issues, so these people have worked together for years and they are professionals. They want to get this done and that is what I am seeing on the part of the staffs up on the Hill.

As for me, I've been spending about 60 to 75-percent of my time with the staffs or members of Congress. Some of you have reached out and wanted to come in and talk to us about what the process is or what we're doing and one reason I am not there is because I am often up on the Hill. The other place I have been spending my time is with business, labor, the AMA, the AHA, the NFIB, various groups who I have reached out to or

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who have reached out to me to talk about how we get this done this year, and I have also spent some time out on the road.

The White House, as you know, kicked off this effort with the president hosting a forum on health care reform where we had more than 50 members of Congress as well as representatives of a lot of the groups to come in and talk to us about this and it is very different than these kinds of things in the past.

This was not just a speech from the president to everyone assembled and they all politely filed out. This time we asked them to break into groups and spend two hours around the table, hashing through how do we lower costs, how do we get everyone covered, and I held my breath during some of those discussions because I was not sure what would come out but a lot – I think you have to admit a lot of progress has been made.

Then, I have been to Des Moines, to Burlington, Vermont, and to Greensboro, North Carolina, to meet with Republican and Democratic governors and have large publicly attended meetings with people who are interested in this subject and I have been struck by the stories that I have heard and Dan, you are right. A lot of them are from small business owners. A lot of them are from people who work for small business or who are newly laid off and who are struggling to

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afford insurance premiums who have been people who have been denied coverage or have had steep increases in their premiums because of pre-existing conditions.

The stories are heartbreaking and I think they are the reason why this president who has spent the last two years out talking to the American people has made clear that health reform must not wait, cannot wait, and will not wait another year. So, I am happy to try to entertain some questions now, Drew.

DREW ALTMAN: Great, wonderful, thank you. For the cameras, we may very well know who all of you are but if you would just tell us who you are and where you are from, it would be very helpful, and let us start with Mary Agnes right here.

MARY AGNES CAREY: Mary Agnes Carey with Kaiser Health News, I have a question for you about the financing of health care reform, it seems like changing the current treatment of tax benefits, I think the current tax treatment of health benefits, rather, is a must have to finance health care reform. Do you agree with that? Do you think it will be in the bills on Capitol Hill, and what other financing mechanisms do you see coming forth?

NANCY-ANN DEPARLE: Well first, the president in his budget put forward his commitment to get health care reform done this year and he did it in the form of a health care

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reserve fund, a $634 billion fund that is a down payment and a placeholder for working with Congress on the details of what the reform bill will look like. And, as I said, the congress has already put its money where its mouth is by saying yes, that is in the budget, so that is the first step towards this.

As far as the tax exclusion, remember that the president's plan is based on, he wants to build on the current system of employer based coverage and so he said for some time that he has serious concerns about any kind of financing that is built on dealing with that tax exclusion or somehow undermining it. He is very skeptical of those plans and he has been clear about that. You know, that said, we are working with the Congress on how this will be financed and a lot depends on the exact contours of the bill that they come up with.

MARILYN SERAFINI: Hi, Marilyn Serafini with *National Journal*, Nancy-Ann can you talk just a little bit about Medicare's financial situation and how that can and should be dealt with within the context of broader health care reform? President Obama has talked about it within the context of broader health care reform, is the administration at this point seeing it as enough, the kinds of reforms being talked about such as the bundling of payments, realigning of incentives, is

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that enough to handle Medicare or are we going to need to do more this year?

NANCY-ANN DEPARLE: Well, first, when we talk about the twin goals here of lowering cost for American businesses and families, we are also talking about government. That is a piece of it, too, and then covering everyone, and those two goals are intertwined. They both need to be done.

In the president's budget, as part of the financing for health care reform, he did lay out a set of proposals that are the next stage of reforms to the Medicare payment system, things like addressing the inequities in the Medicare Advantage Program and the additional spending there, by moving to a more competitive system of setting their payments, things like bundling of payments to get better incentives for hospitals to prevent readmissions so that they don't have an incentive to let people out early who haven't received all the care they need and then they come right back to the hospital.

