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Massachusetts Health Reform: A Giant Step Toward Universal Coverage?
The Alliance for Health Reform and Commonwealth Fund
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ED HOWARD, J.D.: My name is Ed Howard, with the Alliance for Health Reform, and on behalf of Senators Rockefeller and Collins and our board of directors, I want to welcome you to this briefing on reforms to the health care system that are now playing out in the commonwealth Massachusetts. Our partner in today's program is the Commonwealth Fund, a New York based philanthropy that has supported a great deal of analysis of what's happening in Massachusetts.

You will hear from Anne Gauthier of the fund in a moment and I also want to acknowledge a rather unusual situation in which there is so much interest in what's going on in Massachusetts that there is a consortium of philanthropies who have come together which doesn't often happen. The Robert Wood-Johnson Foundation, Blue Cross/Blue Shield Association, Foundation of Massachusetts, to support some of the analysis that you are going to have the benefit of hearing this afternoon, and I want to thank them for their interest and continuing support of that activity.

It has been more than 2-1/2 years now since the Massachusetts plan was enacted by a democratic legislature and a Republican governor. A lot of people in Washington, a lot of people in other states and around the country are keenly interested in how it's going after all of this time.

There has been a lot of tension in the policy community and in the press, I guess, about the concerns over cost and access and among other things today's briefing is a chance to focus on some fresh evidence of how things are going and to take stock, and we are going to pay particular attention today to how employers are coping with the reforms, both in their attitudes towards the new law and the impact those actions are having on their workers.

Just a couple of logistical notes, I apologize to those of you who have been here before and have heard these but I want everyone to know that by close business Monday you will be able to view a webcast of this session on kaisernetwork.org. Within a few days after that you will be able to read a transcript on that same website along with a transcript available on the alliance's website, allhealth.org.

All of the materials that are in your packets will be on both of those websites. You can share them with your colleagues if you care to, and I would ask you at the appropriate time to fill out the blue evaluation forms that are in your kits and take note of the fact that there is a green card on which you can write a question and pass it up to be asked of our speakers at the appropriate time.

As I said, cohosting today's briefing is the Commonwealth Fund. They have been working for about a century now on issues affecting the uninsured and other vulnerable

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populations in Massachusetts and everywhere else in the United States and some places overseas. And representing the fund today and sharing moderator duties is the assistant vice president of the fund and the deputy director of its commission on a high performance health system, Anne Gauthier. Anne?

ANNE GAUTHIER: Thank you Ed. I am delighted to cosponsor this briefing with the Alliance for Health Reform. We are actually 90 years old. We have another ten to go to hit that century mark, and also to cosponsor the research with the two other foundations, the Robert Wood-Johnson Foundation and the Blue Cross/Blue Shield of Massachusetts Foundation. It actually has been a terrific partnership, both in sponsoring the research and in our communication and dissemination activities and may this be a model for the congress and the president going forward on health reform.

To set the stage for our presentations today, I'd like to provide a couple of important pictures and briefly describe the reform, and emphasize why on this day three after the election, congress states and all stakeholders are continuing to look to Massachusetts.

The first picture here reminds us that the problem of the uninsured continues to grow worse, with great variation among our states. This picture combines the figures for adults and kids, so it is all of the non-elderly, zero to 64, who are uninsured, in the period who were uninsured in the period 1999-

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2000 to the latest data, we have 2006, 2007, updating previous versions of these maps that you may have seen.

The color scheme is that being lighter is better. The white color is the fewest number of uninsured and the very dark blue is the greatest number of uninsured, and you see that we did get markedly worse. If you would divide this by children and adults, you will see a very different picture.

About 17 states including the District of Columbia actually increased their status between these two periods but in contrast for the adults we had 22 states in the earlier period who were in the white and we have only nine states in D.C. that were able to improve or maintain their status, so it remains a very serious problem.

Turning to the key elements of the Massachusetts plan to set our context here, I think it's important to emphasize that it is a mixed public private system of universal coverage with shared responsibility for financing. It includes a subsidized sliding scale, expansion for children up to 300-percent of poverty, and adults up to actually 100-percent of poverty although there are partial subsidies, well that's actually in the Mass. Health portion.

Individuals face a mandate to buy coverage, which has been in effect for a little bit over a year, and it has affordability provisions though with some subsidies up to 150-

percent of poverty, full subsidies, and then a sliding scale between 150 and 300-percent of poverty.

Employers are responsible for providing coverage to their employees and if they don't they must pay what's called a fair share contribution of \$295 per employee per year, and they also need to offer their employees access to pay their premiums with pre-tax dollars.

There were also insurance market reforms in the individual and small group markets which were merged in a new mechanism to organize the market called the insurance connector, and finally there was a Massachusetts health care quality and cost council that was formed but only began operations under this, only was enacted under this law, and is really starting to gear up that recognized that the problems of cost and quality were equally important but there were not as many strong provisions at that time. There has subsequently been another law passed in Massachusetts.

So here is our basic context here, and my last graph picture before one more previous is to show you the role of employer coverage. In fact, I want to turn back to this last slide here. There is a picture on this slide and the picture is there to emphasize the percent of uninsured in Massachusetts versus the United States at the time of the reform.

Massachusetts was in a significantly better position than the rest of the country.

If you look at this picture, it shows you the great importance of the role of employer coverage in the U.S. generally, 63-percent of the population in 2006 has employer coverage and you see that in Massachusetts it was even more important and you will hear the results of what has happened since then.

Finally, as we look to health reform in 2009 and to our president elect and the new congress, this part shows just how important the lessons from Massachusetts are. I'm not going to walk you through it but if you take a look at it here on the slide and in your packet you will see that president elect Obama's plan resembles very much the Massachusetts reform.

There are key differences and as he and congress figure out the political strategy, they will also be looking to the way that Massachusetts put a whole package in place versus other potential sequencing options.

