Massachusetts Health Reform: Bragging Rights and Growing Pains
Alliance for Health Reform and Kaiser Family Foundation
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ED HOWARD: — in our board. I want to welcome you on this briefing on the Reforms to the Healthcare System that are now playing out in the Commonwealth Massachusetts. A partner in today's program is the Kaiser Family Foundation, one of the most respected policy voices in the reform debate and the discussion of other policy issues as well. You will hear from Diane Rowland from the foundation in just a moment.

There was a lot of fanfare and not a little of controversy when the Massachusetts' plan was enacted by a democratic legislature and a Republican governor. Now as it is being implemented, a lot of folks are watching to see how successful it will be. We read about some of the concerns that have cropped up over costs and access, and we wanted to take a closer look at exactly what seems to be working and what may not be working quite as well.

As I said, co-hosting our briefing today is the Kaiser Family Foundation. They have been working on the issues of the uninsured both in Massachusetts and in a lot of other places for many years, provide a lot of analytical help to those grappling with reform issues in the Commonwealth and we have from Kaiser, today sharing moderator duties, one of the country's top health policy experts in her own right and the Kaiser Executive Vice President, Diane Rowland. Diane?

DIANE ROWLAND, SC.D.: Thank you, Ed, and thank you all for being here at this review of the Massachusetts Health Plan. The plan

itself was enacted in April of 2006, and I think some of you may have been with us when we had the First Alliance Forum on the Mass Health Plan on May 8, 2006, to really look at how Massachusetts put their coalition together to enact the legislation and to identify some of the key issues. So, I think it is totally appropriate that today, really almost just exactly two years later, we are here to hear what happened, to see what has worked to learn a little bit about what has not, what fixes had to be made, and more importantly what some of the lessons are for National Health Reform as we hear from the presidential candidates that we are perhaps about to engage in another round of trying to fix our system nationally.

I think it is important to also look at Massachusetts because we see that other states have tried to model their efforts on the Massachusetts plan and we clearly see in both the Clinton and the Obama health plan that there is a lot that at the national level is looking at some of the key issues that they struggled with and continue to implement in Massachusetts.

Individual mandate, just one employer requirements and how you get employers to pay or play. Subsidies, what kind of levels of assistance do you need to make healthcare affordable to individuals. What do you need to do to find a place to connect people with health insurance? The Connector, the famous Massachusetts Connector - how is that working and what are some of the lessons from that; and what kind of reforms do you need in the individual market and the health insurance market to make healthcare affordable and accessible to all?

I think another area that clearly, we can learn from Massachusetts is how the public programs in the role of Medicaid and SCHIP can play in broadening coverage for the lowest income population. How well that works against some of the reforms, and then I think we are always interested in knowing how it is all paid for, how the financing works, ready to financing is adequate and what some of the key challenges are there.

So, I think there is a lot of elements in the Massachusetts plan that are not only worth looking at for how well is Massachusetts doing but as broader lessons for the nation and I hope today's conversation will really both update us on how Massachusetts is fairing but also give us guidance for how we can move forward as a nation on our health insurance coverage challenge. Thank you.

ED HOWARD: That is terrific. Thank you, Diane. Let me just cover a couple of logistical items before we get going formally. By tomorrow morning, you will be able to view a webcast of this session - thanks to our friends at Kaisernetwork.org. In a few days you will be able to read a transcript of this briefing, both there and on the Alliance website of Allhealth.org. If you happen to be watching now live on C-SPAN, on either of those websites you can find copies of materials that have been distributed to those in the room including the PowerPoint presentations by the speakers. So, if you have access to a computer, you will be able to follow along yourselves.

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I do want to apologize to those in the room for the relatively washed out character of what is up on the screen and the way of the PowerPoint slides you are going to be seeing. It is the price you pay for allowing the C-SPAN viewers to be able to see at all, and so we thought that was a bargain you would be willing to broaden the reach of the wisdom that you are about to have shared with you. You do have hard copies, I hope, of all of the presentations in your packets so you can follow along without having to see it as clearly as you usually do on the screen.

So, time to reach in, grab your cell phone, set it to vibrate and let us get started. Leading off this morning - that is to say this afternoon - is John McDonough. He is the Executive Director of Healthcare for All, which says here is the leading consumer advocacy group in Massachusetts. He served on the faculty of just about every major academic institution in the Boston area, which is saying something. He has been a key member of the Massachusetts Health Representatives on health issues and next month, he joins Senator Ted Kennedy's staff here in DC as the Senator's Key Adviser on National Health Reform - and let me just add, on behalf of all of us here, the best wishes and prayers of all of us to Senator Kennedy and his family as he comes to grips with his personal health challenges.

John McDonough is going to be laying out some context for us, how the Mass Law came to be and what the basics are of what is in there. So, John thanks for joining us today.

JOHN MCDONOUGH: Thank you. Thanks to the Alliance, thanks to the Kaiser Family Foundation, thank all of you for coming. I hope you can see our slide somewhat up here or follow along in the packet. There are three of us here from Boston today - I guess you could call us the "Three Amigos" today and we have drawn straws for who is going to do what. So, I am going to provide just some brief background on the Massachusetts Health Reform Law.

We have come up with very sexy names for our laws - we call this one Chapter 58 because it was the 58th, last signed in 2006. And John Kingsdale, the Executive Director of the Connector Authority is going to talk about where it is right now. And then, Matt Fisherman from Partners Healthcare is going to provide an overview of how the process is going and how it is working out from various perspectives within the state.

Just starting out with just a brief bit of historical context on Massachusetts, some people heard that we passed a big law back in 2006 and it seemed like it was the first time people heard of anything like this coming from Massachusetts. In fact, I have a term I use, I call it, "continuous policy improvement", kind of a paralleled a continuous quality improvement as practiced the healthcare sector in terms of what we have been doing. By our count, Chapter 58 was the eighth major statute that had been passed since 1985 which laid cornerstones for the Healthcare Reform that we have achieved and what we have been able to accomplish.

And thinking about it back because I entered the Massachusetts legislature in 1985, the path that it has been is it has not been like driving from Kansas or Nebraska where you are on a straight road and it goes as far as the eye can see. It has been more like in Western Wyoming where you are going through the mountains and it is a very curvy road, and it makes certain points in the road but you can never really see ahead.

So, many of the things that we did in '85, '88, '91, '96, '97, all played incredibly important roles in enabling us to put the reforms in place that we did. The other important thing I just noted from this is that in each of the major statutes since the 1988, 1996 and 2006, those were three-year processes. So, when some people ask us that why have not there been other states that have moved and done comprehensive reform since Massachusetts and Vermont did it in the spring of '06? Part of what I try to caution is this is along hard road and it does not come easy and it does not come quickly.

This - I am sorry you can not see it that well - is an overview of what we have done. I kind of audaciously call it the "Power of Incrementalism" because that is kind of what we have been proceeding – big incremental, medium incremental, small incremental. But if you go back to 1995, 1996, these green bars here were where we were in terms of eligibility for coverage - either public, private, subsidized, unsubsidized - and today this is up to three times the poverty level, about 31,000 for a single adult, about 60,000 for family of four. This is the structure of public and subsidized

coverage in Massachusetts today, going step-by-step building on a foundation over and over again. So, I am happy to talk with you more. These are kids over here, these are adults over here, this blue bar significantly are one of the major challenges for the uninsured in the United States, these are uninsured working childless adults who have been one of the major beneficiary groups from the set of reforms that we have done.

Just a little bit about Chapter 58 to give you some of the basics of it, one of the key innovations is the creation of something that has been copied in other states, that Jon Kingsdale runs, it is called the Commonwealth Health Insurance Connector Authority, a quasi-public authority with a 10-member board, all public appointees with three principal responsibilities. One is to establish a new program of coverage for those working adults under 300-percent of poverty who can not get coverage any place else, and that program is called Commonwealth Care. Folks up to 150-percent of poverty have no premiums, folks between 150 and 300 had sliding scale premiums, everybody pays, co-pays in one way or another. There were no deductibles for anybody in that population, and Jon will tell you more about the progress with Commonwealth Care.

Their second responsibility is to establish a program of unsubsidized coverage called Commonwealth Choice which is for folks basically over 300-percent of poverty who are running short and also starting this year for small businesses who want to buy insurance through the Connector, and these are plans issued by six private

insurance companies in Massachusetts and you can go on the Connector website and do something that we think is fairly unprecedented in US insurance history. You can compare policy as a different benefit in premium levels for Harvard Pilgrim, Blue Cross, Tufts Health Plan and others, and doing apples-to-apples comparison shopping on the Connector's website which is thoroughly radical and unprecedented believe it or not in terms of what you have to go through as a consumer to get health insurance.

Then the third major responsibility the Connector has is to define the term affordability in terms of enforcement of the individual mandate and establishing the definitions for what we mean when we talk about the minimum insurance that somebody has to buy to satisfy the individual mandate.

I am going to actually pick up the pace here, believe it or not. We did some significant changes to our Mass Health Program. Mass Health is what we call our Massachusetts Medicaid Program. We extended children's eligibility from 200-percent-300-percent and lifted some enrollment caps, restored some optional benefits and importantly made a major investment in outreaching enrollments so that we have had a significant increase in coverage - and important part of has been a major state-wide advertising campaign as well as what we call boots on the ground across the state on local communities - folks literally going door-to-door, going at every possible place in community to find uninsured and pull them in. We

also did significant adjustments in terms of Mass Health rates for hospitals and physicians who had been significantly underpaid.

