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**Ask the Experts: Children's Health Care  
Kaiser Family Foundation Broadcast Studio  
April 4, 2006**

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**LARRY LEVITT:** Larry Levitt from kaisernetwork.org.

Welcome to "Ask the Experts," our regular interactive WebShow that provides in depth discussion of current health policy issues, and allows you to interact directly with the nation's top policy experts. In conjunction with National Public Health Week, whose theme this year centers around designing healthy communities and raising healthy kids, we are here to explore a range of issues affecting child health. Even as overall life expectancy continues to grow and new drugs and treatments keep people healthier, increasing numbers of children are being diagnosed with preventable conditions such as obesity and asthma. Disparities in health and access persist, based on income, race and ethnicity, and where you live, and at the same time 9 million children are uninsured. That is more than one out of every nine kids nationwide and Medicaid and SCHIP, the primary public programs that serves low income children, face continuing fiscal pressures. We are joined by an exceptional panel of experts to address these issues. Dr. Georges Benjamin is a physician with a long-standing commitment to community health. He is currently executive director of the American Public Health Association, which is the sponsor of Public Health Week. Robin Rudowitz is a principal policy analyst with Kaiser Commission on Medicaid and the Uninsured, specializing in

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health financing issues. Christy Ferguson is president and CEO of FirstFocus, an organization dedicated to ensuring the children and families our focus of budget and tax policies. She has served in a number of state and federal policy making positions and will soon the faculty of George Washington University. You can reach our panel of experts in two ways. E-mail your questions to [ask@kaisernetwork.org](mailto:ask@kaisernetwork.org) or call us here at the Kaiser Family Foundation broadcast studio and ask your question on the air. You can phone toll free at 1-888-kaiser8. That is 1-888-524-7378 and we will do our best to get to as many of you as we can. Thanks to all of you for joining us and Dr. Georges Benjamin, let's start with you. We often focus in terms of keeping people healthy on personal behavior, on diet and nutrition, on exercise, but with Public Health Week this week, you are focusing on communities, building healthier communities, things we can do with urban planning to prevent illness and keep people healthy. Give us some examples of how these urban planning decisions affect people's health.

**GEORGES BENJAMIN, M.D., FACP:** Well think about it when we all grew up, when you could walk to school or when you walked to the grocery store and you carried your groceries back and then fast-forward to today when we put our kids on a bus and they go around the corner to a school or we put them in a community in which they can't walk or ride

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their bike, or we hop in our car and we drive across the community to a store. We haven't built our communities so that they are walkable, bikeable, they are green, and that tends to affect our health and so we are trying to figure out how we can build that community smarter and more effectively for the future, to try to deal with things about childhood obesity and help deal with issues around incidence of asthma and to help deal with this issue around injuries and kids.

**LARRY LEVITT:** And these kinds of planning decisions, I mean health isn't I imagine often the prime consideration. I mean, we are really talking about two different worlds, the public health community and the urban planning or development community. What are some of the ways that you can make those linkages?

**GEORGES BENJAMIN, M.D., FACP:** There have been two different communities, but things are changing. We are now beginning to see health departments and planning departments jointly partner, bringing in community groups to sit down and say okay, if we are going to plan a new community, let's think about what we want that community to look like. How do we build sidewalks? How do we build bicycle paths? How do we build places where people want to recreate in that community? There is an encouragement for people to go out and do those things, or take in some of our old historic communities. How do we reinvigorate those communities? You

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know, get people out to walk, make those communities safer, and revitalize the playgrounds so children can use them.

**LARRY LEVITT:** These changes in the planning landscape, are they to blame for some of the rising rates of obesity and asthma?

**GEORGES BENJAMIN, M.D., FACP:** Well, they are part of the solution. You know, we have got lots of things to blame around obesity in terms of the way we live our lives, the fact that we have supersized everything and the fact that we are eating out more, the fact that we are all playing in front of our electronic gadgets more. We have less P.E. in schools, the diets that our kids are eating in school are not the healthiest in many communities and so we have got lots of people to blame, but we also have very effective solutions and now is the time for us to begin implementing them.

**LARRY LEVITT:** And how about, these kinds of factors don't affect people uniformly, I mean we see disparities in both disease and access based on race and ethnicity, based on income, presumably we see those kinds of factors at play in community decisions as well.

**GEORGES BENJAMIN, M.D., FACP:** Well, they absolutely do, I mean if you think about the fact you're in a low income community, and one in which does not have a grocery store or one which doesn't have a primary care practice. Those folks have less access to providers. They have less access to

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fresh fruits and vegetables. In fact, they may have less access to nutritious foods overall, and in many of those communities the children are totally reliant on the early breakfast programs and lunch programs in those schools. Now those are good things because those kids get to eat, but that makes them subject to whatever is being served and that makes them subject to the vending machines that are in those schools, so we need to really focus on that and of course, when we are looking at underserved or minority communities, those communities get the short end of everything.

**LARRY LEVITT:** Robin Rudowitz, let me turn to you. We've been talking about keeping kids healthy through prevention and planning healthier communities, what about insurance coverage? What role does access to insurance play in both access to care for kids as well as their overall health?