My final slide offers this food for thought, as most of you are finishing your lunches at this point, when comparing Massachusetts and the president elect's plan, my colleagues led by Sarah Collins, compared the president elect's plan and the Massachusetts plan to some important principles for health reform that our commission on a high performance health system put forth, and I think you will note by this picture and if you go down these principles, you will see that both plans rate

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pretty highly and for this we are quite excited as to what is to come.

I will turn this back to Ed to introduce our first speaker and to present some exciting results but I will share that yes, I did prepare two sets of slides. They were due last week, and I'm delighted to have this picture here at the end because it does show some promising plans on the table going forward.

ED HOWARD, J.D.: And the comprehensive version will be on our website. Thanks very much, Anne, and let me just say if you haven't already turned off your cellphone or your beeper, do it now. It will be much less embarrassing when I yell at you otherwise.

We do have an excellent array of panelists for you today, as Anne alluded to, two of them actually have authored health affairs articles that are in your materials that form the foundation of their presentations today and one of those people is Sharon Long. She is going to be leading off today's discussion. Sharon is an economist. She is a senior researcher at the Urban Institute.

She directs the institute's ongoing evaluation of the Massachusetts reforms including some annual surveys that she's been directing, ever since 2006. She is also evaluating state reform initiatives in a number of other states and today we are going to hear from her about how workers in Massachusetts

perceive how the new laws affecting their employer sponsored insurance or the lack of it. Sharon thanks for being with us.

SHARON LONG: Good afternoon. I will be reporting on some new findings from our ongoing survey looking at employer responses to health reform, but before I do that, I want to back up a little bit and review some of our earlier findings on the impacts of health reform on individuals in Massachusetts because that provides the context for the employer response.

In our earlier work, we found evidence of a strong decline in uninsurance in the state, with uninsurance dropping from 13- to 7-percent. At the same time, we found no evidence of crowd out of private coverage, so no evidence that employer sponsored coverage was dropping in response to increased public coverage in the state, in fact we found evidence of increases in private coverage and ESI coverage in the state under health reform.

At the same time, we found evidence of improvements in access to care for individuals in the state and reductions in the cost of obtaining care for those individuals. And then finally, we found evidence for those with insurance that the financial protections provided by health insurance improved in the state, so the share of workers in the state who were under insured dropped under health reform.

Now, as Anne showed you in her slide, the Massachusetts health reform includes many components, expansions to new

programs, expansions of old programs, subsidies, most controversial, the individual mandate and requirements for employers, all of which have changed the health insurance environment that is faced by employers and by workers in the state, and so these changes in the environment have changed the incentives for employers to provide coverage and for individuals to take up that coverage, and so what we wanted to do in this paper was to look at how employers have responded to those incentives.

We are using our survey of adults in Massachusetts. We conducted a baseline survey in fall of 2006 and that was just prior to many of the key elements of reform being implemented and then this is based on follow-up survey in fall 2007, so roughly one year after health reform was started and I would note here the caveat is that the individual mandate was not fully implemented at the time of the second survey so we are talking about employer responses before the individual mandate was fully effective.

And the results I am going to show you were comparing employees' perspectives of their employers in fall 2006 to fall 2007, so I am reporting on the employees' perspective on how things have changed and then when Jon speaks he will tell you about the employers' perspective.

So the first question is: Are employers dropping health insurance coverage under health reform? What we show in

this slide is the share of workers who report that their employer is offering health insurance coverage and so this is offering to anyone in the firm and as you can see the shared workers who are in firms offering health insurance is high and has remained high between fall 2006 and fall 2007.

Now the group of firms that you might think would drop coverage are small firms. The incentives there would be for those firms to drop coverage if anyone did, and what you can see here is we see a slight increase in the share of workers in small firms that are offering coverage, although it's not statistically significant but clearly no evidence of dropping under health reform.

A second potential response by employers would be even if they didn't drop coverage they could tighten eligibility for coverage so make fewer workers eligible for the coverage that they are offering. Here we look at the share of workers who report that they have an ESI offer from their employer and again remains very stable between fall 2006 and fall 2007, including very stable for small firms.

The next slide looks at this issue of tightening eligibility from a slightly different perspective which is if we thought firms were to tighten eligibility, the workers it would be most likely to be excluded would likely be part-time workers or workers with a short job tenure, and so here you can see when we look at the share of part-time workers who report

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an offer and the share of workers with a job tenure of less than one year who report an offer. Both of those are very stable between fall 2006 and fall 2007, so no evidence of a tightening of eligibility for ESI coverage.

Even though we don't see a drop in coverage, we could see employers responding to increasing health care costs or health insurance costs by trying to transfer more of the costs onto their workers so either shifting premiums or making other changes in the way that insurance is designed.

Here we look at the share of the workers' contribution toward the ESI premium, as reported by the worker, and in this slide we look at the share of workers who report a premium of \$1,000 or more if they have single coverage or \$3,000 or more if they have family coverage, and these numbers are the average premium that is reported in the medical expenditure panel survey for Massachusetts so on average what was the premium and this is people who are above the average for premiums. And as you can see, we don't see significant increases in the share of workers with premiums above the average between 2006 and 2007.

We also looked at people who report having high premiums, and these are premiums that are 1.5 times that average, so \$1,500 a year for single coverage or \$4,500 a year for family coverage. So, here we see no evidence of an increase in the share with high premiums and actually a drop in the share with high premiums among workers in small firms,

which goes from 32-percent reporting premiums above that level to 24-percent reporting premiums above that level, so, no evidence of cost shifting in the premiums.

Another strategy for reducing health insurance costs could be to scale back the benefits that are offered or with a network that is available to try to reduce health insurance costs, so in this slide we asked the workers to rate different elements of their health insurance coverage and to rate it on the scale of excellent, very good, good, fair, or poor.

