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TRANSCRIPT - GR 01 10 25 ***"Implications of the Election on Health Policy"*** guest speaker Cameron Webb MD, University of Virginia

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Internal Medicine Grand Rounds

- All right. Everyone. Welcome to our 1st medicine. Grand rounds for 2025. Dr. Brian Newloud. We're excited to host Dr. Cameron Webb, speaking to us on concepts of a plan forecasting us healthcare in the Second Trump Administration. So
- it'll take us through our Cme slides and disclosures. This is again your 1st time at grand rounds. In a while some more convenient ways to be able to claim Cme. Today's activity code is there and will also be emailed out by Tony Brinkman Partway. Through the talk. Today I'll welcome up our chief resident, Dr. Shaina Hassan to introduce Dr. Webb.
- All right. Good afternoon, everyone. It is my distinct pleasure to introduce our grand round speaker for today, Dr. Cameron Webb. I'm talking a little bit about him. He is a native of Spotsylvania, and A. Who, during his undergraduate career, Dr. Webb received his medical degree from Wake Forest School of Medicine, and his Jd. In Health law Certificate from Loyola University, Chicago School of Law. He's now a physician, a lawyer, and public health expert, who works at the intersection of health and social justice.
- Here at the University of Virginia. He is a hospitalist and assistant professor of medicine, and also has an appointment at the Frank Batten School of leadership and public policy.
- An experienced Federal health policy advisor, Dr. Webb, 1st served across the Obama and Trump Administrations as a White House fellow in 2016 to 2017, and later was appointed as a senior advisor to President Biden with the White House Office of COVID-19 response.
- In his years of service in the White House his portfolios has ranged from social justice efforts such as President Obama's, My brother's Keepers, initiative to advising on public health policy, access to care and prescription, drug pricing.
- He is a passionate champion for health equity, and is committed to advocating for the health needs of underserved and marginalized communities. He served as the member of the Board of Directors of Doctors for America, the National Medical Association's Board of Trustees, and on the Virginia Board of Medical Assistance Services, the Commonwealth Medicaid Board.
- We're really excited to host him for grand rounds today, so please join me in the welcoming. Dr. Webb
- didn't trust that right.
- Thank you very much. It's great to be with you guys today to present. I guess, the 1st grand rounds of 2025 just to kick things off. I characteristically have too many slides. Dr. Bell reached out to me yesterday, and he's like, I hope this isn't going to be another 95 slide superstar presentation. I'll do my best. I'm going to be flying for some portion of it but there's a lot to cover. We're going to be talking about all that goes into our anticipation for this upcoming administration. What we're going to see

in the healthcare space. And specifically. You can't know where you're going without knowing where you've been. And so we're going to talk a little bit about the last couple of administrations. What's happened in health care and how it tees up what we can expect to see in the coming months ahead.

- So 1st off, I want to start off with just a quick video. Let me see if I can get this going.
- We will do is we're looking at different plans. If we can come up with a plan that's going to cost our people our population less money and be better health care than Obamacare. Then I would absolutely do it, but until then I'd run it as good as it can be run. So just yes or no. You still do not have a plan. I have concepts of a plan. I'm not president right now, but if we come up with something I would only change it if we come up with something that's better and less expensive. And there are concepts and options. We we have to do that, and you'll be hearing about it in the not too distant future concepts of a plan. And that's the reason for the title of today's lecture. Right? This idea that yes, there's no formulated strong health policy agenda. But there are concepts and ideas that we can pick out to figure out where President-elect trump is going to take us 1st off disclosures. I have no actual or potential conflicts of interest, and just additionally, some disclaimers you heard I worked with President Obama. What you didn't know is we were pretty much best friends, and that's why the eye contact is so fantastic and so yes, I know a little bit about what the Obama Administration was trying to do with the Affordable Care Act, and specifically worked on open enrollment and on the White House health care team. And so you could say, I have some familiarity with what that administration was looking to do. But my White House fellow certificate was signed by none other than Donald J. Trump. Right? So I also do have that experience. I worked longer in the Trump administration on his health care team than I actually did in the Obama Administration. So spent time working specifically on drug pricing reform. But you know again, a lot of that administration's focus was repeal and replace, and I was there on day one on January 20th of 2017.
- I was there to see how they approached launching a new administration and kicking things off. And then most recently, I mean, come on, now, that's my other best friend, right? And I think this is from my most recent time in the White House working on the White House Covid team. Actually, this picture is from just a couple of weeks ago, and Random aside as I was walking up, I thought he was going to remember me from the Covid work. He didn't and as I was walking up and going to shake his hand, he said, you look like you can still play, and I was like, sir, I'm a doctor, so I guess that's what it is. But, anyway yes, I've worked across these last 3 administrations. It's given me a different level of insight into how they stand up the work in terms of health care and the actions that move forward. It also gives me a healthy appreciation for what the Administration can do without Congress right? And so I'll be talking some about what the administrative space can do as well. A couple of goals for this presentation one is to share factual vetted, historically accurate information to present the policies without presenting bias for the politics, to use past actions and statements as the best predictor for future approaches, to provide you all with a starting point of understanding the key landmarks in the road ahead, but not to provide an exhaustive analysis of everything that can and will happen. In other words, my crystal ball is forever broken, right and just for everybody to know any even-handedness that you hear from me today. It's intentional right. The idea is to present this information in as even-handed a way as

possible, right? Because I want everybody to just take it in and develop their own sense of what these policies mean for patients, for providers, for our system as a whole. Please don't allow it to offend your politics. I know that's hard to say in today's day and age, but just wanted to put that out there. A couple of the learning objectives 1st want to analyze historical trends from Trump's 1st administration. Compare them with those of the Biden Administration.