Two of the most controversial parts of Chapter 58 deal with individual and employer responsibility. The individual and responsibilities otherwise called the Individual mandate. As of July 1st, 2007, it is state law that every resident over the age of 18 must have health insurance coverage and there are penalties for the failure not to have coverage if - and it is big IF - if there is affordable coverage available to that individual.

The penalties for 2007 were loss of your personal income tax exemption worth $219. So by April 15th, everybody had filled out their state taxes and knew whether or not they would be subject to the penalty. So, the penalty is in place and it is now being enforced. The penalties this year are higher. They accumulate on a monthly basis up to $76 a month depending upon your income, or up to about $912 a year. The penalties for 2009 and beyond will be determined in the future.

We have gone through our first round with the individual mandate, we have not seen marches or protests on the street around it and we have been able to get through the first round of implementation, and we have gotten into the other sides. We are a living laboratory within probably the next month to two months, we will have an ocean of data from our State Department of Revenue to tell us with great precision who is paid, who is penalized, who was

not, and who they are. So, stay tuned for some significant news on that.

Employer responsibility, the fair share employer-contribution requires employers with more than 10 workers who do not make the fair and reasonable contribution to provide coverage to their workers to pay an annual per uncovered work or assessment of $295 per year, that is being enforced, the revenue being collected, the revenue was less than was anticipated. We can talk about that some more in the discussion.

Also, all employers with more than 10 workers must set up a section 125 Cafeteria Plan, an artifact created by the IRS which means that let us say, for the moment that you all worked for me, you can be happy - that will never be the case - but if you did and I covered you folks over here and I did not cover you folks over here, you folks could go to the Connector via health insurance through the Connector and have your premiums deducted through your paycheck instead of paying directly to the insurance company, and that way you get the coverage on a pre-tax basis, so, a significant benefit that a number of states are copying. And then, there is a penalty called the free rider surcharge if you do not do that.

Moving on, significant experiment in our insurance market, we took our two significant regulated entities. Our small group market with 750,000 covered lives and our nongroup market with about 60,000 covered lives, and on July 1st last year, we merged them into one, so we have created a first market in the United States where an

individual can buy health insurance coverage on the same terms, conditions and prices as a small business and the result for folks who were buying small group coverage. They are now seeing better coverage, better benefits at about literally less than half the premiums they were paying in the old nongroup markets. We have had a significant degree of winners on that.

Other reforms as well - how did that happen? I just do not have time to tell you because my time is running out. But I just want to refer to one thing - all of you here in Washington, DC, thank you very much. Our Federal Medicaid 1115 waiver was a significant political force to push the state to enact these reforms and to implement them, and it has also been a significant part of the financial formula that makes it happen and I would say, no one would disagree that we are not for the Federal resources, the Federal financial resources to come in, Massachusetts Health Reform, would be impossible to achieve.

This is just one of my favorite cartoons. This is from 1993. The guy over there in the corner, that is Bill Clinton and he says, "As we get down the road to negotiating the healthcare plan, we should acknowledge that we all agree with this discussion as really about everybody says health and everybody's thinking money." Sometimes it seems to me the color of the blood coursing through the veins of our healthcare system is not red, it is green because bottom line, it all comes down to how are you going to pay for it? Who is going to pay for it? And who got the benefits? That is very much

true in Massachusetts and that is true in any reform effort in any state or certainly on the national level.

This is just my last slide. This is a slide put together by our friend Nancy Turnbull from the Harvard School of Public Health. Consider what we did a work of art, so you go in with your friend to a museum and you look at the work of art and your partner says, "You know, ugliest darn thing I ever saw. Who the heck had the idea that this was art and belonged in here?" And you look and say, "Hey, not too bad, kind of interesting. I do not necessarily agree." It is possible one piece will fall off and the whole thing will collapse. It is possible that one or two things will fall off and it will actually end up people say, "Oh, it looks a lot better now." We just do not know.

Also, it was a product of a moment and work in time. The Buddha saying, "You can not walk in the same river twice." You can enact the same law ties. We could not re-enact this law in Massachusetts today because of what we have learned, because we know, we have a different governor, different legislative leadership, many, many, many things have happened and that we changed and we make that impossible. But one thing that has not changed, just previewing the comments to come is the basic level of political support that was behind the passage of law has very much stayed in place and stayed very solid, two years now, fully into robust implementation. Thank you.

ED HOWARD: Thanks very much, John. Now, we are going to hear from our second John from Massachusetts, that is John Kingsdale. As John McDonough has said, John is the Executive Director of this new thing called Commonwealth Health Insurance Connector Authority and a lot of those tough decisions that sometimes get made in legislatures and governor's mansions got made in the offices of the Connector by that board that John Kingsdale is writing herd over. He has got a strong academic background as well, experienced both as a senior executive in one of the major health plans in Massachusetts and as a reporter for Forbes magazine. I want to hear more about that.

In the meantime though, he is here to share with us a little bit about how things are going at the Connector. John?

JOHN KINGSDALE: Thank you so much and thank you to Kaiser Family Foundation and the Alliance for this opportunity, and John McDonough, not only for that good summary but for your years of leadership and health reform in Massachusetts. I hope your new move is - I know it is nation's gain, I am afraid it is Massachusetts' loss but in a good cost.

You can see, John's knowledge of health reform is encyclopedic, I am going to back up to about 50,000 and just give you a couple of factoids that might help you keep the big picture in mind. If you think of our 6.2 million residents as some of them are Medicare eligible or they are veteran's healthcare, or they have a special student health insurance plan that might be from out of

state, eliminate about 1.2 million, we have got about five million eligible adults under 65 and about 70-percent to 75-percent of them have commercial insurance currently, almost all the employer-sponsored. When I say currently, I really mean at the start of the reform in 2006.

Almost 20-percent had Medicaid as their primary insurance plan and about 10-percent - give or take 3-percent one way or the other were uninsured. So ours was an effort by sharing responsibility among different elements of the healthcare system to try to reach most of those 10-percent or so uninsured.

My charge is to give you a little bit about progress report on how we are doing. I like to say we are making reasonably good progress. One because it is true, but two, because it sets then right tone in the following sets. We took three years to enact health insurance, the Chapter 58, three years of effort led by people like John, Matt Fishman, Blue Cross Blue Shield Foundation, and political leaders and others - and it is going to take about three years to implement it. So it is a working progress right now.

There are a lot of folks who want to fill in the blanks and say, "Our health reform work or did not work because of X, Y and Z." We are still learning a lot of lessons but as I say, I think it is going reasonably well with 340,000 newly insured as of January 1 which is basically 18 months into implementation. Implementation really began July 1 2006, so 18 months later we have got about 7-percent of the adult population and most of those 10-percent or so

uninsured were adults. We have got about 7-percent of them newly-insured.

These are not only big numbers but they are real people, so they include woman walking around a couple years, occasionally dropping into a nursing care center, getting free care or paying out of her pocket and been given a lozenge and sent on her way, turns out she continue to smoke, turns out that she had throat cancer, she got a Commonwealth Care Card - one of our first enrollee. She got a physician, diagnosis, chemotherapy, radiation therapy, stopped smoking and is still alive today. And there are thousands of those people in this 340,000 number. So it is something very important not to lose track off. They are real people.

It is going well, I think in the senses of political adventure and we were fortunate enough to have very broad support for this when it was enacted, not only our likely voters as I will show you some numbers, still supportive and as they were then, but labor leaders, employer leaders, consumer advocates and something that these audience will appreciate as we have tackled in our 10-person board which runs the spectrum of Massachusetts politics, as we have tackled tough questions about affordability and minimum credible coverage, and so forth.

We have got in by enlarge, in fact, virtually all unanimous votes across those 10 people. Some of them were appointed by Governor Romney, some of them are being appointed by the new governor, a Democrat, Deval Patrick, some of whom come from very

different walks of life and yet they found value in creating consensus which means they all gave something up from their philosophical perspective. That political support and popular support remains strong, and then, finally, I think the cause have been reasonably acceptable and we can all put out our own definition of what is reasonable and then argue about it.

But I will put it this way, the cost per enrollee in commonwealth care is actually below budget. I will show you in a minute that the total budget is above budget as we insured a lot more people with some of them actually think it is success. Since the initial rates of payment were set, we have bid in modest single-digit trend year-to-year increases.

So, those I see as reasonably good progress. We will certainly see more change, I think Healthcare Reform has generated, yet more Healthcare Reform and we have got a lot of challenges certainly maintaining support, political and popular in finding the money to pay for this. This is a huge financial venture and ultimately improving the value of health insurance and healthcare.

I just want to quickly show you some dates because we have been implementing this over the course of 18 to 21 months. It is far from something that just happened a year-and-a-half ago. I will not go over all these dates because time is running short but you can see, we are actually still in the last six months implementing key pieces of it. So, I really see this as a three-year implementation

process. You do not change the financing of 16-percent of your GNP and do it overnight.

Here is the breakdown of 340,000 newly-insured as of January 1st and the most important thing to note about this is that about a third of the membership has been a newly-insured is in private insurance. So this is the first, about 110,000 newly-insured in Massachusetts in commercial private insurance completely unsubsidized of the normal tax subsidies and this is the first significant growth in a stable population state in insurance coverage in decades. About two-thirds of it is subsidized about 15-percent actually contribute towards at subsidized coverage.