So those are truly I think Marilyn, you know, payment reforms. They are not just the usual suspects in Medicare and they would extend the solvency of the trust fund by at least two years, so they are a down payment on what needs to be done for Medicare. And remember also that during the budget window, health care reform is going to be deficit neutral, and outside of that, we expect to be proposing some things and we are

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already doing some things that we think will have a big impact on Medicare and Medicaid long term, things like comparative effectiveness which were in the stimulus package, in the economic recovery act.

So we are getting a start on providing clinicians and patients and plans with the information they need to really know which treatments are going to work best for which patients. That has not been out there before and we expect that to have an impact long term on the cost curve, bending the curve, the health information technology which the Congressional Budget Office agreed would result in some savings to Medicare inside the budget window but we think beyond that will also, that getting everyone with electronic medical records will help to prevent medical errors and will help to make sure that they get the right treatments. Prevention and wellness, so those things long term we think will also help with the Medicare Trust Fund and the president does want to strengthen it for the future.

SUSAN JAFFEE: Susan Jaffee from *Health Affairs Journal*, President Obama has talked about specifically cutting the payments to Medicare Advantage and saying that will generate $177 billion, which he wants to take out of Medicare and use, if I understand it correctly, use it to fund health care reform. Knowing what you know about the troubled past of

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Medicare Plus Choice, Medicare Advantage, how do you think that will work, asking the plans to competitively bid, I don't think that has been done before. Is there a precedent and how would it work?

NANCY-ANN DEPARLE: Well, I don't want to get too deeply into the details of those proposals because that is not where I am spending most of my time, but you are right. The president has proposed to move to a more competitive system and it has been discussed in the past and it would work, essentially the benchmarks that are set right now is what the plans will be bidding against.

What we are trying to deal with here is everyone acknowledges that the Medicare Advantage Plans and particularly the private fee for service plans nationwide have been paid something like a 12- to 14-percent premium above what traditional fee for service Medicare has been paid to provide the same services.

So, it is the next step to remove that additional payment that they are getting and also though to move to having them bid and say versus the benchmark this is how much it would cost us to take care of these patients and that is part of setting that up for the future and I believe it starts in 2011 or so, so the details of it have not been specified yet but that is, when you say removing it from Medicare, in fact the

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Medicare proposals in the budget are part of what extends the solvency of Medicare. So I don't think their removing it from Medicare. In fact, they're strengthening Medicare by reducing overpayments.

ALIZA MARCUS: Aliza Marcus, *Bloomberg News*. I wanted to ask how critical is the idea of a new public plan to President Obama's health idea and would you — this is something Republicans say can be a deal breaker, and how do you envision a public plan?

NANCY-ANN DEPARLE: Well, one thing that's been interesting to me is going around on the Hill and talking about the various elements of the President's plan, and the public plan is one of those, is the fact that you have to get on the same page about what a public plan is when you're talking about it and it's been interesting to talk to people who say I don't like the idea of a public plan. When you actually start talking to them about what it might look like, you realize that you're talking about two different things.

So, I'm actually very hopeful that we'll be able to reach an agreement on that because it is part of the President's plan. If you've heard him talk about it, the reason it's included is because he wanted a mechanism to lower cost and to keep the private sector honest by having a competitive public plan in there.

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And as he said at the forum that he hosted at the White House, if there are other ways to do that, I'd be open to hearing them, but that's why I put it in my plan and so that's why it's in there now. But, it's been interesting to me in talking to members of Congress who have raised questions about it to learn that when you start using examples, people aren't so clear about what it is.

I guess, Aliza, the way I look at it is if these are truly policy disagreements about what a public plan is, when you list those two goals of keeping costs lower, trying to lower costs and keeping the private sector honest or competitive, everyone agrees with that. And there are policy ways of getting around some of the objections that people raise. So, if that's what it is, I think we can work together and have a public plan that everyone could agree to.

If it's a philosophical debate, then that may be another thing and people may not be able to agree.

CHUCK LEWIS: Hi, Chuck Lewis from *Hearst*. You say there are different definitions of a public plan. Could you give us your definition of a public plan?