**ROBIN RUDOWITZ, M.P.A.:** Well, I guess I would make a pretty basic point that health coverage really matters and is really important. There have been just a ton of studies that show the numerous benefits of having health coverage. Kids with health insurance coverage have much better access to a usual source of care. They have much better access to the services that they needs, and they are more likely to have better health outcomes. You mentioned before about Medicaid and CHIP, and I think those programs have been

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extraordinarily successful in expanding the health coverage to low income children, and over the last decade those programs have brought the number of uninsured low income kids by about a third and the programs cover about one in four kids in the country now, so they have done a very successful job at expanding coverage for kids.

**LARRY LEVITT:** If we look at recent years, the number of uninsured has held steady at the same time the number of kids with employer coverage, which is the main source of insurance for both kids and adults, has come down, so in some sense Medicaid and SCHIP have really kind of cushioned the impact of employer covering in recent years, is that right?

**ROBIN RUDOWITZ, M.P.A.:** Exactly. Most kids still do get their health coverage through their parents and employer, about 60-percent of kids, that is how they get their health coverage but many low income parents work for firms that don't even offer health insurance coverage so Medicaid and CHIP have always been responsible for bridging those gaps in employer coverage, and recently as you said, during the economic downturn many people lost their private or employer sponsored coverage and many kids were picked up by the Medicaid and CHIP program, so the number of uninsured adults actually climbed by about 6 million while the number of kids, uninsured kids, actually fell because of Medicaid and CHIP

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because the eligibility levels are much more generous for children than they are for adults.

**LARRY LEVITT:** And in some sense if not for Medicaid and SCHIP, we would have seen a growth in the number of uninsured kids based on what is happening with the employer coverage.

**ROBIN RUDOWITZ, M.P.A.:** Exactly.

**LARRY LEVITT:** There have also been in the news recently some states that have tried to offer universal coverage to kids or at least talking about expanding coverage, give us a sense of what some of those initiatives are.

**ROBIN RUDOWITZ, M.P.A.:** Sure, well just to start off with a little bit of a baseline I guess. There is about 38 states in the country now have eligibility levels for Medicaid and CHIP that are at or above 200-percent of the federal poverty level, which is about \$30,000 for a family of three. There have been a number of states who have been aggressively looking to expand coverage for kids. I guess two good examples would be Illinois and California. Illinois has passed legislation to implement a program to cover all of their kids and that is going to be in effect starting in July of this year, and California has been working to expand kids' coverage through the counties and the counties have been launching outreach campaigns to get kids enrolled in Medi-Cal

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and California's medicaid and CHIP programs and they have also been providing county based coverage programs that are covering about 80,000 kids now. On the flip side, there are some states who are also restricting eligibility for kids and Missouri is an example there. They recently implemented pretty significant declines or eligibility cuts for parents coverage, which of course affects the number of kids who enroll and coverage programs, and they have also implemented some changes to their SCHIP program that have also worked to restrict eligibility in that state, so it is a little bit of a mixed bag going on in the states.

**LARRY LEVITT:** Christy, you ran health departments and oversaw health departments in two states, both of which worked to expand coverage for kids and we will certainly give you credit for that. Are kids still a focus of governors and policy makers at the state level, do you think?

**CHRISTY FERGUSON, J.D.:** I think kids are a focus. I think that it is a relatively inexpensive group to provide services for. I think the danger, however, is that there is a tension between the kinds of services that are necessary and the kinds of delivery systems that are necessary in order for kids to get the benefits of coverage versus a simple slim down benefits package so that you can say 100-percent of kids are covered but as we all know, a card with coverage doesn't mean that you are going to be able to address the asthma

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issues in a cooperative way, a coordinated way, so I think that the challenge that we face going forward, particularly with the Reconciliation Act that was just passed, is whether or not this will be an area that has very narrow benefits and narrow coordination, but very broad coverage and I think that in the policy arena, the people who work in public health and work in medicaid and work in the insurance industry, that debate right now is starting to heat up and I think that will be the biggest challenge because I think it is very simple and it is a good rallying cry to talk about 100-percent coverage for kids, and it is possible to get there. It is really possible to get there. The challenge is when you do that, how do we handle kids with disabilities? How do we handle kids who are from families where the access to the actual delivery of services is not readily available? How do we handle those things and make sure that our packages consider that?

**LARRY LEVITT:** Let me come back, when you talk about the Reconciliation Act, this gave states greater flexibility and what benefits they –

**CHRISTY FERGUSON, J..D:** Right and it is still flushing itself out, so I think the challenge is that for adults, for governors and for policy makers in the legislatures of states as well as members of congress, it is a lot easier to talk about kids than adults in terms of

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health care coverage. The difficulty is that where the flexibility has been given to states is around kids who are the cheapest part of any Medicaid program and where the flexibility hasn't been given to states is around adults, and they are, not adults with long-term care services or disability services, that is where most of the money is spent, and so what is naturally going to happen is states are going to go to where the flexibility exists and they are going to play with those issues and that may affect children in a negative way, so we really have to be cognisant of both, of three legs to this stool, which is coverage, access to services, and what the delivery system looks like.

**LARRY LEVITT:** And where do you think we need to be careful in terms of looking at access or the delivery system issues or benefits?

**CHRISTY FERGUSON, J.D.:** I think the thing that we have to be most careful about is what it is we are trying to achieve and I think that as a state person, I always found myself in the situation of people talking about coverage as the goal. That is not the goal. The goal is to have kids who are healthy. Coverage is a means to get to that end, and I think that the difficulty that we have in the policy arena and the political arena is that we don't focus on what that end is. The end is that coverage has to lead to healthy

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kids, and that means prevention, it means a wrap around of services that just simply are at risk.