- Describe some key policy areas likely to be impacted during a second Trump administration, and I'll get into those and then discuss the anticipated effects of these changes on key stakeholders and outline strategies for health professionals to prepare to adapt. And I'll be doing that kind of throughout the conversation.
- So for background, I want to give a quick snapshot of the United States healthcare system and to do so really want to start with the overall framework. Right? It's a mix of public and private for-profit and nonprofit insurers and Healthcare Providers. The Federal Government. There's Funding for the Medicare program, also various programs for veterans, low-income folks, including Medicaid and Chip States, manage and pay for aspects of local coverage and the safety net. There's private insurance. That's the dominant form of coverage. And we'll talk about that quite a bit today, usually provided by employers. So today, about 54, 55% of private insurance is provided by employers, and then insurers set their own benefit baskets and cost sharing structures within Federal and State regulations. I always frame healthcare. This is too big of an issue to work without a framework, and so I like this iron triangle theorem, which was described by a physician and Economist Bill Kissick in 1994. The idea is that no society in the world has, or ever will have, enough resources to provide, all of the healthcare services that its population is capable of utilizing. And so there are these 3 competing elements that ultimately determine the true nature of that system that's going to be access. It's going to be quality and it's going to be cost containment. And so you can improve any one of those 3, but not without compromising one or both of the other 2. Any health policy intervention on access, for instance, has to pay key attention to cost and quality, and the same is true with the other aspects of the triangle. Hence the name iron triangle. Now some evolving theory or evolving views. There.
- It's not a fixed framework, it's actually a look at how the American healthcare system currently functions. It's more dynamic than the name suggests, because cost of care change constantly. And we'll talk about that quite a bit today. And then finally, American healthcare really hasn't been disrupted like a lot of other fields. We're seeing more disruption these days from a lot of large companies that have gotten into disrupting health care technology that's disrupting health care. But again, there are regulatory mechanisms that keep folks from getting in and really disrupting health care the way that other fields have been. So again, with more disruption we can see this iron triangle broken, but for now it's still a useful framework for us, and as I get into the conversation, I'm going to be framing this largely as access, quality and cost, and we'll probably spend most of our time on access and costs today, just a quick look at access. This is what health insurance coverage looks like today. Right? And this is as of 2023 data. But you see, 8% of the population is uninsured. 92% have health insurance. That number sometimes surprises people. But we've had over the last few years historically low, uninsured rates. Again. You see, employment-based insurance is kind of the dominant insurance mechanism.
- And then, you see, the public plans are large as well. Medicare, with about nearly 60 million folks on Medicare Medicaid, with upwards of 75 million folks on Medicaid,

between Medicaid and the chip program as well. So these are large programs in our again, nation of 330 plus 1 million individuals. If you look at who's uninsured. This is kind of the breakdown of that 8% or 25 point 3 million uninsured individuals right? About a 3rd are eligible for tax credits under the Affordable Care Act. So I want that to stick with you for just a second. The Affordable Care Act has these tax credits. Folks can get cheaper insurance through that mechanism. The last few administrations have addressed that. And so we'll talk about it next a quarter. Are Medicaid, eligible, right? So would be able to enroll through the Medicaid program. You see that there's nearly 20% who are ineligible for coverage due to their immigration status. We don't expect that needle to move much in the coming years, and then you have some who are ineligible for financial assistance, due to having affordable employer coverage or marketplace coverage available to them. So that's another reason why folks are unable to get additional financial assistance.

- And then you have a smaller percentage. 5% who are in the coverage gap, and that's that gap where folks are not able to get coverage in part because their state hasn't expanded Medicaid or something along those lines. And speaking of the Medicaid expansion at this point
- 41 States, including DC. Have adopted, we still have 10 that have not, you see, on the other side. The income eligibility limit for each State in terms of what would make you eligible by income alone to get Medicaid in these non-expansion States. So in a state like Alabama, for instance, you would need to have 18% of the Federal poverty limitfor a family of 3 in order to be eligible for Medicaid, and that's somewhere around $6,000 that you make a year right? So extremely low. It's really a disincentive for folks to be eligible for Medicaid in these States by income alone. So the preference would be that you're eligible by some other mechanism. But you see, there's a spread Wisconsin. It's 100% of Fpl, right? So these states are not all identical, even though there's a lot of geographic similarity in terms of where many of them are located.
- The next thing is just the Aca marketplace. It's grown significantly in recent years, you know. Again, in the Obama administration it was around 1112,000,000 folks. And I remember when President Trump 1st came in, they said much ado about 11 million people all this marketplace stuff. But you know it's only 11 million people. We've seen that number since double, and it does have a market effect as well. But you saw it was kind of flat during the last trump administration, this red line here.
- And so that's that red line. And then, as it continued to rise in the Biden administration, there are a couple of reasons for that. Just a few days ago we learned that we had record enrollment in the Aca over the last year. It's rare that people call it Obamacare these days? Right? It's been rebranded as the Aca marketplaces, much to Obama's chagrin.
- And then, finally, this is total national health expenditures. We're up to 4.9 trillion dollars. That's a trillion with a T that we spend on national health expenditures. So a really large percentage, it's a little less than 18% of our gross domestic product. But you see, almost a 3rd of it goes to hospitals right? 20% physicians and clinics. That's where the spending is this prescription drug portion, usually around 9 to 10%, depending on kind of what new drugs are on the market. And then, you see, kind of the other professional services. The smaller categories that add in as well. Last slide I have is on that background is just people's affordability of health care right when they say healthcare costs at a glance. You want to say, Well, what do people think about cost? And nearly half of adults say, it's difficult to afford

healthcare right? And you see how that breaks down by different groups. I'll just take a second so really quickly for uninsured folks. Almost everybody says it's unaffordable. Right? Makes a lot of sense.

- So then we say, how do we get to today? Right? If we're looking back the path to today's healthcare scene we have to start. I'll start here right. This is the signing of the Affordable Care Act. This is when, then, Vice President Biden said, this is a big effing deal, right? And then along those lines lots of different pieces of the affordable care Act, the individual mandate, the employer requirements, the different public programs that changed, etc. So lots of different pieces.
- That was 2010. That that was signed, you know, really saw the real provisions jumping in around 2014, and there was a lot of discourse, a lot of debate about it. I'm not going to get into that. This isn't an Aca lecture, but I will say when President Trump won in 2017, there was an expectation that it was going to change one of his 1st actions was signing an executive order to minimize the economic burden of the Aca pending repeal key words there pending repeal. The expectation is that it would be gone shortly. So we asked all the agencies to that they, to the maximum extent permitted by law, they should waive, defer, grant exemptions from, or delay implementation of the law, so it doesn't burden individuals, families, states, health care providers and insurers. They were just saying, stop doing stuff because we're going to get rid of this soon, and we all know how that played out. Of course, over the next couple of months they weren't able to repeal. It didn't have a good replacement plan so ultimately as trump now says, you know he saved the affordable Care Act. It's been limping along, as he says, and he put enough in it so that it could survive and be the best that it could possibly be. And in the clip I showed earlier. That's actually how he begins that comment. He says, I saved the affordable Care Act, and that's why we have what we have today.
- So now we'll talk about the Trump Administration specifically, or at least the 1st Trump administration. What I've done is I've been able to break down a lot of the key policy actions on this side. You'll see we're kind of tracking these 9 different categories, the aca medicaid drug, pricing price, transparency, equity, reproductive health, public health, mental health and substance use. So that's going to be the thread that we're following between the 1st Trump administration the Biden Administration. And then what we can predict is going to happen in the upcoming trump administration. And so, you know, the 1st thing in the 1st Trump administration we saw there were a lot of efforts to repeal and replace. Of course those were legislative in nature. There was the American Health Care Act narrowly failed in the Senate, and so, because that didn't work out, they reduced funding for Aca enrollment and outreach. They ended some of the subsidies to help support folks get affordable insurance through the Aca.
- They expanded these other plans that weren't aca eligible, called short-term limited duration health insurance plans, you know. Critics would call those junk health plans right. They don't meet the standard in terms of the different features that an Aca plan meets, and the trump administration expanded it from being able to only have those for a number of months to being able to have them for over a year, and in some instances for longer than that. And then they removed the individual mandate penalty through the tax Cuts and Jobs Act.
- They changed Medicaid right? There's a lot of discussion about Medicaid work requirements in the Last Trump administration, and just a word as I'm going through this, I want you to keep in mind part of why we're talking so much about what