On the other hand, a lot of money involved. FY09, the cost of commonwealth care at $869 million is just a projection. We are not even in FY09, so these are guesstimates that we are dealing with. But the important thing, I would know, although it is not showing on the slide is over the last two years since we started this program in FY07, the annualized rate of increase in the average cost per enrollee has been 6.5-percent so FY07 projected to FY09, 6.5-percent which is acceptable, reasonable. Knock rate, we all like to see it less but not the double-digit inflation that we so often have experienced nationally and in Massachusetts.

I mentioned that an important element is to maintain and enhance support. Here is a survey result from last fall that shows that 55-percent of employers, a key constituent as you know because they so often have reservations given how much they are already

contributing towards health benefits to an expansion of health benefits dictated by government, if you will. Yet, majority of 55 to 41-percent last fall still support the idea in Massachusetts of requiring that they make it fair and reasonable contribution.

In fact, most employers in Massachusetts do contribute to held insurance. About 72-percent versus about 60-percent for the national average and as I mentioned, other 110,000 growth in private insurance just encounter year 2007 – the first in the Commonwealth in decades, about 25,000 of that was nongroup, direct purchase out of your pocket and about 85,000 of that was growth in employer-based insurance.

I mentioned popular support, I wish I had a more recent poll for you but here are some survey results from unbiased set of sources done in September of '06 and then again in June of 2007 among likely voters indicating good support in fall of 2006 for reforms, 61-percent to 20-percent opposed, about three to one ratio and increased support almost a year later. So that is after we went through those tough issues about what is affordable. Think about figuring out what is affordable, obviously controversial. What is minimum decent insurance? The board went through those, took unanimous votes and we actually increased popular support.

One thing I do want to dwell on because I think it is a real success of reform in Massachusetts – I think it is incontestably successful and unique in the country. That is the reform of the nongroup insurance market. So, these are people who have to buy

insurance directly without employer subsidy and this is a very troubled market in this country. It does not work very well in most places. Sometimes it is cheap but then they throw you off insurance so they double your premium if you get sick.

In Massachusetts, we have actually been able to make this nongroup market as called function. I defined functioning this way. You can get virtually the same value in direct buy nongroup insurance as you can in Massachusetts now with group insurance so it is guaranteed issue, it is guaranteed renewal, and as you can see in this pre and post reform comparison of the typical uninsured individual in Massachusetts who is a 37-year old male living in Boston in June of 2007.

The price, the premium for the lowest available cost plan almost dropped by 50-percent, went from "no drug" coverage to "full drug" coverage, a deductible drop by 60-percent. Still, substantial expense, health insurance is expensive. Healthcare is expensive but a big improvement over what was the case before.

John mentioned that Connector as a marketplace as an exchange so the Travelocity of health insurance, if you will. This is unsubsidized insurance and these are much smaller numbers. This is not the 176,000 we have in subsidized Commonwealth Care, but this is actually 60-percent to 70-percent of the new growth, the net growth in nongroup insurance which is the only thing we offer in our unsubsidized Commonwealth choice program right now. We saw, as result of this reform a 50-percent expansion in nongroup purchasing

in 2007 -- a growth of 25,000 and about 16,000 of that came through the Connector.

I am just going to finish up with two quick slides. The other part of financing, this is to move people and dollars from a grants directly to institutions without as much accountability as we would like, called our pre-care pool into insurance. Here you see in the bottom line as – in the top line, as insurance coverage gross, the pre-care pool expenses declined. This is through August of 2007 so most of that declines is yet to come.

I think we have made reasonably good progress. We have got a lot of challenges to deal with. Matt Fishman's going to tell us how we are going to solve all of them, I am sure, but I would put them this way - taxpayer acceptance, we are as John McDonough mentioned going through the first tax filing season, I have beat up our office security, but so far we have not had to use it and in fact, we will have pretty good news to release on that next month. There is also the issue I have been raised about do we have enough physicians to care for this population?

We are paying attention, frankly to an old longstanding national problem of adequacy of primary care physicians. We are paying attention to that Massachusetts precisely because we are in the midst of health reforms and it is a continuous evolution. In fact this legislation and private efforts to deal with that because of reform. Proud, it is always an issue and we are going to be

facing that, trying to deal with that and then ultimately, can we control the cost of care?

I would just add this by way of paraphrasing Matt's comments. We are having I believe the first adult serious conversation in the Commonwealth of Massachusetts in this country in the 30 years that I have been trying and failing to control medical care cost in my career that I can recall. And that is a direct result of saying, "We are going to abandon the national policy of cost control".

We have a national policy of cost control in this country and it is that every year, we throw two million people on to the roles of the uninsured; either because the employer could no longer afford the offer or the employee can no longer afford to accept. In Massachusetts we said no. Let us get everybody onto the tent and have that discussion. It is proceeding in a very serious way now. Thank you very much.

ED HOWARD: Thanks, Jon. Now, we turn to Matt Fishman, the last of the three amigos. He is Vice President for Community Health at Partners Healthcare which is non-profit integrated health system comprised of both mass general and Brigham and Women's Hospital. He's been the senior official in Mass state government including as part as the 1988 reform effort to bring universal coverage to Massachusetts.

We have asked him as the Johns have described, relate for us today both how reform efforts are affecting the safety net in

Massachusetts and to give us a glimpse of what he sees as the major assets and challenges facing the reform effort. Matt, thanks for being with us.

MATTHEW FISHMAN: Thanks very much, Ed and I want to thank the Alliance for Healthcare Reform and the Kaiser Family Foundation for sponsoring the forum today.

As Ed said, I will bring several perspectives to this conversation. I helped design the 1988 Massachusetts reform law. Since 2001, as a board member, I have helped shaped the Blue Cross Foundations efforts and for the last 15 years, I have worked for a leading healthcare provider, including three years as an Emergency Department Administrator which is a good way to get a sense of what works and also what does not work in our healthcare system, especially what does not work.

This slide gives you a sense of some of the most important elements in our success today in somewhat political terms. I am actually just going to focus on one of these which I think is the most critical, which is that we have an exceptionally strong commitment from our political leaders.

Every time a serious problem comes up, and they do – those problems do come up all the time - these leaders are strong and clear in their statements and actions that we will solve whatever the problem is and we will move forward. Part of why that works is because Jon Kingsdale and his team at the Connector, John McDonough and other of the consumer advocates are on this stuff everyday. I

get see that up close because I participate as one of a number of stakeholders in the group that helped make the 2006 law possible and that it continuous to focus again everyday on making sure that it succeeds.

Now, let us take a look at a couple of elements of how you make this work on the ground. Jon Kingsdale mentioned primary care capacity as a very significant issue. It is one that requires a comprehensive solution, as all of you know. When Healthcare Reform became law, our Massachusetts community health centers, for example, were sure by at least 100 doctors and nurse practitioners.

The solution to this and the larger primary care shortage is still very much a work in progress in Massachusetts as it is elsewhere. But here is one building block, a $5 million grant for loan repayment from Bank of America for their effort to help make sure the Healthcare Reform succeeded, followed a state commitment to match the banks grant.

This program in its first full year attracted 47 caregivers to make commitments to the program which has provided access for 84,000 patients. This also provides a very strong signal that there are physicians and nurse practitioners willing to practice primary care if we can begin to change the economics. In this what you have at your seats is the Boston Globe's coverage of the results that we announced last week for the program.

Another challenge in making this law work on the ground is informing uninsured patients, many from previously qualified for free

care about their new insurance coverage options and supporting them in signing up for a coverage. Financial counseling for patients when they come in to community health centers at hospitals for care is one of several approaches in new state-wide to supplement the work that John McDonough described that healthcare and for other organizations are doing and the work that they health insurance Connector is doing.

The results are quite promising as Jon Kingsdale mentioned, free care cost are downstate-wide. He was using statistics in the Massachusetts Hospital Association which cover a four-year period. The statistics I am using here are for the last two years and show that free care is down at the Partner's hospitals including Brigham and Women's Massachusetts General by 17-percent in two years. Actual free care cost going down.

And more importantly, we are seeing a steady increase in the number of patients with Commonwealth Care coverage in a decrease in the number of free care patients. You see the dark bar declining, that is people with free care. And the lighter bar increasing, that is people with commonwealth care and the actual numbers are well beyond these but we were only able to track this when people actually come in for care with their new cards.

So now let us go from the ground to 30,000 feet or perhaps 50,000 feet as Jon Kingsdale said. Key decisions that have gotten us this far and have also setup what we need to do next. Throughout 2005 in the first quarter of 2006, John McDonough said pretty much everyday, "I want to get something meaningful done." Getting

something meaningful done meant creating a bill that would have broad support. In contrast to the 1988 law which barely cleared the state legislature. So the stakeholders involved focused on coverage first. That was based in the shared sense of the moral imperative to move on this critical issue and a shared sense that near universal coverage was within reach.

We also - and this is very important - took a deep breath in deciding we are willing to try new approaches. The 1988 Employer Mandate had not worked. Maybe as the urban institute suggested that the Blue Cross Foundation and individual mandate combined with subsidized coverage and significant insurance reforms as John and Jon have already described would work. John McDonough and his consumer advocacy colleagues at the Greater Boston Interfaith Organization deserve a lot of credit for the political courage it took to support the individual mandate.

And elsewhere in political spectrum, Governor Romney also deserves credit for the courage he showed in making the reach which the individual mandate required of him.