NANCY-ANN DEPARLE: Well, my definition is a public plan is something that's sponsored by the government and therefore, has very low or almost non-existent administrative costs compared to others, doesn't have the need to have brokers

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out selling. It wouldn't have the need to have a lot of cost and profits the way private plans would. So, it has that advantage. It could operate by the same rules that all the other plans do. It could have payment rates that are very similar or it could have payment rates that are the same as Medicare. That's one idea that's been used, so there are various ways of looking at it.

If you look at the marketplace right now, there are a number of examples. One example is there are state employee plans out there that some people would regard as public plans. They're sponsored by the government, but they have lower administrative costs, so they tend to be less expensive, but they're often operated by private plans. So, there's that model out there.

There are other models. Medicare is obviously a model of a public plan. So, there are different breeds of public plans that could be part of this and I think, again, the goal is how do we make sure that within — we're talking about here the insurance pool or the exchange. How do we make sure that inside that exchange the people who are shopping for a health insurance plan or looking at things that are low-cost and that they are competitive and they have some choices. So, I think that's what we're looking for.

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DREW ALTMAN: I'm right-handed and I've been unfair to the left side of the room.

EMILY WALKER: Hi, I'm Emily Walker with *MedPage Today*. Thank you. You just said that there are some policy ways of getting around the disagreements over the public plan. Can you be a little more specific on that?

NANCY-ANN DEPARLE: Well, when you sit down and talk to people and they say, one thing I have a problem with is I don't think I like this public plan idea. My response is, what don't you like? And one thing that's come back a couple times is well, it'll be based on Medicare payment rates and those are too low for providers now or even if they don't think they're too low, they're concerned that if more people chose a public plan, there'll be so many people in it and if the payment rates are Medicare rates that it would shift costs to the private sector. So, it has to do with how you price the providers if there's a public plan.

Well, if that's an issue, there are various ways of doing that. You don't have to use Medicare prices. You can use something else. There's some analysis out there that just because this is all beginning, they're making assumptions about what the payment rates would be and making assumptions about how many people would go into a public plan. And depending on

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which assumptions you use, you could decide, gee, I don't like this. But these are policy disagreements.

Now, if it's a philosophical disagreement of I just don't want the government offering a plan, that's a different thing and that maybe something that's harder to bridge. But, I think if it's a policy disagreement, there are ways of bridging that gap.

TODD LEEUWENGURGH: Todd Leeuwenburgh with *Thompson Publishing*. The fee for service system has been talked about as being responsible for a lot of over-utilization and I'm wondering what in the present Congress plan would be the fate of the fee for service system. If maybe, again, forfeited in favor of a — I've heard — a system that either pays for quality or pays for outcomes and it just seems to me that would be a rather difficult switch to make and you might be susceptible to the same problems of waste and unnecessary care and so on. Could you talk about that pay system and how it might change?

NANCY-ANN DEPARLE: Sure. The fee for service system is something we want to strengthen and the President's budget does that. It proposes a number of changes to it to try to change the incentive. I talked about one if them earlier. I hate to get into wonky talk, even with all of you health reporters here, but, to bundle payments to hospitals to cover

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some of the post-acute care, things like home health, some nursing home care that people often get after hospitalization.

And the reason to do that is to create more incentives for hospitals to make sure that people get the treatments they need when they're in the hospital and don't have to leave and then ping-pong back to the hospital, get re-admitted, which is a terrible thing for patients and their families and also costly to the system.

So, those kinds of policy changes will help change the incentives that hospitals have right now under the current prospective payment system to just take care of them during the hospitalization and get them out as soon as possible. Make sure they get the right treatments when they're in there.

So, no, we're not – everything that we're doing – if you talk about health information technology, for example. That assumes a robust private system and a robust fee for service system. We want to incentivize physicians to use electronic medical records in a meaningful way for better treatment, better care, more convenience, better administration in their offices.

That's building the strengths of the private system, the fee for service system and trying to make it better. And this will be something – it's dynamic – we'll have to keep doing. It's not like you have a silver bullet here and we

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solve everything, but we want to move towards these things that will bend the curve and create better incentives for physicians and hospitals to treat patients in a smarter way.