And this slide shows three different elements of health insurance that they rated. The first column is that they rate the services available under their ESI plan as very good or excellent.

The second set of bars is that they rate the choice of providers under their health insurance plan as very good or excellent and the third is they rate the quality of care under their ESI plan as very good or excellent. As you can see, if anything, that has gone up slightly over time. We see no decline in those characteristics of the health insurance available from the workers' perspective.

Finally another potential response to health insurance costs could be to shift more of the cost of obtaining care onto the workers, either by raising deductibles or co-pays or putting restrictions on the services that could be covered. So in this slide, we look at two measures of health care costs.

The first set of bars is that the worker had extensive medical bills that were not coverage by their ESI plan and the second is that the worker had a doctor who charged more than the ESI plan paid and again very stable between 2006 and 2007. We have seen no shifting of high costs onto workers.

Finally we looked at out of pocket health care costs so this is spending on health care beyond the premium for health insurance coverage over the past year and the first set of bars look at spending above \$1,000 a year and the second set looks at spending above \$3,000 a year so no evidence that workers are spending a greater share of their income out of pocket under health reform.

So at the end of one year of health reform, which is when this survey was conducted, it's clear that employers are still supporting ESI coverage in the state. We see no evidence of a drop in ESI offers, no evidence of any scaling back of the benefits that are available, and no evidence of increasing cost shifting onto the workers.

Now for the caveats of course which is as we look forward and think about health reform, it's important to keep in mind that this is impacts at the end of one year. Our follow-up survey was fall 2007 which was before the individual mandate was in place so we are not capturing the full effect of Massachusetts health reform as it is in place now. We do have

another round of surveys in the field now, so we will have more information early next year.

The second caveat is that we would expect most of the response to be among small firms and small firms tend to be slower to respond to changes in the legal and regulatory market than larger firms, and so we may just not be on the right time cycle to pick up their responses based on the survey data we have now.

ED HOWARD, J.D.: Thank you so much Sharon. Now let us turn to the other principle author of the other health affairs article you have in front of you and that is Jon Gabel who is a senior fellow in the D.C. office of the National Opinion Research Center. Many of you know Jon's work for many years as sort of the go-to guy on the HRET employer survey of the shape of employer sponsored insurance. He also has had a great deal of experience in both the federal government and the private consulting world and we are pleased to have you with us, Jon.

JON GABEL: Thank you Ed. Let me begin by thanking the Robert Wood-Johnson Foundation and the Blue Cross/Blue Shield Foundation of Massachusetts for their financial support and let me also thank the Commonwealth Fund and Anne for making this seminar possible. I would also like to thank my many coauthors on the study and with that, let's begin.

First of all you can see from the title is the conclusions, so let me move to the objective. Let me note why

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the response of employers is particularly important for this study. Number one is the fact that in America the most political, the most powerful political force is the business community. And for those of you who disagree with me, you can debate them with one another. You can get the political scientists to agree or disagree with that statement.

Number two, specific to Massachusetts, in 1988 under Governor Dukakis, the state passed a universal coverage plan. This plan included a play or pay mandate which was vehemently opposed by the employer community. The employer community was able to delay the plan and eventually with their political opposition lead to the repeal of the plan in 1996 so it never went into effect.

Let's just talk very briefly about the study methods. This is a survey of employers. We went out in the spring of 2007 and 2008, so the results in 2008 are after the mandates, after the individual mandate, after the fair share mandate. Firms are randomly chosen and our sample sizes are over 1,000 in Massachusetts and about 2,000 nationally. The questioners are very similar.

Now, let's go to the results. Here is the bottom line question. Overall, by 53- to 33-percent, Massachusetts employers agree with the statement "overall the Mass Health care reform has been good for Massachusetts." And the majority of all firms support this statement.

We asked this question, asked employers to respond to this statement, all employers bear some responsibility for providing health benefits to their workers and you can see about 77-percent of all employers agreed with that statement both years, no statistical change, and 84-percent of firms offering coverage agreed with that statement.

Then we gave this statement. All individuals bear some responsibility for buying health insurance if their income is above the poverty level. And here we see that about 82-percent agreed with this statement, no difference between 2007 and 2008.

We then gave this statement, employers with ten or fewer workers should not be exempted from the requirement of either offering health benefits or paying the fair share contribution and here we see that 55-percent in 2007 and 53-percent in 2003 agreed with that statement and a majority of firms with three to ten workers agree with this statement. In fact, further analysis shows that firms with three to ten workers that offer coverage are some of the strongest proponents of this view.

This was Exhibit 4, again saying firms with fewer than 11 workers who currently are not required to offer coverage, should they be required? You can see both years the majority of employers agree with this statement including the smallest firms with three to ten workers.

Exhibit 5, recall that in Massachusetts every firm with 11 or more workers is required to offer a Section 125 or cafeteria plan and this shows the change from 2007 to 2008. You can see overall the number goes up from 32 to 43-percent but that is misleading because most firms have three to ten workers. If we look at by firm size, there is substantial growth for every single size required and for example 54 to 72-percent for 11 to 50 workers.

Now we did an additional analysis and we found among the firms who were not offering cafeteria plans, they did not understand the requirement, 90-percent who did not understand the requirement did not offer a cafeteria plan.

Now we move to the subject of crowd out. Crowd out is the idea that if a government offers subsidies for coverage that the result will be that some employers will not offer coverage or some people will move, will choose not to buy coverage from their employer, but instead use the public plan.

Now, work by Jon Grueber has estimated that for every \$1 you put in there's a crowd out of 60-percent. Now there are researchers at the Urban Institute which disputed that crowd out figure. What did we find in Massachusetts? We found that actually from 2007 to 2008 that the percentage of employers offering coverage increased overall from 73 to 79-percent, statistically significant change.

