State Coverage Initiatives: Will Moving Toward Universal Coverage Make the System Work Better for Everyone?
Commonwealth Fund and Alliance for Health Reform
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SARA COLLINS: —Access to care, because so many people across the country are uninsured or underinsured is highly unequal. Poor access to care is also linked to poor quality care. People who lack health insurance are much less likely to have a regular source of care to receive preventive care services to be able to manage their chronic conditions. They have both poor health status and shorter life expectancies.

People without coverage also create inefficiencies in the delivery of care, more duplicate tests, records not being available at the time of appointments. A highly-fragmented demand side, multiple purchasers of care makes it difficult for us to gain control of costs. Financing of care for uninsured and underinsured families is inefficient and characterized by cost-shifting. Incentives in both insurance markets and in benefit design often promote both unhealthy competition and unhealthy behavior.

In 2006, we saw the largest increase in the number of uninsured people in four years. Forty-seven million people are estimated to be uninsured; this is up from 8.6 million in 2000. Across the states there's been a remarkable deterioration in adult coverage. The number of states where 23-percent or more of adults under age 65 are uninsured rose from two to nine of 2000 to 2006. In contrast, because of the implementation of

the State Children's Health Insurance Program, many states experienced gains in covering children. The number of states with more than 16-percent of children uninsured actually fell from nine to five over that same period.

The Commission's state score card which we released in June, finds that across states higher rates of insurance are closely associated with better quality. States with the lowest rates of uninsured residents tend to score highest on a share of population receiving preventative services, having appropriately-managed chronic conditions. Children are more likely to have medical homes in these states, and they're more likely to receive both preventive medical and dental care. In fact the top five performing states overall in the score card on about 32 measures of performance — Hawaii, Iowa, New Hampshire, Vermont and Maine — all have high rates of insurance coverage.

Recent evidence also suggests that leaving so many people uninsured may have long-term cost implications for our health system and the Medicare program in particular. A paper by Michael McWilliams and colleagues in the New England Journal of Medicine this summer found that previously-uninsured Medicare beneficiaries with heart disease or diabetes have much higher reported rates of doctor visits and hospital admissions,

and consequently hire overall medical expenditures than did previously-insured Medicare beneficiaries.

Universal coverage is clearly integral to improving our health system's performance, but the way in which we design it will matter greatly in terms of whether we can cover everyone and whether we can make sustained improvements in quality and efficiency. With this in mind the Commission recommended in the report several key principles of reform. It will be critical, for example, that proposals provide benefits that cover essential services with appropriate financial protections. The premiums, deductibles and out-of-pocket costs are affordable relative to family income. Health risks should be broadly pooled. It should be simple to administer. People should be covered automatically and continuously over time. Dislocation at the outset should probably be kept to a minimum. People should stay in the coverage, or be able to stay in the coverage they have if they so desire. Financing would need to be adequate, fair and shared across stakeholders.

Governors, congressional leaders, presidential candidates have proposed strategies to reform the health system, and we're going to hear from three states who have recently implemented or proposed universal coverage. The approaches currently being discussed at both the federal and state level can be broadly characterized as those that would

provide tax incentives for buying coverage on the individual insurance market, those that would build on existing public and private forms of coverage, group forms of coverage, some with individual mandates and employer mandates with new group insurance options referred to as connectors, in the case of Massachusetts, or exchanges, with premium subsidies for low-income families.

And a third approach are those that would cover everyone through pubic insurance programs like Medicare. When we measure these approaches against the key principles in our report, both the mixed private/public approaches and the public insurance approaches would have the greatest potential for broad system improvement. Massachusetts has recently implemented a mixed private/public approach. Governor Schwarzenegger has proposed a similar approach in California, is in a heat of debate over reform. Governor Rendell of Pennsylvania has also put forward a private/public proposal. These three states and several others are taking a lead on health care reform. Their experience can inform other states and also federal policy, and we're eager to hear the updates on their experiences today. Thank you.

ED HOWARD, J.D.: Thank you very much, Sara, and thank you for persisting through the buzzes and the whistles. Next we're going to hear from Sarah Iselin, who's the Commissioner

of Massachusetts Division of Health Care Finance and Policy. That division has a very broad portfolio of responsibilities, including the implementation of many aspects of the Massachusetts Health Reform Plan already in law that's aiming for universal coverage, as Sara pointed out, as Sara Collins pointed out. Sarah Iselin has experience in both public and private sectors including with Blue Cross Blue Shield of Massachusetts and their associated foundation where she actually supported some of the bipartisan efforts to enact reform law in the first place. So she's been at it from the beginning, and we're very pleased to hear a progress report from the front line. Sarah?

SARAH ISELIN: Great. It's great to be here today, and it's a really fun time to be out talking about health reform in Massachusetts. We're a year-and-a-half in, a year-and-a-half almost practically to the day since our law was signed. And I thought that I would use the time to do a few things. One, to just give you a brief overview of our law, a little background to give you a sense of where we are, the progress we've made to date and then a view of some of the challenges that we see ahead, and do all of that in six to eight minutes, which is a challenge for a law that is as complex and comprehensive as the laws in Massachusetts.

So why are we getting so much attention? I think I don't probably need to tell this audience that, but it is because as folks here and Ed have said, we've set out an incredibly ambitious goal for ourselves to get as close to universal coverage as we can, that we were able to advance a plan that got not only bipartisan support from a Republican governor and a Democratic legislature, but also brought together all of the stakeholders in our community that don't often all agree on things — consumers, and payers and providers, and utilizing a lot of novel approaches. And then just to give you a sense of where we started and why we were able to do this, we have a very relatively low rate of uninsurance in Massachusetts about when we started, depending on whose estimate you use, 400,000 to 500,000 people without coverage, a rate of about 6-percent to 7-percent.

We have a long history of coverage expansions — we've actually tried to do this before — a broad Medicaid program, a really extensive 1115 waiver as part of our Medicaid program, the Uncompensated Care Pool in Massachusetts which is a pretty unique financing vehicle that brought all of the dollars that finance uncompensated care in our state together in one place to the tune last year of about $600 million, and a highly-regulated insurance market. So the major components of our reform are pretty significant Medicaid expansion, up to 300-

percent of the FPL for kids, subsidized coverage up to 300-percent of the poverty line for adults, changes in our insurance market, we merged our non-group and small group markets and significantly created, as I'm sure you've heard lots about, the Commonwealth Connector Authority, which brings our market together to make it more efficient, create more choice, more transparency, portability of insurance coverage and to ease the purchase, our individual mandate, and also new employer responsibilities.

So how do all these pieces fit together in terms of our uninsured in the state, we targeted about 20-percent with our Medicaid expansion, about 40-percent through Commonwealth Care, that's the subsidiary program up to 300-percent of the FPL, and then the remaining 40-plus percent through these other provisions in our mandate. So where are we, how are we doing? Since we started implementing reform we have newly-enrolled just over 50,000 people in Mass Health, our state's Medicaid program. Commonwealth Care, the subsidized insurance program for folks up to 300-percent of the FPL as of the beginning of the month had over 127,000 people enrolled.

When you look at the bars here you can see the difference between under 150 there are no premiums. We've had incredible success getting people enrolled in the part of the program that has no premiums in part because we've moved people

who were known through our Uncompensated Care Pool we automatically converted them over to Commonwealth care.

The green bar shows our enrollment progress enrolling folks who have — or between 150 and 300 who have premiums, you can see it starting to grow. We're expecting a lot more growth because we are just in the process of implementing reforms in our Uncompensated Care Pool program as it's transitioned over to this new name, the Health Safety Net. And so those are going to be — they went into effect October 1st, but we're transitioning about an additional close to 50,000 people who are between 150-percent and 300-percent later this month who've been known to the pool, really trying to support getting them enrolled in Commonwealth Care, because they will no longer have access to the Uncompensated Care Pool moving forward.

In terms of where we are for the Commonwealth Choice, which is that as I just mentioned, administered through the connector — new products that get the connector seal of approval, that are available both within the connector but also outside of the connector, extensive outreach advertising efforts. We've actually gotten the Red Sox on board — which, you know, go Sox, great day to be here today — really supporting all of our efforts to both get the word out about this law, how it affects people, but also the availability of all of these new health insurance products.

So where are we? We have about 8,000 folks actually enrolled in these products through the connector. These enrollment statistics don't reflect people who've enrolled in these products outside of the connector where they are also available, so these numbers are, in fact, higher but there not being publicly reported at this time. And then I'm not going to have time to talk about the mandate, but you've got these — in any great level of detail but you've got these in your slides, just to say that the mandate has gone into effect as of July 1st but folks are not actually subject to the penalties unless — they actually have until December 31st of this year to enroll in coverage. So we're expecting to see that enrollment in Commonwealth Choice as well as through other vehicles to pick up. The penalties also in the first year of the mandate are being phased in, so they're relatively low this year, only about $200 they'll phase in as the mandate continues to go into effect, so I think we'll have a lot more to say, hopefully, about enrollment in all of these other programs in the months to come.