DREW ALTMAN: In the back.

LESTER FEDER: Lester Feder with The Nation. Nancy-Ann, you made a point of talking about the reserve fund being in the budgets and of course, the president asked for a dollar number and neither the House nor the Senate provided a dollar figure for that fund and I'm wondering why that looks like something that was a victory, as you were saying and not as a sign that the amount of paying for universal coverage is going to continue to be a stumbling block. And even if we do get everybody covered, you're not going to be able to pay for sufficient benefits to have that be meaningful.

NANCY-ANN DEPARLE: Of all the things I worry about, that's not one of them. The reserve fund, being in the budget is a huge victory, I think. For those of you who follow the way budgets are done, the fact that there isn't a number in there isn't what's dispositive. What is dispositive to me and what is meaningful to me is that the Congress said we want to do health care reform this year and they included a reserve fund in there.

And then, obviously, we have to work out the details of exactly what the number will be and it'll be based on the plans

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that they come up with. They're starting from the President's plan, so we're working together on that and I think we'll be in concert. And I think the kind of benefits they're talking about are going to be just fine.

FEMALE SPEAKER: Hi, I'm just wondering how the medical home concept fits into all these plans. This is sort of a big buzzword among doctors.

NANCY-ANN DEPARLE: It is a buzzword and this relates to the other question I got about fee for service. How do you improve that and strengthen it? The idea there – and it's been talked about – it's actually something we began working on when I was at HCFA 10 years ago, is to try to create for patients a less fragmented experience so that there's someone managing their care.

And the idea is that it might be a primary care physician or clinician. A health professional would help to make sure the transitions between care are managed, that they're getting the right medications, that they have a place to go.

Right now, in fee for service, for all of its strengths, one of the problems is if you're a senior, for example, in fee for service Medicare, yes, you have a lot of choice, but you could be referring yourself to a specialist and back and forth. And they don't have, often, medical records so

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they don't know what you're getting or whether you're getting the right medications.

Ron and I have talked about this and there's legions of stories of people who are just going back and forth in the system. The idea would be to have a more centralized place or a person they could look to, a health professional, who would be helping them to manage their care and yes, that's a part.

There are demonstrations, very robust demonstrations going on of this right now and in the private sector, some insurance companies are doing this already and they've shown real promise and we hope to move forward with that in Medicare.

FEMALE SPEAKER: So, it would remain a priority to incentivize the medical home concept, both for specialists and primary care physicians in your --

NANCY-ANN DEPARLE: Well, I don't know the details of how specialists would fit into it, but I know that the idea is to make sure that patients, this is centered on patients, to make sure that they are getting the care that they need when they need it and to help them manage that and to help them understand the importance of being compliant with their medications and those sorts of things.

And so I think, more likely, it would be a primary care clinician of some sort who would be helping to manage that and

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helping to decide which specialists need to be seen or when they need to see them.

DREW ALTMAN: Again, to help us by telling us who you are and where you're from. You've been trying for a very long time.

DAVID HOAGBERG: David Hoagberg [misspelled?], *Investors Business Daily*. I wanted to ask you about budget reconciliation. The House has included health care reform in reconciliation. The Senate has not. My understanding is they're going to try resolve that next week. Since including health care reform would make it easier to pass, will President Obama push to see it included in the budget resolution?

NANCY-ANN DEPARLE: Well, the President, when he talked to me, made clear to me that my job was to go up and work with both parties and work with both Democrats and Republicans in trying to get this done this year and that's what I've been doing. So, we'd like to see this be a bi-partisan bill.

Certainly, when I talk to Republicans, many of them say – well, all of them say they agree with what we're trying to do – and they have said they want to be constructive and work with us and that's what we hope will happen.

DREW ARMSTRONG: Hi, Drew Armstrong from *Congressional Quarterly*. Just following up on that, Senator Daschle, when he came up for his hearings and meetings with members on the Hill

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said he did not want to use reconciliation when he was going to be having your current job. Then, when Governor Sebelius came up, she said she wanted to keep it on the table.

