



NATIONAL LEAGUE OF CITIES
Institute for Youth, Education, and Families

Health Care Reform: How New Federal Policies Will Impact Your City's Children and Families
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National League of Cities (NLC)

Speakers:
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Susan Smith, Executive Director, Texas Municipal League Intergovernmental Employee
Benefits Pool; and
Pam Walker, Acting Director of Health, City of St. Louis, Mo.

JOHNSON: Good morning or good afternoon, depending on where you are, folks. This is Clifford Johnson. I'm the executive director of the Institute for Youth, Education, and Families (YEF Institute) at the National League of Cities. Delighted you can join us today for our monthly audioconference sponsored by the YEF Institute. Today's audioconference is on the topic of "Health Care Reform: How New Federal Policies Will Impact Your City's Children and Families." We've got a great panel for you today. We've been chuckling a little bit or laughing at ourselves a little bit here in recent weeks as we've been planning for this call, because back in the summer when we laid out our slate of topics for audioconferences, we thought surely, surely, surely if we just – if we set an audioconference in mid-December on health care reform, we would know what the end of the story was, and we would have certainty about the bill that had been enacted by Congress and signed by the President. And as you all know, that is not quite where we are at this point. There continues to be a fair bit of uncertainty about the final shape of the competing bills, the House, and what's moving forward in the Senate. And there also is, of course, at least, you know, some uncertainty about the final outcome in terms of any final passage. But we do know a lot about the outlines of the health reform proposals that are in front of the Congress, and thought it was still a great time and a great opportunity to share with all of you the latest in what we know and what seems to be emerging from a variety of perspectives as key issues, both for children and families and for cities.

So welcome again today. I want to introduce our three speakers today who are joining me on this call. First, we have Pam Walker, who is the acting director of health for the City of St. Louis, Missouri. Good morning for you, Pam.

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WALKER: Good morning, everyone.

JOHNSON: Second, Susan Smith is with us. She is the executive director of the Texas Municipal League Intergovernmental Employee Benefits Pool. That's a long mouthful Susan, welcome. Thanks for joining us.

SMITH: I appreciate it. And welcome to everybody in attendance.

JOHNSON: And last but not least, we have with us Neil Bomberg, who is here at the National League of Cities with me. He is our principal legislative counsel on health and human services and education issues, so he's in our Center on Federal Relations here at NLC. Welcome, Neil.

BOMBERG: Thanks very much. It's a pleasure to be here.

JOHNSON: I want to start out with just a couple of minutes of conversation about the needs and challenges that are out there in communities, cities, across the country – pre-health care reform. So I know that we all know a lot about these, but to just sort of make sure that our conversation today is grounded in the realities of what we're seeing in communities across the country, and so I want to start with Pam at the city level. And Pam, it would be wonderful to get your flavor, your sense, of the kinds of needs you're seeing in terms of needs for health care and health care access and health insurance coverage among children and families in the City of St. Louis.

WALKER: Sure. St. Louis City has a population of about 350,000 in a region of about two million, and the entire region is really struggling with this. And basically we're dealing with what everyone else is dealing with in that we have a universal health care system but it's through the emergency room door. That system is bankrupting our businesses, our city government, our hospitals, and our own personal health, and it hits us in really four areas: the money we have to put into the safety net; the money that we put into employees' health care; the money that it's costing the hospitals to see the uninsured; and the premature disability and death that we see in our poorest neighborhoods. Just to give you a couple of quick examples, the hospitals across the state in Missouri put \$23 million in St. Louis City's safety net system alone. And the city itself, our budget – \$5 million comes out of my budget for that safety net. And 90 percent of the primary care visits – about 641,000 – are uninsured or Medicaid, so it's extremely costly. Our hospitals are seeing 94,000 ED (emergency department) visits a year from the uninsured and 180,000 from Medicaid.

JOHNSON: Wow. Those are big numbers

WALKER: It's a huge cost. And then, our own personal employee health costs, we have a budget of about \$400 million in the city. Thirty-five million of it goes direct to health insurance payments. Sixty-five million goes to pensions. That's a fourth of our budget. You know, we cannot sustain that over time.

JOHNSON: So that's the glimpse of, you know, St. Louis as an employer and as a source of health insurance coverage for large numbers of employees, right?

WALKER: Yes. We have about 7,000 employees, and it's a fourth of our budget.

JOHNSON: Pam, what does this look like with your focus on kids, right? I mean, sort of kids who are not getting access to the health coverage they need or are getting emergency care but at too late a point, from any sane perspective.

WALKER: Right. About a third of those visits, whether you look at the primary care visits or the emergency department visits, are pediatric visits. And so, kids really are getting into the system through urgent care systems instead of primary care.

JOHNSON: I see.