Another very important decision, we decided not to try to do everything at once. All the stakeholders knew cost were a very serious issue. We also all knew that we would not reach agreement on a package if we try to do coverage and cost in the same vehicle. There is simply was not enough agreement on what to do about cost if we went ahead with coverage because we thought it was urgent to deal with that in the best way we could.

A couple of other important elements, one that is particularly important, is that once the bill became law, the stakeholders involved made a very critical decision. Unlike in 1988, this time, every one stayed engaged, realizing implementation would be as challenging as putting a lot together in the first place.

We have used that engagement to do everything from a $2 million public information campaign, paid for and executed by the private sector in support of Healthcare Reform implementation to providing the Connector with additional options and some of the toughest policy choices at its states.

I can tell you somebody who is part of the implementation in the 1988 law that we thought that too much of it was up to the government and we did not involve our non-governmental colleagues who could have been quite helpful to us in the ways that it could have. Of course, there were fewer people supporting that law because it relied almost entirely an employer mandate with some additional public coverage. It was not nearly as balanced in approach as 2006 law is.

Of the challenges we faced going forward, and we have listed a number of them here and I certainly agree with John Kingsdale we are proud as another, by far the most important challenge, the most serious challenge is health system cost containment. Success in cost containment would mean that we would need only manageable and therefore sustainable financial commitments from state and Federal governments. Success would also mean that

businesses in Massachusetts would continue to be able to offer one of the highest rates in employer-sponsored coverage in the nation.

Managing system cost is the toughest challenge we face in part because it means big change for everyone. We are only beginning to understand what these changes need to look like. One of the early tests is getting from or is moving from talking about changes to making them and seeing what actually works. What are listed here are some very important conversations about the changes that need to happen.

Now, if we look at the next slide, I wanted to give you a sense between this slide and this annual report which many of you picked up when you came in, of the kind of changes we are trying to make at Partners Healthcare which is the region's largest healthcare provider. There are some promising results - electronic medical records, computerized physician order entry, disease management including some very striking results for patients with congestive heart failure and process improvement.

One example, Improving operational efficiency in radiology at Newtown Wellesley Hospital, enough that the hospital did not need to buy a $500,000 additional X-ray machine to cover increased patient volume. It was able to do it by making the system of care in that department work more efficiently.

But at Partners and throughout the healthcare community, we have a very long way to go – redesigning primary care to provide patients with medical homes and doctors with doable jobs payment

reforms which reward excellence and focus on outcomes like reducing avoidable hospital readmissions, an insurance product and other administrative simplification. Partner's employs 685 people working on billing issues involving insurance. Forty percent of them work only on rejected claims. This is added expense without added value for patients and assuming that we need to change.

As we go into this challenge, we have got some assets and it is because of these assets and the urgency of the cost situation that I am optimistic that we will be able to meet the cost management challenge and the other challenges we face in sustaining Healthcare Reform. And leaving Massachusetts aside, what is more important is that many states have these recomparable assets.

Through the work of the states, the Kaiser Family Foundation, the Alliance for Healthcare Reform and other organizations, Congress and our new President, I believe it will turn out that our nation too has the assets it needs to solve these very tough coverage and cost challenges for the entire country. Thank you very much.

ED HOWARD: Thank you very much, Matt. I should point out that your pan-ultimate slide was not in the pre-printed version that you have so you were not somehow hallucinating past that one as it was described. It will be, however - in fact already is I believe - on the website for you to check out later. Similarly, I want to make sure that everybody has hard copies of our next speaker's slide which were distributed right before we started the program. So if you do

not have one, either we have them in the back or if we do not, we will make sure they are on the website for you to check out afterwards.

Okay, our final panelist is Grace-Marie Turner, who is President of the Galen Institute. Grace-Marie founded Galen in 1995 as a forum in which to discuss market-based ideas to reform healthcare in America. She is one of the most active and articulate participants in the health reform debate. She described her travel schedule in the electronic newsletter Health Policy Matters that I get every week. I get tired of just reading her itinerary. Now, she says she is not a fourth amigo. That is not because of the gender of the word, though she is friendly enough, she has a somewhat different perspective on the Massachusetts Health Reform Plan to share with us today, and I am very pleased to have you with us.

GRACE-MARIE TURNER: Thank you. Is that better? Wonderful. Thank you, Ed. Thank you, Diane. Thank you to alliance. Thank you to Kaiser and thank you all for coming. I think this really shows the tremendous interest in the Massachusetts Plan. I really want to commend Massachusetts for taking a leadership role in moving forward with health reform. It is really a wonderful example of the laboratory of democracy to help other states learn from the experience, the challenges and both the successes of this plan. Massachusetts had a little bit of a head start. It has significantly lower uninsured rate than most other states. It has a very sophisticated medical infrastructure and it had committed political

leadership to really take action on this issue. So, we are all going to learn from what they are doing. It is very much a work in progress.

I will preface my remarks by saying that I am, by no means, the expert on the plan that the two Johns and Matt are who really have been working and living and breathing this plan for the last several years. I will sort of try though to take an outsider's look at the plan and to really help you see some of the things that might be instructive for other states so that are thinking about adapting some of all of these reforms. One of the things that help me is really trying to figure out the language because everything starts with the C.

You have got the Commonwealth Connector. Commonwealth Connector, we have got Commonwealth Care and we have got Commonwealth Choice and it helps me to sort of say, "Okay, what does that mean?" A Connector is this – as I understand is the overall exchange through which the various programs under this umbrella are run. Commonwealth Care is the program for those who are eligible for subsidized coverage. Commonwealth Choice is the plan that allows people who are looking for coverage in a market of approved plans to be able to get access to health insurance but they are generally not eligible for subsidies. So, care and choice are sort of the crucial defining words and that sort of helped me understand what is going on.

Most of these slides are actually from – many of the slides – from the Commonwealth website which is actually quite informative

about progress on the plan. This shows, and it is a little hard to see on the slide, but perhaps those who are joining us on C-SPAN can see on the web. Those of you can see on your hard copies that the enrollment in Commonwealth Care subsidized plans has really been quite robust.

Particularly, in the plans that require no premium coverage - give something to somebody for free then you are going to see a lot more enrollment and attention. So the orange part of the bar is those who are paying no premium, and the green at the top is those who are paying premiums. This is sort of the continuation of that slide that shows that actually more people are now enrolling in premium paying plans but still significantly, the enrollment in the Commonwealth Care program is among those who do not pay any premiums.

And when you look at the prices, they really are quite affordable if you make – these are plan types. The plan types are primarily very, very similar coverage, but you are eligible for one plan type or another based upon your income. So plan 1, 100-percent or lower; plan 2, up to 300-percent; and plan 3 and 4, 4 is being phased out but those are for people – 300-percent above poverty. So that shows you that the monthly premiums, anywhere from zero to $105 depending upon the plan you choose and the premiums before, as I said which are being phased out were basically dependent upon your choice of plan.

Again, not surprisingly, you see that type 1 is the beige at the bottom, type 2 and 3 - these three are the plans that are very

highly subsidized. That is where the great majority of those enrolled in the plan are type 3 where the premium is up to $105, less enrollment - this dark wedge here - and then four, is really not been popular, not surprising as being phased out. But you will see that, again, very heavily subsidized through these plans and that sort of roles of the enrollment are then.

In Commonwealth Choice, enrollment has been much less robust. We will see in a minute why that might be. Instead of a 176,00 enrollees, we have 18,000 in this plan that does not mean that is the only enrollment in private insurance because people as we have heard, also enrolled in job-based insurance and other private plans but through their Commonwealth Choice plan, where people do not have subsidies, 18,000 so far as of this May enrolled.

I guess, when you looked at the premiums, you can sort of see that this is a little bit of a heavier lift. If you are a young adult looking for coverage, you pay $2,000 to that so your premium will be about $2,280 as I think Matt had one of his slides. But if you are looking for a less of a deductible and a more comprehensive plan, then obviously the price goes significantly higher.

Then, if you just start to skip down an empty nest couple - somebody maybe 50 years old — for a $2,000 individual, $4,000 family deductible, you can get a plan for $7,800 a year, but if you want full coverage, it could be as much as 22,000 for this plan. So it is a pretty heavy lift for people purchasing health insurance through the Connector, clearly they are looking for other options as well.

This plan, I think shows graphical — this slide — some of the challenges that Massachusetts may face going forward. One of the quickest, earliest enrollments was expansion of Medicaid. Now, about 7,000 people in Medicaid expansion, a 76,000 enrolled in Commonwealth Care, only 48,000, 49,000 of them actually paying premiums. Then, over here, 300-percent and above — this is again just in the Connector, there is much less enrollment.

So, these higher income categories are where the enrollment is still lagging. And where I think Massachusetts really faces its biggest challenges in trying to make this coverage both more available and more affordable for those who are not enrolled in subsidized plans.

So, just quickly, some of the risks moving forward — this stays approved to 12-percent rate increase for next year, an insurance so that particularly presents a challenge. All of the plans, of course are going to raise their rates by the 12-percent, but that certainly is a ceiling that they could move toward in order to be able to joggle the cost that they have, make sure those plans can stay in business and stay in the system and also be able to continue to provide care and pay the bills for they are insured. Fines for individuals do continue to rise.