happened in the Last Trump administration is because again, past this prologue. So you're going to see a lot of this come back up as we talk through the next 2 pieces. But Medicaid work requirements. Again a couple States submitted those what are called 1115 waivers, waivers to the Medicaid program, Arkansas, Kentucky, Indiana. They got those waivers. They were ultimately blocked by the courts later on, and then not renewed in the Biden Administration. But the Trump Administration also proposed shifting Medicaid to a Block grant model. That's not new. Almost every Conservative administration in recent years has proposed block grants in the Medicaid program and then overall, they encouraged more state waiver flexibility. This idea that states could use these Medicaid waivers that are innovation waivers to test new approaches like adding premiums, switching Medicaid to health savings, accounts, and even limiting coverage for a certain amount of time right? And some of those expansion waivers that were approved included restrictive provisions, things like cost, sharing lockout periods for noncompliance with eligibility, requirements, etc. These are things that again. You wouldn't see in the Obama or Biden administrations. But the Trump Administration was really trying to decrease the cost of the Medicaid program for drug pricing the big piece was that President Trump and I mentioned that I worked on drug pricing in the Trump Administration. And it's interesting because it wasn't actually a priority. On day one the priority was repeal and replace the Aca, and I remember it was March of 2017, and he sent a tweet. And you guys remember how that was? Back in 2017 he sent a tweet, and he just said, We're going to make drug prices really cheap for you guys, it's going to be awesome.

- And I was on the White House healthcare team, and they said, We don't have any plans around drug pricing. And all of our staff, which was 4 people, were focused on repeal and replace. So that's how I got the job of working on drug pricing because of a Tweet right? And the idea was he was upset that the rest of the world was getting a quote unquote, better deal than Americans on the cost of prescription drugs.
- He was really into this idea that we shouldn't be losing in any of these spaces where we're innovators and creators. And drug pricing was one that really vexed him. And so one of the ideas was promoting drug importation. And I always say you're not re-importing drugs. You're re-importing policy, right? Canada gets the same medications for cheaper than us, because their Federal government does it cheaper. So they negotiate a lower rate and that's why we're re-importing the rate that their government negotiated. But allowing States to do that, and that was one of the proposals. He had this idea, and initially it was the International Pricing Index. Ultimately it grew into this idea of the most favored nation rule as the name suggests. It's just that we should get a better price than whatever country negotiates the best price on certain medications. Ultimately that rule faced legal challenges wasn't able to be implemented. He did have an executive order that required Fqhcs to pass along, discounts on insulin and epipens, and then also targeted Pbms. That's the pharmacy benefit managers that have rebates making sure those go directly to consumers. Pbms have kind of been the odd man out in this discussion of prescription drug pricing because big Pharma has a lot of might, a lot of power to negotiate for itself as the manufacturers. A lot of the retail pharmacies have a lot of ability to negotiate for themselves. Pbms are a bit of a black box. They're the go-between. They help create those formularies, and as such they don't necessarily have the same amount of sway in Congress. They say

there's 4 Pharma lobbyists per member of Congress. So that idea that there are folks who are saying, Here's who you need to go after. Here's who's driving up the cost in health care. I think, in a lot of ways. Pbms have become the target both for Republicans and Democrats. They say Pbm's part of the problem because we don't know what they're doing with the savings they extract and how they pass that along. So that rebate rule was part of it.

- I'm also in the drug pricing space, some reforms to medicare drug pricing. So part d modernization wanted to cap out-of-pocket spending and have greater flexibility and also have medicare advantage and part D plans implement step therapy. So patients would have to try lower cost drugs before moving to more expensive ones. And then I mentioned the International pricing index already. So that's kind of the drug pricing piece. And if you think about it, so affordable care, act and medicaid, those are our access pieces. Drug pricing price transparency. This is more in the cost space. And I would say, if there's a hallmark of the 1st administration in terms of really saying, here's how we're going to get the job done on changing health care. It was his work around price transparency, and relatively early on he had this hospital price transparency rule that he wanted to advocate, for the idea was that every hospital would need to publish its chargemaster on its website, make it easily accessible for patients for the community, so they can go in, pull up the chargemaster, see how much their health care, services, cost and shop around make informed decisions, and of course, for a lot of critics, they felt like that wasn't a realistic goal, because chargemasters aren't easily used documents. It's hard for patients to look at a chargemaster, and oftentimes you're in a medical emergency. And so you're not going to do the same kind of shopping around that you would do in other spaces, but just the same, that hospital price transparency rule. It did go into effect.
- It did have a lot of opposition from hospitals, and did have some legal challenges, but the idea was that patients were really excited about hospitals having to be accountable for what they were charging. We've all heard of the $25 motrin right? We wanted to see where that was and it wasn't just hospitals, transparency and coverage. So insurance providers as well had a transparency rule, and then a proposed rule for drug price, transparency and advertisements. The proposed rule was that pharmaceutical companies would have to display their list prices on their television ads, have you guys seen that on the television ads?
- No, that didn't happen right? But it was a proposed rule at the time. And you can imagine that would be just as small print as the side effects on some of those commercials right in the health equity space. I have to say this was not an area that President Trump was interested in. In fact, they sent out a memo early on, didn't want to use language of equity. They dismantled or de-emphasized several of the Health Equity offices across the Federal Government.
- They rolled back nondiscrimination protections for Lgbtq plus individuals under the Aca, and then they ended Daca's program protections for recipients which impacted their access to health care. So these are all things that they did. But it was in the context. You can see, that's in the context of immigration that's in the context of some of the broader, as you say, culture wars or discourse around Lgbtq rights, and it certainly made its way into health care as well.
- I could give an entire lecture on reproductive health and kind of what happened, and didn't happen over the last 6 or 7 years, I'll boil it down to in the Trump Administration. The judicial appointments were key right Federal and State, Federal