WALKER: And that's increasing for us about five or six percent a year. We've worked really hard to address that. We created a very innovative regional health commission where all the partners, the hospitals, the community health centers are at the table. We've shifted funds to those five community health centers. And they are seeing large increases in their primary care visits. It's just not enough. More and more people are dropping out of the system. You know, the other thing is when you look at our six poorest zip codes, we have three times the mortality from heart disease, cancer, stroke, and diabetes than anywhere else in the country. We have the highest infant mortality rate than any place else in the country. They simply are not accessing places that are incentivized to provide good health outcomes.

JOHNSON: Wow.

WALKER: They might get in. They might get a procedure done. They might get diagnosed. But they aren't in a system that pays providers to get them healthy. And until we fundamentally change that somehow, access won't matter, money won't matter, continuing to throw dollars at this won't matter. We have got to fundamentally change what we're buying. And we're not buying good health outcomes right now.

JOHNSON: That's a very compelling picture, Pam. Thanks for that. Susan, let me turn to you with more of your statewide perspective. You know, you're interacting with municipal governments and municipal leaders all across the state of Texas, and I know seeing a lot about what they're struggling with in terms of their role in paying for health care and, in some instances, providing health care through city governments. What do the needs and most compelling challenges look like from your perspective?

SMITH: The municipalities that I have the opportunity to speak with are extremely concerned on, you know, where they buy their health care today. As most of us know, cities and towns probably spend about \$87 billion for health care for their employees and families. Eighty-six percent of the cities and towns actually provide health care benefits to their employees, and

that means it's about 17 percent of their personal budget. And when they're watching health care reform on TV, the calls that are coming in to me are, you know, "Are we going to still have access to the pool?" because a lot of political subdivisions buy their health care benefits through one of their state pools. In addition to that, they, some of them say, you know, "We don't get our health care through the pool. We get it through the private sector. What's going to happen to the rates through the private sector, because I'm a group of 25 employees and am I going to have to be compliant with the actuarial equivalency of those plan designs because I'm 25 or less? And what's that going to do to my bottom line?" And some of the cities are extremely concerned because they have a lot of full-time employees, but their parks and recreation or other divisions within that municipality have a lot of part-time employees. And one of the requirements under the health care reform is that we take care of and we make health care available to part-time and full-time employee populations. And they're thinking, "What's that going to do to my bottom line?" And I had one person tell me that they had about 526 part-time parks and recreational people that today do not have health care through their employer. And so, they're really at a loss of "How is this actually going to impact me, and is there going to be special funding?"

In addition to that, some of them are very, very excited about having the option of a public plan. And they say, "Okay, great. We can have the pool, we can look at private sector, and then we can look at the public option, and then our employees can make a good, educated choice of what's most beneficial for them." And so, I think they're a little bit excited because of another option out there to increase the competitiveness of health care reform and health care benefit options. But, they're very, very apprehensive about what's going to happen to the cost of health care. And, because there are some constraints that we'll go on in later in the presentation about the underwriting and what's actually going to happen to that premium, they're wanting to know what's going to happen to my bottom line, because everybody's on budget constraints.

In addition to that, I think the other huge question for the municipalities that I've communicated with, what's going to happen to our early retiree population? And some of our municipalities have self-funded plans where they take the financial risk, and a lot of them allow their retiree population, 65 and older and their pre-65 retiree population, to stay on their plan. GASB (Government Accounting Standards Board) 43 and 45 put a big hindrance on that because they have to be financially identifying that on their balance sheet. And they're just asking, you know, "Is anything good coming out of health care reform that's going to protect my retiree population?" and it's because those people have worked for municipalities for 30, 35 years and they definitely want to make sure they can continue to take care of them.

So you know, then, the other big deal is the – and this is a very quick comment – is they're wondering, you know, today they say they get complaints because their people can't get access to a health care provider quick enough. And if we do – which is the intent of health care reform, is to give access to coverage for all the underinsured or uninsured. What's that going to do to widening the door of health care and are we going to have to wait in lines? And, you know, everybody in the United States wanted it yesterday, and they're concerned about, you know, is there going to be a wait? So the groups that I talk to, they're really wanting to know what's going to happen to self-funded. They've heard the information on the street that self-funded plans might be excluded from actuarial equivalency. And then, it came back last week where they're not going to be excluded. There were discussions about them identifying self-funded plans at a certain census level. And the big concern from the government is are those

plans funded appropriately so they can continue to offer health care benefits to their employee population? So I think, you know, they're just hearing bits and pieces out there, and they're definitely concerned about how they're going to roll this thing out.

And the other big push that we do in Texas is preventive and wellness. And in health care reform, there's a huge promotion on preventive and wellness which, in my opinion, will manage the cost of health care. And in addition to that, the area that we're working on very, very closely is what we're doing with chronic care patients, and how can we educate and get personal health engagement from those folks quicker so that we can manage that high dollar catastrophic claim. And so, there's a ton of education and it's a great opportunity for us to talk to the consumer. It's just how fast can we get out there and how fast can we get the employer and the employees educated so they know how to access.