I'm not really going to talk about the affordability schedule, but it's in your handout and being sensitive to time — and as I'd said the individual mandate, you have to have coverage by December 31st. It's actually being administered through our tax cycle so folks will be filing with their taxes

in April. There's a new form, a new tax form, indicating whether or not — everyone loves new tax forms — [laughter] a new form in which they'll indicate whether or not they had coverage.

And finally I just wanted to say a little bit about — I talked about a lot of the enrollment increases, the impact that this has had in terms of uncompensated care demand and financing. The pool, as I mentioned, was over $600 million last year. We're expecting it to be cut in just about half in state fiscal year 2008. This reflects there's a little bit of a lag in terms of when we get data on claims. But this really shows that we are, in fact, seeing — as we were looking at that enrollment picking up we are seeing a pretty significant decrease in demand for the pool, and this is even before all of those new regulations I mentioned go into effect in the coming months. So expect to see these trends continue, but this is definitely heading in the direction we want to see since we're relying significantly on that funding to support the funding of these new subsidized products.

And then finally I won't talk in any great detail about the employer responsibilities, but significant new responsibilities for employers as well — Fair Share Contribution. So employers with 11 or more employees are required to either make a — offer coverage which is measured in

a couple of other — make a fair and reasonable contribution to coverage, excuse me. These are the tests. If they don't pass these two tests they then have a liability of $295 per employee per year. We're in the midst of implementing that, collecting information from employers. We'll know more about that in the coming months and be happy to come back and talk about it. I'm running out of time?

ED HOWARD, J.D.: Well, no, that's all right. Why don't you take one more minute and do the challenges, because people are interested in that.

SARAH ISELIN: And then just a view — a view of the challenges ahead are continuing to really get the word out, make sure that people are aware of the new law, that they're — we're really supporting them in terms of getting enrolled in all of these new programs, sustaining public support for the mandate. You know, early indications in terms of polls that have been done in recent months really do indicate that the public, you know, is on board. We've got good support for the law, but really maintaining that moving forward. We know that it's more than just about getting cards and coverage to folks, that we also, you know, are confronting challenges around primary care shortages and other things but really need to get them engaged in the health care system.

You know, financing will be a challenge as we move forward. We have a renewal of our 1115 waiver coming up in June, so maintaining federal support for that waiver is critical. And then finally costs, you know, something I think will be on all of our lists, but really getting a handle on health care cost growth is critical to the long-term sustainability. So thanks.

ED HOWARD, J.D.: Great. Thank you very much, Sarah. We're all watching. We're also watching Pennsylvania. And here to help us guide our vision is Ann Torregrossa.

SARAH ISELIN: Pass the—

ED HOWARD, J.D.: Yes, okay, you've got it. Ann is the director of policy, among other things, for the Governor's Office of Health Care Reform in Pennsylvania, where she's working to bring about the kind of comprehensive reform initiative already enacted in this Massachusetts — maybe not exactly the kind, but incomprehensiveness, anyway. And that would be the prescription for Pennsylvania, Governor Ed Rendell's proposal for among other things universal coverage. Ann's an attorney, she's worked in Medicaid a matter of both law and policy, and we're very happy to have her with us today. Ann?

ANN TORREGROSSA: I need to borrow your—

ED HOWARD, J.D.: Yes.

ANN TORREGROSSA: Good afternoon, and greetings from equally soggy Pennsylvania. We're delighted to be here today to talk about Governor's Rendell's health care reform proposal which is, as you heard, called Prescription for Pennsylvania. A major premise of the reform is that cost access and quality must be addressed in order to achieve the reforms that we're seeking. When we started this process, the first thing that we did was look at who the uninsured were in Pennsylvania. And you can see our state has lower percent of uninsured than most states, only 9-percent, but because we're such a big state it adds up to a lot of numbers. So our uninsured are more than the total population of Alaska, Delaware, North Dakota, South Dakota, Vermont, Wyoming or D.C. That's fairly staggering.

Most of the uninsured adults work, 71-percent. Far too many have been uninsured for more than five years, and are suffering with chronic disease. Seventy-six percent have incomes below 300-percent of the federal poverty level, and they're going to need help from their employer and/or the state and federal government to afford health care coverage. And far too many work for our largest-growing segment of the economy, which is the service industry and retail. And 38-percent of the working uninsured had their employers offered health care coverage, but they couldn't afford the employee premium.

We started looking at what was happening with cost in our state, and we saw a really unsustainable situation. As you can see, between 2000 and 2006 cost-per-family coverage have gone up 75.6 percent, while wages have only gone up 13 percent, and our state economy has only gone up about 15 percent. So at this rate no one's going to be able to afford health care coverage. We have to do something. And the governor finally realized that we can't wait for Washington. We looked at other costs. What are some of the costs that are driving this phenomena? Well, this is for 2005. We had about $1 billion in cost for adverse events in hospitals that quality improvement programs could fix. We had $1.7 billion in cost for avoidable hospitalizations because people under the age of 65 were not getting the chronic care that they needed in the community. If you add the people over 65 to that, that figure's $3.7 billion. Staggering.

We had another $3.5 billion in hospital charges for extra days because people got avoidable hospital-acquired infections, something that needs to be stopped. And finally the uninsured were getting health care coverage. They were often— not coverage, but health care. They were often getting it in the ERs, and were being hospitalized when they didn't get health care. We learned that through cost-shifting every individual policy was increased about $200 a year from cost-

shift from uncompensated care, family coverage over $600 a year. And this is not going to get any better. We're looking at $1 billion in increased cost shift beyond that in the next five years if we don't do something, so thus we have the governor's prescription for Pennsylvania. You can see from the logo we think this requires integrated strategies, and working on all these problems at the same time.

I will not go though all the components. You would be here till breakfast tomorrow. If you go on our Web page you can find the fact-based reasons for these proposals and what the governor is recommending. It's quite comprehensive. I think it may be the most comprehensive proposal in the country. Where we first started with Cover All Kids — our advisory panel told us that kids can't wait, we need to immediately work to get coverage for kids. We had an SCHIP program that provided us federal subsidy up to 200-percent of the federal poverty level. We had a state subsidy program that went up to 235. We immediately filed for a state plan amendment to increase subsidy up to 300-percent of the federal poverty level and allowed parents who had incomes above that to be able to purchase at cost, if they could not get affordable coverage in the marketplace. It has been amazing. The Cover All Kids logo has brought in more kids who are already eligible for Medicaid

because now parents come because they think well, everyone can be covered.

We're now trying to build on our successful Cover All Kids program to have Cover All Pennsylvanians. There are two ways that you can qualify for coverage. One is if you're a small low-wage employer and you haven't been offering health care coverage in the last six months, if you enroll enough employees and pay $130 a month as the employer portion, we will provide and subsidize health care coverage for your employees. The other is individual enrollment similar to Cover All Kids.

As you can see, the premiums are quite affordable. We did focus groups all over the Commonwealth with small employers who were not offering health care coverage, and the average amount they said that they would consider paying to start providing health care coverage to their employees was $130 a month, and we've tried to price that to that figure. You can see that the employee premiums are very reasonable. And if an individual has income above 300-percent of the federal poverty level they can purchase the product for cost, which is $280 a month, much lower than what's available in individual market.

The benefit package is basically good. It really focuses on providing excellent chronic care, wellness and health assessments and having people work to maintain their health. We propose to have this be provided through managed

care with our non-profit Blues being mandated to bid. The governor originally proposed that this be funded through a fair-share assessment on the payroll of large employers who did not provide health care coverage. A lot of our legislators have taken a no new tax pledge, so we are in conversation with the legislature about how exactly they want to fund this.

We've had some successes. The legislature's been picking bills out to pass. We passed the Assisted Living Licensing Law. We passed the most comprehensive house-acquired infection control law. We had the worst laws in the U.S. about SCOPA practice as far as what nurses and dental hygienists could do. We passed six SCOPA practice laws so now we can have a much better team approach to health care. We significantly expanded subsidized school breakfast, wellness mobiles and seed money for FQHCs. But we feel that what is absolutely critical is passage of Cover All Pennsylvanians, and that without it we can't make our health system work better for everyone.

ED HOWARD, J.D. Thank you. Ann, you mentioned the website where you sent people. What is the URL?

ANN TORREGROSSA: If you just google Pennsylvania and you'll get the Pennsylvania State website, and then you'll see the RX, the Prescription for Pennsylvania logo, click on that, it'll take you to the plan. And the governor just was on a Tour to Insure, going all over Pennsylvania in a bus. And a

lot of people who are uninsured wanted to be videotaped, and their stories are up on that website and they're very compelling.