So, I am going to talk in the end why I believe that this occurred. Now one more bit of evidence about crowd out is this, that firms in Massachusetts in responding to a question are less likely to indicate they plan to offer to drop coverage in next year than nationally.

So, let's go to the conclusions. First of all, there is continued support for health care reform in the employer community. Number two, the majority of firms support the fair share requirement, the \$295 requirement, and would, actually a majority also would expand it to firms with fewer than 11 workers and third I asked the question where is the crowd out?

And lessons learned, well first of all ask why do employers support health care reform? I think a very important factor has been that employers participated in the authorizing legislation and continue to have a seat at the table. And number two, I believe crowd out has not occurred because of the individual mandate.

I believe that employers became more cognisant and more sensitive to the fact that if they did not offer coverage, their employees would have to purchase coverage. Now I have some questions for the future, things very important that we don't know about now and only next year or the year after will we know the answer to these questions. Number one, how will employers respond when we have a sharp economic down turn which is occurring today?

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Number two, it is not until 2009 that minimum credible coverage with certain minimum requirements goes into effect, how will employers respond to minimum credible coverage? And number three, next year the connector, also called the exchange in the Obama plan, goes into effect, meaning employers can buy through the connector and how well will the connector work out? How well will their services be? And at that, I thank you.

ED HOWARD, J.D.: Thanks very much, Jon. Now we turn to the representative of the most powerful political constituency in America, the business constituency, as exemplified and personified by Jim Klocke, who is the executive vice president of the Greater Boston Chamber of Commerce. The Chamber plays an active role in the ongoing debate over the fate of the Massachusetts reform plan.

It was very active in the original consideration and it continues to look out for its members interests both as employers which of course is inherent in the nature of the organization and for the wellbeing of the health care sector which is one of the main components of both the Boston and the Massachusetts economies so we are very happy to have such a powerful person representing such a powerful constituency with a powerful story to tell. Jim?

JIM KLOCKE: With an introduction like that, I don't know where to go. Thank you, Ed and Anne, and to the Alliance and the Commonwealth Fund. I smiled when it was noted that

Anne prepared two sets of slides. In the event of an Obama or a McCain win, she's ahead of Gary Trudeau, who if you caught the story earlier this week, admitted that he only prepared one set of Doonesbury cartoons this week and he got it right and so the cartoons fit the moment.

What I thought I would do today is just cover for you five or six topics in this slide presentation and they are up on the screen ahead of you. The baseline conditions pre-reform, key elements with the Massachusetts plan, and we will go through those quickly because the previous presenters covered them very well. How it came together strategically, what are some of the recent issues that we've been dealing with in Massachusetts, and finally what suggestions would we offer for the federal effort?

In terms of baseline conditions pre-reform, we are all aware of the fact that we have been fortunate in Massachusetts that even before reform, we had both a percentage of the population with health insurance well above the national average and employer provided coverage availability while above the national average.

One of the other pre-reform conditions we had which turned out to be important in the political strategy as to how this legislation came together was our free care pool. This is a pool of money which had been used basically to pay the medical bills, mostly emergency room bills, of people who

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showed up needing treatment without health insurance. That pool had been around for a couple of decades. It had been through different permeatations.

Every so often it would run low on money and it would have to be restructured but the basic model was that the funding came from three sources, roughly in equal proportions, first from state and federal governments, second from hospital payments, they were direct hospital payments that were netted out of the money the state would give to hospitals and third insurer payments which showed up as a surcharge on employer bills. The system being what it is, number two actually wound up being carried mostly by employers as well as because hospitals would understandably pass along large majority of those payments to insurers and then to employers.

The other two political conditions on the ground in 2005 and '06 which really provided a lot of impetus to the Massachusetts bill, one was that we were up needing to get our medicaid waiver renewed and that medicaid waiver included the money that goes into that free care pool.

There had been signals from the administration that they wanted to see states move in the direction of expanding people on health insurance rather than providing more funds to provide care for people without insurance.

The second was that there was a ballot initiative coming, which health care for all and other advocacy groups had

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organized, which would have instituted I believe a 6 or an 8-percent payroll tax on all employers, your tax payment would have been reduced by the amount you were contributing to employee health care premiums as well as some other very significant structural changes to the health care system.

So, those two swords if you will hanging over all of us, the threat that we would lose our medicaid waiver and also this ballot question which would have had a big effect both on the employer community but also on the health care sector really focused everybody's attention, kept everybody at the table, and in no small part helped provide the focus and the motivation that kept everybody at it until we got a bill done.

Next, the key elements of our plan which you are all familiar with, the individual mandate, the subsidies, these last two pieces are the employer parts and the Section 125 requirement is actually as noted before a requirement to offer to make available a cafeteria plan. That requirement does not contain any requirement to contribute to premiums.

If you violate that requirement, we are going to start billing you for all the care that your uninsured employees receive if they show up at an emergency room. This provision I think has gone into effect I think in a very good way, obviously not quite completely there yet as was pointed out earlier but it is the lowest, the easiest to do, the lowest

cost requirement of employers in this package, and then finally the fair share assessment.

The fair share assessment is not an employer mandate. We actually, our attention was focused very early on. The speaker of the Massachusetts House put forward a proposal which contained that same payroll tax that was in the ballot question.

That really struck everybody as an employer mandate. There was a lot of concern and early strong opposition to that proposal from folks across the business community, ourselves included. What wound up in the legislation is this fair share assessment, which is basically a mechanism to make sure that all employers are contributing to free care.

It is defined in legislation based on the amount of free care pool usage that occurs in Massachusetts every year and if we go to the next slide you can see just a little bit of the detail. The amount is as I say calculated, pretty complicated formula that is right in the law so there is no uncertainty as to how it is calculated or what it is based upon.