JOHNSON: Well, and your comments, you know, underscore that the media coverage of the health reform debate, because of its complexity and whatever, ends up focusing on a couple of flashpoint issues, right? Is there a public option or not? Is there this or that? And there are all these other things that are on the table and embedded in the plans that could matter enormously. Your references around prevention just jump out at me as one of those where, you know, certainly from a children and family perspective, you know, the prospect of having a major step forward on prevention in the relationship to health care costs could matter enormously. But you don't read much about that, you know, or see much about that on the evening news right now.

SMITH: And just to complement what Pam was saying when she was talking about, you know, how much the kids are costing. It's because, you know, unfortunately our kids have grown up in a culture where, you know, we don't stress nutrition enough. We don't stress physical activity enough. You know, it's just changed, and how are we going to – I mean, we have so many diabetic young children in the school systems today, and how are we going really educating and trying to get them to be personally health engaged so we can manage the cost of some of those chronic disease states? So, I think, you know, all of that is embedded in health care reform. Like you said, we don't hear enough of, you know, really what's going on in those areas.

And the other area that I'd like to comment on real quick is just the underwriting perspective, because health care reform does want a guarantee issue regardless if you're catastrophically ill or not, and that's a great humanistic approach. It just costs money. And so, some of the political subdivisions that have communicated with me are, you know, "What's going to happen with the premiums?" And that's their biggest question, because they give their employee health care today and they pay for a portion of it. How much more are they going to have to pay for? Are they going to have to pay for the dependents? What are the penalties going to look like? And I've got a couple of cities, and I joke about it to them. You guys have heard on TV the Cadillac plans, and those are the plans that cost per employee per year a set dollar amount that's over what they think is normal for health care to cost.

JOHNSON: Right.

SMITH: And I have one city tell me, "You know what, Susan? I don't have a Cadillac plan. I have a Lexus plan." I said, "Well, you might not be so proud of that when you look at the excise tax." So you know, all of the – you know, it's just a ton of information that's going on. And all the bits and pieces is really where we have to focus on education when we're talking to municipalities and council of governments.

JOHNSON: So, let me – that's a great segue, Susan, and let me turn to Neil here and pull him into the conversation to help us understand the state of play on Capitol Hill right now and where some of these things are. The National League of Cities has a great resolution, a great policy around health reform. And it focuses a great deal on three key issues, you know, one being universal coverage. Can families and individuals get access to health insurance coverage and therefore to health care? A second big concern around cost containment and how we change the trajectory of cost escalation on the health side, which I think everyone would agree, and both Pam and Susan's comments have already underscored, is really unsustainable for cities and for the country as a whole. And then, the third issue being around flexibility to continue to provide health insurance to employees and to provide coverage and access to care in ways that work and make sense for units of local government, because, you know, one thing we always know from a National League of Cities' perspective is that on any given issue there's a great deal of variation about how municipal government carries out its core functions and the different structures that have developed over time to make it work. And so, Neil, maybe we can start with the universal coverage piece, and can you give us a snapshot of, you know, in the House bill and the Senate proposals that are now on the table, how far would it get us? Does it – are the pending proposals things that would really make a difference around access to coverage?

BOMBERG: I think it's fair to say yes. Would they make a total difference? The answer is no., and let me give you the specifics that'll help explain that. The estimates now run between 45 and upwards of potentially 49 million Americans are without health insurance. That number fluctuates because – depending on whether people are working or not, depending on whether they have access to COBRA benefits or not – that is, the ability to keep their insurance while they're unemployed. All of those things play into this number. Whether they're eligible for Medicaid or not plays into that number. But, the estimate is somewhere between 45 and 49 million Americans are without health insurance. Under the House bill – the House bill that passed November 7th of this year – 36 million uninsured Americans would gain access to health care. So of the 45 to 49 million, 36 million, in the House bill, would get access. And it should be noted that part of that 45 million, perhaps four or five million of those, are what are defined as illegal immigrants, undocumented workers. And they are explicitly prohibited from obtaining insurance under this health care proposal. So the estimates on the House side are that we get to about 96 percent of eligible individuals covered. In the Senate, the number is a little lower. It is 31 million Americans who are currently uninsured would obtain health care coverage and that gets us somewhere to about, I believe about 91 or 92 percent of all Americans having access to health insurance. So as I said, the answer is in part yes, it makes a significant leap forward but it doesn't get us to 100 percent of the population.

JOHNSON: And Neil, this is the way, though, that progress would be made is through a mix of expanding public coverage and providing subsidies for folks to purchase private coverage. Is that right?

BOMBERG: Exactly. Depending on your economic – or your income, your family income, you might be eligible for expanded and enhanced Medicaid services or for a subsidy that you would get which would reflect your salary, because there is a cap – and I'm not going to remember it, and maybe Susan will remember it or Pam will remember it – but there is a cap on the amount of one's income that can get spent on health care. I believe it's around 12 percent. And if it steps over that line, there's a subsidy that comes into play even if you're middle income. But, certainly if you're lower income, there is a subsidy to keep the price as affordable as possible and to keep the incentive there for individuals to buy health insurance.