and Supreme Court appointments that created a judiciary more likely to uphold the State's abortion restrictions and then expanding restrictions on abortion through the Mexico city policy. This global gag rule, which really made it so that Us. Funding couldn't go to nations that were, or to international organizations rather, and nonprofit organizations that were providing or promoting abortion. And then, finally, they implemented this title, X rule in 2019, prohibited family planning clinics from referring patients for abortions, and led to the withdrawal of a lot of organizations like planned parenthood from that program on the Public health side. Of course, Covid became the big public health piece. And so I think that's probably where you're going to see the dominant discourse around what the Trump Administration did for public health. But really it was their handling of Covid-nineteen drew a lot of criticism because of some of the downplaying of the virus of the pandemic, the inconsistent messaging, but kind of interestingly, the trump administration, spearheaded operation, warp speed, and you can see kind of the thought process, as he was initially saying, Hey, I got all these vaccines created. I'm building great vaccines for you all. Then, with all the backlash to vaccine mandates, kind of backed off of that right. But operation warp speed was successful in accelerating the development of those vaccines, and then a lot of environmental health stuff rolling back regulations, including rules on air and water quality and then briefly, on mental health and substance. Use a lot of credit does go to the Trump Administration for some of the work on the opioid epidemic. They declared it a national Public Health emergency in 2017 expanded access to treatment by increasing funding for opioid use, disorder treatment programs and Naloxone distribution and then developing these non-addictive pain medicines really promoting that development working with the FDA. And so that's kind of the bulk of it. I'm going to pause there and drink some water because my mouth is dry but I mean the other thing to keep in mind. At the end of the trump administration we went from a time in 2016 2017, where healthcare was top of mind for folks. What's going to happen to the Aca? Right? We get to 2020, 21, and healthcare is top of mind in a different way because of the covid pandemic. It's more about the emergency and not about the structure of our system. And so that makes the way that health care manifests in the early days of the Biden administration very different.

- And so I'm going to jump ahead into the Biden administration because that's going to tee us up. For where we are today. So again, going through that same category, those same categories of area, we saw a lot of policy innovation.
- Conversely, the Biden Administration supported and improved upon the Aca. The American Rescue Plan, one of the 1st major pieces of legislation that came out in the Biden Administration. It expanded premium subsidies making coverage more affordable. It eliminated the income cap for subsidy eligibility. So a lot more people were getting subsidies for the health insurance in the marketplace, and then it ensured that individuals earning more than 400% of Fpl. Again, 400% of Fpl is a much higher number wouldn't still wouldn't be paying more than 8.5% of their income on premiums, which was one of the original ideas in the Aca.
- You saw these enhanced enrollment periods. So really creating more time and space for folks to enroll in the Aca. In the early days of the Trump administration, they cut the funding for marketing and navigators by 90%. The Biden Administration came back and put a lot of resources back into enrolling folks, and we saw that a couple minutes earlier, where I showed you the graph with Aca enrollment going up

and then rebuilding marketplace infrastructure again, the functionality and the user experience State level collaboration. All those are things that the administration really looked into earlier. Again I mentioned the navigators. So, putting more funding into Aca navigators. The family glitch is an interesting piece of the Aca. And so this was literally just a loophole. Nobody intended it from a policy standpoint but if a family member had access to employer-sponsored insurance that was affordable for them as an individual, but not affordable for the family. Then the entire family still wasn't eligible for marketplace insurance. It didn't make sense. It was kind of a glitch in the way the law was written, but of course, since 2010 there really wasn't an environment that was amenable to fixing the family glitch in Congress because it needed a legislative fix. And so ultimately that was done through this rule in 2022, and then, you see the more recent pieces extending subsidy enhancements. So the subsidies that the Biden administration gave those were enhanced, and then they were extended in the Inflation reduction act in 2022. So we saw those subsidies live on. There's an interesting thing that happens when you give something to people like a subsidy, reducing the cost of a good or a service, and then you give it to them even more is that it makes it that much harder now to take that subsidy away for folks who are even up to 400% of the Federal poverty line. They expect that their health insurance premiums are going to be lower, they may even lose sight of the fact that it's a subsidy that makes this possible. They may just think that it's the nature of the marketplace, and so extending these subsidies, really helped entrench that idea of subsidization in the Aca marketplace as a good thing, and that helped spikes in cost for marketplace enrollees on Medicaid. So really trying to incentivize States to expand Medicaid for States that adopted the Medicaid expansion in the 1st part of the Biden Administration. They were offering to have an increased Federal matching rate for the 1st 2 years. Again, some States try to do this through ballot initiatives again. A lot of that had already played out.

- But you know, seeing states like North Carolina come around, that was a big deal reversing the work requirements. The idea behind work requirements in Medicaid has always been that it's not really about folks enrolling in work or saying that they're working it really is. Are they able to report? Are they able to say
- I'm looking for work or not? And that's why we end up losing millions of folks off Medicaid roles. So this kind of got rid of those work requirements and then streamlining the enrollment and coverage gaps as well expanding home and community-based services. That's something that we intersect with some in our roles, right? So temporary increase in funding for Hcbs. And then coverage for postpartum and maternal health, extending that coverage in Medicaid from 60 days. So 2 months, where it was to 12 months after childbirth. So that was a big deal and something the administration really highly touted. One of the biggest wins, I would say, in the Biden Administration as they saw it was the Inflation Reduction act allowing the negotiation of medicare negotiation of drug prices through Medicare. It started off with 10 drugs in 2024, it's supposed to expand to 15 drugs in about 3 weeks. So 15 more drugs should be selected, and then caps on out-of-pocket costs for medicare beneficiaries, inflation-based rebates for drug manufacturers, and then the insulin price cap interestingly both parties now claim credit for the insulin price cap. But again, I think it was limited to medicare beneficiaries, caps it at $35 per month, and just kind of seeing that and seeing the number of States that have done similar things has been really interesting also in the prescription drug space. So the

Biden Administration was trying to promote competition. So they wanted federal agencies to take actions to promote generic drug and biosimilar development and then also more transparency in terms of drug pricing. This should start to sound kind of similar to you. Right? Some of the drug pricing pieces. There's less distance between the Trump and Biden administrations than a lot of folks would expect. And so it's 1 of the areas where you really could reasonably see some progress.