The amount is capped at \$295 per worker per year. The second bullet over there overrides the first, in case the formula produces a bigger number than \$295. Everybody's expectation was that number, the calculation would decline over time as we got more people on health insurance, fewer people

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needing emergency room care without insurance and those predictions have largely been realized. We have a lot more people on insurance, free care pool usage is down and so the early returns are encouraging.

The assessments paid by firms with 11+ employees who don't make a fair and reasonable contribution, fair and reasonable was the magic legislative language which helped get an agreement done in April of 2006 and the definition was worked out subsequently in the regulatory process. The vast majority of firms are in compliance.

This assessment in the most recent 12 month period produced I think \$6 or \$7 million. It was originally projected to produce, in an earlier incarnation it was projected to produce \$45 million, the expectation off the final legislative language was \$25 but as you all know in this business estimates of the cost of legislation enacted today taking effect tomorrow are very uncertain business.

Strategically the main elements that we think really help produce the bill were threefold. First, compromise in the sense that each of the major stakeholders got some, but not all, of what we were looking for, and that includes the governor, the speaker, and the senate president.

They each put their own proposals forward, big, serious, comprehensive proposals, and if you compare what they proposed at the beginning with what the final law was, you find

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elements of each of their proposals in the final law but you also find frankly that there were some things that each of them sought in the beginning which were not realized.

We in the business community certainly made compromises and we know that folks in the advocacy community did as well. It wasn't easy for anybody but it got us a bill at the end of the day.

There was a 6-8 month process over which all this happened. There were times when it looked pretty dire, when the speaker's payroll tax early on hit a wall and it took quite awhile before some other alternative ideas came forward to get negotiations jump started but there was a guiding principle all the way through that a lot of the biggest strategic players had which was to keep everybody at the table.

I think there was a sense that if all of the people stayed at it, we could get a bill, but if any one major party or faction walked away, the thing would die of warning.

We have had some recent debates in Massachusetts about the fair share assessment. The Patrick Administration put forward a proposal a few months ago to change those regulations which defined fair and reasonable. Not that the changes would apply to fair share assessment to more companies, would bring in more money, it was offered under the guise of needing more money for health care reform.

The first version of it was frankly something which caused a lot of concern among business groups. We and others felt that the first version of it really did cross the line into heavy employer mandate territory and so we raised concerns. We worked with the administration. All the stakeholders came back together.

The hospitals got involved in this, the advocacy groups worked on it, and I think a decent compromise was worked out and I'm happy to share the details of that with you in the Q&A or in the days ahead if you would like.

Minimum credible coverage which was mentioned before, we recently concluded the debate with a good compromised outcome as to how precisely defined MCC should be. Regulatory lists of approved procedures and disallowed procedures can just become a nightmare and what people arrived at was an agreement that we should define minimum credible coverage on an actual equivalent standard.

The Commonwealth Connector has three levels of plans for individuals buying health insurance, gold, silver, and bronze, gold being the most expensive, and the agreement was that MCC would be a plan that is equivalent actuarially to a bronze level connector plan.

Finally I think our biggest challenge going forward is health insurance premium inflation. One of the reasons the Patrick Administration put their proposal forward a few months

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ago for a change to fair share and also some expanded assessments on insurers and hospitals was out of a concern that health care costs had produced an increase in individual health insurance premiums which consumer groups earlier in the year had agreed to go along with begrudgingly.

They stepped up to the plate. They saw that there was a cost increase coming and so other stakeholders needed to do the same. We face the prospect of going through that battle every year going forward and I sincerely hope we don't.

It wasn't easy over the past several months but we know health insurance premium inflation is out there so in a state where you have an individual mandate where you are requiring people under force of law with financial penalties to buy health insurance, steady, strong increases in the cost of that health insurance represent a serious challenge for the program going forward.

Last but not least, suggestions for the federal effort, if your experience is like ours, reform will evolve over time as all these proposals come forward and get picked apart. A bill we think with one to three significant reforms is preferable in all the good ways, not just because it's easier to get done to a comprehensive reform bill. You are going to learn all kinds of things as you debate these proposals and then you are going to learn a whole lot more when you implement

whatever gets passed. That has been our experience over the past few years.

Health care is such a complicated entity. There are so many variables, so many stakeholders, so many forces at work, economic, financial, political, and most importantly people's health conditions, that no one can predict fully how any one bill or reform will fully play out.

So our advice is get some significant things passed, don't try to do it all at once, don't try to rewrite the system in one fell swoop, remember that the perfect is the enemy of the good and if you keep that in mind you should be able to get a bill that will do good things and will set the stage for further progress in the years ahead. Thank you very much.

ED HOWARD, J.D.: Terrific. Thank you very much, Jim. Your turn. You have green question cards. If you would like to write a question on one and hold it up, someone on the staff will snatch it from you and bring it forward. There are three microphones that you can use to ask a question and we would encourage you to do that because I can see already that the number of cards coming forward is going to be substantial.

Let me just ask a very simplistic clarifying question and both you and Jon referred, Jim, to the Section 125 requirement. I would bet there are a lot of people who don't know what Section 125, account provision, what everyone calls

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it, plan, really is and if somebody could explain that briefly and simply it would be helpful.

JON GABEL: Section 125 allows you, allows the employer, allows the employees, to pay your premiums, your contribution for premiums on a pre-tax basis. So, suppose your contribution for single coverage is \$50 a month. That \$50 will be deducted from your income so you're not paying taxes on it.

Now more complex forms of a section 125 plan are sometimes called medical reimbursement flexible spending account. You may be allowed to set aside \$3,000 a year and not pay and use that to pay for your out-of-pocket expenses. Now that is not a requirement of Massachusetts's legislation. The Mass legislation applies only to being able to pick employees, contribute for the premiums on a pre-tax basis.

ED HOWARD, J.D.: Okay. Thank you.