ED HOWARD, J.D.: Great. Thanks very much. All right. We're continuing our east to west tour of the United States. We now hear from Leif Wellington Haase. He's the Director of the California Project— California Program for the New America Foundation. And in that capacity he's been an advisor to many of the main players in the executive and legislative branches in California as the officials there struggle to come to an agreement on a major reform plan that you may have heard about. So Leif, thanks for being with us, and we're looking forward to hearing you.

LEIF WELLINGTON HAASE: Thank you so much, Ed. Former President Jimmy Carter once said that whatever starts in California unfortunately has an inclination to spread, and presumably he didn't mean surfing. California may not have kicked off the current round of state universal health coverage initiatives, but Governor Schwarzenegger's proposal has opened up a real chance for the most populous state with the greatest number of uninsured to adopt the universal coverage. So we're attempting to reverse the logic of Carter's remark and to win this uphill battle.

My name is Leif Wellington Haase. As Ed mentioned I direct the California Program for the New America Foundation. It's a non-partisan think tank based in Washington D.C. As you know, Governor Arnold Schwarzenegger proclaimed 2007 the year of health care reform in California. And earlier this year he proposed a mixed private/public universal coverage plan much along the lines endorsed by the Commonwealth Fund Commission. It's key features are an individual mandate, a minimum 4-percent payroll tax on employers, a 4-percent fee on hospital revenues, expansion of Medi-Cal and the creation of a state purchasing pool for low-income Californians, a cap on insurers' administrative costs and profits, and broader eligibility for children regardless of immigration status through Healthy Families, California's SCHIP program.

Until recently the governor's plan hadn't been put in legislative language, but in mid October his office released this language and the proposal's now being debated in Sacramento during a special session of the California legislature. The main alternative proposal's been offered by Senate President Don Perata and Assembly Speaker Fabian Nunez. This Democratic leadership's Pay or Play plan, supported by much of labor, levies a 7.5-percent payroll tax on employers and contains a coverage mandate for workers but not for individuals. It aims at major coverage expansion rather than

universality. Citing its potential impact on business, Schwarzenegger vetoed the Nunez/Perata plan last week, and for similar reasons he vetoed the popular Single Payer Proposal, which had passed the legislature last year.

By way of background, New America's been closely involved with the cycle of health reforms in California from the outset. Our founder and president, Ted Holsted, met with Governor Schwarzenegger soon after he took office to discuss an individual mandate, and our staff continues to speak often, as Ed mentioned, with the governor's office. The research by New America's Len Nichols and Peter Harbidge on the hidden tax, the higher premiums paid by employers and individuals because of provider cost shifting, children's health and the individual mandate is frequently used by the administration and credited to the foundation.

The foundation is part of an unusually broad set of players, including a substantial part of the business community that are trying hard to bring health reform and universal coverage to California. The breadth and persistence of this interest in reform combined with strongly favorable public sentiment is one major reason for optimism. Seventy percent of Californians think the system needs major change, while a recent poll by the Public Policy Institute of California showed that 72-percent backed the governor's plan, and 61-percent the

Democratic leadership's proposal. Support for the governor's plan with conditions has come from the California Hospital Association and the Los Angeles Chamber of Commerce. The CEO of the Silicon Valley Leadership group has editorialized in favor of universal coverage.

The state's major retail trade associations unusually have suggested the sales tax might be raised to help pay for expanded coverage, and surprisingly survey's show the majority of small business owners may be receptive to reforms. And finally one can't over-estimate, even at this stage, the impact that Schwarzenegger, a moderate Republican with star power, who despite having had mixed success with the legislature and with earlier ballot initiatives, brokered a landmark global warming bill last year.

So what stands in the way of reform? A number of things, some unique to California and others that crop up in every state as we've heard that is going down this route. Compared to other states California has a very large number of uninsured, many of them with lower incomes and a lower base of employer coverage than in many other states. This raises the price tag for universal coverage. Schwarzenegger's current plan is a $14 billion price tag, and widens the need for subsidies. The financing of the proposal depends heavily on maintaining and increasing federal funding for Medi-Cal and

Healthy Families which may not easily be one or sustained. I should add that most independent analysts think that California's revenue picture is likely to worsen by next spring, potentially complicating any proposal that involves new spending.

California's political structure also tends to impede reform, thanks to it's two-thirds rule for passing the budget and any bills that raise taxes. This gives the Republican minority, which is opposed to all tax increases and anything that appears in the guise of a tax de facto veto power of such legislation. Earlier this summer their 52-day holdout over passing a state budget also sapped the momentum for health care reform. This intransigence is why the effort to pass reform, should it move forward, likely will involve a two-step process. First the legislative passage of a bill, and then the financing being taken to a ballot initiative probably in November 2008, that requires only a majority popular vote.

As all of you who work on similar plans will know, the affordability of coverage especially for middle income folks who make too much to qualify for full subsidies, is a major stumbling block. Health advocacy groups argue that a mandate transfers too much risk to individuals and places too little responsibility on insurers to offer plans that are decent and affordable. They fear that the high deductible plans that

maybe the minimum legal requirement would wipe out the savings in assets of most Californians. Many of these points as well as related criticism of the modest cost containment elements of Schwarzenegger's proposal are legitimate points for discussion, whether or not this specific proposal goes ahead.

Looking at the results of a recent UCLA and Berkley study on the proportion of family income Californians now spend in the non-group market, 8.1-percent of income for those in the range of two to three times poverty, let me make several observations on this. First, it shows that substantial subsidies may be needed in that range. Second, that holding down the amount families spend on health care to 5-percent of income as envisioned in the plan supported by labor would involve quite high and possibly unaffordable subsidies. However, given that Californians of modest incomes without employer-based coverage already spend a considerable amount in premiums and out-of-pocket on health care, a compromise might be struck that would offer relief for many without breaking the bank.

When it comes to middle-income subsidies, a strong element of politics will always be present in debates over affordability. Moreover the focus on what may or may not be affordable now underestimates the impact that mandates may have on insurance markets. Without mandates insurers will not

accept the guaranteed issue conditions, and payments based on adjusted risks that are necessary for genuine health insurance reforms of this kind. With almost everyone in an insurance pool, insurer underwriting and risk selection in the individual markets is likely to wane and premiums to go down over time.

So where do we go from here and where do things stand? Last week the California Labor Federation, the state branch of the AFL-CIO went beyond criticizing the Governor's plan and into outright opposition, mainly over this affordability issue. The group is sponsoring vigils at the Governor's offices, and may run television ads opposing the plan. The response from other labor and advocacy groups has been somewhat more measured, but generally unfavorable. Whether this is principally a bargaining ploy or not is disappointing because it represents a true hardening of lines among major stakeholders. Up to now such a public split has been for the most part avoided. It should also be said that the governor's delay in putting out his plan in the legislative language and with only modest changes from the original proposal probably undercut his case.

Despite this setback and the pessimism in California and elsewhere that is unavoidable created, an opening for a deal remains. Considering the governor's proposal, the Democratic plan and labor's plan, the gap between the payroll

tax levied on employers and the levels of eligibility for subsidies are substantial but hardly unbridgeable. Whether it happens with depend partly on linkage with other state issues such as proposed changes to term limits and even water policy following the old adage that all politics is local, and partly on whether the governor is willing potentially antagonize his base in the business community and whether Democratic leaders are willing to do the same for their labor constituency. Assembly speaker Nunez has already invoked the Nixon and China example in this debate. To pull out a last-minute victory for universal coverage, he and the governor will have to travel a similar long road together. Thank you. I look forward to your questions and comments.

ED HOWARD, J.D.: Thank you, Leif. Finally we're going to hear from Tom Miller. I'd call him the clean-up hitter except he's number five, right? Can we get that clicker, Leif? It doesn't look like a bat, but maybe you can figure out how to use it.

TOM MILLER: Well, I have an OPS over 900. [Laughter]

ED HOWARD, J.D.: This is appropriate because at one point in his checkered career Tom Miller was a play-by-play baseball announcer. Now he's a Resident Fellow at the American Enterprise Institute specializing in health policy. He's also been a senior economist for the Joint Economic Committee here

on the Hill, and I'm pleased to say a panelist at several previous alliance seminars. It's nice to have you back, Tom, and let's—

TOM MILLER: Okay. You want to give me a little more than three on the clock? [Laughter]

ED HOWARD, J.D.: I'll figure out how to make it work. Yes.

TOM MILLER: Okay. Well, thank you, Ed, for inviting me to comment in this target-rich environment as you can sense from my title. Strap on your seatbelts. We had a lot of time in maintaining production values in the studio, so I apologize for not having the slides in advance, but you can get them from me before they're on the Web, tmiller@aei.org, if you really have nothing better to do. [Laughter] I'm reminded how our national health reform debate in Washington operate — operate like another recurrent cycle in our region. We come out about every 17 years, sort of like the appearance of sacadas, you know, that we were familiar with, in a slightly different interval and frequency. You can cut a little sound. The sacadas are thought of harmless but annoying pests [laughter] which after a few months burrow back into the ground until they return again in another 17 years. Now any coincidence and analogies to today's topic, of course, are purely coincidental.