JOHNSON: I know, Neil, that there's a lot more debate or – the question of how effective the pending bills are in containing costs is the subject of great debate here.

BOMBERG: Yes.

JOHNSON: Do you have a take from a city perspective in terms of what NLC was hoping to see in these health reform proposals and how much progress we're making with these pending bills?

BOMBERG: Well, I think it is fair to say that until implementation actually begins, it's going to be very difficult for us to be sure of what the level of cost containment will or won't be. But what I think is important here is if we look at some of the numbers from the Congressional Budget Office (CBO). And what is really critical here is that both the House version, which passed the House in November, and the Senate version, which is currently being debated, will result in at least a reduction of the federal deficit. And this is really quite significant, because the federal government does spend a huge amount of money on health care. And part of the result, part of the reason that the deficit will decrease is, one – because health care costs will be more evenly distributed across the population so all of us will be, if you will, paying our fair share. But the other reason also is that we actually are looking at the possibility of reducing the annual cost of health care to individuals and families. In the case of the Senate bill, the CBO predicts that the deficit will be reduced by about \$130 billion over 10 years. In the case of the House bill, they say that that deficit reduction will be closer to about \$100 billion. So the Senate bill definitely, based upon CBO projections, will save money.

Now, I think there's another important factor to consider here. And I'm just, as I'm speaking, trying to find the exact table that I can refer to. And I'm not finding it, so I'm going to have to sort of wing this. But, the Lewin Group, which is supposedly a nonpartisan health study group out there, just released a report comparing the cost in coverage impacts of the House and Senate leadership health reform bills, and looking at the cost to governments, employers, and employees. And I think what is really important to note is that the Lewin Group determined that there would be a substantial savings to state and local governments as a result of this health care reform. I think it was in the neighborhood totally of about \$90 billion, which interestingly is

about the equivalent of one year expenditure that cities and towns make for health care. We spend about \$87 billion a year right now. This is good news. The bad news for cities and towns in this figure is that most of the savings will be the result of reductions in Medicaid and public health or public hospital expenditures, because as people increasingly have insurance and access to insurance, the cost to hospitals of paying for uninsured individuals, the cost to counties and to states, will go down. What they do estimate will occur – and I think Susan alluded to this in the question that she mentioned that some of her local government or city governments have about coverage – is that the cost for premiums will go up for cities, towns, counties, and states. But I think it is important to note that overall there will be a significant savings.

JOHNSON: That is big news. Let me pause and see. Pam, Susan, thoughts, reactions to what Neil just talked about, either in terms of the coverage issues or the cost issues?

SMITH: I read a document the other day, and it said that currently an average family spends about \$4,193 per year on their health care premiums. And they're estimating that it should drop about \$387 per family.

JOHNSON: Wow.

WALKER: One of the things that Susan brought up is part-time employees, and some and some of the mandates for people to get coverage. And, you know, that's a big concern for us from an economic development standpoint and an individual cost standpoint. Just to give you an example, we have 900 food service establishments in the city. So they probably employ anywhere from 12 to 15,000 mostly part-time people, all uninsured. And they can't – the companies can't afford to purchase the insurance. The individuals can't afford to purchase the insurance. And Neil, one of the things I saw was to mandate, you know, that on both parties, and if individuals don't purchase the insurance then they get a lien on their taxes. And I'm sitting here going, okay, I'm going to have the worst health outcomes in the nation plus, if they have a car, now they're going to have an IRS tax lien on it because they're not going to buy health insurance. And so, some of those mandates and how those play out over the next few years and whether it's true incentives versus punishment are really going to make a difference on whether we do see those savings in the other areas like hospital emergency rooms and Medicaid. And I don't really have my arms around all of that yet.

BOMBERG: I do agree with you. I think one of the things that both bills include that is important is, depending on the size of the business and depending on the individual, as I said, their economic circumstance, there will be subsidies both to businesses to help them defray the costs of health care and subsidies to individuals. And I think we're going to have to, over time, look at those subsidies very carefully and see what the state, local, and community impacts are. I think you raise a very valid concern that are we going to create a penalty situation for individuals that will not give them the incentives to buy health care but will nonetheless penalize them in a way that is quite costly and, especially for lower income individuals, quite problematic? So I think there are reasons there to look at this carefully, but I am optimistic that in both the House

and the Senate bills, there is really an attempt to reach out to those small businesses and individuals who are in need of assistance to cover their health care costs.

JOHNSON: Key issues. Let me take just two more minutes then, Neil, to come back around to this question of the mechanics of providing health coverage and whether the bills that are pending have addressed the concerns that we've had on behalf of city governments across the country around sufficient flexibility in terms of how they go about – you know, through pools, etc., – doing what they do.