**LARRY LEVITT:** We had a number of questions, and we can go to some of our e-mails now about quality of services and really just that point, that we give kids an insurance card, but don't do a lot to measure the actual quality of the services they are receiving. What would you say is the state of the art in measuring quality of care for kids?

**CHRISTY FERGUSON, J.D.:** There are not enough of them. I don't think that we do a particularly good job at it right now and I think much more has to be done, and I don't know, Georges you probably know more than I do about some of the best examples of measurements. We have some good HEDIS measures. We have good measures that are out there but they are not being used to actually improve benefit structures I think.

**GEORGES BENJAMIN, M.D., FACP:** Yeah we do a couple of things; we obviously have to begin the whole health care accountable for a range of problems, from medical errors to whether or not people are getting adequate service. The health care system, we provide great care in some places and we provide poor care in other places, and we need to be able to measure that and we need to get a report on it and then I think one of the more important things we need to do is empower the consumer, the patient, and our citizens to be

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able to utilize that information to make informed decisions. Now, that is a big difference than making them accountable for who pays. That is a big debate amongst itself, because many of us, you don't choose at 2 o'clock in the morning, in many cases, where you are going to receive your health care. You go to where you can get that health care, and quite frankly sometimes at 4 o'clock in the afternoon on Friday you don't get the option to choose where you go, so we have to balance that very much so. We do in a lot of things, report cards. Pay for performance is a new tool that people are using. We will see how it works.

**LARRY LEVITT:** You mean paying doctors for their performance?

**GEORGES BENJAMIN, M.D., FACP:** Paying doctors for high performance but you know, remember what is driving this is cost. There is a lot of discussion around quality and I would love to see the whole debate being driven around quality as the major driver and then paying adequately for services and appropriateness for services as probably the secondary driver.

**LARRY LEVITT:** And focusing on child wellbeing, which is certainly different from adult wellbeing, certainly the kinds of services they receive, where is our highest bang for the buck in quality or access with kids?

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**GEORGES BENJAMIN, M.D., FACP:** Well making sure that kids get adequately screened early for preventive services, making sure they get those preventive services, and reminding. Christy was absolutely right, providing these services for kids is the cheapest and most efficient thing that we can do, and yet we've just passed legislation as Christy mentioned, to cut the Medicaid program, but they are not cutting it in the right place, and they are not focusing on the right part of the program. That is part of our problem. That is part of our ongoing problem. In fact, I believe we should make sure that all of our kids have access to health care, all of our kids should have insurance coverage, and we should pay that out of our first dollar and then build a health system that can communicate electronically, where we are measuring what we are doing, but we are not doing any of those things and then communicating effectively with parents to give them information so they understand the health and well-being of their kids, and we are not doing any of that stuff.

**CHRISTY FERGUSON, J.D.:** I think the one other thing that offers us a tremendous opportunity in terms of both the quality and the breadth of coverage is the idea of not looking at the conversation about outcomes in a pure health perspective. In other words, if we are successful in extending the inter birth interval between children, that has

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an impact on the education system. It has an impact on the childcare system. It has an impact on a series of things, both from numbers perspective as well as more importantly from a learning perspective. You have fewer learning disabilities there are fewer issues that affect the educational system. Same thing is true with mental health, and I think we do not do a good job in the health care community of connecting from a coggle perspective what it is that we invest in health care and how that affects education, childcare, family status, the economy, in a much broader perspective and that is where we are really falling down and my only issue with some of the quality conversation is that it happens without the other conversation going on and we need to invest in studying the long-term outcomes.

**LARRY LEVITT:** Broadening what we define as the outcomes. Christy, you mentioned the schools and we have a question from Arizona about really the flip-side of that, not just looking at the educational outcomes from better access to health care but also looking at what you can do in school around prevention, since kids spend most of their day in schools. Georges, are there any sort of best practices out there that you have seen about using schools as a way to reach kids around prevention?

**GEORGES BENJAMIN, M.D., FACP:** Well certainly in our school based health centers, marvelous opportunity both to

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ensure that kids are healthy and given a healthy education, actually building health into the health curriculum so that when we are reading about Dick and Jane, we are reading about Dick and Jane doing healthy things. Looking at ways in which we can build physical activity into our schools is a good way to do that, having asthma educational programs in schools, good opportunity to teach those kids how to self-manage their asthma, teaching teachers how to help those kids do that kind of thing, so it doesn't become a burden on the educational system but part of simply normal flow of ensuring those kids are healthy. There are many things. There is a whole mental debate around ensuring kids with a mental illness, or early identify or taken care of properly through the school system, put into the proper environment to enhance their educational attainment. All of those things can be done, but it requires a holistic approach.

**CHRISTY FERGUSON, J.D.:** And there are examples of dental clinics actually being in schools where there has been a tremendous uptake in the kind of screenings that need to occur so I think the schools are a critical first place and I think the challenge to that is that our financing mechanisms, whether they be insurance or they are medicaid, have to be shifted and that is part of the interesting aspect of the quality conversation because all of the issues of how you get certified as a provider really fall right in to that whole

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school conversation from a practical perspective and we have not done a very good job of figuring out how to answer those questions. [Inaudible - interposing]

**LARRY LEVITT:** Robin, are there opportunities in medicaid that you are aware of to get some of those funding streams into school-based centers?