The administration seems to be pushing towards the position of using it. Can you just explain, then why in January the administration was talking about not using this, the reconciliation process and now it seems to be increasingly on the table or at least being pushed forward as an option? I think some of us are just trying to figure out where exactly the administration is on this since it is such a big issue.

NANCY-ANN DEPARLE: Well remember, it's Congress who's working on the budget resolution right now, so it's really for them to comment on that, but I'll tell you, as I just said to the previous questioner. The President told me that my job is to go up and work with both Democrats and Republicans to try to get this done this year and that's what we want to do.

Both parties have used reconciliation from time to time. The Republicans certainly used it. It's not our preferred method and I'm working with the Congress on both sides of the aisle to try to get this done this year and I'm hopeful that we'll have Republicans supporting it.

JOHN REIKHARDT: John Reikhardt with *Congressional Quarterly*. Just going back to the insurance exchange controversy, I'm wondering if the administration would be

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willing to live with an insurance exchange organized by the government, but offering only private plans?

NANCY-ANN DEPARLE: John, you're making news here, because I didn't know there was an insurance exchange controversy.

JOHN REIKHARDT: Oh, well, there is one [laughter].

NANCY-ANN DEPARLE: Well, what John's referring to is the President's plan and many plans that have been discussed over the last decade or so have talked about having a way of pooling risk so that small businesses and individuals could purchase coverage more easily and putting people together and that's what the Massachusetts plan is based on. In fact, they have two or three exchanges, I think. So, your question is whether we could live with a –

JOHN REIKHARDT: Well, maybe I used the words insurance exchange inaccurately. I'm really talking about a public program – public in the sense that it's government-organized – but offering only private plans. Would that be acceptable to the administration as a public program?

NANCY-ANN DEPARLE: I'm not sure I follow you. Are you asking –?

JOHN REIKHARDT: In other words, like fee, for example, or state employee programs that Governor Sebelius in her confirmation hearing talked about, those do not have on their

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menu of plans a government plan per se. They have Blue Cross Blue Shield or other private insurance options. So, the menu is simply private insurance plans. So, I'm wondering if that kind of a model would be acceptable to the Obama Administration.

NANCY-ANN DEPARLE: I'm sorry, but I'm not sure I understand. I think you're not really talking about the insurance exchange. I think you're talking about the public plan again.

JOHN REIKHARDT: Right, that's what – let's shift the question about a public plan rather than the insurance exchange.

NANCY-ANN DEPARLE: Well, that idea hasn't come up yet. The President's plan talked about a public plan and we were – I think what was contemplated was one that would be a government-sponsored plan. We're working with Congress on details of this and I really don't know where they're going to come out. There'll probably be some give and take on it. He said all along that he'd be open to a model that lowers costs and has competition and choice to keep the private sector honest.

So, I'm not sure – this, I guess, is part of what I was saying when I said one of the interesting things has been talking to people about the public plan and trying to make sure we're talking about the same thing. So, I think we need to

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maybe take this offline because I'm not sure I completely follow your question.

DREW ALTMAN: You found the question and the answer.

NANCY-ANN DEPARLE: I think so.

DREW ALTMAN: I think its Kerry.

CARRIE BUDOFF BROWN: Carrie Budoff Brown with *Politico*. I just wanted to get a little bit more information or get more insight in terms of your interactions with Congress. You talked about providing technical assistance. You're on the Hill 75-percent of the time. How engaged are you and what is the technical assistance or advice that the White House is providing right now to Congress? If you could just kind of break down the balance of power, for lack of a better word, in terms of how this is playing out, in terms of negotiating a bill?

NANCY-ANN DEPARLE: Balance of power. Well, I think of it as a team and we're working together with them as a team. So, we spend time talking to them about ideas like the insurance exchange John brought up or I thought he was bringing up. It turns out it was kind of a different question, but what does that look like? And they have very specific questions. They're engaged in drafting specs for bills and in some cases, language, so how does Massachusetts work?

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They've talked to people in Massachusetts. We've talked to people in Massachusetts. They have three exchanges. Is that really necessary or would it be better to have one? Things like that. We spend hours talking to them about those kinds of issues and giving them our feedback, guidance, reactions. In some cases, presenting to them on what we've thought about. In other cases, responding to things they've thought about. So, it's a very active give and take, back and forth, mostly with staff, sometimes with members.