- But some of the trump era policies they did reverse, of course, the most favored nation rule which would have tied Medicare drug prices to prices in other high income countries. There were questions about the legality of that, which is why they kind of backed off of it and then expanding access to low-cost drugs. So funding for community health centers also funding, you know, in support for something called the 340 B program. That also gets prescription medications to certain healthcare centers on price transparency. The Biden administration didn't back off the price transparency stuff. In fact, they were like, there's nothing wrong with promoting price transparency. And so they thought, this is a good way to promote competition. President Biden signed an executive order, saying, Hey, we're going to continue enforcing this. Think about that. An executive order that we're going to continue doing what the last President was doing but it was just a signal that this is something that sure has value in our healthcare marketplace. I want to pause for a second, because I'm talking so fast that I have some extra time the idea in price transparency. You may be thinking, well, obviously, you show people prices that's not going to be a bad thing, right? But in health policy spaces there's a real debate over whether or not that's a good thing and it comes from this economic analysis of Danish concrete, and the idea that in a marketplace in Denmark, where they made all the prices visible for concrete prices went up for everybody. So once one company saw that somebody else was making more than them they raised their prices rather than folks competing downward, and there was a real concern in healthcare that we would see the same thing if every hospital sees that somebody else is making more money, and the market is willing to pay it, they might actually raise those prices. So the price transparency hasn't always been an idea that's not controversial. So the idea that both parties now are saying it's Ok is actually a big change from even 10 years ago. And then, you see, more enforcement of the price transparency rules, so you can say, Publish your chargemaster, but if it doesn't have teeth, nobody's going to do it. There have been some reports that say that somewhere between 20 and 30% of hospitals are actually compliant. Some folks say those reports are kind of overinflated in terms of how bad it is. But either way. There's these potential penalties annually for hospitals hospitals that the Administration was advocating for. And then the No Surprises Act. This was a lot of conversation a couple years ago, but protections against surprise billing. So it's also in the price transparency space. The Biden Administration did a lot around health equity. They created a job for me. So that was the White House, Covid-nineteen Health Equity Task Force, and the work that I helped lead with Dr.
- Marcella Nunes Smith, who's at Yale. And really it was just trying to find a way to embed equity in the work of addressing the pandemic additionally, then, strengthening the nondiscrimination clauses provisions. You see, that's a direct counter to what we saw in the 1st Trump administration and then investing in community health and social determinants funding for community health centers and then initiatives that are addressing housing, nutrition, economic stability.

- He's on the data research side and actually let me take another sip so awkward. It's like Marco Rubio in that debate. You guys remember that?
- But but yeah. So on the data collection side.
- Interestingly, one of the biggest challenges I had in the White House trying to do equity work was that our data is terrible. Even if you look by race ethnicity. If you look by a lot of different indicators. We just don't have great data and I'll use the example of how we often think that Asian American populations are overperforming their white counterparts in a lot of health indicators. But what we knew from experience on the ground in the Covid pandemic was that wasn't the case across all Asian American populations. And it was just because the way that we collect data on Asian populations in the United States wasn't disaggregated. And so we miss out on who's having worse health outcomes. We miss out on opportunities to advocate for health equity. So a lot of the work that this Administration has done is work with the office of management and budget, expand the categories and census reporting so that we have better data at the local level on who lives where? Right? Not seeing folks as a monolith, which was important, it also added a category, for are those kind of demographic categories. So added the kind of Middle Eastern category as well which I think was helpful in Northern African nations. So tribal health and rural health support. Again, we have a obligation to really adequately fund the Indian Health Service. We have not done that historically, I know there were some investments made in this administration, still, certainly not enough. And then expanding telehealth services in rural areas. We saw the success of telehealth early in the Covid pandemic, so trying to expand that on reproductive health there was a lot because it was trying to counter the Dobbs decision right? So the Biden Administration had these executive orders on protecting access to reproductive health care services, and so work with Hhs calling for more public education, trying to get more access through Title 10. Through Medicaid you had securing access through, or actually making sure that folks were protected to travel out of state if they were looking for abortion services. So these are all things, both through regulatory action, through executive orders and through the regulatory process rulemaking.
- They were trying to move the needle a little bit, ensuring access to medication abortions. So, working with the FDA to make these particular medications more widely available and then, you see protecting interstate travel for abortion, which is something that I mentioned earlier. So directing Doj to ensure that no State restricts it. Now, you can already imagine how a lot of the work that was done to overcome the Dobbs decision. The Biden Administration is prime targets for what the trump administration is going to undo right?
- And then you see more support for providers and clinics. I think this is probably the area where I have the most data here, right? This task force on reproductive health services and then working on these legal challenges, these ongoing battles. So the challenge with Federal Government is, if the Federal Government is party to a lawsuit right? If they're defending a regulatory action or defending alongside the States on any particular issue. When the administration turns over, there's still a party to that lawsuit, and the new administration has to decide. Do we want to continue to be a part of this lawsuit? Or do we want to dismiss it? Right? And so you can imagine those legal challenges are going to be up for discussion as well.
- And then, of course, on the pandemic public health side. We talked about Covid, huge investment in terms of the public health response there and then a lot of

investments early on for strengthening global health security because of kind of how the Trump Administration pulled out of the World Health Organization and really was kind of backing away from participating in global health, from a public health perspective. And so I don't want to give too much credit here to the Biden Administration, because while there was a big investment in public health in the context of the pandemic, I think most critics would say it wasn't sustained in any meaningful way. After 2022, especially after those midterm elections and a lot of the pushback for the role of public health. And so we didn't really see that continuity of investment that would leave us in a better place today. Most public health departments locally are going to tell you they're not significantly better off today than they were 4 or 8 years ago, right on the Mental health side there's a National Mental health strategy. And then on the opioid epidemic side National Drug control strategy. So a lot of work to try to tackle the crisis again. This is building on the public health crisis that the trump administration named. And so that takes us to today. Right? We're talking about the upcoming trump administration. And I got about 17 more minutes to pull this off.