JIM KLOCKE: That, I think, just points to one other very interesting significant issue at the federal level going forward. That requirement grew out of something that the Romney administration had in their original proposal. They had actually, they understood a lot of the very strong effects that the federal tax treatment of health insurance has.

This is an attempt, among other things, to try to get the ability to buy insurance with pre-tax dollars available to more people. We will be very interested in how the debate plays out here on this issue over the next few years. It's an

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accident of history, a well-intentioned accident of history that if you get your coverage through an employer, it's pre-tax dollars whereby in many states for many people if you're buying on your own, that's not the case.

That actually is also one of the biggest reasons why we think employers have stayed at the table and continued to provide coverage while the crowd-out issues hasn't been realized because the federal tax exclusion means that for many employers, for most of their employees, it is cheaper for them to pay people with health insurance than it is with cash.

Now that falls apart when you have people with no federal tax liability. At that point, the incentive to do that disappears, which is why we have an uninsurance problem unfairly so for people with low incomes. This federal tax exclusion is regressive as hell. The benefit to the employer goes up, the higher the worker's salary but in Massachusetts, the attempt to try to deal with this in the world of an individual mandate was to make these section 125 plans available through, to everyone who's employed through their employer.

ED HOWARD, J.D.: Anne?

ANNE GAUTHIER: Jim, I'd like to, as we're gathering the questions that have come up, ask another question. In Massachusetts, you have employers that are local employers; presumably the small employers but you've also got large

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national employers. Was there a difference in terms of a power or in terms of the views for passing reform and what lessons might that have when we're looking nationally?

JIM KLOCKE: Two years ago, there was, I think, a modest difference. It was a little bit of a tougher sell with smaller employers not totally surprising. It's been interesting because I think in the implementation that has been a bigger challenge for large multi-state employers really because of the minimum creditable coverage issues that were mentioned earlier, that minimum creditable coverage standard. What does your health insurance plan have to have in order for it to meet the individual mandate?

One of the big debates when those regulations were being written was whether or not that standard would include prescription drug coverage. There was a lot of back and forth mixed opinions within the employer community, strong support for that in the advocacy community and I think in the health care community. At the end of the day, it was included in the definition of minimum credible coverage.

There were some large multi-state employers who are offering plans to employees in different states, which have some very generous benefits but which don't automatically include a prescription drug benefit. For those employers, if Massachusetts begins to require this, then they have to force the decision do I add this in other states or do I have a

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situation in which my similar employees in two different states are getting two different benefit packages

That issue, I think, so far we have muddled through it. There is still a strong political support in Massachusetts for this prescription drug requirement. Someone tried, in our legislative budget debate a few months ago, to move a rider, which struck that prescription drug requirement and it went down something like 130 to 20. So that requirement is staying in place in Massachusetts.

Our sense is that for most multi-state employers, they're going to be able to manage but it's a little bit of a warning sign. Some folks would like to expand this MCC standard so that it's bigger and bigger and bigger. Let's have for getting everybody health insurance, let's give everybody the biggest and best package we can.

That's an understandable desire, runs into two problems. One, the richer you make that package, the more you may put some of your employers at a competitive disadvantage. Number two, politically in a state with an individual mandate, every time you make that mandated package richer, you're raising the cost of it for a lot of those individuals who are paying some, more a big part of the cost themselves.

ANNE GAUTHIER: Jim, your comments raise a related, about the benefits and what's in the benefit package, raise a related question. We have looked, as has Sharon, at the, that

the problem of the underinsured, those who have to pay out of pocket costs because their coverage did not cover certain benefits or had cost sharing limits that were quite high. Sharon has written in an issue brief that looks at the underinsured in Massachusetts and I thought this was a good opportunity for you to make a comment or two about those findings.

SHARON LONG: And I mean one of the issues in Massachusetts, which came up, was would people gain insurance but would it be good insurance. So we looked at underinsurance among workers in the state and how that had changed between 2006 and 2007. We actually found that the financial protection from health insurance increased in Massachusetts where it's been going down as the Commonwealth has shown in their study, going down nationally. It actually went up in Massachusetts so that there were less people who were underinsured in Massachusetts in 2007 than 2006.

I think part of it is the minimum credible coverage, which is part of what's in Commonwealth care and Commonwealth choice and I think some employers have moved to incorporate that in their packages in advance of the requirement.

So there are tradeoffs there. It reduces underinsurance. It does cost more. It's a more comprehensive package.

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JON GABEL: Let me just add, Jim, I'm sort of surprised hearing about the multi-state firms having problems with prescription drug coverage. I say that because in our Kaiser Family Foundation survey, HRET survey, maybe more than 95-percent of all employees have prescription drug coverage and those that do not are usually small firms. The one exception I can think of would be the big retailers. That might be a problem.

ED HOWARD, J.D.: Yes. I lost that thought and therefore I'm going to turn to a card addressed to either John or Sharon. Has there been any evidence of employers leaving the state since the mandate's been implemented?

JON GABEL: Our data, I couldn't answer that. Our data doesn't address that.

SHARON LONG: Yes and ours don't either. Maybe Jim?

ED HOWARD, J.D.: How's your membership?

JIM KLOCKE: Our membership is good and we don't have evidence of people leaving the state because of that. We've had a, our general kind of cost competitiveness climate has become a little worst, not a little better over the past two years. So that's a challenge for us but I think our experience from our members really mirrors what was in the survey results.

People feel as if it's the implementation has gone well, it's been a big positive and it's something that there's a lot of support for. I think going forward if we can keep the

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coalition together I think we can keep that support high. If we wanted to take a shift and to dramatically change or expand the employer requirement part of health care reform, I think you then would see some issues.

I mean we know, people say in legislative negotiation you want to push people to their maximum point of pain and then dial it back until they say yes. We hit that point early when the payroll tax was proposed.