All right, let's get started with today's game. My players on my team are taxpayers, consumers and patients. Oh, I'm not on the next one. Okay. Here we go. So what we're going to do is play Jeopardy. Now remember when you play Jeopardy you have to make your answer in the form of a question. But since we're at a Commonwealth Fund and an Alliance for Health Reform event, the answer is always — it doesn't matter what the question is. [Laughter] Okay. Look, there's a lot of material on the latest Commonwealth Fund report primarily, folks, and I even agree with some of it. The tendency, though, is to get it backwards, however, over time. Where we actually need to improve the system performance of our health care system it gets drowned out by the universal coverage impulse and the therapeutic imperative. We first need better performing patients, consumers and physicians, and then we might be able to afford more coverage.

Let's us try a little further disclosure the evidence behind some of the contentions in that report, though, some of the slides in the package. I sometimes like to refer to this type of work as stupid human research tricks. For instance, just how much out-of-pocket spending is there in the United States versus insured spending compared to other countries? Now this slide actually just kind of showed nominal dollars, and it looked like it was pretty big. But what's important is

the ratio of the out-of-pocket spending in the U.S. to total spending on it. That's what drives the leverage in terms of the spending equation in our health economy. And if you look at that, the public and private share, the U.S. actually has a very low percentage of out-of-pocket spending because we have a lot more private health care spending which is more insured than the private spending in other so-called, you know, single payer or state-dominated countries. Cuba, of course, is looking terrific, France, that's a different story. But I'm just trying to show you, there's a different context in terms of kind what is actually the way in which our spending system operates as opposed to how it's sometimes portrayed.

Let's try another case of presenting selected correlation without causation. Have it the wrong way, sorry. This is the slide on Access in Quality based on the state's scorecard measures. Now remember this is kind of the link that, you know, better access means better quality. I might differ on what the right indicators, whether they were used or if even exist, but let's play along with some other measures used by Commonwealth to evaluate a high-performance health care system.

First of all, about half the quality markers were in effect, kind of pseudo-access measures or things, kind of besides the point. But let's take a look at healthy lives

versus access dimensions and plot that. It looks like a very different scatter plot. We call it random in the trade. You know, healthy lives is supposed to be what the health system is supposed to be about. Now the measures of that are not perfect as well, but at least it's kind of in the direction. So don't you want to kind of have healthier people from what your health care system is doing? Well, there's very little correlation with access. You can actually — I colored some of the states. It turns out the Western states where people were healthy, maybe they don't invest as much in the "health care" system because they're busy kind of being healthy because of other factors. And the same way some of the northeastern states begin to drop down from one quadrant to the other.

Let's try another correlation. This would be the healthy lives and quality dimensions. I'm using the state scorecard numbers. Again, basically you've got a random distribution there — the R-squared, technically speaking, before this other sophisticated analogy we normally do is .7 on the access and quality, here we're kind of at .1 and little fraction beyond that. In essence we don't even have correlation let alone causation. Now what am I trying to say in a larger sense? We need to get beyond health insurance alone if we want healthier lives and better health outcomes. We'll be doing a conference at AEI probably in February and

March on that very topic. There's a lot of other things that go into the health production equation besides how many dollars did you reimburse me and it wasn't covered? So we need stronger tools to improve health, avoidable deaths, a whole different story. If you look at the literature about 40-percent of deaths are caused by behavioral factors that could have been modified by some type of preventative intervention, social consequences, circumstances with another 15-percent of deaths, 5-percent environmental exposures. And what is the number for shortfalls in medical care causing death? About 10-percent. That's McGinnis in health affairs a couple of years ago. There's other work in this field.

In the same way, preventive care. It's a great idea, except it doesn't always matter or work as well as it is if it's perfectly targeted. There was a calculation in a 2003 journal article which said that if the average primary care practitioner had to deliver all the preventive care that was recommended to the average patient he would take about more than 1,700 hours out of his working year in order to do it. We can't rely on physicians alone to deal with what we really need, which is primary prevention well outside the health care system but important in terms of producing health.

In the same way there are many patient-related factors, education is a strong one, which go into actually shaping what

are going to be those health outcomes way down the road. So there are limits on that. And then finally in terms of insurance, you know, premiums can go up but at the end of the day they're reflecting the underlying claims cost that came into the system and came out of it. And I don't have time to kind of give you the sites on that other than just very quickly there's plenty of work in this field and I'm shamelessly plugging a couple of my own articles at the top.

Administrative cost, another hobby horse. You've got to look at whether administrative cost for the private health insurance system, not the aggregated administrative cost, and then you want to show that ratio over time rather than a snapshot. That's the plot. It shows kind of they used to be much higher as a percentage of premiums, dip down, go up, dip down, go up. Sometimes we call that the insurance cycle, which is another thing in terms of underwriting.

In addition, Medicare costs are undercounted, traditionally. There's a lot more costs that come out of Medicare than are logged in the book on this. The extraction cost of additional taxation through public financing, the deadweight loss of public spending, these are real costs which are kind of like the other ledger side that need to be matched up against the administrative cost component of private insurance. That's just a different type of display of growth

in premiums over time, growth in administrative cost on a year-to-year basis. It bounced around. Sometimes you get some huge bounces, but the point is there's some years where premiums are growing faster than administrative cost, other years where administrative costs are growing faster than premiums.

There was also a six-year calculation in the Commonwealth Fund's report 2000 to 2005. Well, you can pick your six-year figures as you want, but let's take a look at all of them since 1981. Basically the ones in yellow are six-year bans — that's the first year on the left, which says, what was the average growth, annualized growth, in premiums versus the annualized growth in the administrative. Plus it turns out in those yellow bands the premiums were growing faster than the administrative cost. You can cut, and slice and dice, none of these are exactly predictive. I'm suggesting it's a much more uneven field and there's no direct kind of parallel always in the same direction.

I'm going to skip over what's gotten into health policy. That was the Johnny Cash song, I got it one piece at a time and you got a pretty ugly looking car as a result of it. Quick hit and run on Massachusetts Mirage or Miracle. I was at a conference about a month ago, two months ago, actually, no, a month ago. John Gruber was talking about it. He said, you know, we know how to do coverage. We can do coverage all kinds

of ways. Cost control? We haven't figured that out yet. We'll get to that in 10 or 15 years. I'm paraphrasing. That's the problem with Massachusetts. It's great to kind of have the ambitions, but at the end of the day where's the cost containment, where's the sustainability, and also the capacity in the system. As you bring more folks in who are going to have a spike in demand for what they want, you don't have any more doctors the next day, any more hospitals the next day. You're flooding one end, it's a different version of the emergency room through insurance, but you still have kind of problems of mashing it out. I'll get back to Massachusetts later if we have some time. The other thing is, of course, if you start out on third base and say you hit a triple, it's a lot easier to claim success in other states. [Laughter]

Pennsylvania, I'm kind to Pennsylvania. I think it was a good signal they kind of talked about — the governor, in fact, talked about — controlling costs first, the insurance mandate later. Good focus on expanding the supply way beyond kind of the conventional scope of practice excellence; actionable information, accountable transparency, good progress in that part. What's not going to fly, of course, is the fair share contribution and the higher taxes. People don't want to pay more, you can't get around the risks so go back to the drawing board.

California. You know, exaggerating hidden taxes — I'll get to that in a second — but there's some barriers to real ones in California, not going to get past that in the two-thirds vote or, I think, in an initiative referendum. The mandates that were tried to be imposed through taxes and fees and elsewhere, a very heavy lift even for Arnold, the individual mandate is not going with the labor unions. They'd rather just play the old game of loading it on to the employers.

Now let's talk about that hidden tax for just a minute. The calculations by both the Hoover Institution and New America Foundation left out some stuff. The bottom line is, the part-year insured spend differently than the uninsured do, and in fact the out-of-pocket share — the out-of-pocket payment is very different in terms of kind of how they get contributions to it so that hidden tax is much more microscopic if you go back to the Hadley-Holohan stuff.

All right, I'm running out of time. Quick thing on there, let's get over the individual insurance market pooling in shallow waters. It just is kind of harassment value for regulation, which doesn't make a difference in most cases. There's a lot of pooling going on in that market you need to understand. And if you read some of those things, you might. Some numbers to remember, 30-percent is roughly the variation

in cost in Medicare, which is pretty much waste, suggests kind of a single-payer system, doesn't operate that well.

Talk about the recommended care, 55-percent is all you get under the current system, 40 and 10 are the avoidable deaths in the amount due to medical care. How about that 70 trillion? All right, that's roughly it. That's the unfunded liabilities of Medicare. We didn't hear anything about that. That's the infinite horizon. Thirty-eight trillion we do in trust funds, 2009 is when this all comes down. Eighteen percent of GDP is about where we're going to tax, and we have always. It's not going to change, so find the money. But I can — little cautions on what could happen, but I'll be constructive, that's what you should do. Thank you.