CARRIE BUDOFF BROWN: Is it just you or do you have a team of folks from the White House who are going to The Hill and support –

NANCY-ANN DEPARLE: There is a team of people in the administration who are working on this.

CARRIE BUDOFF BROWN: Can you tell us who some of those folks are?

NANCY-ANN DEPARLE: Well there are people at HHS, there are people within the White House, at OMB, and the NEC. It's a small group of people and its small group of people on the Hill who are working on it.

JILL WEXLER: Jill Wexler with Managed Healthcare Executive Magazine. In discussing the public plan option there has also been talk about that applying to Part D, the Medicare drug benefit. And I'm wondering if you're looking at more

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competition in offering the drug benefit or other changes that would have the government involved in how that plan is organized and how prices are set?

NANCY-ANN DEPARLE: I don't have any information about that, again, you're ahead of me in hearing talk because I haven't heard talk about Part D in a public plan.

FEMALE SPEAKER: [Inaudible] other options for increased government involvement in negotiating prices or organizing [inaudible].

NANCY-ANN DEPARLE: I don't have any specifics on that. Remember I'm not running the Medicare program anymore. You may be thinking of me in my previous incarnation.

DREW ALTMAN: Craig, let's get the mic over here.

STEPHEN LANGEL: Yes, Stephen Langel with *Roll Call*. I was just wondering if the president was presented with legislation that had no public plan option, if that was what he needed to take to sign a bill into law, would he be willing to do it?

NANCY-ANN DEPARLE: You guys are really interested in the public plan aren't you? Well, again, I'd answer this the way the president did which is that he has a couple of goals when he put the public plan in his plan when he was running for president. And that was he wanted to make sure that he could keep costs low and a public plan is one way of doing that.

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And he wanted to make sure there was competition and choice for consumers and that you have a way of keeping private plans honest. But as he said if there are other ways of doing that he'd be open to talking about them.

STEPHEN LANGEL: I see because there was mention yesterday at the World Health Congress or this other event by Dora Hughes that there are eight principles that he values in a healthcare reform bill. And those are first and foremost and if was necessary to sign a bill into law that didn't have a public plan but it met those principles then that would not be a vetoable offense. That would not be something where he would turn the bill away. I mean is that accurate?

NANCY-ANN DEPARLE: Well I would never get into talking about vetoes, ever, so we're not talking about that. But as I understand it that isn't what Dr. Hughes said and in any event I've given you the answer that the president has to this which is that he included a public plan in his plan because he wanted to make sure costs could be lowered, he wanted to make sure there would be competition and choice for consumers. And that's where we are and that's what we're working with Congress on.

DREW ALTMAN: Let's see if the *News Hour* has a question about a public plan.

NANCY-ANN DEPARLE: Surely.

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MURREY JACOBSON: Murrey Jacobson with *News Hour*. I'll shift it a little bit, I'm wondering if you can give us, oh thank you, hi. I'm wondering if you can give us any further philosophy or intelligence about how you see this being paid for. We've talked about some of the tax proposals from the president that have run into opposition. You didn't rule out but seemed skeptical about the idea of changing tax deductibility. So, where do you see the shapes of a compromise on paying for it?

And I also wanted to follow up on the question of Massachusetts when you see what's happening with costs there and you say you're looking at Massachusetts does that raise some concerns for you about containing costs?

NANCY-ANN DEPARLE: We have been looking at Massachusetts and it's not – the evidence about cost is sort of mixed. I mean it's been interesting. They say that for the first time, I think, premiums aren't going up. And they think they've gotten some control over it but as you say they're also looking at ways to control costs and some people say they should have done that earlier.

You know, that said and talking to some providers up there, their position is that getting everyone covered is what brought them all to the table to talk seriously about constraining costs. So it's interesting and instructive and we

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are looking at that carefully. As far as how do we get – how do we pay for this. Look, there's, you know, the president made clear that within the budget window, the ten-year budget window this will be deficit neutral.