BOMBERG: My read of the bills at this point – and I say that at this point – is that we have done relatively well in not just the mechanisms for delivery of health care benefits, but also in the broader framework that we've been talking about. So I would say first of all that with the exception that, and both Susan and Pam have raised this, of knowing what the fiscal impact will be of increased health care coverage for temporary workers or workers who are not full-time, that they will have to get coverage. But setting that aside, we retain the flexibility to use the mechanisms we are using now. For example, state pools that actually do provide insurance will be able to continue. In addition, cities and towns that choose to purchase their health insurance for their employees from a private sector health insurance company such as Blue Cross/Blue Shield, Aetna – to give a contrast of generally nonprofit versus profit – that cities and towns will be able to continue to do that. And we do have a substantial number of cities and towns either through a pool like the one that Susan operates, which serves a large – I believe Susan's pool, yours serves over 500 cities and towns?

SMITH: About 680.

BOMBERG: Six hundred and eighty cities and towns in Texas. But, cities and towns that choose to go the self-insured route, whether through a pool or individually, will be able to continue doing that as well. So my read at least – and Susan, please, if you think I've misrepresented this, please, you know, jump in here – but, my read of this, at least for now, is that we have been able to, either through silence in the bills or specific mention, been able to ensure that cities and towns will be able to continue to deliver health care service, insurance, to their employees in the ways that they have been doing so all these past years.

SMITH: I think one of the concerns that some of our political subdivisions have is, you know, what are they going to do to that self-funded market? Because there have been discussions about them either making sure that self-funded market is excluded or it is compliant actuarially with the public plan option benefits. That will impact all of our municipalities that we service regardless if they're self-funded or they're purchasing through a pool or the private sector, because there are definite benefit improvements that the health care reform supports. And some of those improvements are really deleting lifetime maxes or putting a cap on a lifetime max, which typically, the plans that we service, run two to three million lifetime max. They are also in great discussion about any type of calendar year maxes. Now, the current debate that's going on in regards to that is that, instead of saying it's prohibited, it has to be reasonable. And so, then you'll see the underwriters go back and put some sort of calendar year caps, or lifetime

maxes that are reasonable. And as health care changes, those numbers go up or down just because of how we need to take care of the people that we service. And I do think that has an impact on the premiums.

In addition to that, there was a lot of discussion today on the news about what they're going to do with pre-existing. Initially, we all heard that the preexisting limitation was going to go away and everybody was going to be guaranteed access. And today, after yesterday's conversations, they're saying that they really want to put a cap on how much you can underwrite a person who has a catastrophic or chronic illness, and the cap is 50 percent more than one of the other active employees. And so, all those debates continue to be discussed. They are talking about the meat of the issues, which are how we deliver health care to our covered individuals. It's just how all that rolls out. And there's a price tag on every single one of those decisions. And so, until we measure all that, you know, we're all kind of sitting and waiting to say, "Okay, how can we make all that work?"

BOMBERG: And I think Susan's point is well taken. While there is no change to the mechanisms by which cities and towns may provide their employees with health insurance, there may be changes to the business model across the entire – or I shouldn't say there may be. There will be changes to the business model across all of the possible ways of providing insurance. And to the extent that those changes occur, we may see some kinds of insurance delivery mechanisms disappear and new ones potentially even emerge. But, that is a function of the business model that will have to emerge as opposed to a legislative decision that says, "No more self-insured plans or no more pools or no more direct purchase."

SMITH: Well, and the other big idea is all of us, I think, can comment that today the way health care is delivered, it's a broken system. So, for the business models to change, you know, some people are like, "I can't believe that's going to happen." It has to happen if we want something to be different. And so, we need to wrap our arms around, okay, the business model's going to change, but let's make it change for the better. And so, I think we're all waiting to see, you know, what are the pieces out there. We all do not want to go backwards. We want to go forwards. And it is an opportunity for different relationships to come to the table because, you know, that private and public sector, you will see more alliances be created so that the delivery product to the covered individuals is going to be more efficient and we're going to get better outcomes, because there is a big, big push for evidenced-based medicine. And I think out of all the benefit things they're looking at, that has the most noise to the people that we service, because the doctors typically do things that are not evidence-based medicine. And today, we're paying for them. And there's a ton of fraud out there, and today, we're having trouble catching it. I think, you know, change in business models, being more in tune to evidence-based medicine, and being more cognizant of the fraudulent activities that are occurring in health care will save everybody money.

WALKER: Yeah, that's going to be absolutely critical. That's one of the most important pieces to getting costs under control. And you can mandate people talk to a health coach or you can, you know, cut their – charge them more if they don't do certain things. But, until you really start paying the provider system for better health outcomes, we're not going to have a cost

savings. When they have patients with high blood pressure, you have to pay them for getting the blood pressure down, getting the weight off, getting the diabetes under control, not just running the tests. And it's backwards now, and until we flip that somehow, and I don't know if it's going to be through more regulation, a public option, universal health care, a system that allows for creative solutions and new business models, but something's got to give in that area or we just aren't going to see the kind of health we need in our communities.