[Laughter]

ED HOWARD, J.D.: Any questions? [Laughter] While you're queuing at the microphones and scribbling on your green cards, I'm going to give the opportunity to our panelists to respond to anything they've heard, and if they don't want to respond to anything, I've got a couple of questions that I'd like to ask. Okay. Tom, this is a softball. You talked about the need for stronger tools to improve health. What kind of stronger tools are you talking about?

TOM MILLER: Go right back to that last slide. Thank you very much, Ed. I appreciate that. Look, we need healthier

people, and there's a lot of things that go into producing healthier people. That also means kind of better performance measurement by the folks who are delivering health care. Now to be fair, this is being done in different pieces in Massachusetts, in Pennsylvania, California better on transparency. We need to ramp that up a lot more, though, because it's what's gets delivered in terms of the value that matters, but there's a lot of other softer factors. Education is a much stronger correlant with better health and all this other stuff we're pumping into the system. Let's make sure that we have people who kind of have longer time horizons, are better decision-makers, navigational assistants. Spend a little bit less on regulation, a little bit more on helping people get through the system with kind of some tools to do it. This is kind of how the system actually what it delivers and what it produces as opposed to kind of what we kind of put on the shelf and say you're going to get it somehow randomly. That's essentially the argument.

ED HOWARD, J.D.: Good start. Okay, yes. Would you identify yourself and be as brief as you can.

CHRIS PETERSON: Chris Peterson with CRS. Sara Collins, I was puzzling as well over your graph that Tom had highlighted, and maybe these are the same side or the same one we're looking at, but not getting into that, so northeast of

Virginia in your graph, and actually on the map, these states seem to be in the northeast or kind of the upper Midwest where's better access. And why is that? And maybe, Tom, you could weigh into that as well. I mean, I've heard some of the — we're talking in the upper right-hand corner we've got the states that are kind of these overachievers, Massachusetts and Connecticut, and they're trying to go another standard deviation out. And I've heard these folks talk before and a lot of them will say look, this is our culture. We think that coverage is important. So what's going on here? Is it culture? Is it social economic status, what are the characteristics that seem at least to appear in geographic terms on this chart?

ED HOWARD, J.D.: Sara?

SARA COLLINS: I think there are a lot of demographic factors that do factor in to long healthy lives, and I think we do say that in our report. I think the evidence is very clear starting with the Institute of Medicine's report in 2003, and an enormous amount of evidence that has mounted ever since that, that having insurance coverage is the most important component of access to care. You must have coverage before you can get adequate care. So in the states on the graph that have the higher rates of coverage, people tend to have better access to care. So I think it's really hard to make the case that

because we're not seeing it showing up downstream, that health insurance isn't important for people. The evidence is just too strong that health insurance coverage does improve access to care. People who don't have access, people who don't have health insurance or who have a high out-of-pocket cost do not have the same level of access, do not have the same clinical outcomes that people that are fully-covered for the year or have more comprehensive coverage.

ED HOWARD, J.D.: Okay. There's another question that we got on a card, Sara, that's directed to you as well. The Commonwealth report says one of the reasons there's a connection between levels of coverage and a high-performing system is that a fragmented health insurance system makes it harder to control cost. Then the report endorses a mixed fragmented public/private solution. How do you explain that?

SARA COLLINS: That's a great question. Clearly if you look at Canada, if you look at Germany where you have a monopsony buying power, single purchasers, or even, in the case of Germany, the ability of purchasers to negotiate rates with providers, you do see lower prices, lower provider prices and lower costs. The more ability providers have — I mean purchasers have to negotiate with providers, probably the more control we can gain over cost. But the Commission chose to endorse the mixed private/public approach to universal coverage

primarily because of the ease at which it would — how much simpler it would be to move from where we are now to a universal coverage system. So you would not have to move 160 million people out of employer-base coverage if they didn't want to.

And we saw in the Clinton health reform effort in 1993 that one of the main fears that was ultimately exploited by the opponents of the plan was the fact that people were going to have to move out of coverage that they liked. And you see in survey after survey that people actually have — do place a high value on employer-base coverage. So that I think we do recognize, and it's hard not to agree that the better care for all would lower administrative costs, it would make it easier to lower provider prices, and a whole range of other things including continuous enrollment, automatic enrollment. But the pragmatic appeal of the other approach is why the Commission ultimately came down on that side.

TOM MILLER: Ed, could I try a different language in translation of that?

ED HOWARD, J.D.: Sure.

TOM MILLER: When it comes to the individual market, he preference is to not only have the individual housebroken but neutered. When it comes to the employer-sponsored market, that's okay to be kind of an abused pet. You can kind of

criticize and load some stuff onto it, but then you kind of padded the cages because you need the infrastructure in order to kind of deliver it, and you can't go overnight. You can only annoy people so much in terms of kind of going to something as a buy-in approach. But in the long-term the idea is if you can get everybody inside the same tent then the government can deny care for you, which you're currently complaining about not being able to get through private insurance.

ED HOWARD, J.D.: Okay. Yes.

TOM PIAZZA: Hi. My name's Tom Piazza [misspelled?], I'm a hospital administrator in Maryland. And I just had three quick points I wanted to make. One is I think it's interesting while valuable that there's economists on this panel, I don't see any health care providers. So the comment that physicians — the hours we require for physicians to do this, primary care practitioners are averaging six minutes a patient, so they can survive. And that comes from the evolution of the payment system. So in the 80s they build they whatever they want, they got whatever they want — or in the 70s. The 80s the insurance came back and killed the providers and now we're trying to figure out where it goes. I realize you know all that, but one of the reasons that it is the way it is, is because the system now pays for procedural activities way more than it pays for

any kind of thought process or [interposing]. Right. And that needs to be fixed first.

So, and the other question I had is no one has mentioned the fact that patients expect their health insurance to be covered, period. They just do. They walk in the doctor's office they expect to be covered. They're not looking for out-of-the-pocket. And nobody's mentioned whether anybody feels like the government should take that on the way they take on defense, the way they take on road infrastructure and things like that. People that expect to pay for that stuff with their taxes now, if it was well-explained I think they would think about it for the health care, because they do expect when they walk in the doctor's office that they don't have to write a check or pay anything.

ED HOWARD, J.D.: Anybody want to respond to that? I know there's a question in there somewhere. Yes, go ahead, Ann.

ANN TORREGROSSA: Yes, in Pennsylvania, going back to the earlier part of your comment, we looked at health care cost, and you've heard the old adage that 78-percent of the costs are for 20-percent of the patients. And they're the people with chronic conditions. And they are not getting all of the evidence-based care that we know that they need, and they think that there's a magic pill. They should go to their

physician or their nurse practitioner and everything will be made right. Well, a lot of things result from lifestyle — you know, hypertension, obesity, whatever. And if you don't begin to involve patients in taking care of themselves in setting goals and reaching them, you're not going to achieve the kinds of change that you want.

We have a Commission that's really looking at how we reimburse. We're paying a ton of money for avoidable hospitalizations, but we're not paying physicians and nurse practitioners to really work with people with chronic conditions. So we're really trying to realign our payment system to get the results that we want.

ED HOWARD, J.D.: Yes.

TOM MILLER: And as much as we could do at the state level, Medicare is a bigger player in that. And Medicare reimbursement drives a lot of this paying for stuff rather than out-of-cost [misspelled?].

ED HOWARD, J.D.: And at least it's my hope that over the course of the next year or so we will be spending a fair amount of time on payment policy and the attempts to tweak it or to change it radically either in Medicare or in some of the private pay-for-performance operations or other venues as well. So I've welcomed the kinds of suggestions for programs that we

can put together that can help spotlight some of the strengths and weaknesses of those developments. Yes.

CHARLENE MACDONALD: Charlene MacDonald with the American Association of Orthopedic Surgeons, and a question for anyone on the panel. Several of you sited SCOPA practice expansion as a cost-containment strategy, and I'm wondering if anyone has looked at the effect that that policy has on quality of care and how that figures into health care reform?

ED HOWARD, J.D.: Did you get that? Yes, go ahead. Sara, do you want to start?

TOM MILLER: What kind of practice expansion is the practice is the—

SARA COLLINS: Yes.

ED HOWARD, J.D.: Would you must make sure that we all understand exactly what kind of expansion you're talking about, this coverage expansion.

CHARLENE MACDONALD: [Interposing] No, SCOPA expansion, leaning towards nurse practitioners and such.

ED HOWARD, J.D.: SCOPA expansion. Yes, I'm sorry. Okay. That sounds like she's talking to you. Yes.