As John was saying, there was $219 the first year up to $912 on the next year. Some younger adults face a smaller penalty if they are not enrolled in coverage. But that is $1,800 — more than $1,800 for a couple that decides that not enrolling and paying the

fine maybe more affordable than some of the insurance premiums that we saw earlier. The fines, I think were going to continue to be an issue especially as they go up.

And then, the shortage of doctors in some areas — and absolutely right, there's a shortage of primary care, physicians around the country, but because many of the plans, your in take physicians is a primary care physician - if you cannot get someone to take a new patient, then you are really are restricted on your access to the healthcare system.

Rising cost to taxpayers as John mentioned than the crowd out of job-based insurance, just a little bit about that — so the state budget calls for $869 million of fiscal 2009 but the Director of Finance says that it easily could go to $1.1 billion. Yes, that is because many more people are enrolling and also many more people enrolling in the subsidized plans. But basically, when you look at the 330,000 Massachusetts residents that are now newly insured, at least 263,000 of them are in free or subsidized plans. So it shows you again, the heavy lift of expanding access to health insurance especially when the taxpayer is paying a large part of the bill.

Then crowd out, there is are several newspapers stories recently about the concern that there are many people, as many as 40,000 workers that have health insurance at work but make less than 300-percent of poverty and under certain conditions, they could also be eligible for Commonwealth Care. The value could be significant, if they have example in one of the articles that said that the

tracking company that employees are were turning down coverage in which they had to pay $70 a month for coverage because they could get care for $39 a month through the Connector.

All sorts or other conditions have to be met and they are really trying to create barriers to not have that become a cascade but you can see that more attractive, the more affordable care is, the more the types here can be on the hook for some of these costs. The budget estimates are of only 10-percent of those eligible shifts from job-based insurance to Commonwealth Care, the total cost next year for the additional $90 billion and possibly as much as $550 billion by 2012.

So the title of the program is Growing Pains and I guess the question is are the cost and complexities of really major changes to the health sector even in the state that had a head start, really far greater than anticipated?

I have printed out just one set of regulations that one of the regulatory boards had promulgated about what people do as far as the hearing process if they want to make sure they are eligible and for which level of compensated care. As you see, this is a really pretty significant and detailed set of regulations.

And just one example that this plan type 2B, there are specific very detailed rules about enrollees about this category will be equal to the standard employee contribution of the enrollee chooses the lowest priced plan among plan type 2 offered on enrollee service area. If the enrollee chooses plan 2 option rather than the

lowest price plans etcetera and etcetera. But it is a very, very detailed set of rules and regulations about what people will be eligible to get as far as their enrollment in Commonwealth Care.

This is the minimum coverage standards for 2009. Another challenge that Massachusetts is facing is that some of the job-based plans that people have do not meet this minimum coverage standards. I will not go through them, but you can see that they are really pretty significant and some enrollment employees or employers are not going to be able to meet these standards, and then the Commonwealth will probably have to decide, "Do we lower the standards or do we exempt some of the employers as they get together?" This one — sorry, it really does not show up at all. But this is just to make the point that the government is now deciding what is affordable for people. As far as their eligibility for a waiver for the individual mandate.

For many people, these are going to be affordable and for others that have cost that we may not know about, it may not be. So that is a specific eligibility waiver process that is going to have to be gone through for everybody very cumbersome, and then finally, this signing ceremony — I thought was pretty good. You can see right here Senator Ted Kennedy, and over here Bob Moffat from the Heritage Foundation. And somebody said afterwards that when you have Bob Moffat and Senator Kennedy in the same picture at the same signing ceremony, somebody did not read the bill. Thank you all very much.

ED HOWARD: Thanks very much, Grace-Marie. Now, it is your turn to get into this conversation. We have microphones where you can come to ask your question orally. They are toward the front of the room this time. We also have the green question cards that many of you are familiar with, if you would like to write your question out and hold it up, someone on the staff will grab it and bring it upfront for us to pester the panelists with. We would encourage you to use the microphones. That is the way to make sure that your question actually gets asked.

Diane, we have some questions that we got in advance and if you would like to start, you can pick from one of those or ask your own.

DIANE ROWLAND, SC.D.: Sure. One of the points that was raised in I think your comments, Jon, was that the primary care physicians and the shortage of them. This question relates to — they know that there has been bills proposed to address for giving medical school debt to graduating medical students who will commit to practice primary care and the under-served area, but what else can be done to address this.

JON KINGSDALE: That is an interesting problem and I really do believe that we are paying attention to the so-called primary care shortage because we have actually about the national average of primary care physicians because of Health Reform, and we had some interesting mix of responses from the table and it reflects what

happens when you get people engaged in the market and in the insurance.

When you say the answer is not going to be just from a couple million more people on the role, so they are uninsured. We have for example, CVS coming about a year ago and saying, "We would like to do at Massachusetts what we are doing in other countries. We like to put nurses on street corners, in our stores and make them available." And to be perfectly blunt, there was a sort of typical reaction from the guild from the Mass Medical Society and from certain advocates and for some providers who felt threatened by it.

And I kind of expected being a fairly regulatory state, Massachusetts might just say, "no," and instead because of Health Reform and because of that need to continue to make more providers available, responsible as - let us do this responsibly and let us encourage CVS to take its capital, to take its money and recruit from nurse practitioners to Massachusetts - even though some of us, and I am not speaking for myself, but some of the critics said, "That is not what we think is ideal care." But you know what? Maybe we should not be deciding what ideal care is. Maybe we should let the market do it.

And on the other hand, we have state government teaming with the private sector to say, "We train a lot of primary care docs in Massachusetts in more than we could ever use, we could retain them." Let us encourage more of them to stay here by doing alone forgiveness program. I do not that we will ever satisfy this sort of

almost inexhaustible demand, if you will, for primary care. If you put another 500 out there, would they probably find a way to stay busy? But I think we are seeing private and public solutions because we have people now involved and engaged in the market.

ED HOWARD: Yes. We have some folks lined up at the microphone. If you would ask your question, identify yourself if you would and keep it as brief as you can.

JOHN GREEN: OK. I am John Green [misspelled?] with the National Association of Health Underwriters. Under HIPAA, you have certain portability and consumer-protection rights and I was wondering if you had evaluated what happens now that you have combined your individual and small group market. What happens to those rights? [Interposing]

JON KINGSDALE: I got to show my ignorance. We work very closely in our division of insurance and legal advice about HIPAA and staying on the right side of HIPAA. So, I have to tell you I am slightly less — I am not quite sure what the conflicts are that you are referring to are the problems. Could you be either more explicit or maybe we can take it offline?

JOHN GREEN: Well, I do not know since you are the first in the nation to that, kind of combining the individual in small group markets now that changes perhaps the status of those are in the individual market.

JON KINGSDALE: I think I see where the question is coming from. We combined the market for rating purposes. What happens

after July 1, 2007 is that insurers have to charge — use the same rating factors to rate an individual as they would use to create a small employer, small group composite rate so they can use age, they cannot use gender, they can use geography and its adjusted community rating within a two to one band. But individual insurance is still individual insurance and group is still group. So I do not think there is a change from a HIPAA perspective.

DIANE ROWLAND, SC.D.: Jon, if you could follow-up. There is a question here that is quite similar about what the primary cost of the nongroup premium decline was and whether that was for the combination of the small group and the individual market or what other factors are you attributing to that?

JON KINGSDALE: Interesting question and wide questions are always the most complicated to answer. I have four answers and I do not know how to prioritize them in terms of weight and I may have missed a few. First of all, we combined small group and nongroup. So, I mentioned there was a poultry nongroup market, just 50,000 people in Massachusetts with directly buying it themselves pre-reform, and 750,000 in small group, and nongroup was far more expensive.

So just merging the two and rating the same means there was a big subsidy from a small group to nongroup. But beyond that, much more importantly I think for the future of this program, here is one of the positive aspects of the individual mandate. With a little cajoling, we got private insurers to price their nongroup product as

if they were going to get a cross-section of healthy and sick people, rather than just sick people who would buy enlarge the demographic that was buying nongroup before that.

Then, we did competitive solicitation, so we selected only six out of 10 carriers who proposed, and then we put it all on this Travelocity-type display for easy shopping. Instead of having to call Blue Cross and wait for 20 minutes and then write down what they told you with their two products and then call Tufts and wait for 20 minutes and write down, you could go on our website, put on three pieces of information; your household size, your age and your zip code, which benefit level you want and have it all displayed there. The combination of getting insurers to price for a range of risks doing competitive bidding and then making the shopping experience easy, I believe is what lead to that dramatic change in the price and value of nongroup insurance.

KATE GROSS: My name is Kate Gross [misspelled?] staffer here on the Hill, following up on some of the ERISA questions. Matt had mentioned that 40-percent of the rejected – 40-percent of the work that folks then help partners deal with is rejected claims and I was curious if there were other consumer protections that should be considered on the federal level that effect kind of the progress that Massachusetts makes in terms of quality, health insurance coverage or that other states might need to consider, or it might help other states and moving forward with something similar.

JOHN MCDONOUGH: We think there is some real value to look at the structure of individual coverage and to in particular address the insurance market rules in many states that really are design to work for the benefit of companies and not for the benefit of consumers.

Those include the ability to do medical underwriting which we eliminated in Massachusetts in small group 1991 and in a nongroup in 1996, and other kinds of protections that mean that you will have insurance not just when you are able to pay the premiums and when you are healthy but we did also have insurance coverage that meets your needs when you are sick as well. I think that is probably the most important thing that we have done and the way that we are able to make these reforms work functionally is in fact, because we were willing to experiment within individual mandate.