It was very clear to us that an eight-percent payroll tax on all employers even though their tax would be reduced by the dollars they paid for coverage to their employees up to a salary of \$100,000, even though that was an offset and quote there would be no new costs for most employers who were providing coverage, we got a swift and sure negative reaction from our members and we're one of the more moderate business groups in the state.

So we've got a good balance here. We've been able to maintain it and I think going forward, I think that can be extended to at least some other states. Could you extend this exactly as it is all the way around the country? I'm not sure. I think from a political standpoint, the most interesting political question is could you impose an individual mandate at the national level? Many have tried nobly before and the policy arguments for it are pretty strong but the political hurdles it presents are also pretty high.

ANNE GAUTHIER: We have a question that came in that asked could you please analyze how costs have been controlled in the Massachusetts model and I think there might be some who would ask if costs have been controlled but this is certainly an issue and I think it would be helpful to hear about what's being talked about at this point. If you have anything from your data and survey, that would be very helpful.

JON GABEL: Well I can't really say, first of all, anything in the legislation that addresses cost control. Let me say this about the cost of health insurance in Massachusetts. Before the legislation was adopted, health insurance costs more in Massachusetts than it did in the rest of the nation.

Costs were increasing more rapidly than in the rest of the nation. Now from our data, the same relationship still holds, still holds. It does look like costs, not that there was an increase in the rate of premium increases but it still remains higher than the overall increase in the rest of the country it appears.

JIM KLOCKE: That's entirely consistent with our experience. I think it's the next frontier for us. We know that there are a lot of efforts going on in that regard including one, which has a lot of the big stakeholders that were involved in this reform bill coming together to try to find the best strategies.

There was, as was noted before, a cost and quality council in the Mass reform bill. It was set up with great intentions. It was really in legislative language not provided with any real teeth to be blunt about it. It's a mechanism for information gathering and information sharing via the web and that can be very powerful to let people know how much the cost of what they're buying is and how it compares to other providers but I think we would all agree in Massachusetts, we've taken small steps so far.

We did a cost containment bill just a couple of months ago, which included state force with some subsidy of computerized medical records around the state within the next five years but much, much more to come on this one.

SHARON LONG: And I think it's worth noting that Massachusetts made the decision to go forward and expand health insurance coverage knowing that they weren't addressing the cost issue, that it was to expand coverage first and then address costs so that that was not a surprise, that that was on the table now.

ED HOWARD, J.D.: And let me just follow up on some of the points that Jim was making about the prescription drug benefit and we have some other questions coming up here about other specific benefits that people are interested in whether or not they're included.

It goes to the question of what constitutes the minimum creditable coverage. Anyway, the question really is as much political as it is economic or health policy and that is in the Massachusetts instance, the legislature and the governor agreed to kick those questions down the road to the connector.

Congress is famous for deciding that a particular kind of treatment will be covered by Medicare or not. What kind of dynamic was there that allowed that assignment of such discretion to a non-elected board like the Connector Authority?

JIM KLOCKE: I think the dynamic was that we had to get something done to preserve our Medicaid waiver and all the leaders wanted to get something done and this being one of those insoluble issues, they having addressed a few of the other insoluble issues in the legislation said we've got to get this done. It's time to move. We'll defer to the regulatory body on that one.

I think in this case, it was a good thing. We do have legislation that does mandate health insurance coverage for a number of medical procedures as do other states. We've all had those debates. In this case, the Connector Authority is actually highly skilled and has an interesting governance structure and we think they've done a pretty good job with it.

They are a quasi-public agency created in this bill. They actually receive funding every year from the proceeds of insurance products that they help sell but they have a

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governing board, which includes three of the governor's cabinets, secretaries, and leaders of all the major stakeholders that were involved in health care reform.

Their board meetings are public, so a couple hundred people attend every board meeting of the Connector. All the issues they debate get really dissected and tossed around in public and private for weeks before they are voted upon. That has actually worked.

That prescription drug debate we mentioned before, when all the debate was going on about whether or not MCC would include a prescription drug benefit, at the end of the day, the business representative on the board, the head of the largest statewide business group did vote to include it in the spirit of compromise and unity because with his vote, there would be a unanimous vote on the Connector for the MCC standards.

The Connector has had pretty much unanimous support for every one of the final regulatory packages that they've moved over the past two years.

When it comes to defining precisely what should be in these health insurance packages, should we include a Connector requirement to meet the individual mandate, you have to have chiropractic coverage, etc. that is territory we're just starting to venture into and I think we'll continue to have those debates but for now, there does seem to be a center holding, which says let's define it as an actuarially

equivalent. Let's not go too far down the road of prescribing every detail because we may bring ourselves more pain and trouble than it's worth.

ED HOWARD, J.D.: Okay. Anne, do you want to get a-

ANNE GAUTHIER: There's a clarifying question that I think may be interesting for John in terms of his employer survey if we're looking at the results of employers while we're organizing these other questions. Someone asked who answered the employer survey. Is it the owner? Is it a top executive? Is it the human resources director and does this matter in terms of the satisfaction and some of those types of questions.

JOHN GABEL: It is the human resource director but for the small firms, that very often turns out to be the owner or sometimes the chief financial officer.

ED HOWARD, J.D.: And here's a question that actually flows from the discussion of benefits and costs. The questioner just wants to know whether or not the minimum coverage package includes dental benefits.

JIM KLOCKE: It does not at this point and that, of all the benefit issues that are still out there, I think that's one of the more significant challenging issues because there are a great many people who don't have that coverage today. As we all know, everybody needs it and it has serious health consequences if it's not addressed.

My guess is we'll have that debate over the next couple of years. The prescription drug benefit was the largest most visible debate in MCC standards last year. One of the other issues that we addressed this year with some of the revisions that were talked about was high deductible health plans. The original legislation does state that high deductible health plans will be allowed to be satisfactory of the individual mandate. The MCC Connector regulations confirmed that just a month ago but not without some debate.