ANN TORREGROSSA: Well again, going back to the chronic care the fact that most of the health care costs are driven by a small number of people, right now so much is on the shoulders of physicians, and they have six minutes to do it under our

present reimbursement system, and that's just not going to cut it for a diabetic or for a person with asthma trying to figure out how to get this chronic disease under control. And if we don't go to a team approach where we — in a population-based management approach where a health care team can look at all of their diabetics that are in their practice — see who has and who has not gotten whatever evidence-based care, be much more proactive about reaching out to those who haven't come in to care and not have it all be on the shoulder of the physician. We need to involve dieticians, nurses, social workers, et cetera, in wrapping around the patient to help the patient begin to self manage and take care of their condition. And we're looking at the Wagner model, Ed Wagner from the MacColl Institute has been working with us, and we think it will make a significant difference not only in cost but particularly in quality, and quality of life.

LEIF WELLINGTON HAASE: I'd like to follow up and also get back to Tom's point about containing costs first before you get universal coverage. I think it's well worth looking at another state that isn't represented on the panel — Vermont — where a governor vetoed a bill a couple of years ago that would have been a pay-or-play employer-base system, and then got with the stakeholders, worked on it and now they're going to be, or close to passing universal coverage bill. It really tries to

take on cost containment and universal coverage simultaneously through disease management and cooperating with providers, and very interesting in intriguing ways. And I'd commend all of you if you haven't seen it, the interview with the governor recently in health affairs, but that's another state model in which they're trying to do these two things at once.

ED HOWARD, J.D.: Okay. Yes.

MCGORY TIKANA: Hi, my name is McGory Tikana [misspelled?], I'm with the Bureau of National—

ED HOWARD, J.D.: Lower that microphone down a little. [Laughter]

MCGORY TIKANA: I'm with the Bureau of National Affairs, my name is McGory Tikana [misspelled?]. I have a question for Ann. You talked a little about the governor's proposal. I want to know what the next steps are besides the state tour. What are some developments as far as compromising on this funding question?

ANN TORREGROSSA: Well, the governor firmly believes that the fair share assessment, despite Tom's comments, is the fairest way to go. That employees can't afford to take on the burden of health care coverage themselves. They need employers to help employers to help pay some portion of that. So he is still strongly pushing the fair share assessment. He has asked the legislature to pass Cover All Pennsylvanians by the end of

December. His other two priorities are a smoking ban in public places or wherever employees work. And his third thing that he's seeking this calendar year is insurance reform. Pennsylvania is only one of three states that does not regulate in any way the rating factors that insurance companies can use for small business in individual coverage. So that if you have a small business with — insurance used to be we would share risks so health care was affordable for more people.

In Pennsylvania they've gone to a very aggressive demographic rating. So if you have a small group with someone my age, up go the rates. You've got women of child-bearing age, up go the rates. If you have someone with a chronic condition, you probably can't afford to provide insurance. So we are trying to do insurance reform, CAP, and smoking ban, are the top three priorities for this calendar year.

TOM MILLER: My Republican sources in the State Senate said that fair share is not getting through. You've got major ERISA problems with it as well. At the end of the day, just because it appears that someone else is paying the bill doesn't mean that the price tag, the real cost has changed. Now there are important things to change that price tag, but that's what's more important than the kind of the payment flows.

ED HOWARD, J.D.: By the way, those of you who are not playber [misspelled?] lawyers may not know about ERISA and its

impact on the kinds of plans that we've been talking about. There are a number of resources collected in a little primer that we have put together on the Alliance website. If you go to it and put ERISA in the search box you'll come up with it, provide you some kind of background in the obstacles that ERISA presents to state legislators and governors trying to put these plans in place.

Before we go to the folks at the microphone, I did want to get to this question that came in early, and it's directed to Sarah Iselin along with a related one. The questioner writes that 20-percent, she understands, of your population has been exempted from the individual mandate because of affordability. Could you please comment on how this affects the goal of universal coverage? And before you do that I would add to it another question that came in early that wonders about the effect of those people exempted from the mandate on possible selection problems for insurers, if you've got a lot of people who are exempted, and no mandate.

SARAH ISELIN: Well, I didn't get to talk a lot about the mandate, so I'll take some time now. In devising our mandate, the connector board was really charged with answering a couple of critical questions, one around the comprehensiveness of coverage. So what was the — what would the minimum leverage of coverage be? What would that look like

that would satisfy the mandate? And then the other piece being the supportability question in terms of what kind of proportion of income, and what would you be expected to pay toward to the cost of coverage? And the answer to that question really defines who the mandate applies to.

And as you can imagine, there's, you know, a very careful balance in terms of trying to strike a reasonable balance between those two things that would be able to, you know, get the support both of the board, and they were able to navigate amazingly both of those separate regulatory decisions with unanimous support across the connector board which has folks who represent consumers, who represent business, and representatives from government, and providers and others. And so, you know, it was a very, very challenging decision that on the benefit side really went more toward, when you look at the minimum creditable coverage standards, a pretty comprehensive benefit package. So a lot of really tough conversations around Massachusetts as a state that has a lot of health insurance coverage mandates while the law required an evaluation that we actually have in the works right now.

The impact of all of those mandates left it up to the regulatory process to determine should those be part of this minimum credible decision or not, and ultimately the decision was they would be. So when you look at that slide that I have

up there you'll see it's, you know, a pretty comprehensive benefit. So then that, then balanced with the decision of what are the cost of those policies in the market and, you know, how many people should be at the lower income levels, should they — you know, what's a reasonable expectation in terms of what people should have to pay relative to their income and be subject to the mandate. And I think this is something we're going to be continually reevaluating, you know, as we move forward with reform. But that's where we are right now.

TOM MILLER: You've got non-conforming plans that will be coming up in 2009 as to whether or not you're going to require prescription drug coverage or other types of things?

SARAH ISELIN: Well, there's an active conversation right now about prescription drugs, the initial decision on this minimum credible standards in drugs were a very, very active area of discussion was to include drugs. So as Tom's pointing out, the minimum credible coverage standards, they're not effective until January 1st of 2009, and there are, you know, plans on their market right now that don't have drugs. There are, in fact, Commonwealth choice plans right now that don't have prescription drugs. But our expectation is that, you know, as we all understand when people are making decisions in 2008 about what coverage they want to sign up for you generally sign up for a year. So I think our expectation is

both that that will be shifting in coming months despite that not going into effect until ’09, but there are also active conversations amongst the connector board about are there other options or other kind of creative ways to look at structuring that prescription drug benefit to maintain prescription drug coverage, but really try to support, you know, maintaining the affordability of the products that are on the market. So I think these are things that, as I said, we’ll be continuing to talk about it in the program.

TOM MILLER: It’s another affordability problem with employees of larger companies who the cost of contributing to the insurance is actually greater, I think, than what would be the premiums available. And the question is whether you’re going to subsidize folks who have access to employer coverage, and even though their income may not match what the cost is.

SARAH ISELIN: Well, we’re not. I mean there are crowd-out provisions in the law. So for instance, you know, the law was very specific, but if folks have an employer sponsor insurance offer, there’s an evaluation process that looks at if your employer offers to contribute — as it’s written right now — 33-percent towards the cost of an individual policy or 25-percent toward the cost of a family plan, you’re not, in fact, eligible for these subsidized plans. And that was, in fact, actually — when we have implemented

these changes in our Health Safety Net program which is the program that really supports the financing of care for people without coverage, we've actually had added in an evaluation of employer-sponsored offer within that financing vehicle as well that dovetails with the affordability standard.

So it's kind of a tougher test, but looks at if your employer-sponsored offer is considered affordable. For the affordability standard you won't have access to the Health Safety Net either. So we're really trying to align all of these provisions to reform to support maintaining the base of employer-sponsored insurance we have. And in fact, you know, one of the expectations for shared responsibility is that we're hoping it will grow, because of the mandate more people will take up the employer offers they have, so.

ED HOWARD, J.D.: Okay. I hate to break up the chain, but Bob has been waiting at the microphone.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. In the Commonwealth high-performance measure study, there are lots of measures of inefficiencies in the health care system, as you described. And I'm wondering how states are looking at variations in inefficiencies within geographical areas in the state. For example, if a community has a single hospital versus multiple hospitals, does that affect coordination? Does that affect

opportunities for improving efficiency? Are there data collection issues that you need to undertake at the state level in order to identify the inefficiencies and ineffectiveness, and are there regulations at the state level that you're trying to put into place in order to make the health care delivery system more efficient?

ED HOWARD, J.D.: Sara, would you—

SARA COLLINS: I'll start, and then states can jump in. We actually point out a couple of key elements of reform that would address the efficiency issue. And one of the most important, obviously, is broad risk pooling. Despite what Tom said, there are substantial differences in administrative cost depending on how broad risk pools are. And a lot of the estimates of plans and bills that we've done in the past year really do show that broader risk pooling you get the larger savings you get in administration overall. So that's one major area.