That actually creates then the confidence in the part of the insurers that they are not going to be left just by people showing up and trying to get coverage when they are sick. There is a responsibility in both sides. The responsibility for consumers, and there is a responsibility for the insurers as well. We think that is a basic-level of reform that is something that is really worth looking at by many, many other states. We know that, for example, Governor Schwarzenegger, when he proposed his reform in California, included with it those kinds of reforms in the individual market.

JERRY GEISEL: I am Jerry Geisel [misspelled?]. I am a reporter with Business Insurance Magazine. My question is for Jon

Kingsdale. One of the unfinished items on your agenda is to develop specific rules as to what constitutes credible coverage right now. There are some general rules, more specificity lies ahead. Can you tell us how far along you are in that? What maybe is the basis of what you will be looking at?

JON KINGSDALE: Hi, Jerry. We talked frequently and you are one of the better informed – best informed observers in Massachusetts I have interacted with, so you must have some inside information because we are about a week away from releasing them.

ED HOWARD: Yes, go ahead.

RACHEL WINCH: Good afternoon. My name is Rachel Winch. I am [inaudible] National Hunger Forum with a House of Hunger Caucus. I was wondering with the individual mandate, who proves that an individual does not have an affordable program for them and if that burden is placed on the individual to prove?

ED HOWARD: Jon, that sounds like affordability issue.

JON KINGSDALE: Yes. There is a schedule that we publish annually and update what is considered "affordable" and this is one of those tough judgment calls that the legislature – I think in its wisdom – decided to talk to this 10-member board that oversees the Connector and it is actually, I think the 2008 draft affordability schedules on the last one of Grace- Marie's slides if you want to see what the numbers are.

But basically, it says if you are low-income defined at below 150-percent of federal poverty which is about $15,000 a year

for an individual and about $31,000 a year for a family and you have to contribute anything to insurance, it is not affordable. Then it has a monthly schedule progressive there on up and at about median income in Massachusetts which is the high-income states, about $55,000 for an individual and about $110,000 a year for a family of three plus. It is no longer matter of how much the premium is. It is just that at that income-level, you are expected to buy insurance. This is published in new — fill it out on your tax return and self-exempt yourself on that schedule if you fall outside the bounce.

RACHEL WINCH: Thank you.

DIANE ROWLAND, SC.D.: It has a follow-up question, have the individual mandate penalties been high enough to motivate individuals to purchase under the plan, or how are you going to evaluate that?

JON KINGSDALE: Have they been high enough? Well, it is like beauty, is not it? It is in the eye of the beholder. I guess a one answer will be, is there substantial uptake in the insurance offer and that is probably since everybody can easily disagree on what the number — 219 is too much or too little depending on whether you are a libertarian or at the other end of the spectrum.

Unfortunately, we are a month away from being to release the Department of Revenue statistics but our early sense is that there has been considerable uptake. If you look at 340,000 newly enrolled, and you look for example on the bar graph that Grace-Marie showed at December, which was when the mandate really became subject

to penalty for not complying with the mandate and saw that large uptake.

What we saw coming in to the Commonwealth Choice Program interestingly because the uninsured are majority male and their pretty young and to be perfectly blunt, a lot of them do not think that illness can happen to them, we saw a large uptake in the number of young males taking insurance when the penalty – just $219 came to be real – that is in December of 2007.

I think it is having a significant impact. We will see when we release the data – what other people think.

JOHN MCDONOUGH: I would just add to that. We are in a strikingly experimental phase in this. We do not have any data yet in terms of how it is going and we are going to learn very soon. But I think there is a lesson perhaps for folks in other states and down here as well, which is go carefully. When you go into something like this, do not come in with a sledgehammer. We have been able to do something to our knowledge, except for the Netherlands and Switzerland, no other governmental entities ever created a mandate quite like this and we had a much larger proportion of folks affected by it.

So, we think a slow cautious careful approach where you really study and then understand and pay attention really makes a lot of sense in terms of getting the political buy in which is frankly been one of the important positive hallmarks of the implementation period of the slot.

ED HOWARD: Matt?

MATT FISHMAN: I would add to that, that in signing 6,500 people up at two of our hospitals, we found that explaining to people that they can get coverage, that it can be affordable and that otherwise, there will be a penalty, does motivate people. But based on the people say, "If I am going to pay something, why do not at least get some coverage for it so I know can get my prescriptions covered and come to see the doctor when I need to." I think it is an important motivator.

JON KINGSDALE: If I could just add one thing. I get asked a lot about the mandate and the idea of how can you mandate people to do this. But we do live in a society where when you step off the curve and you get hit by a bus – to use that proverbial example – you do expect to be picked by an ambulance, taken to an emergency room and treated in the ICU if necessary, and that is literally tens of thousands, can be hundreds of thousands of dollars that you expect somebody else to pay for. The proposition here is if you can afford it, we can all agree or disagree what affordability means, you ought to be required to participate in the financing of the system that you will expect at that moment and that your society absolutely is committed to providing to you.

ED HOWARD: Yes, at the microphone.

JULIA DOROTHY: Hi. My name is Julia Dorothy [misspelled?] with Dorothy Healthcare Consulting and I have a follow-up question related to the insurers and the impact they claim if they have been

able to assess it yet, the community-based rating for the nongroup folks has had on their ability to maintain adequate premiums. The real reason I came up was just to ask the much more general question as in other countries, we look at the percentage of the total folks that are insured in any given state or country.

Maybe I missed it, but I am curious as to what that percentage is now in Massachusetts and where you expect it to be when the implementation is complete. I am assuming even though there is mandate, everyone — some people might choose not to participate nonetheless.

JON KINGSDALE: We all have different expectations. If we have roughly to start and just give or take 2-percent or 3-percent, 10-percent uninsured, I would expect to cut that by more than half, hopefully the cut us by substantially more than half. I do not think we are going to get to a 100-percent even in Netherlands and Switzerland which also have mandates. There is about 1-1/2-percent on insurance rate and as you all know, with other mandates like auto insurance, there is substantially more actually non-compliance that even the 10-percent on insurance rate we have with healthcare to start.

JOHN MCDONOUGH: Just to add, we never call this a universal healthcare line. We hope that it is near universal. Grace-Marie actually pointed out one of the gap groups. If you are under 300-percent of poverty, you would be otherwise eligible for Commonwealth Care, but if you work for an employer who offers

coverage that you cannot afford, you are not eligible for Commonwealth Care.

If you drop coverage, as long as the employer still offers it, you are not eligible for Commonwealth Care, and the estimate is somewhere between 30,000, 50,000, 75,000 folks we will find out pretty soon actually fall into that group. We would love if we could get all those folks covered tomorrow. We understand there is about three quarters of million folks under 300-percent of poverty who have employer-sponsored insurance now. If we were to create a mechanism where those folks could pile in, we would bankrupt the program overnight and have nothing for anybody.

So, it is a challenge and that is why we are saying, do not assume we figured out - if you assumed for a moment we are up here saying we figured all this out, please think again. We know there were weaknesses, holes, problems. This is life and we are doing it as best we can and we think we are making some unprecedented progress but we have by no means figured it all out.

GRACE-MARIE TURNER: One of the things that people wonder about that you may or may not have figured about is we hear a lot about the Employee Retirement Income Security Act or ERISA as a barrier to state reform activities. How do you figure that one out?

JOHN MCDONOUGH: Before the ink was dry, there were people writing memos all over the country saying, "This violates ERISA. This violates ERISA. This violate..." Direct violations, the fair share assessment, the Win25 requirement, the free rider surcharge,

the requirements for employers to report and disclose, as well as on indirect acquisitions of the individual mandate violates a risk and so. We have seen them all and all we can say is two years and one month into implementation, no one has filed an ERISA action against any single provision of the law. We know that there have been law firms all over the country, scouring the Commonwealth, looking for clients and they have not been able to find one. They have not been able to find one because, again, implementation has gone in a way that has kept the business community largely supportive of what we are trying to do.

So, the national law firms wanting to make a name for themselves by channeling this on ERISA grounds have not been able to find a client. Now of course, that could change this afternoon. But all we can say is, two years and one month into it, we have survived any ERISA preemption activity and we are moving ahead to implement.

MATT FISHMAN: Some very careful work as you would all imagine when into putting the provisions and legislations together. We thought that might be vulnerable and certainly there are people who are involved in that part of the drafting who would be glad to talk with anyone who have more questions offline.

ROBERT MGCARRAH: I am Robert McGarrah [misspelled?] AFL-CIO Office of Investment. We want to commend you in Massachusetts for this amazing effort. This is really quite a leadership effort for the whole country. I wonder, is it fair to say, when we take away from this all be that there really is no political backlash that

you can see at this point from the individual mandate, or in terms of taxpayers for the mandate subsidies that are being required for this system, or do you dodge that bullet, or do you see this is something that is still hanging out there over your heads all the time?

JOHN MCDONOUGH: I would say it is always hanging out there. I would say at this point it is fair to say there are the legislatures up for reelection. The candidates have filed who are running against — we have not heard of a single candidate who is running against somebody on the basis of them having voted for and supporting this law. That is a one barometer. There are no demonstrations out there in the street.