**ROBIN RUDOWITZ, M.P.A.:** Yeah, two points I think the schools can also be a very effective way to increase awareness and outreach to enroll kids in medicaid and CHIP, because they are there all the time and the parents are involved with the school activities.

**LARRY LEVITT:** And there are many kids who are eligible for medicaid or SCHIP who are uninsured and not enrolled in those programs.

**ROBIN RUDOWITZ, M.P.A.:** Right so through the schools is a great way to expand that outreach effort and the other point, and this also relates to Christy's point, is that if the school-based clinic can be certified as a medicaid provider, they can receive medicaid funds to provide some of those health services to kids that are eligible so medicaid can be helpful in providing coverage and the schools can get the kids enrolled and provide some financing to get kids those services in the exact places where they are for a great portion of their day.

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**GEORGES BENJAMIN, M.D., FACP:** And it's important to link that school-based health center with the child's medical home and there should be effective linkages between the two so that a primary care provider knows what is going on in the school and help engage and support the people in the school-based health center.

**CHRISTY FERGUSON, J.D.:** If it is done properly, there is no reason that a school-based health center couldn't be a child's medical home. I mean, the reality is there is nothing that prevents that from happening except a whole bunch of stereotypes about what those clinics do.

**LARRY LEVITT:** Certainly convenient.

**GEORGES BENJAMIN, M.D., FACP:** Well you know, in some communities you can actually build a school-based health center. It can serve as a health center for the whole community if you do it correctly.

**LARRY LEVITT:** And in many communities, I know certainly in Boston which I am familiar with, the health centers are not divorced from the social service centers as well. I mean, often these health centers serve as really almost a multipurpose community center.

**GEORGES BENJAMIN, M.D., FACP:** Particularly small communities.

**LARRY LEVITT:** We have a caller on the line from Washington, D.C. Caller, please go ahead.

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**FEMALE CALLER:** Yes hi. We have been hearing a lot about the national children's study, a major study proposed by the federal government on how environment can impact children's health and development. It sounds as if the study could address a lot of the issues that you have been describing here today, obesity and asthma and others, I am wondering if you are familiar with the study, if you support the study and feel that it would be helpful and adequate in addressing some of the issues that you have been discussing here?

**GEORGES BENJAMIN, M.D., FACP:** Yes, I am absolutely familiar with the study and support it, but we have got to get it adequately funded. One of our big challenges, in fact one of our pushes for this week, it's National Public Health Week, is to encourage our legislative leaders and make sure that we adequately fund a children's environmental study.

**LARRY LEVITT:** Where does it stand in the legislative process right now?

**GEORGES BENJAMIN, M.D., FACP:** It is money, is the problem, trying to actually get it funded. As you know, this has been a very difficult time for domestic funding for many very important public health and domestic programs and so when I am encouraging people, I tell them talk to the folks in the house, and try to get the house to put 7 billion

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dollars more into a funding formula so we can then approach them about these very important public health programs.

**LARRY LEVITT:** And describe a bit what the study would do?

**GEORGES BENJAMIN, M.D., FACP:** The study is going to measure, it's kind of the Framingham Study for Kids, and it is going to look at a range of health care outcomes from kids in effort over their childhood. It is a very important study. Remember, Framingham was the adult version where they went to a small community and they looked at a whole range of things and that is why we know what causes cardiovascular disease and cancer, because we have looked at things over a period of time and they want to do the same thing in kids, they want to look at kids that have exposure to environmental hazards, they want to look at things that happen in the home, things that happen in the school, they want to measure health outcomes, and in doing so, try to get a picture of what things affect kids' health.

**LARRY LEVITT:** And this wouldn't be a one time survey, which is what many of our surveys are now, but [inaudible - interposing].

**GEORGES BENJAMIN, M.D., FACP:** Surveyed over time and it is very important for the study that we think needs to be funded.

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**LARRY LEVITT:** Christy, you sat there in congress and were certainly involved in decisions like this, how would you say legislators would look at an issue like this?

**CHRISTY FERGUSON, J.D.:** I think the difficulty is that it is not something that you can talk about at home immediately. It takes a long time. You don't generally get the results for years, and so it doesn't feel quite so immediate to members, but I think that the challenge that we have is that there is a lot of good information out there now that if we can begin and continue to as APHA does a phenomenal job of and a lot of people really work with the data that we have now and exploit the fact that a lot of times these members are saying to us as staff or as advocates why don't we have information about this? Why don't we have information about that? Well, we don't have information about it because you are not funding it and because you are not putting dollars into contracts on medicaid to really look at outcomes. You are not funding the kind of research that would be necessary in order to demonstrate how these things work or don't work, and this is the IOM study?

**GEORGES BENJAMIN, M.D., FACP:** No, I think it's the NIH study.

**CHRISTY FERGUSON, J.D.:** Is it 200 million over 10 years or something? [Interposing]

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**GEORGES BENJAMIN, M.D., FACP:** I don't remember exactly how much it is, it's a fair amount of money.

**CHRISTY FERGUSON, J.D.:** Yeah there needs to be a real push on the part of the medical community and the insurance community as well as the state folks about the need for this information and I think that there is an audience for it and it needs to be pushed really hard.