And, frankly, been talking about the budget resolutions and they both say that too. So we're all in agreement, we and the Congress, are in agreement that we want to pay for this within the budget window. Outside the budget window we've talked about the various things that we call game changers that will, over time, begin to bend the cost curve. So, those are things like the dispersion of health information technology which the Congressional Budget Office in the Economic Recovery Act said would result in savings to the Medicare and Medicaid programs.

They scored $12 billion in savings to federal programs. They also said that there would be savings to the private sector. Those haven't been scored, if you will. We haven't taken account of those yet. But I expect they would be in a healthcare reform package because they will be things that will bend the cost curve over time. Prevention and wellness, we made a $1 billion investment in the Economic Recovery Act in that. We expect that to show dividends to the private sector.

When you look at how much healthcare spending has been increasing and the percentage of GDP it is and where it is in

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relationship to the rest of growth in the economy it's clear that there is a couple of percentage points there above GDP that we need to bend down. And even if you decreased it by, you know, .5 percent or 1 percent you'd be talking about hundreds of billions or trillions of dollars. So, there is more than enough money there to pay for what we all want to do in increasing coverage to people.

And if you just look at the exercise we have in front of us now with the Congress there is plenty of scorable savings in the federal budget. And also things that we can do to change the delivery system and to move towards smarter care that we think will produce the kind of savings we need to fund this. And as you said the president did put on the table also a revenue change. We're in discussion with Congress about that right now. So, I'm confident there will be savings enough and the right mix of savings and revenue to pay for this.

DREW ALTMAN: We're in the last quarter, to use a sports metaphor that doesn't fit the baseball season, so let's get a few more questions out and then certainly we want to offer Nancy-Ann the opportunity to make whatever final comments she wants to make and we'll go way in the far end because we haven't been to the far end.

CHRIS SILVA: Thank you, good morning. Okay, hello? Yes, hi, Chris Silva, American Medical News. There has been

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some concerns about a shortage of primary care physicians, particularly, in the country; too many specialty services but not enough primary care services. Some groups have raised concerns about that. I believe MedPAC may have tried to address that within Medicare by proposing some shifts from speciality services towards primary care.

Some recommendations have come up about possibly incentivizing better for medical students. Does the administration have any comment on that at all?

NANCY-ANN DEPARLE: Well, it is something that I heard about around the country when I was attending the regional forums. And it's something that we know is on the horizon. There is a shortage of workforce for healthcare. And it's not just physicians. It is primary care physicians, as you said, but it's also other allied health professionals; nurses, certainly, technicians. And to your question about medical home there is maybe a new type of worker that we need who's helping to manage patients. And we haven't had that before. So there will be a need for more of them. The president's budget or the president's Economic Recovery Act that he worked with Congress on included a $500 million investment in the healthcare workforce especially for healthcare shortage locations to get the National Health Service core clinicians out there. So, it's something that we recognize. I don't have

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any announcements to make about proposals there, right now. But we are working with the Congress on that as well.

DREW ALTMAN: Okay, way in the back.

BERTHA COOMBS: Hi, Bertha Coombs with *CNBC*. Mine is sort of a follow on in that. People always concentrate on winning the war. How do you win the piece if you suddenly get 45 million people who have access to healthcare. How do you contend with that increased demand? In Massachusetts we've seen very long waits with people unable to get into access to healthcare because all of a sudden, you know, you have higher utilization rates.

NANCY-ANN DEPARLE: Well we know that there is a mismatch in our country. There are areas where there are probably more clinicians and more services than we need. And some areas where there are fewer and everyone has seen the maps that the Dartmouth Atlas has done about both the supply and also the volume and intensity of services that are provided.

So there is some things there that we need to work on together. Your question, though, poses a high-class problem because I'll be excited to work with my colleagues here when we get this bill done and we're working on implementing it and dealing with the problem of having people going to the doctor who haven't been able to before. And that will be great. But I do think we need to make some investments. That's one reason

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why the president's Economic Recovery Act did make some, a down payment in trying to improve the healthcare workforce situation to make sure there are enough clinicians out there to serve these people.

BERTHA COOMBS: But does that result in extra costs? I mean, you need to [inaudible] more people to service needs.