There are folks who come on to our blog everyday and put a pie in my face for being in associated with it. But I would say for the most part, we have done implementation in a way that has gotten us past that and in terms of a political backlash, the anniversary was April 12, and we were concerned. The Blue Cross Foundation was trying to organize an anniversary event and they try to coordinate the schedules of Governor Patrick, Speaker DiMasi and Senate President Murray, and they could not do it.

It was mission impossible. So we said, "Heck, we just cannot let this anniversary go by and not have something." So, we called an event in the State Senate reading room, a nice eight-room across from the Senate chamber and we said, "Come if you can." and we ended up having Governor Patrick, Speaker DiMasi and Senator Murray attend in there with Kingsdale and other legislators.

Some reporters came up and said, "Well, there is nothing new here." I said, "No, there is something new here. What you are seeing is two years into this." There is the same level of political backing behind the slide that there was when it was signed as you saw in Gracie's picture and you cannot buy that. You cannot buy that.

GRACIE-MARIE TURNER: Is not one of the other points that your coalition has stayed together and worked through implementation? I think that one of the lessons is you cannot stop it. At enactment, you have to continue to have that coalition hold through the whole process.

JOHN MCDONOUGH: I have been in public life for about 25 years or so and I have never seen an implementation process this robust, this involved. One of the signal pieces of this process, both leading up to enactment and implementation has been the involvement of the faith community. We have one group in particular, Greater Boston Interfaith Organization to give them national plug who come to the Connector Board meetings.

Sometimes in their clerical guard and other things to put all kinds of subtle pressure on John and the board members. It has been a remarkable process, unlike anything I have ever seen this implementation working, and it is one of I think that John has pointed it out, one of the successful lessons to think about is the ability to which, the extent to which the legislature in craft in Chapter 58 was willing to delegate a host of hugely difficult

decisions and processes into the regulatory stream and not have to write them and to find them all in a statute.

I remember the first couple of months when we would go around and explain the law and I talked about all of the sets of rules, yet to be written, yet to be defined and people would start to laugh because there was so much that was not done. The two years, the 25 months has been one hill after another where people said, "Oh, my God. Look at this big hill. You are never going to get after it." We have just taken these hills one at a time and we have gotten through. Who knows? We may collapse tomorrow but two years and one month in, we are still standing and making this work.

AL MILLIKIN: Al Millikin [misspelled?], Washinton Independent Writers. Does anyone have further observation and reaction to how the political leaders involved have responded to what has happened thus far? Has any politician surprised or shocked at you?

JOHN MCDONOUGH: There is one state representative from Cape Cod, who has spoken out against this and he was one of the two state reps who voted against it two years ago, and to our knowledge, he is the only elected official we hear who is speaking out against the law. Everyone else is saying, "This is important. We got to do it and we have to make this work." I think there is a shared understanding that the price of success – and make no mistake – the price is higher than we had anticipated. Yet, there is still the

shared belief at the price of success is significantly higher than the cost of failure.

MATT FISHMAN: I think if it has been anything that was a surprise, it was that as some of these issues came up including additional spending that the political support remain very, very strong and now on its own where our state is facing some challenges economically as many states are on the country. The revenue picture while good this year, there are people certainly worried about what it looks like for next year and because as Jonathan was just saying, this offers so much to so many people, everyone has been willing to stay with it and has remained a very high, really top priority for all free of the state-based political leaders and certainly Senator Kennedy's support continues to be very, very strong.

So, I do not think it has been a surprise, but it has been very reassuring to see that as issues have come up as the real problems implementation have we probably had to confront, that that support has not only been very steady but has meant the people would stretch. In need for additional revenue?

Okay, let us think about the fact that we may need to raise the tax on cigarettes. No one wants to raise taxes but there is a relationship one can argue between the cost of smoking and the cost of insurance, and let us see if we can get a little bit more revenue that way that will help us meet the additional cost of legislation. Well, that is not yet final. It is something that both the House and the Senate have acted favorably on or about to act favorably on and

we expect that that will be a building block that will help us get through the fact that there is an increase in cost.

ED HOWARD: Let me just say I neglected to mention this before as we go into this last 10 to 15 minutes of questions. I wonder if you could pull out the blue evaluation forms from the left side of your packets and fill them out as we move along toward the conclusion. Yes, Jon?

JON KINGSDALE: I think that question about political opposition that because I think one of the great lessons of Massachusetts, but I want a caveat it is that it can be done. Now, we should not be a country that is so in so or that we do not believe the experience of dozens of other OECD comparable economies that can have anything to do with us, nevertheless being one of 50 states that is actually tackling this problem seems to be inspiring to those who have felt that politically just get close to the — you woke up to the table but you can never get seated.

On the other hand, I do amongst all that goodness and joy after point out that it maybe easier to do it in a Commonwealth that has the cultural reform that John McDonough referred to where the people who deal with healthcare are mostly in non-profit institutions, whether it is domestically domicile health plans or hospitals where they interact with each other on a weekly, if not a daily basis.

There is a certain amount of trust, I would say, that is characteristic of the culture of healthcare which is a prominent

industry in Massachusetts. What other paper record would have four reporters dedicated to healthcare often covering on its front page and that is hard — I do not know how you translate that nationally. I think that is a challenge to translate that perhaps to other states or nationally and I do not point that out to discourage people but just to say when you are talking about changing, financing of 16-percent of GNP which is 33-percent larger than manufacturing and 16 times larger than agriculture, you are talking about a tough challenge politically.

ED HOWARD: Grace-Marie?

GRACE-MARIE TURNER: I think we often talk about what other country should we look at in and Switzerland often held up as a model. Interestingly, Switzerland has about the same population as Massachusetts. So, when you think about the country in Switzerland doing an individual mandate and National Health Reform plan, that is the experiment we have here is Massachusetts — that is about the same size as Switzerland.

So, trying to translate this to a country as diverse as the United States with 300 million people who will require much greater sophistication than you have heard about the tremendous sophistication and implementation of this plan. Just one sort of caution also, a great deal of the impetus for creation of the Massachusetts Health Reform Plan was the threat of a lost of Federal money and a waiver that was expiring. That waiver, as I understand

is due to be reauthorized this summer so that is another challenge because it has so much federal money coming into it.

Are the rules that Massachusetts has created compatible and is it still going to be legal under existing Medicaid law for this — the Federal waiver to continue. So that is a third challenge and I think finally, the affordability issue is really crucial. The slide, the told cartoon is exactly right. Everybody is thinking health but we are really thinking money. Being able to make this coverage and this care affordable is really going to be the critical issue and whether or not people are going to be able to comply with the mandate, and whether or not the state is going to be able to continue to increase the number of people that do have coverage in the state. Thank you.

DIANE ROWLAND, SC.D.: Just as Grace-Marie talked about Federal money, we do have a question from a congressional staffer about the August 17th CMS directive on SCHIP which put some limits on coverage above 250-percent of poverty asking how that will impact Massachusetts' ability to provide coverage for children and families in that income, the band above it.

JOHN MCDONOUGH: So Massachusetts under Chapter 58 expanded kid's coverage under SCHIP to 300-percent and we have implemented that and expanded it and it is one of a number of states that are now being reviewed by CMS. One of the requirements that CMS is now asking is that before states go over 200-percent of poverty that they

demonstrate, that they have covered at least 95-percent of the eligible children.

There is an important message there and not to speak on the merits of that role because you know, it is very controversial. We believe we have actually got pretty darn close to 95-percent. So, there is in fact a lesson there from Massachusetts that we think is important for the nation which is that you can in fact go out and find those eligible and un-enrolled, and you cannot do it for free. It takes an investment.

So to state in the three years of Health Reform so far has been investing about three and a half million a year in directive appropriations to invest in a robust outreach in enrollment effort. There have been other support from organizations like Partners and Blue Cross that have made a really robust effort, on Massachusetts has an electronic enrollment system so that we can actually go out and enroll folks online.

So we have done a whole series of changes that have really gotten at this issue of the eligible and un-enrolled. There was one recent estimate that suggested of the 47 million, 48 million uninsured, about 12 million of them are actually eligible for coverage today and un-enrolled.

So we think there is actually a good lesson from Massachusetts from the rest of the country – we can in act go out and find these folks and we cannot do it for free. If we are willing to

invest it in, we can find those folks and get them in and keep them in coverage.

ASHLEY THOMPSON: Hi, Ashley Thompson [misspelled?] with the American Hospital Association. My question has to do with the employer pay or play responsibility. In my understanding, I think you mentioned that employers, if they do not offer coverage, if there are certain size, etcetera, they have a per-worker payment make to the state that surrounds $295. You mentioned that that did not bring in the revenue that you expected it would.

I am just wondering what other reform plans out there in talks of whether a percent of payroll and in the sentiment, is that dollar figure enough and we can argue about the dollar figures. But has there been any talk about those issues and I really appreciated you explaining on the employer mandate and wonder if you could just do the same on – I am sorry – the individual mandate earlier – if you could do the same with the employer pay or play responsibility?

JOHN MCDONOUGH: So just a little history, the $295 was a political compromise between the House of Representatives on one side that wanted the 5-percent or 7-percent of payroll assessment, the Senate and Governor Romney that did not want any. And the agreement, the compromise was the $295. Governor Romney actually was supposed to the $295, he vetoed it. His veto was overwritten and so it was put into place. The Romney Administration wrote the rules in the way to define them to exempt as many employers as possible from having to

pay it. So we were not actually – in my organization – surprised when it came in and it was significantly less.