**GEORGES BENJAMIN, M.D., FACP:** Well it is, and obviously we have lots of challenges on our elective leaders and our resource allocators, but the message, I think the take home message is let's invest domestically, let's understand that these investments will pay off. You know, it is very difficult for all of us to go back home and say we've got trouble with kids learning, that we have got all of these health problems, and we have rising costs of health care and those are problems, and here are the solutions, you know, investing in knowledge, investing in prevention, doing data driven decision making. Well, to do that you have got to have the data, and you have got to fund the infrastructure to do this. If we had spent the kind of money ten years ago in our health care system so that we could exchange simple things, like electrocardiograms across the street, blood tests across the street, we would tremendously reduce our administrative costs and then we would have the money to reinvest in our health care system and we would see savings

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as Christy was saying, both in education, in the criminal justice system, in many other parts of our daily lives, but we have not made the investments that we need to make in a variety of things, primarily in public health.

**CHRISTY FERGUSON, J.D.:** It is a challenge between short and long-term goals. It is the challenge from both an advocacy perspective as well as a political perspective. It's always a challenge between being able to show what you have done in the six month period as opposed to, the same thing with business, quarter by quarter where are your profits? It is not is this business going to thrive over the next 5-10 years, it is what can we do right now to get the best return immediately? And I think the challenge that we have in health care is that so much of what we do needs a real look that appreciates the long-term impact and appreciates that you can't just make an eligibility cut this year and save money and expect that it is not going to have an impact somewhere else three years from now, but that is not the way state budgets are set up. State budgets are set up on an annual basis, so you have got that problem at the state level. At the federal level, we don't have the problem. That budget doesn't need to be balanced but the deficit just keeps creeping up so these are the programs that get cut first.

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**GEORGES BENJAMIN, M.D., FACP:** But you know in the stock market, people do invest in growth. That is because someone who is their financial advisor sat down with them and said okay put this money on the table. We are not going to touch it, we are going to put so much in every month and at the end of some period of time, this is what we think you are going to make. We don't know for sure what you are going to make, but we know that it always goes up, and we have always made that argument, so I think we have got to begin making those investments. I think that the argument, the point you made about the investments we made in SCHIP and Medicaid very early on in effect buffered these kids losing their health insurance during the recession and we probably should be going back and championing those legislators and rewarding them for their long-range vision and insight because I think that was wise that they invested in SCHIP and Medicaid back then and we ought to be saying hey we want people in congress, we want the resource allocators, we want public policy people who can invest in long-term stuff and we are going to reward them, however we do that, for those kind of thoughts.

**LARRY LEVITT:** Do you think there is a difference between investing in a health financing program, like a health coverage program like Medicaid or SCHIP, and public health activities which might seem more intangible to people?

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**CHRISTY FERGUSON, J.D.:** It's harder. I can say as having run both Medicaid programs and public health programs, it is harder in the sense that you have to demonstrate, it's harder in bad economic times on the public health side than it is on the coverage side. On the flip-side, you can do small improvements on the public health side in terms of line items whereas when you do something on the Medicaid side it's an entitlement expansion, and so it is a balance of both sides but I have to say it is much more of a challenge on the public health side to get the kind of investment that is necessary and when you think about what happened in Katrina and when you think about the pandemic flu and all of those issues, there is a public health forum or public health official, as Georgia's was, and you don't sleep because we have not made the kinds of investments in our infrastructure that are absolutely essential but those are not visible to people right away and that is the difficulty. [Interposing] Yeah, it's just when something goes wrong.

**LARRY LEVITT:** Christy, you mentioned earlier the deficit reduction act and some of the changes in Medicaid and we have a question from a reporter asking about how will the deficit reduction act affect Medicaid and other programs for children and Robin, maybe you can start by just giving a quick summary of what the act did with respect to Medicaid and other child health programs.

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**ROBIN RUDOWITZ, M.P.A.:** Sure. Well, the deficit reduction act was signed in February and there were a number of provisions that affect the medicaid program in that bill. I guess I will focus primarily on the ones that are relevant to this discussion, related to kids' coverage, two of the ones that will affect kids' coverage the most I think are the provisions to require increased documentation and proof of citizenship to apply and be eligible for the medicaid program and those provisions are effective for all medicaid enrollees currently and for all future applicants.

**LARRY LEVITT:** And that is a requirement on all states.

**ROBIN RUDOWITZ, M.P.A.:** It is a requirement on all states. It is effective July 1<sup>st</sup> of this coming year, so it really will change the way that states have been structuring their eligibility processes. I think states were previously moving in a direction to simplify medicaid and CHIP applications and move in a direction of less documentation and this requires additional documentation which creates barriers to enrolling in the programs.

**LARRY LEVITT:** And not necessarily just for immigrants but you have got a longer application which is just going to make it harder for everyone to absorb.

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**ROBIN RUDOWITZ, M.P.A.:** Right it's for everyone and there are a number of people who don't have access to these documentation readily and in many states there is actually a fee to get a birth certificate so it is almost a little bit of a hidden fee to actually apply for the medicaid program. It's going to increase the burden on states to process these new requirements as well, and certainly a number of people are expected to lose their medicaid eligibility if they don't produce the documentation.