SMITH: Well, and Pam, one of the things they're talking about is going with diagnostic-related groupers for outpatients. So, if you're a diabetic, the plans are going to pay you \$2,000 regardless if they see you every day or three times a year. That's what the plans are going to pay you. So they're capping that payment which will then encourage the doctors to treat more efficiently and effectively and hopefully get good outcome. My only panic in doing that is if you're a noncompliant patient, the doctors aren't going to want to treat you because, you know, you're going to cost too much money and they're not going – you're going to be a cost center for them. And so, I'm hoping that, you know – and health care reform is over 10 years. I'm hoping that goes slowly so that people then do get personally health engaged, we do get that change of behavior, and we don't have a lot of people where doctors won't see them because they're noncompliant with their treatment plan. But, all of us need to be – I mean, people take four pills and feel better and they don't take the rest of the medication. It happens all over the place. And it's a very big cost center for health care.

JOHNSON: So, let me interrupt for just a second. I want to pause because we have – for our listeners on the line, I want to give them a sense of how they can pose a question to you all. Let me invite the operator to give instructions for a minute.

OPERATOR: If anyone has a question or comment, you can hit star-one on your telephone keypad, star-one, and I'll access your line.

JOHNSON: And there's a second way you can pose a question, which is by email. So, if you're at a computer and that's a preferred way, you can send an email message to Karpman, K-A-R-P, that's P as in Paul, M-A-N at nlc.org and we'll get that email and try and work your question into the conversation.

For listeners who joined us late, I'm Clifford Johnson. I'm the executive director of the Institute for Youth, Education, and Families at the National League of Cities. We have three resource people and speakers on the line. Pam Walker is acting director of Health from the City of St. Louis; Susan Smith, the executive director of the Texas Municipal League Intergovernmental Employee Benefits Pool; and Neil Bomberg is principal legislative counsel here at the National League of Cities.

Pam, let me come back to you for a second. You know, if – when you listen to this debate and follow this debate and hear this conversation, are there opportunities that you think are posed for this City of St. Louis and its residents that you are particularly focused on or excited about?

WALKER: Yes. I think – I'm a real advocate of the public option. I just have to say that right up front, because I think that's where you're going to get your innovation and your experimentation. To try to regulate these kinds of changes through an existing insurance system is just overwhelming. I mean, I just – I don't think regulation necessarily is the answer. And so to have those options – to be able to look at your health outcomes like we have and say, you know, St. Louis City needs to do something different than maybe another city where their population's healthier – and have an option that lets us do that and lets us buy insurance differently, pay medical bills differently, and have some evidence-based health outcomes is really the first time – and I've worked on health reform since the early '90s – it's really the first time those discussions have even been at the table. So it's very, very positive for me that people are getting that. And it's not just about access to health insurance or even access to a provider. It's about access to a healthy lifestyle and what that means. So it's a huge opportunity to really make a difference in people's health.

JOHNSON: Susan, what do you see as opportunities on the landscape here for cities as they're thinking about how they're addressing needs both for their employees and for their broader pool-group of residents?

SMITH: I think the biggest opportunity is – you know, and I'm on the payer side of the business – is really all of the standardization that that's going to back up and support improved health care by evidence-based medicine. You know, they've got a big, big focus on health information technology, and all of the insurance companies are going to be mandated to standardize the way we correspond with a covered individual so that if you move from Aetna to Blue Cross to United to TML, the way we communicate with those people is using the same verbiage so that they know what those words mean and they know how it is actually operationalizing in their access to health care. They definitely want to standardize web wellness portals. They want to standardize all of the open enrollment piece. And there's several million dollars attached to each one of those. They want to go with electronic explanation of benefits. They want to move to electronic payment of providers, which TML is in the middle of doing right this moment. And I think just getting access to the information so that we can work more effectively will encourage everybody. They definitely are on a big push to electronic medical records. And right now, there is today an operation where all the payers out there are having to communicate with Medicare, and we have to rely on sending them information for anybody who's actively at work for 65 and older. That definitely has been a headache for lots of pools and lots of political subdivisions out there. But, in the end, it will minimize how many times we double pay a provider and it will maximize how efficiently we can manage the premium cost for health care. And so, all of those things intrigue me because there are so many complications behind the scenes outside of delivering health care to those covered individuals. And President Obama has a big, big push for health information technology, and I'm hoping that is one of the big areas where we see a savings so that we can manage and stabilize the cost of that premium for the people that we service.

WALKER: Yeah. And Susan, all of those things will help purchasers buy the best quality for the best price. I mean, a hospital is the only place you go into and you say, "How much is this going to cost?" and they say, "I'm not going to tell you."