NANCY-ANN DEPARLE: It could, it could result in some extra costs. And as I said we made a down payment on it. You know, one thing that's instructive here is I've looked back at when Medicare was started in 1965 and 66 and there was a big worry at that time, it was July of 1966 that people actually were going to going the first time with their Medicare cards and it was actually 4th of July, I think. The administration then, the Johnson administration, was very worried about what if all of these seniors show up at the hospital and we don't have enough people to care for them.

And, in fact, that isn't what happened. People were more – it was a more normal situation. It wasn't a situation where hospitals were flooded. So, I'm sure when we get to that point we'll have a newsmaker breakfast and talk about how we're going to deal with it. But at this point I don't think that it's going to be quite the dire situation.

DREW ALTMAN: We're going to take two more questions. And that's all we have time for. Oh my God, how can you –

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SUE DARCEY: There's a lot of ways to save money on Medicare. And MedPAC recommended, I'm Sue Darcey from *The Gray Sheet*, my readers are medical device companies. There has been two ways to save money in Medicare recommended by MedPAC. One is the competitive bidding program for durable medical equipment. And the other one is changing the way imaging is calculated so that imaging payments would be less under Medicare.

But Congress keeps fighting back on those, particularly the competitive bidding program. They delayed it last year. What would you do to persuade Congress that these sort of cost savings have to go forward?

NANCY-ANN DEPARLE: Well, I don't have the details, Sue, about those two items. Again, I don't run the Medicare program anymore. But I will say this, competitive bidding isn't just something that MedPAC recommended. It's something that was recommended 12 years ago. Well not recommended it was enacted into law 12 years ago by Congress. The demos were originally in competitive bidding. In fact, I did those demos in durable medical equipment.

And my observation is that those demos were successful but they're quite different than what I think was going on last year with competitive pricing for medical equipment. And that may be why Congress decided it didn't like what it saw. So

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obviously the answer here is to work with Congress and that's what we'll do. But they were convinced, they've been convinced before that a more competitive marketplace for durable medical equipment is the right way to move forward. And I think there is a way to do that and to meet them halfway.

DREW ALTMAN: Everyone thinks you permanently run the Medicare program. And our last question.

JANET ADAMY: Yes, Janet Adamy from the *Wall Street Journal*. You talked about addressing the concerns of small businesses. Can you tell me a little bit about how you've been working with large companies and large employers to address their concerns about keeping their healthcare costs down?

NANCY-ANN DEPARLE: Well I've only been there a month but I have met with a number of representatives of large businesses. And, frankly, a lot of them have reached out to me and to the White House to say we really need to get something done here. We support shared responsibility; we're willing to work with you on moving forward and trying to get healthcare reform done. They've asked how they can be helpful.

I've met with the Chamber of Commerce and they too have said, you know, they represent a lot of large businesses as well as some small businesses. And they've said they want to work with us. So, you know, so far I think we're seeing a lot

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of support from large businesses. They, too, are very worried about how they're going to lower costs.

They're seeing this as a competiveness problem for them versus their counterparts in other countries. It's hard for them to stay competitive when costs keep going up. So, they want to work with us on some of the ideas to bend the curve, to change the delivery system as we move forward with covering everyone. And they all support the president's principles.

DREW ALTMAN: Nancy-Ann would you like to make a final comment?

NANCY-ANN DEPARLE: Yes, I'd just like to say that it's exciting to me to be back working on what I think is one of the most important problems that our country faces and I'm going to be back here to fill in those question marks on Drew's chart and say that we were successful in getting this done this year.

And as I go out in the country and talk to patients and clinicians about what they want to see changed it's quite clear that they want to see a better healthcare system where physicians can treat their patients in a smarter way, get them the care that they need. Patients want to have stability with respect to their costs and so do small businesses. And I think all of this is within our grasp.

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I think we can get everybody covered and we can lower costs and I can tell from the way that we're working with Congress that they're very committed to the same goals.

DREW ALTMAN: Thank you all for showing so much interest in this morning's breakfast. And good luck to you in your extraordinary assignment.

NANCY-ANN DEPARLE: Thank you.

[END RECORDING]

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