The two other provisions I think that will have the biggest impact on kids' coverage are related to cost-sharing and premiums, and the bill prior to the deficit reduction act, kids were exempt from cost-sharing and premium under the medicaid program and the bill gives states additional flexibility to impose cost sharing including for kids and also premiums for medicaid enrollees at higher income levels, and there are numerous studies that show that imposing financial requirements create barriers for people receiving care at the point of service and premiums, even though they might seem small, for low income populations it definitely reduces participation in the program.

**LARRY LEVITT:** And that is an issue we will have to wait and see, because it gives governors that flexibility but not necessarily a requirement on states. [Inaudible - interposing]

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**ROBIN RUDOWITZ, M.P.A.:** Exactly so we will have to watch and see what the states, the first one the documentation requirements is a requirement that states must move forward with, whereas on the cost sharing side, states have the flexibility to adopt these new flexibilities and we definitely need to monitor whether the medicaid program continues to be affordable for people who are participating based on these new options.

**CHRISTY FERGUSON, J.D.:** The other piece is the PSDT program.

**ROBIN RUDOWITZ, M.P.A.:** Right there is some additional flexibility provided to states around benefit packages and they have the option to move for certain populations to more CHIP like benefits package, which is more like a private insurance benefits package. There are requirements. There is a mandatory service under the medicaid program called EPSDT which is early and periodic screening diagnostic and treatment services and that mandatory benefit actually provides kids with a very broad range of services under the program and provides access for kids with all sort of special needs and mental health issues to treatment services that may or may not be available under the traditional medicaid program. While these services are still required under the recently passed deficit reduction

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act, they can be provided as wrap around services to these new benchmark benefit package plans so that will also be another issue that I think we need to watch and monitor how that provision is implemented and whether kids maintain access to those mandatory services as they currently have them under the current medicaid plan.

**LARRY LEVITT:** Robin, you talked about mental health services in the context of EPSDT and we have gotten several e-mails about mental health issues, specifically for kids. Christy, give a sense, I mean what does the mental health system for kids look like?

**CHRISTY FERGUSON, J.D.:** I think the mental health system for kids is sorely lacking throughout the country and it is a problem that almost every state that I have ever dealt with or talked with in terms of my colleagues is really struggling with. There is a lack of providers. There is a lack of payment adequacy. There is a lack of penetration. It is a huge and burgeoning problem that we face and my concern is that as we look at paring back a lot of what has been done, particularly for kids. We are going to be exacerbating a problem that is seriously impairing the ability of our kids to succeed in school and in other venues. I just completed doing a commission in Massachusetts for the governor around some of the issues involved with the Dept. of Children's Services in the state and it was an abuse

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situation but one of the core elements of that was how the mental health system interacted with the health care system, interacted with the DSS system and it is just so clear that our services, and advocates have been talking about this for the last ten years. This is not new, but it is becoming increasingly acute and I think the challenge that we have in Washington in terms of our federal programs is really beginning to look at what the impact of the lack of those services is on the overall health of our kids and the ability of our kids to succeed in school. It is a serious, serious problem.

**LARRY LEVITT:** Georges, do you think, is the problem we are facing here, the services crumbling, services diminishing, or needs growing or a combination?

[Interposing]

**GEORGES BENJAMIN, M.D., FACP:** There are huge disparities issues that result from this and it is a combination of many things. It is the lack of early identification of the need, patient by patient. There is a lack of follow through of our systems. The kids, they get lost in the systems. There are inadequate numbers of providers to see these children, and all you have to do if you really want to document this problem is go to our juvenile justice facilities and see the number of young men and women in those facilities with primarily mental health

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problems that have not been addressed and the even worse part is that we know they have got mental health problems. You pull their medical records and you draw the dots and then you can always find some point where they were clearly missed and if you really look hard, you find lots of places where the system just fell apart and again, Christy is right, this intersection of social services, health care, and as they get older the criminal justice system, which just doesn't work for these young men and women.

**LARRY LEVITT:** Christy, in the context of the commission you worked on, what are a couple of tangible things you think we could do improve?

**CHRISTY FERGUSON, J.D.:** I think that every state has to make it a priority to look at what the reimbursement policies are, what the quality of real review of quality measures, that the disparity both from an urban/rural perspective and from racial perspective is just glaring in a lot of places, and the lack of communication, really the lack of communication between the education system and I would include the safety, criminal justice system as well as the health care system. There is a real opportunity, I think, to learn from what we have done in medical errors over the past ten years, to think about that from the perspective of what the impact on kids overall is because when you have a kid who falls through the cracks, they are falling through the cracks

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because there has been an error in the system and generally what happens when a kid falls through the cracks is everybody wants to find somebody to blame and the reality is it is the system that needs to be blamed and so the question then becomes how can you take the lessons that we have learned in medicine in the past ten years, which is ten years, well 20 years behind the airline industry, 30 years behind the airline industry, how can we take those lessons and apply them now that we have technology available to us? The difficulty is the investments in technology and the investments in research, which are the two areas that are absolutely critical and which are done privately in the health care systems and in the corporate system, how do we apply those same kinds of investments to the social services system to create the kind of technology that allows that collaboration and how do you balance that against the privacy issues? If we could solve some of those problems, we have the infrastructure in this country so that no child falls through the safety net.

**LARRY LEVITT:** In some sense, the problem of an electronic medical record system is difficult enough, but are you suggesting that, particularly with kids, you almost need to broaden that notion to a record system to include schools, social service providers.