- So the thing about this discussion when you think about the upcoming trump administration is, if you have to start with an understanding of who cares about this today? And in this election healthcare was not one of the top issues for voters in the same way that it was in 2016, 2012, 2,008, right in 2024, if you look at trump supporters, and again overwhelmingly, I think most folks would say, this is a pretty decisive victory for the trump campaign.
- You have the economy, immigration, violent crime, and foreign policy, all above health care and health care is neck and neck with things like gun policy, Supreme court appointments. Right? So it's not at the top of the list. And when they did exit polls, and they asked voters what mattered most to you again for Vice President Harris's voters.
- It wasn't health care. More broadly. It was that discussion of abortion. It was the reproductive health discussion which tended to dominate the health care discourse in this election for better or for worse. That was kind of what Democrats went with as their main health care issue. And that's what Republicans went with as their main health care issue. So we weren't talking about things like access or the affordable care act. You haven't heard anybody talk about repealing or replacing the affordable care. Act right? That's not the discourse that we were hearing.
- So the question becomes, What's next? So what's next? For the affordable care act right. And so first, st those enhanced aca subsidies, these tax credit subsidies. They helped folks get more coverage. They were passed as part of the American rescue plan. They were extended through this year in the Inflation Reduction Act. It's unlikely that they're going to continue beyond this year that the Trump Administration is going to say, we're just going to continue these enhanced subsidies because it's kind of antithetical to their basic premise, and similar to what they did in 2021, or in the last trump administration they decrease the subsidies. The challenge now is that you have a lot of folks who've been getting subsidized for their health insurance for the last few years, and so he's got a kind of electoral challenge of folks now, seeing the cost of something that they've been receiving go up if they end the subsidies. So it's going to be interesting. He hasn't said specifically that he's going to end the subsidies, but I think a lot of folks believe that Congress is not going to continue these subsidies beyond 2025.

- If they were allowed to expire, an estimated 4 million people are going to lose their exchange coverage. So remember, we're at 25 million. Most that we've ever had. They think about 4 million of those will lose that coverage without these enhanced subsidies. We do expect in the next trump administration that they're going to do away with a lot of the special enrollment opportunities under the Aca. So, having a longer time to enroll in plans having more navigators that helps us drive that number up to the 25 million that we see today in the marketplaces. You're not going to have that same investment in the 1st Trump administration. They cut that investment by 90%. I think you can expect similar decrease in funding for that kind of work in the next administration.
- So that's the piece on the consumer assistance and outreach programs. So the short term limited duration plans that I mentioned those you know, junk health plans, as critics would call it. We do expect that they're going to reinstate those short term. Limited duration plans and kind of extend that length back out to being over a year. Again the Biden Administration tried to pull those back because they don't have the same amount of protections or cover the same amount of things that the Aca approved plans cover. But we think that in the trump administration. Their belief is that consumers are interested in this product, and there's no reason to limit this product if it competes.
- And similarly, we may see an expansion in association, health plans as well, allowing small employers and professional associations to come together to purchase group insurance on the Medicaid front again, we expect some changes in Medicaid enrollment. The Biden Administration did put in some rules over the last year to try to make it easier for eligible folks to enroll in and retain Medicaid. There are a couple of mechanisms. The Trump Administration has to just claw back any rule that was finalized by the biden administration after August 1st of this year, and so for a couple of these, they might just on day one kind of claw back some of those regulations, and I think the thought process is, I think the Trump Administration is going to have a different approach to the Medicaid program. It's going to want to see more innovation from the States in these waivers, trying to drive people away from long-term Medicaid and enrollment, and more toward seeing it as a limited good. You have this amount of money for this program for this amount of time, and working to get folks off of Medicaid. I think it was George W. Bush who used the phrase, the soft bigotry of low expectations, and a lot of Republicans have clung to that idea that when you put people on programs like Medicaid, and expect that they need to stay on it forever. That's another form of racism or bigotry, right? And I think they use that as an argument
- to advocate for mechanisms to get people off of Medicaid. I think we'll see those mechanisms in the coming months. They also are going to likely delay implementation of those provisions that haven't gone into effect yet. So the 1115 waivers we talked about that in the last administration. So you're going to see them that that include work requirements. Again, that conversation is still out there, and that's going to impact people's medicaid eligibility or their premiums. Right? So we expect to see that again.
- Drug pricing front. It's interesting, right? The drug price negotiation. President Trump has said that he actually doesn't intend to necessarily just get rid of that Medicare, negotiating those 10 drugs. It's gonna be 15 this year. So the
- Biden Administration has been working with his transition team to select the 15 drugs that are going to be sent out on the list in February. So you know, I think the

thought process is mechanistically, it'd be really hard for them to pull that down for this year, so we expect that we'll have those negotiations for 2025. Beyond this year. The expectation is probably the trump administration is going to add some other pieces to that negotiation, possibly even that most favored nations piece that they were in favor of over their last administration.

- And then the FDA is going to look more like the FDA looked in their administration 2017 to 2021 pushing to bring more therapeutics to market. They were really big advocates for bringing drugs to market in the rare disease space, and he was in favor of a lot of right to try policies, and then more work around drug importations as well. You know, the FDA in the 1st Trump Administration was actually, from a policy standpoint, really thoughtful, organized, and executed at a high level. Scott Gottlieb's a physician leader. I think he did a great job in another leader, Anna Abram, just in kind of guiding the FDA through their work. And so I think this time around, it's a different crew, right? It's not going to be the same folks who have the kind of experience at the FDA. It's going to be Marty Mctari, but I think it's going to be interesting to see how their policies look on price transparency.
- He's going to go back. He's going to claim a lot of the credit for price transparency, and say, we're going to do more of it right. And so you might even see some legislative pieces to advocate for more price. Transparency equity is going to move even farther in the other direction. Right? There's been even stronger language in the last couple of years, saying that they want to move away from the government, being in the business of promoting Equity or Dei. And so we think that the Trump Administration is going to rescind a lot of the Biden Administration's activities in the Biden Administration. Every agency was required to submit an equity report, saying all their agency activities aimed at driving equity and health and human services was one of those you're going to see the complete opposite. It's going to be, and I think the statements that trump made were that he felt like it was consistent with an anti-white feeling in America and and you might even see he's threatened or said that he intends to pursue some civil rights cases against schools that engage in racial discrimination under the guise of equity. Right? So I think it's going to have a chilling effect on some of that equity work likely going to see rescission of a lot of those Lgbtq protections that we saw in the Biden Administration and in specific President Trump has said that he wants to pull back on any of the funding and support for gender reassignment work, or particularly for minors or gender affirming care in general. So I think that's going to be a big challenge that we see on the abortion front. He's been kind of interesting since the campaign trail, because, he said, he does not intend to restrict access to medication abortion, but he kind of leaves open space to change his mind. He said, he's not going to force the Comstock Act to ban the distribution of these medication, abortion pills.
- But again he leaves space to change his mind on that. And so, you know, I think we'll see. We do expect that they're probably going to rescind some rules prohibiting health care, providers, plans, and others from disclosing information. So the idea for Conservatives has always been the
- potential of being able to report in states that providers are participating in abortions is one of the tools that they have. I think he's going to make that a little bit easier. So that's some of the hipaa protections piece, and then they're unlikely to defend the pending litigation and challenges to the hipaa privacy stuff as well.
- Certainly he's going to revoke the rules authorizing access to abortion, care for the Va. For active military, and he's going to separate payments for abortion coverage