SMITH: That's correct. And that's transparency. You know that transparency's key, especially in pharmacy benefit services. You know, when drugs are a huge piece of our access to health care, especially the biotech drugs, and there is big conversation on the Hill regarding what they're going to do to biotech drugs because now they're coming out with biosimilars, which are generics of the brand. And they want to maintain a monopoly on those brands even though those biosimilars are a little more cost effective. So you know, just even the purchase of prescriptions, you know, we definitely need to manage that. And if we're not going to do it the first step in health care reform, then my recommendation, and you've talked a lot about evidence-based medicine, Pam, there are areas where we can do more evidence-based medicine on prescriptions also. And it does assist us in buying more cost effectively and educating the consumer. And that transparency is a word thrown around, but people still don't know how much does the purple pill cost and how much does a day in that hospital cost?

WALKER: And if you have really good insurance, you never see the bill. Even afterwards, you don't know what it cost.

SMITH: That's correct.

JOHNSON: We're getting close to 20 minutes after the hour. Let me check with our operator, see if there's someone in queue for a question.

OPERATOR: There are no questions in queue. But just a reminder, if anyone does have a question, you can hit star-one on your telephone keypad, star-one. There are no questions in queue at this time.

JOHNSON: Thank you. We'll check back. Neil, I know you don't have a crystal ball there in your office. Do you have – what's your sense of where the debate is heading right now? Do you – is the endgame becoming clearer for you? What issues do you think are going to be the critical ones hanging in the balance that cities and children and families would care about?

BOMBERG: I'm sorry. I lost you on the last part of that question.

JOHNSON: Oh, just, you know, whether you see sort of one or two pivotal issues emerging from a city perspective or as the Congressional leadership and the administration try to move to closure here.

BOMBERG: Well, I wish I had a crystal ball, because certainly earlier this year I was saying that we would have health care reform by the summer. Then, I was going with September. Then, I was going with November. Now, I...

JOHNSON: Then you stopped making predictions, right?

BOMBERG: Right. Right. I'm not sure when I went to. If I were to predict the outcome before Christmas, that is whether the Senate will be able to pass its legislation or not, I would say at this point I believe there's a 55 percent chance of passage. Not as good as – I think from the perspective of the League of Cities – not as good as we would like it to be. I think the two pivotal issues – and they're not necessarily pivotal issues for cities and towns – but the two things that are really holding this legislation up are, one, the issues that have been raised around the public option and the related effort to expand Medicare. So it's the question of how much direct involvement in health care delivery does the federal government have? I mean, I think we're naïve if we don't think the federal government is heavily involved in health care, but is the federal government actually providing that insurance, etc.?

JOHNSON: Right. Right.

BOMBERG: So, that's question number one. And the other question is the issue of abortion. Because we basically have two members of the Senate Democratic Caucus – Senator Lieberman who is actually an Independent, who, of course, is vehemently opposed to a public option, vehemently opposed to Medicare expansion, and therefore has proposed or has said that he would join the Republicans to prevent the bill from coming to the floor, and then we have Senator Ben Nelson of Kansas who has also expressed concern, and that being over the abortion issue. Although the difference, I think, between Ben Nelson and Joe Lieberman is that Ben Nelson has said repeatedly, "I want to vote with the majority to pass health care. I just need slightly better language, slightly better ways of keeping federal dollars and private dollars separated on the abortion front." I think they will get a resolution to the questions raised by Ben Nelson, Senator Nelson, of Kansas. What I don't know they're going to – I'm sorry, of Nebraska. What I don't know if they're going to be able to ultimately do is satisfy Senator Lieberman, and that is because if you follow the discussions that he's been involved with, he just flip-flops from day to day. So as soon as he gets a little more, he asks for a little more. And it's at what point does it become impossible? If they can get those two folks in line, then I think the chances of passage are very, very significant. And I would say as a final note on this that the core values of reform, the notion of universal access, the notion of reducing or cost containment, the notions of making sure that people who need health care get it and don't go bankrupt as a result of it, all of those core values currently exist in the Senate and the House bill. What we have and what we're fighting over right now are the visible externalities of getting to those points. And so, I remain optimistic so long as those core values hold together we can get over the externalities. The moment, though, we start to see those core values disintegrate, then we're in for deep trouble. And that's what I think we need to watch for.

JOHNSON: Very helpful, Neil. Let me check with the operator one last time to see if there's a question.

OPERATOR: There are no questions in queue.

JOHNSON: Okay. Then, let me turn first to Pam and then to Susan for a closing thought or two, either about a worry or a hope or a prognosis, a prediction.

WALKER: Well, I'm not going to try to be Neil and prove I don't have a crystal ball.

JOHNSON: Exactly, no crystal balls in St. Louis, either.

WALKER: But, I would love to challenge people on the phone and people across the country to contact their Congressional representatives, you know, just about the core values that Neil described. And if they feel like the country is with them on those, then, you know, I've found over the years in government in the United States, because we don't tend to shoot each other when we have regime changes, etc., a reasonable person, irrespective of party affiliation, presented with the same set of facts will make a reasonable decision. And I trust our Congressional members to do that, I really do. But, they've got to feel like the public is going to go with them on this ride that's going to take really, even if something passes, two to three years to sort out afterwards. And so, you know, I agree with Neil. We've got to be clear that those three guiding principles have got to guide this and we need to tell our members up there working for us that we support their decision-making in this, and we'll make it work and not fall out over those extreme issues like abortion and not let those divert the core business that this is about.