I think also redirecting incentives, so aligning patient incentives with provider incentives, giving patients the right incentives to get appropriate care and also thinking about the incentives that we give to providers and aligning those incentives so that they also provide the right care efficiently. But there are dynamics both in the insurance

markets that really need to be addressed as we move to a newly reformed system.

TOM MILLER: So you want to measure something you have to have some data to do it, and I'll give a bow to Massachusetts in that regard because their efforts to do multi-payer data pooling is critical, and an excellent job in that regard. And a cross-promotional plug, of course, we'll be having a conference on November 5th talking about performance measurement at ADI, and why you've got to be able to get kind of all the stuff into the basket including the Medicare data.

ED HOWARD, J.D.: Sarah?

SARAH ISELIN: So I didn't speak much about some of the other provisions of our bill, but our bill is more than just about coverage. So in fact it created — and this is in part what Tom was alluding to — of quality and cost council that was charged with articulating goals, quality and cost goals for the state, but also was given the statutory authority to require and develop for Massachusetts an all-payer dataset. So those regs actually just went into effect. We expect to begin getting that data in as soon as December 1st, and that's going to really — and will be used to populate a consumer website, so really trying to push transparency efforts. But that dataset is going to allow us to really monitor one of the significant goals. And just to get back to the point that Tom made in

terms of the need for cost containment and the fact that while our law created this council, was not — and created significant structures to start having those conversations was not as specific as, you know, some of what's on the menu in Pennsylvania. But that council has set out some incredibly ambitious goals including limiting cost growth to no more than the, you know, rate of unadjusted growth in GDP. And having this all-payer dataset is going to allow us to really drill down and understand, you know, at a much more granular level, all of these types of issues we've been talking about. So we're optimistic, and optimistic about given the coverage base that we have and the progress we're making we're going to be able to build on the coalition we pull together to talk about coverage, to really starting having the tough conversations about cost.

ANN TORREGROSSA: The prescription for Pennsylvania calls for the creation of a commission to look at basically our health's infrastructure, and to see where we need more coordinated health, and where perhaps we have too much. We know from the Dartmouth's Atlas that supply really of hospital beds really drives costs. The other thing that we're looking at is electronic health records providing physicians with a patient registry so that they have all the data they need for their chronic care patients, and can really have a planned

visit to take care of patients. So we think that coordination infrastructure is critical.

ED HOWARD, J.D.: Before we go to the other microphone, I just want to ask that you listen to these Q&A exchanges while you fill out that blue evaluation form that's in your packets. Yes. Go right ahead.

MARY GILIBERTI: I'm Mary Giliberti [misspelled?] with the National Alliance on Mental Illness. And one of the chronic conditions, Ann, that you were talking about can raise costs as serious mental illness, not only in the health care system but also in the criminal justice system when it's untreated. And we also know, then, in that system, mental health care, we also don't get access to evidence-base practices which you started to talk about. Can you give a little more detail on the behavioral health care benefit in the package that you talked about? And I know that Massachusetts is built under parody legislation, but I'd be interested in also California in addition to Pennsylvania.

ED HOWARD, J.D.: Ann?

ANN TORREGROSSA: Cover All Pennsylvania, our adult basic program now does not have any behavioral healths, and that's a real shortcoming. So we have added much more of a kind of commercial behavioral health package to the Cover All Pennsylvanians. We also realize that in working with patients

with chronic conditions that depression and other behavioral health factors can be critical to addressing to be able to help them address their other chronic conditions.

ED HOWARD, J.D.: Leif?

LEIF WELLINGTON HAASE: The California proposal, as I said, has behavioral health components in it, but it's not an emphasis. I'd have to get back to you on the particular—

SARAH ISELIN: And just so everyone knows, you alluded to the mandate in Massachusetts. Just to be clear we do have a mental health parody mandate, it's one of the mandates that I mentioned that covers nine biologically-based conditions. Lots of actually going on right now about there are some more comprehensive parody bills that are being considered in Massachusetts. But when I was alluding to the decision by the connector board to include all of the mandates within this definition of minimum credible coverage in order to fulfill the mandate, just be clear mental health parody was one of those mandates that's included.

ED HOWARD, J.D.: Thank you. A question that came both in advance and on a card here, and I hope the person who asked it is still around because I'm a little confused. The question is did you — in this case meaning our guests, the folks from the state experiments — did you look at the Ashville Project in North Carolina for any of your modeling, and why or why not?

Problem is that our intrepid research staff at the Alliance came up with two Asheville Projects, one of which is a volunteer physician program that meets a need for the safety net. The other is a program operated by the city of Asheville for it's employees trying to help them with their chronic care problems by teaming them up with a community pharmacist. So if the person who asked that question is here, can you tell us which Ashville project you meant? If not, anybody want to try one or the other? Go ahead, Leif and then Ann.

LEIF WELLINGTON HAASE: One of the projects that's going on in California is not directly to the governor's plan is the universal health access in San Francisco, who's — Gavin Newsom, the mayor, and others I believe did look at the lessons perhaps of Asheville, certainly other programs. The idea is to give everybody in San Francisco access not to universal health insurance, but access to a clinic and to a provider. And the early indications are that this program is going reasonably well. And again, this gets back to Tom's point about things other than health insurance that actually can produce help. I think getting the universal coverage is absolutely critical for a variety of reasons including its effect on access. But San Francisco in particular is taking a different novel and interesting route worth looking at.

ED HOWARD, J.D.: Go ahead, Ann.

ANN TORREGROSSA: We looked at the other Asheville Project, which was the pharmacist one. When people with chronic conditions were coupled with a pharmacist and got their questions answered about medication, I think the cost of drugs tripled, but because people were taking their maintenance drugs and understood the importance of taking them, and total cost were significantly reduced. So as part of our chronic care model we do want to include pharmacist and reimbursement for consultation with pharmacist, because they meet a critical need as far as helping patients understand and answer their questions about medication.

ED HOWARD, J.D.: So the answer is maybe both of those were part of the model in some places. Here's a question for Tom Miller. When you're looking at administrative costs, the questioner asks, why should we pay more attention to private insurers than to those in Medicare, as you suggested.

TOM MILLER: No, I didn't say we should pay more. Traditionally it's as if Medicare is kind of such, you know, a costless exercise, whereas, you know, I paid all this private insurance premium, where's my tee shirt? I got nothing back from it. It depends upon how you evaluate first what the costs are. There's ways to kind of adjust Medicare cost of administration that include other costs within government, which are actually part of the administration of that larger

Medicare benefit which are often left out of the equation. As I've pointed out there's a certain deadweight loss cost to trying to run things on the margins through higher public financing and taxation depending upon how you do it, which is a real cost. Sometimes it costs much more than a dollar to raise a dollar of revenue, and you move up the chain.

On the private side, although certainly there is some waste in private insurance, there also, within that component of what I call administrative costs are actual services. Someone does have to answer the phone, someone does have to provide the nagging nurses to kind of tell you to take your meds. Who's going to do the risk assessments? Who's going to do the disease management? A lot more of this is being internalized by insurers, and that's part of a medical benefit which may not be logged as a, did you pay a physician or a provider as kind of part of your loss ratio.

ED HOWARD, J.D.: I don't have your slides in front of me, obviously, but I thought I remembered at one point you did a comparison between private-only administrative costs and something else.

TOM MILLER: Private premiums, private insurance premiums. There's a bundled item which is called administration and the cost of private insurance in the national health counts. And actually that was, I think, one of

the original Commonwealth slides. There's a subset of that which is actually which gives you the 99 billion figure for the last year, which is just for the private insurance cost. This is the way that CMS accounts for it. And there's a public set of cost and a private set of costs, and they have different trend lines.

ED HOWARD, J.D.: Okay. Very good. Yeah, Sara?

SARA COLLINS: Just in terms of the premium dollar, though, I think it's important to line up Medicare employer-base and the private individual market, so as a share of premiums administrative costs — and what I mean are underwriting profits, marketing, claims administration — 25-percent to 40-percent of the premium dollar in the individual insurance market goes to such administrative costs. This is compared to 10-percent in the large employer group market and 2-percent in Medicare. So there really are large differences in terms of the amount of the premium that's spent on medical care across those three different markets.

TOM MILLER: That's correct, and those differences are primarily by the better evaluations marketing and administration. It's very hard to find people who will buy those policies, and it costs a lot to get them, and it may not be the best distribution system. The risk pooling differential

is a much smaller set of that spread between the individual market as opposed to the larger employer market.

ED HOWARD, J.D.: Okay. Got a question for Sarah from Massachusetts. With the disappearance of the Uncompensated Care Pool, how will undocumented immigrants fare, and what aspect of the reform addresses this situation? Will they be the only ones using the Healthy Safety Net?

SARAH ISELIN: Well, just to be clear, you know, as we've said, you know, we're getting as close to universal coverage as we possibly can. But, you know, we realize that there are going to continue to be people who were left out of our coverage system despite all of our efforts. And so while the Uncompensated Care Pool is going away, it's in fact been renamed, and our commitment to supporting the financing of care for people who fall outside of the system and kind of sharing the burden of that across the health care system remains. So the Health Safety Net will continue as a financing vehicle to support care at acute hospitals and community health centers.