The legislative leaders who crafted the bills said they believe that the definition violates their legislative intent as they perceived it themselves when the law was crafted so this is an ongoing issue. One of the issues that is moving forward that we are dealing with in Massachusetts right now is how equal is this shared responsibility – one of the underlying values of health reform is that fixing this problem requires shared responsibility by government, individuals, employers, you might include insurers and providers as well.

But those three are key and there is right now as we are facing the issues of how to pay for this over the longer haul, is the shared responsibility formula actually equitable in very much the issue of the fair share assessment and employer responsibility is very much a part of that conversation. So stay tuned.

JERRY SMOLKA: Yes, Jerry Smolka [misspelled?] AARP's Public Policy Institute and you have discussed it a little bit more already but I would like to hear a bit more about what you did in like volume of resources that were committed and the types of resources committed to outreach an enrollment. I am thinking not just about the people who are eligible for public programs but do not know about them or do not know that they are eligible but people who do not like to shop or do not know how to shop in the nongroup market, and to what extent the online mechanism that you have made

available through the Connector has brought in unsubsidized population as supposed to the subsidized population and how that is working in compliment to the usual nongroup market mechanisms?

JOHN KINGSDALE: Maybe I will kick it off, Jerry. Both Matt and John are very involved in outreach assumption. They want to supplement this.

One of the advantage of this broad support is we could position the sense of community effort and I actually am trained as the historians are, remember back in the 1930s when Blue Cross plans were first founded and you would see the Mayor in the subways donating a space and there was a public spirited outreach program and we benefit from some of that. Talk about transparency when our board meets, we have 300 people routinely attending, including all the local press. So we have what is called earn media.

We have the best brand in Boston, supporting us, the Red Sox and not only do we advertise there but they donated hundreds of thousands — I am probably not supposed to say this — free advertising to us and give us a booth at their home games and have ambassadors that go around the state and so forth and so on. We have CVS, Bank of America, the Mass Transit Authority and others who donated outreach as well.

So, there is a lot of sort or public spiritedness around us. The website, we get 80-percent of our applications for the unsubsidized plan by electronically. I think when we saw the mandate start to come in to effect July 1, I think we saw spike were running

– I have forgotten the numbers now — 25,000, 30,000 hits a week on our website and these people are going 10 pages deep into the website. So they were not just glancing at it.

So been a tremendous amount of that kind of effort and then of course among those partners are the organizations that Matt works with and many other hospitals, physician groups, health centers and organization that John leads and the co-coalition that John helped put together doing act reform.

JOHN MCDONOUGH: I just say — forgive the military metaphor but there is an air war and there is a ground war, and John has been kind of – and the Connectors in general for the air war and there are host of grass roots organizations work going door to door out there on the street corners, our friends at the Greater Boston Interfaith Organization go to churches and find members who qualify for any kind of coverage.

So it has been a very sophisticated effort at multiple levels, you can probably count 25 different things that have been going on and it is not just one of those, it is the combined impact of all of those together so you had the public advertising on TV and you did not have the community-based effort or if you just had it vice versa, it would not had been nearly as effectively as putting all of those pieces together.

ED HOWARD: One of the elements we fight that happen to is that doctors and nurses and the people who work with them, financial counselors who helped patents with the insurance coverage - these are

people who are very committed to helping their patients so what we said to people throughout our organization and the same has happened in community health centers and hospitals throughout the state is, "Here is our chance."

We have always wanted to have people who are uninsured be able to get coverage, now we can do it and the idea is that anyone that a patient comes in contact with, either is knowledgeable about how to sign up for Commonwealth Care and the other elements of the program working immediately, route use somebody who is. That means as you can imagine, all kinds of training for staff, doing everything we can to make this available electronically so that we can make it easy when patients come in to register, "You are still free care. You haven not signed up for coverage yet, let us go through that with you," try to do that in a short period of time and we are finding that patients are responding very well.

The staff, whether they are nurses and doctors or people who are signing patients in at registration have responded enormously well. People are willing to put in time beyond their scheduled shifts, put in weekend time, do anything they can to help make sure that patients are aware that this coverage is available and help them get signed up. So we have really tried to tap into that in a very organized and thoughtful way, and by partnering with kind of work with John McDonough described and the kind of work that Jon Kingsdale described, that the Connector is doing.

We have time for just perhaps one more question and then the couple that we want to tidy up here that connected to some of the discussion. Go ahead.

PAUL BENNETT: Thanks, Ed. Paul Bennett [misspelled?] with American Benefits Council. My question is also on this whole ground war area and outreach because it seems to me like one of the things we should all agree on is the importance of those who are already eligible for public programs but are not enrolled.

I am just wondering if any of the panelist have any thoughts about how you take some of the practices that seemed to be working really well in Massachusetts in this area and from a public policy point of view is an incentive payment from the federal government or anything that as part of overall Healthcare Reform that would encourage more states to do more aggressive outreach of this sort to get those who are eligible actually in the coverage and just one thought for Jon Kingsdale's – you could maybe get the Patriots involved along with the Red Sox probably closed the gap entirely, right?

JON KINGSDALE: I got John McDonough, I do not need the Patriots.

JOHN MCDONOUGH: We think first of all the State of Massachusetts under Governor Romney set up something called the virtual gateway that allows for electronic filing of applications. At my organization, healthcare for all, we have a helpline - people can call. We can do a screening of somebody in 10 minutes flat, find

out which program they are eligible for, if they are. We send them a completed filled out, ready-to-sign application to their homes with its postage paid return envelope. They send it back to us with the supporting documents and we file it with the state.

If the state loses the paperwork which happens more times than you would ever want to know -- we find out, the client never finds out. We follow it and make sure that folks actually get enrolled. That is just kind of one example of the incredibly robust effort that is going on but there is a need to invest in systems. I mean, in so many states right now, if you want to sign up for your Medicaid program, you fill out one of those lengthy paper applications and it is a real impediment so we need to invest in systems that make it easier for folks to be able to sign up, get coverage.

Also, resign up for coverage because we are finding that signing people up, doing the re-determination process can be just as onerous and burdensome on individuals that is signing up in the first place so there really needs to be an investment in more robust systems and we think, probably there is a role for the federal government to assists states to move into that place.

ED HOWARD: Diane?

DIANE ROWLAND, SC.D.: One of the areas that everyone is concerned about, as you move toward Healthcare Reform is what is the effect of Healthcare Reform on the safety net? The two questions we have here, one from a hospital perspective are the safety net

hospital's experiencing a real decline, is there a real problem there. Then also, what is the effect been on community health centers and their ability to meet their needs.

Matt, you want to start with the hospitals?

MATT FISHMAN: Well, I think I will take the health centers first, if that is okay because that one is a clearer answer, I think.

Health centers, I think are finding that the Healthcare Reform law has for the most part been really an excellent step forward. Health centers reporting dramatic reductions in the percentage of their patients who are uninsured.

The large community health center in Lynn Massachusetts going from 40-percent of its patients uninsured to 23-percent as result of people being able to sign up for coverage, certainly want that 23-percent number to go down further but that is a pretty big change to have happened in a short period of time. Other health centers also finding good results but they also point out that there is a lot more work to do. You have to make sure that people's coverage is current.

If you have to ask people for co-payments, you actually have to be pretty serious about collecting co-payments. That is a change in culture for institutions whether they are health centers or hospitals that have been traditionally more focused on — "If you are here and it hurts, we will take care of you on what the paperwork maybe," be a secondary consideration. This is a much more accountable system.

The safety net institutions in Massachusetts, Boston Medical Center, Cambridge Health Alliance and others are finding this to be a pretty challenging period of time. They are thrilled to be able to have more people have coverage but the provisions of the law and the federal waiver that are designed to have money follow patients rather than money go to institutions for support institutional services, that transition is a tough one.

It is a multi-year transition that was built into the both federal and state commitments around this but it can be difficult to predict in advance, gee, is transition that can happen in two or three years or is it maybe going to need to be four or five years? That is one of the issues that is under discussion in the waiver negotiations right now.

Do those institutions needs some additional support as they move to a situation where many, many more of their patients have insurance and have choices or are they going to be able to complete that transition as originally scheduled. I think as John McDonough has said, that is not the one we have to stay tuned on and see how it develops.

GRACE-MARIE TURNER: That is right. The safety net hospitals really are among those that are facing the biggest challenges because the assumption was that many more people would have insurance and so there would not need to be [inaudible] payments that would compensate the uncompensated care payments.

So the uncompensated care payments have been cut back and they still are saying quite a number of people that are not insured and several of the safety net hospitals are actually threatened with bankruptcies. So the question is, whether or not they will be able to survive long enough to get through this transition, but right now, it is a very difficult time for some of these most vulnerable hospitals.

ED HOWARD: I think we have come to the – not the end of the discussion but at the end of our time to carry at the discussion as far as we can at least today. Once again, thank the Kaiser Family Foundation for its obvious role in both shaping this discussion and helping us get where we need to be and its co-sponsorship for the event. Thank you for being so active. We are going to try to talk these panelists into responding in writing to some of the questions in writing that we did not get to. We will keep you posted on how that works.

Somebody referred to this as a robust effort in Massachusetts and I can imagine anything more robust than the discussion that we have been able to have today and I ask you to join me in thanking our panelist for being part of this.

Thank you all for coming and do not forget those blue evaluation forms as you go out. Thanks very much.

[END RECORDING]