in the Aca marketplace plans. So for those 25 million folks, you're not going to see the same mechanism to pay for abortion care through marketplace plans in his last administration. They did just that as well. So separate those out on the public health front. You got rfk, Jr. And so that is going to be that's going to be interesting. So you're going to see a lot of Federal vaccine recommendations that again federally, they don't necessarily have the power to say you cannot require vaccinations in schools. Right? That's not the province of the Federal Government, but they can make it a little bit more challenging, so they can influence or bypass Federal advisory commissions regarding those vaccine approvals. You can adjust criteria for vaccine approvals. They can end emergency use authorization right, which is what we had which we used in the Covid pandemic.

- You can make state and local funding contingent on certain policies like not having vaccine mandates in schools. So you can't directly. Say you can't have vaccine mandates, but you can exert pressure financially and through policy to make it a little bit harder, and then also just overall how they communicate to the public can add to the mistrust of vaccines, which I think is certainly problematic, and then the last piece, I'll add, is on Medicare.
- The Trump administration is very fond of Medicare advantage wants to expand the number of folks in Medicare advantage, and we've seen that it went from about 20% of seniors to now, over 50% of seniors are enrolled in Medicare advantage just over the last 10 years. So you've seen this huge boon in Ma. I think we're going to continue to see investment and pushing people toward kind of the more private side or private adjacent side of the Medicare program.
- I added this just because of the audience. Right? You may have seen in the news that the physician Fee schedule took a hit. We're scheduled to take a pay cut through Medicare this year, just like we took a pay cut last year. There were some legislative efforts at the end of the year to try to stave off this pay cut. Unfortunately, those didn't go through. So we went down 1.2 5% last year, 2.8 3% this year.
- So certainly not what we as physicians wanted to see. But at the end of the day
- I don't think the Trump Administration specifically is going to counteract this price cut because the reason why it was pulled out of that bipartisan negotiation at the end of the year was because they're trying to save money through the Federal government and physician pay cuts are part of that. So I think you are likely to continue to see these scheduled payment cuts under medicare for physicians. It's going to be hard advocacy with a Republican-led House Senate and President to see this reversal. But we will see.
- And so, just to conclude a couple of things, what can the healthcare industry expect? And this is from pricewaterhousecoopers. They looked at a lot of the potential impact of some of these policies I've discussed reversing binary policies you know. Less regulation is good for industry, I think, for the most part, and so I think they're chomping at the bit for kind of less biden era regulation strengthening Medicare. That's the Medicare advantage piece good for payers, good for providers, probably not as good for Pharma, one less person paying them.
- But I think that when you look at supporting State oversight of abortion services, payers and providers aren't too excited about that Medicaid work requirements, payers and providers not too excited about that reintroducing risk pools. We didn't talk about that specifically, but that is a theory that's out there that you may want to make the Aca marketplace specifically start to tap into this idea of risk of assessing risk, much like we did before the Aca again payers and providers not particularly

excited. And then, on pricing transparency I mentioned earlier hospitals. Don't like it.

- Drug manufacturers don't like it. Insurers don't like it. So it's not popular with industry, but it is popular with consumers. And then on the chronic disease management side again. That's a good thing. Rfk, Jr. Has said, he wants to focus on chronic disease prevention, which I think some folks are excited about that potential right? That's part of that. Make America healthy again agenda, and then expanding primary care, access and age in place services.
- I guess if I'm looking overall at the forecast for health care in this second trump administration. I'd say this, despite how decisive this electoral victory was. There's still a broad swath of what could happen with health care and what I know in the health policy space is that significant change doesn't just happen overnight. It's very slow going in some ways that's protective. I will say that this trump administration. I've had lots of conversations with folks is more adept at navigating Washington than the last administration. They did not know how to navigate all the back channels all the regulations, right? They just didn't have the those actors. This group, I think, is going to be a little bit more effective than the last. But I think it's still going to take time. And so just that process of debate, judicial proceedings, implementation. You're not going to get everything that you hear coming out of folks mouths. But there's a unique alignment right now. You have. You know, the bicameral Legislature is aligned with the President. You have a right-leaning Supreme Court and the Administration interestingly, and I'll click ahead. You know the leadership on the healthcare side of this trump administration is all from outside of Washington and that is a sign to you that there's going to be an intention for some disruption. And, as President Trump has said, he's going to kind of give over the keys to Rfk. Jr. If he is named. If he does become the Hhs secretary, he's going to kind of give over the keys to have at it with health care. I think when you have folks who come from outside of government, they're going to look to do a lot of disruptive kind of innovation which again has potential to be impactful, can also be challenging right? And I think the longer one of the things you want to look at is, how long are they in these roles? If they're in these roles for all 4 years, you can get a lot done in 4 years if they're there. If Dr. Oz is at Cms for a year and a half and wants to go back to TV, then he's not going to get too much done. It doesn't really work that way. So again, just taking a look at who's there? What their backgrounds are? Kind of what they've been saying. I think that gives us a sign that we're going to see a lot of attempts, at least from a rhetoric standpoint, to be disruptive in health care, and to do things differently than Washington's always done them. But we'll see what ultimately makes its way through. And I think the other piece to keep in mind is that the Legislature matters right. The House the Senate. They've got to pass bills. For most of these things. The power of executive action has been limited over the last few years through the courts. And so it's going to take the Legislature to get things done, and the Republican party has a lot of debates a lot of fractures within it in terms of how to proceed. Some folks are decidedly anti-government intervention. Other folks want to see a more Populist agenda led by the Government. It's going to be hard to get them all under one coalition, especially with such a slim margin. So I think that you know from my perspective, I think you're less likely to see big sweeping change from this administration on health care. You're more likely to see some executive and administrative action in the

rulemaking space, a lot of reversals of what we've seen the last few years and a lot of talking on fox news.