So, you know, it's somewhat limited in scope, though pretty comprehensive compared to what's available in other places for folks who kind of fall outside of all the other provisions of reform. And a significant group is also folks who as I described we are adding this new evaluation of folks who have access to affordable employer-sponsored — or

evaluation employer-sponsored insurance. But if that's determined to be affordable, the Health Safety Net would be available to those folks and would also be available to folks who for reasons of the documentation of their immigration status may not be eligible for other programs. But our commitment to that financing mechanism, while it's much smaller, it's much smaller because a lot of people are moving out, but we'll remain.

ED HOWARD, J.D.: Leif, I understand there might be an undocumented immigrant in California.

LEIF WELLINGTON HAASE: There's one or two. [Laughter] Obviously one of the big differences between California and other states is the large undocumented immigrant population. The governor's proposal will cover all kids regardless of their immigration status. It will not cover undocumented adult immigrants. That's also true of the Democratic leadership's plan. Uncompensated care will still be provided at the county level. This is particularly severe in LA County. But under the new provisions of the Governor's plan that's been in legislative language, I believe there's going to be $500 million more given to public hospitals to try to cover undocumented immigrants. Again, how this is all financed as a whole is still up in the air.

One of the things I didn't mention in the talk is that Schwarzenegger is now thinking of privatizing the California State Lottery to help pay for health care reform, which is not something I would favor, because it brings among others the education interests and the Indian tribes into play, as if you didn't have enough, you know, competing interests already that would make it even tougher. But obviously you try to cover as many people as possible, and still provide uncompensated care as necessary.

ED HOWARD, J.D.: Okay. Yes, go ahead.

MICHELLE CARPENTER: Michelle Carpenter from American Public Health Association. This is a question to follow up about California. You mentioned that the governor's proposal would cover all children regardless of immigration status. Is that going to be through the SCHIP program, some other program, and how does the pending changes in SCHIP that would prohibit undocumented immigrants from being enrolled in SCHIP? How dos that pay into all of this?

ANN TORREGROSSA: Is that for me?

ED HOWARD, J.D.: No, I think it was for Leif.

MICHELLE CARPENTER: California.

LEIF WELLINGTON HAASE: Oh, wait, can you repeat that a second?

MICHELLE CARPENTER: Sure. You mentioned that the Governor's proposal would cover all children regardless of documentation of immigration status. Is that through SCHIP, and how does the change in SCHIP that documentation is required, how would that play in—

LEIF WELLINGTON HAASE: It's through Healthy Families, that—

MICHELLE CARPENTER: Which is the SCHIP program.

LEIF WELLINGTON HAASE: It's the SCHIP program in California, yes.

MICHELLE CARPENTER: And SCHIP is probably going to be changed such that undocumented immigrants will not be eligible for SCHIP. So how—

LEIF WELLINGTON HAASE: How will that work?

MICHELLE CARPENTER: Yes.

LEIF WELLINGTON HAASE: That's an exceptionally good question, [laughter] and I will, you know, I'll have to say I'll look into that.

MICHELLE CARPENTER: Okay.

ED HOWARD, J.D.: And if he looks into it and shares the answer with us, we'll post it on our website.

MICHELLE CARPENTER: Excellent. [Laughter]

ED HOWARD, J.D.: I think we have come to the end of the string here. I'd like to give our panelists one last bite

at the apple, if you would, to give us a thought to carry away. And let's do it in the reverse order from the order we started, which would mean I start on my left, I love to say this, with Tom Miller.

TOM MILLER: Thank you, Ed, that's a rare moment of positioning. I have to confess that every night, you know, I go sleep worrying about the hidden plight of the over-insured, all the damage their doing for themselves and the rest of the health care system. I think we need to kind of focus on that problem. It is a serious one. In addition kind of as a wrap up, there are things, you know, that I'm very much in favor of, and we don't have the system we want in many ways. But if you're going to isolate the fact, and just kind of a summary, this was on the last slide, these are the things we need to be talking about kind of producing better health – the factors of education, early childhood interventions, the culture, behavior, time horizons in which people go about making their decisions relating to health, decision support, navigational assistance, real incentives, transparency, accountability, competition, decentralized choice, deregulation, targeted assistance to those who need help, and tax reform. That's not everything you heard about today, but it's an important part of the solution.

ED HOWARD, J.D.: Thank you, Tom. I guess, wait. We're doing California next.

LEIF WELLINGTON HAASE: You never went wrong betting the House against universal health coverage either, at the state level or at the federal level. But the reforms we've heard about today have a real chance of succeeding, and I can't disagree with most of what Tom has said, but in terms of priorities I think universal health coverage has to come first. And we have, in California, after years of efforts something that's tantalizing close to being passed, and I think we shouldn't overlook — we shouldn't look at all the other problems with the health care system and fee for service reimbursement and reimbursement for procedures rather than on outcomes is obviously one of the biggest and something that I usually talk about a lot more. But we shouldn't focus on the forest of health care system problems and overlook the trees of getting things passed that will really make a difference.

I think one of the critical things I've heard today, and I've been thinking about this for a while, is what's happened in Massachusetts and the fact that there's a mechanism through the connector for actually talking about affordability over time. One of the things in California that is a real obstacle is that people don't think about affordability in discussion of health care reform as a process. They think of

it still too much as a snapshot. And to have the kind of structures in place that you can talk about these issues over time and to have that kind of good will among stakeholders is what we're trying to reach in California, and I hope we reach it in every other state House in the country, and finally here in Washington D.C.

ED HOWARD, J.D.: Great. Thank you. Ann?

ANN TORREGROSSA: I think what we've realized in the Rendell administration is we can't wait for Washington. And even if an act of God, we had single payer and the federal government provided everything, there's still huge, huge quality and cost issues and immigration issues that states are going to have to grapple with anyway. Health care reform by states is really, really tough. We've got the whole ERISA issue that Tom alluded to. Obviously the governor would not have proposed what he did without, you know, a big law firm telling him it was ERISA cool. But we need some ERISA safe harbors so we know what we can do, and it's really hard. We need this SCHIP thing settled so we can figure out at what income level is the federal government going to participate in sharing costs for lower income people. And universal health care coverage is not the silver bullet. We have to do a lot of the things about helps being more healthy that Tom alluded to and spoke about. But it is a critical component, and unless we

can include universal health care coverage states within their ability trying to provide as much access to affordable health care coverage as possible, we're not going to get to the goal that we're seeking.

ED HOWARD, J.D.: Thank you. Sarah?

SARAH ISELIN: So having listened to this conversation intention about which comes first — coverage, cost — I'm reminded of something that I've heard Jim Mongan say many times, which was kind of characterizing the health coverage debate as having been held hostage by the conversation about how we will manage health care costs. And we've taken a different path in Massachusetts, and I think the progress that we're making on coverage, the coalition that we've, you know, brought together, really presents an incredible opportunity at a state level to really focus our energy on making progress on costs and starting a conversation about given, you know, what we're spending, what we're getting. And so I think a lot more to come.

ED HOWARD, J.D.: Thank you. And Sara again.

SARA COLLINS: Just again on the cost before coverage issue, or coverage before cost issue. I think that in terms of coverage we know that about 70-percent to 80-percent of costs are associated with chronic health conditions in the United States, and we also know from a huge party of evidence the

people without insurance coverage and who have chronic conditions do not get adequate care. And there's just a tremendous body of literature on this, and in particular this recent study out this summer showing adverse long-term cost implications for the Medicare program for previously uninsured people with chronic health problems. But also just in terms of how we design a universal coverage system, universal coverage is not a sufficient condition for a high performance health system. It's necessary, but we also need to address all the rest of the inefficiencies in the health care system.

So trying to do health reform correctly, if we do choose to build on the current system whether at the state level, whether at the federal level, we want to build on the good parts of the system and not replicate its failings, those being fragmentation, poorly thought-out or not well thought-out at all incentives, both in insurance markets and in the delivery of care. And, you know, bringing a system that is to a system that is very much without it right now. So it's not just coverage, not just replication of what we have, but thinking globally about the full system as we move forward.

ED HOWARD, J.D.: Thank you very much. Who'd have thought that we would have had a fair amount of overlap in those final summational statements, and I think we ought to take that to heart as we try to shape the conversation about

health reform both in state capitals and in Washington. And with that profundity, let me just once again thank the Commonwealth Fund for providing grist for the conversation, a great speaker for the conversation, and supporting co-sponsorship for the event. Thank you for being here and for filling out your evaluation forms, and thank the panel for an incredibly useful, I think, dialog on a very difficult subject. And I ask you to join me in thanking them.

[Applause]

It's easy. Just get out of the way. Thank you.

[END RECORDING]