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**CHRISTY FERGUSON, J.D.:** Absolutely. You have to. Twenty percent of our kids, if you think about the demographics of the United States and what we look like nationally right now compared to what is going on in the world, we have a replacement rate of kids being born to people they have to support that is just on the level. In Japan and parts of Europe, they have huge problems because they have so many older people and so few younger people that the younger people can't support the country as a whole. We can't afford to lose one child in this country. We can't afford to say 10-percent of our kids, you know, if 10-percent of our kids fall through the cracks, well that is just life. We can't afford it, so if you look at it from a purely competitive and economic perspective, we can't afford to do that and the investment that it would take to really provide that safety net across education, health care, criminal justice, mental health, is not that big compared to the benefit that you would get, and compared to the potential that these kids have, it is heartbreaking that we don't do it.

**GEORGES BENJAMIN, M.D., FACP:** We have lots of meetings, but we haven't reengineered the system, and that is the problem. We meet around the crises and we don't meet around the front end and say okay, you know, we have got this assembly line. They are born and then we grow them and then

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out the other end we say oops, we have a problem, and then we are trying to scramble to fix the problem versus saying okay what is wrong with the assembly line? How do we catch this early? How do we provide effective mental health counseling and health care counseling? You know, you get a kid who is having some trouble and nobody notices that they had a high lead level, and then we go back in the home and we fix the lead level, we bring the lead level down but we don't pull the lead out of the house, you know, and take the lead out of the ground, so we don't build a system that collaborates effectively so that the products at the other end are valuable children who are taken care of.

**CHRISTY FERGUSON, J.D.:** If you took a cross section right now of kids in a state who are from 16-21 who had learning disabilities or who had kind of fallen through the cracks, if you took a cross section of those kids and you just did a backwards history of them, I could virtually guarantee you that between the ages of 2-6, there were a series of things that happen in the family, that happened in the medical, or that didn't happen on the medical side or on the school side that would have had an impact, and if you could take those examples and walk yourself back and change your systems not because of financing mechanisms or because we suddenly want to work together, but literally because here are case studies of kids that fell through the cracks that

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didn't have to, and this is why we have to fix the problem.

I think you would have a very different set of conversations.

**LARRY LEVITT:** But does it come back to these financing systems?

**CHRISTY FERGUSON, J.D.:** Absolutely! It always comes back to the financing systems but I guess what I am trying to say is that what I have found in the last 15-20 years is that we seldom make decisions based on learning from mistakes, and if you look at what has happened on the medical side in terms of errors, where they have made improvements to address medical errors, it is classically not what they would have done had they not looked at that outcome cases, instead focusing on the bad outcomes and really looking at what happened over that period of time and trying to address those kinds of issues from a systems perspective which then requires financing, technology, a whole series of things, but you have got some pattern that you are looking at as opposed to just, we've got to merge these two departments now because it is going to give us savings from an administrative perspective.

**GEORGES BENJAMIN, M.D., FACP:** When you mention around the crisis, you are trying to resolve the crisis, which may not be the problem. The root cause is what you need to get to and the only way to do that is to step back and put a bunch of eyes with people looking through very

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different lenses to understand the problem and then you can probably solve the problem a heck of a lot more effectively and much cheaper.

**LARRY LEVITT:** And who is it going to take, we had a question from Michigan about is the state leadership, federal leadership, I mean, who specifically does it take to look at the system in that way? Are we talking about a governor? Are we talking about a secretary of HHS? Are we talking about a mayor?

**GEORGES BENJAMIN, M.D., FACP:** Everybody. It requires leadership at all levels.

**CHRISTY FERGUSON, J.D.:** It requires a confluence of people. It requires like all of the stars lining up in a particular state so that you have got everybody willing to say okay, you have got a four year term, you are in your first year. We really are going to take a cross section of things. If this case, for example that I am talking about in Massachusetts, had happened in the governor's first year, I think there would have been even more opportunity to really look at it as a keystone case, or cornerstone case, and I think the same thing is true with people coming in. If we could do a better job of saying here are some ways that you could address these problems and still get some political benefit from it, I think that the people who are in state systems really want to do the right thing, but they need to

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have leadership that allows them to do that, and at the federal level we need to get more in touch with what is actually happening at the local level so that it can be supported, when those efforts are made it is supported as opposed to looked at differently, and I think the foundation world has to step in too and think differently about what they are doing.

**GEORGES BENJAMIN, M.D., FACP:** And you know, we on the advocacy side, we can help the elective leadership and the policy folks. They reach out, we reach out to them, they all care about kids in their community, I mean, they are obviously the [inaudible] for their community, and we need to reach out to them and find ways we can help them. I mean, we have resources. We have ideas. We can make linkages. For us, that is what national public health week is all about, making these partnerships, but they work. You are a superintendent of a school, in the community, and you notice a pattern that you think might have a healthy impact on your community, pick up the phone. Call your local health department. Do the opposite if you are the health officer. I think these are ways that work.