- So with that, thank you so much for your time, and I know it's like 1 14, so I don't think I have any time for too many questions, but I'll hang around for a little bit. So thanks, y'all excellent.
- So the question about Rfk, Jr's potential to really impact the chronic disease space. I think it's significant. If you think about the vehicles within. Hhs, right? You've got the Cdc. There's a lot you can do there. You've got, you know, a lot of the different mechanisms. You've got an office of minority health. You've got the Assistant Secretary of Health. You've got all these different entities within Hhs that he oversees and can direct, and then they have their rulemaking process disease. So I think that it's pretty significant his ability to move the needle on some chronic disease pieces. There's no funding for it without Congress. And so I think that you know, when you've got folks like Elon Musk and Vivek Ramaswami, who are coming in saying, we want to cut a lot of the spending. I think every agency is going to be looking at a haircut, and every agency is going to be deciding what's mission critical. So, even though that may be his intention, it may initially at least, look more like messaging than new policy. We say an ounce of prevention is worth a pound of cure. You got to invest in that ounce of prevention. I think that that's not likely to happen in the short term. But yeah, I think it'll be kind of interesting to see how it plays out.
- Actually talk and thanks for your perspective.
- So this has probably always been true, but it seems to be more of a light on your help.
- What your health rate looks like.
- So how do you see this playing out
- video that or roll up team versus those that are.
- I think, by and large. If you are insured through your employer, you're not going to see tremendous amount of change in the health care that you receive and how it looks. I think that where you're going to see the most change in these States is, if you're on a program like Medicaid you're gonna see a tremendous amount of change. If you're uninsured in one of those states, it's going to be that much more challenging for you to access what you need. And even on Medicare, right? Pushing people toward Medicare advantage providers taking a pay cut the impact that has on access and availability. So I think on public programs, you're going to see more of an impact. But again, 54% of folks are privately insured through their employers. So I think that the other piece in a place like Virginia versus a place like we'll say Mississippi, you'll see very different public health messaging in the years to come. And I think that that's going to have huge impacts because we can anticipate that we're going to have other. You know public health threats, pandemic flu, whatever it may be, and our ability to rise to those moments is going to be very different, especially without an overarching Federal Government telling us how to proceed or how we should proceed. So I think that kind of the public health apparatus is going to look widely different, depending on where you are.
- And then the last thing you know, I can't say enough about the, you know, access to reproductive health services and care that patchwork does not work well, right? And it really is going to be really challenging for folks. You're going to see a lot of cross State lines traveling to access those services, and I think it may have a chilling effect on certain providers practicing in certain States, and so a lot of different

pieces there. But I think for the majority of folks kind of to the detriment of the policy discourse, a lot of folks are going to feel like they're not feeling a difference. And I think that's part of why healthcare wasn't rising to the top of the list of people's concerns because it didn't feel dramatically different for most Americans.

- No, I think it's way too popular. And I think a lot of those provisions like kids staying on your parents insurance until you're 26. Those provisions around insurance reform are incredibly popular. Because again, people don't like health insurers. And so they're kind of like, yeah, anything that makes them pay for more of my stuff. I'm with it. You don't want to be the administration that takes that away and says, No, no, they can.
- They can screw you over like they used to. So I think you're unlikely to see those changes. I think what becomes a little bit harder is how, when you pull back a lot of regulation, it's like, How do you enforce some of this? And I think without the regulatory or the enforcement paradigm, you may see new ways of keeping people away from the care they need emerge. And a government, a federal government that's less inclined to see it and nip it in the bed. But so we'll see a change in research funding in the, in the short term future of the next administration in terms of Nih and other Federally funded research. Okay, that's a great question.
- Nih, historically, has been really good about still getting funded, no matter who's there. And I think that that's kind of the posture they've had.
- I think part of the challenge is, Francis Collins isn't going to be there right? You don't have that longitudinal leadership that they've had in the past, and I don't know. I know he's a Stanford based clinician. I don't know the new, I guess the proposed Nih director, but I think that that's going to be to some extent.
- You know, Congress deciding how much money they want to send Nih's way. It's always on the chopping block in every conservative budget proposal. They say we're going to cut Nih funding.
- And then, you see, everybody say, don't you dare cut the National Cancer Institute funding right? And then they don't cut it. So I think it becomes more of a posturing thing from these administrations where they say we're going to cut Nih funding, but Congress doesn't do it because their constituents don't want them to. To be honest, I can predict much better what trump's going to do than I can predict what Congress is going to do right. And I think that's the part that I think is the that is the the more challenging aspect. Right? I think that there's too narrow a Republican majority for me to believe they're all going to come together behind any.
- You know. Idea a lot of Conservatives do not want anybody to touch nih funding. Right? So so I think more likely you're going to see continuing resolutions, budgets continuing to pass. I think some of it is. What are Democrats going to do to help or to stop this Administration? This Republican House Senate, White House from being successful. That's 1 of the things I hate about politics. Right?
- Is that no matter which side you're going to have a group of folks who are trying to stop them from achieving their policy goals because you don't want them to have a win, because that gets you more votes. And so I think one of the questions is who's going to create some alignment because we're so bitterly polarized? You don't get the kind of crosstalk that we used to have, and so on the Nih front. And so I say all that because you're less likely to see budgets get through, get approved. You're more likely to see continuing resolutions to continue the kind of funding we've had recently long answer. But hopefully, that made sense believe for a last question. It's from the chat, fortunately with their computing. Id. So I don't know who it is, but it

says, prior authorizations have become increasingly burdensome and used to contain costs. Is there a projection on whether there will be any changes to the increasingly restricting PA requirement prior author form really high on the list for a lot of writer advocacy groups the headwinds I've heard is that the Administration thinks it's reasonable. I haven't heard a lot of folks say, no, we don't need prior author reform, so I do think it's possible. I think it's just a question of what legislative package do you put that into? And it's not really like a poison pill? It's not going to talk anybody out of passing a budget, but I think what it is going to do is it's going to complicate matters because it's going to have a cost to it and I think this Administration is going to be instructing Congress not to add anything that has a cost.

- So I think I think that'll be one of the challenges. But, prior author again.
- I think there's support for it, in part because nobody likes insurance companies right now in Washington. And so they're just kind of like, sure you can stop doing so. Yeah, I've seen across both both sides of the aisle. I've seen support.
- Alright, thanks. Y'all.