JOHNSON: And Pam, there's a message implicit in your comments, but I want to ask it directly. I mean, are you confident that if some version of what's been before the House and the Senate were to make its way into final law, would it make a difference for children and families in the City of St. Louis? Would you see a big difference in people's lives?

WALKER: Absolutely. If those three things, if we make progress in those areas at all, it will make a difference in thousands of people's lives. We have about 30,000 people uninsured. Most of them are adults. They're working two part-time jobs. They're struggling, you know, week to week just to survive. I see things like in public health, like we have a shigella outbreak right now in a daycare center, and you think, "How does this impact that?" Well, we have to ban the child from the daycare center until we get two negative stool samples. That can be two to three weeks. These people have to go back to work. So, you know what they do? They take the sick child to another daycare center. And then, we have the outbreak there, and pretty soon we're closing daycare centers. So it all ties together. It is all so tied together that--you know, of people's ability to get in, get treatment, get what they need, go on with their lives. And it's become a second – those of you who have health problems know that when you have a health issue, it becomes a second job for you, figuring out how to even get the care that you need and find the doctor and pay for it. So for people who are in these lower incomes struggling to just get by, they just think we're all kind of crazy.

JOHNSON: Yeah.

WALKER: And it's just too hard for them. So making it easier, making those medical records transfer, you know, reducing the costs, getting more people covered, putting equity in the system, those will have a major impact on people's health. They really will.

JOHNSON: Thank you, Pam. Susan, final thoughts for us?

SMITH: Well, I think the biggest area, and we didn't get to talk about this but I want to throw it out there.

JOHNSON: Sure.

SMITH: One of the areas, Pam, that they're looking at putting equity in is looking at the medical loss ratio. And if it's over a certain percentage, you have to give it back either in better benefits or in rebates to the consumer.

WALKER: Um-hmm.

SMITH: That in itself will change how we manage health care, because they started with 85 and if you, you know, if you have any excess over 85 and then you have to give it back in rebate format, that will pull that private sector in and it will minimize what they're giving their shareholders, because that in – from that, those dollars will go back into the community in the response of better health care or access to health care because the premiums are lower. So I think there's a lot of things embedded into health care reform. It definitely is going to change my business model. I do think that it will pass and I do think it will probably pass before the holiday season. But, then they'll come back, and I think there is probably going to be six or seven days of debates over amendments. And then, we've got a 10 year stretch to implement. And during the 10 year stretch, whatever they said was going to happen today will be evaluated and probably reformatted five or six times before it actually goes out to the consumer and we have an opportunity to continue to make the system better.

JOHNSON: That's a great reminder that in many ways whatever happens here if we have a bill enacted into law, it's certainly –in any sensible view – a beginning and not an end. It's a beginning of a long evolutionary process to really change a huge sector of our nation's economy and, in many ways, the quality of American life. Neil, a final word for our listeners?

BOMBERG: Yeah. I do think that ultimately we will get to health care reform. I think this has been a very painful and excruciating process. I'm reminded that the same kinds of processes occurred in the passage of any major social reform, and this is clearly one of the great major social reforms to move from essentially a system that is hit or miss to one of universal care and universal access, or universal coverage and universal access is a major reform. And so, but we will get there. It will take more fits and more starts and more, I think, moments of questioning whether it's possible or not, but I do believe we will get there. And I do believe that ultimately just as Medicare has become a major success, just as Social Security has been a major success, just as the unemployment system, which needs some updating and modernizing, has also proved

to be a success for those people who can access it, that this health care reform will ultimately prove that way as well. And as has been stated, it will go through a series of iterative processes whereby we will make improvements, we will make adjustments and changes. But ultimately it is going to pass, I believe. It will be useful to cities and towns. And I think most importantly, whether from the employer perspective or from the perspective of mayors and city council members who care deeply about the general health and well-being of their residents, it will be a success there as well. That's it for me

JOHNSON: Thank you, Neil. Pam Walker from St. Louis, Susan Smith from the Texas Municipal League, Neil Bomberg from National League of Cities, thank you, all three of you, so much for giving us your time today for this conversation. Really appreciate it.

BOMBERG: Thank you.

SMITH: Thank you.

WALKER: Thank you.

JOHNSON: Let me--for our listeners, thank you so very much for being with us. And let me just note that in the new year we will continue our audioconference series. Our next audioconference will be held on January 21st. It will be at 2:30 Eastern Time, 11:30 Pacific. And the title of the audio conference is "New Ideas for Promoting a Local Asset-Building Agenda at Tax Time." So, I hope you folks will come back and join us again for that next call. Happy holidays to you all. Have a great holiday season. Thank you very much.