**LARRY LEVITT:** Any candidates of communities where you think there is real potential to make some of this happen?

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**GEORGES BENJAMIN, M.D., FACP:** Well, there have been a lot of communities who have tried, and we tried doing some of this in Maryland, particularly in children's mental health. We made some real progress on children's mental health. Not enough, but we have made some progress. I think there are other communities that have looked a lead. Baltimore City really did a comprehensive approach, looking at the lead problem in Baltimore City. Smart Growth, there is a committee in Centennial Park in Atlanta, a city that we are actually going, we gave an award to yesterday, which looked at totally redesigning intercity community so that it is more livable, more walkable, etc. We are seeing that around educational programs for people who have actually tried to get together a collection of people to try to look at how things are done in the schools. We continue to see these partnerships, but you know we don't do very well. We don't transfer knowledge very well. We hold these blue ribbon communities up and yet we don't then resource them. Sometimes it's just knowledge so they can go out and they can replicate those programs and that is one of our weaknesses.

**LARRY LEVITT:** Tell me Georges, sort of midway through National Public Health week now, if you were to work into the office of a member of congress or a governor and he/she said what two or three specific things can I do that

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would make a difference? That are both doable, achievable, and productive, what would you tell them?

**GEORGES BENJAMIN, M.D., FACP:** I would tell them that Senator Robama has just introduced a bill that is looking at health impact assessments and putting research in place as a way of trying to galvanize people around making more livable communities. I would ask him to look at it, to seriously consider cosponsoring it. I would ask him to pick up the phone and ask their local or state health official to come see them and just sit down with them and say okay what are the problems in our community and how can I help you get your job done from my seat in congress? That is what I would do. If I was a governor, I would do the same thing. I would pick up the phone and say you know, we are obviously concerned about avian flu and that is a threat that we are real concerned about, but tell me what really kills people today in our community, and what can I do both in the short-term and the long-term to try to impact that, to make my community more healthy?

**CHRISTY FERGUSON, J.D.:** I would also tell them that they should have a three-pronged approach to cover all kids by a 2008 or 2010, 100-percent coverage, make it mandatory, ensure that we are looking at what the impact of that coverage is to the larger, both to health outcomes for kids and to the educational system and the social welfare system

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in states, and thirdly to make sure that in that coverage they are looking at the outcome of healthier children as the goal, as opposed to simply being coverage as the goal.

**GEORGES BENJAMIN, M.D., FACP:** And I'm thinking as they look at the cost of doing that, don't just look at the cost of coverage, but look at the savings part. There is a huge savings for the education system, for the criminal justice system. You know, do the calculation on that side. I think when you find that you do that; you will find that expanding universal coverage to all children is a very, very affordable proposition.

**LARRY LEVITT:** Robin, to help wrap this up, you started talking about a couple of states that have taken the initiative in providing universal coverage for kids, looking a few years out, what are the challenges for states trying to expand coverage or even maintaining coverage?

**ROBIN RUDOWITZ, M.P.A.:** Well I think we mentioned a bunch in this whole conversation. The biggest one is that there are still 9 million kids without health insurance coverage, so there is still a lot of work to do to get those kids who are already eligible enrolled in the programs and that is a combination of securing adequate financing for the programs for both medicaid and CHIP and also expanding outreach for those programs. I think there is some work at the federal level that needs to be done to do that, but I

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think a lot of the action is going to be at the state level and what options states take up in terms of cost-sharing and how they implement these documentation requirements and other policy decisions that the states are going to make going forward are really going to determine how affordable the medicaid program remains, how available it is, and if that coverage remains meaningful to the people and to the low income beneficiaries that are current receiving those services, so I think that there is more work to be done at the federal level and we need to watch and see what more states are going to do in terms of running their medicaid programs.

**LARRY LEVITT:** And one key decision point coming up is the reauthorization of the SCHIP program, right?

**ROBIN RUDOWITZ, M.P.A.:** Right and that will certainly be a federal issue in terms of financing and right now the financing for the program is about 5 billion dollars annually and if that funding level is actually maintained, there is not going to be adequate financing to support the current number of kids on the program and the number of enrollees will actually decline so there will need to be more attention to financing to support both programs going forward.

**LARRY LEVITT:** Christy, I am going to give you the final word here. You have sat in policy making decisions at

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the federal level, at the state level, in multiple states, what advice would you have for people in your old jobs as they navigate these issues?

**CHRISTY FERGUSON, J.D.:** Be very creative. This is a time for real creativity and thinking outside of the normal box in terms of coverage. Find a way for public health to think about their delivery system in the context of the realities of medicaid financing. Make those connections in a really strong way and have the goal be in your state, you know, really try to give your governor and your legislature a way to get to universal coverage. Find a way to do it. Don't find all of the ways that we traditionally have come up against. And I think that there are opportunities now. The reconciliation act is not the best piece of legislation from my perspective that they could have passed, but there is always something in those bills that you can build on and find the positive piece of it and work with it, and I think that is what those of us in the policy community are in the midst of trying to figure out, how can we use it effectively? But the key thing is to remember why you are there, and I know that this sounds like it's preaching to the choir to a certain extent, remember why you are there. You are there because you believe in achieving a set of goals and it doesn't matter who the commissioner is or who the secretary is or who the governor is, there is always a way to get

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further along that line and if you keep that in mind and you surround yourself with colleagues from other states and nationally who support you, take the risks because these are kids who nobody has been willing to take a risk for and if we can do that, I think we are on the cusp of being able to ensure all of our children. That is a radically different situation than 15-20 years ago.

**LARRY LEVITT:** We don't always end health policy discussions on an optimistic note, so I think that is a good place to end. Christy, Robin, Georges, thank for joining us and thank you all for watching. This has been "Ask the Experts" and we look forward to joining you next time.

[END RECORDING]