ED HOWARD, J.D.: Let me just follow up for the questioner and I don't know whether one of you folks could provide national data or Massachusetts's data but is a dental benefit fairly common? How much of an extra burden is it going to be if it gets included?

JON GABEL: I wish I could remember the numbers. It might be about 60-percent. Shova [misspelled?], do you remember the number? Maybe 60, maybe I'd say between 50 and 70-percent of people with employer-sponsored health insurance have dental coverage. There's substantial numbers of Americans that do not have dental coverage.

ED HOWARD, J.D.: Yes, would you identify yourself?

LYNNE FAGNANI: Sure. Thank you. My name is Lynne Fagnani with the National Association of Public Hospitals and Health Systems and this might be a better question for another day when the panel can focus on the impact of health reform in

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Massachusetts on the safety net and the public health care infrastructure but I represent the public hospitals, Cambridge Health Alliance and Boston Medical Center.

Right now, Cambridge Health Alliance is being brought to its knees by both health reform and the state, the impact of the economic crisis on the state budget in Massachusetts. They're taking a cut of \$100 million this year on their budget, which is about 22-percent of their budget. Two out of three hospitals in their system are likely to close.

They're the largest provider of mental health inpatient psych mental health care in Massachusetts. All of that access is also threatened with closing. I'll just say that when you take safety net financing, which is another major source of financing in the Massachusetts health reform and move the dollars around, you need to be careful because the safety net relies on it. It's not just about emergency department care. There are primary care clinics in the community.

There are specialty care, outpatient services where there are no physicians in the community willing to take low-income patients and there's inpatient care and there are psych services and all kinds of services that are at-risk when you move dollars around.

So I just urge people to look at what's happening to the health care infrastructure and access to care in

Massachusetts right now because it really is dramatic and it's

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precipitous this year. I don't know if anyone up there can comment on it but it's something we're very worried about. It's certainly a lesson for health reform if people are looking to take these dollars for expanded coverage.

It's not that our organization is opposed to expanding coverage. These are the patients we serve. We've always stood for having those populations have coverage but you need to be careful when you take on dollars that we're currently getting to serve those populations and shuffle the dollars around.

ED HOWARD, J.D.: Can I just ask do you have any notion of whether patient load in your Massachusetts endangered institutions has actually; the uninsured patient load has actually declined?

LYNNE FAGNANI: Cambridge has seen an increase in residual uninsured and those are folks that won't be covered in the Massachusetts health plan but they also have other issues, the fact that half their beds are mental health beds and when the state decided to raise provider payments in the Medicaid program, they left mental health care out.

So we're getting way below cost at Cambridge for mental health care. So it's just, as I think the gentleman from the Chamber said, it's a complicated system and so you move dollars around. You can have unintended consequences that can be pretty severe.

ED HOWARD, J.D.: Jim? Sharon?

SHARON LONG: In our survey, we're looking at individuals and we can't address directly where they're getting their care. We do have questions that ask about unmet need for care and what we saw in that first year under health reform was that unmet need for care, that is people saying they were not getting health care that they needed that that dropped except for one area, which is a small part of unmet need but unmet need because they could not find a provider who would see them or could not get an appointment with a provider increased.

So it does seem that in that first year, there was more of a capacity issue. This is among the low-income populations. So it's likely to be among safety net providers. We have added some new questions for the next round of the survey to try to look in more depth at this population and look at that issue but I know it isn't an issue in the state.

Laiden Koo [misspelled?] at George Washington University has a study underway now looking at the impact of health reform and the safety net. So you might want to give him a call.

JIM KLOCKE: Just as a follow up to that, one of the things that people expected and that has happened is that the demand that primary care clinics, demand for primary care physician services has grown dramatically, as you would expect it to, and I guess that's a good thing because more people have insurance but it places pressure on the system including the

primary care area. The state tried to provide some more funding for that in that cost containment bill they did earlier this year. We have a ways more to go on it.

On the question of the provider dollars, that was also one of the big issues that at the heart of the 2006 reform. One of the things that the hospital community argued accurately and successfully was that the state had been under reimbursing hospitals for a long time for Medicaid patients. Increases in those reimbursements were part of the 2006 package.

In addition, there was a great deal of discussion and negotiation, which resulted in some payments targeted towards the safety net hospitals that have been mentioned. This past year, as the state has had a budget squeeze and as the administration tried to put together a package, which would quote provide some more dollars for some parts of health care reform, those hospital payment reimbursement increases came under some pressure.

I'm not as expert on it as the hospital folks are but there's been concern throughout the industry this year. Finally that issue is also something that gets intimately tied up with your federal waiver negotiations. We did get a waiver extension. Our waiver came up in '05.

We did the legislation in April '06. They extended us and then they gave us the rest of the waiver, which meant that in the three-year waiver, we were up again middle of this year

and we were fortunate to successfully conclude those negotiations two months ago but not without a very long, tough painful negotiation between Massachusetts and the federal government as to the federal dollars that would flow to us for health care reform, what the terms would be going forward, how much money there would be. This very issue about payment and support for safety net hospitals was at the heart of the discussions.

ED HOWARD, J.D.: I've got a couple of questions addressed to Sharon Long specifically. Do you have any sense of how sensitive your survey results are to changes in premium costs borne by employers, that is, the percent increases that are potentially reducing coverage levels and premium support? Were you able to examine the results for employer groups of fewer than ten employees?

SHARON LONG: Two good questions. With respect to the first one, since we're interviewing individuals, they're unlikely to know what the full cost of the SI coverage is, that the full premium is. So we've only asked them about their share of the premium. So that's all we can report on.

So if employers are passing on an equal share, their premium share will go up but we can't tell what the component is. Then on the firm size issue, where John's interviewing employers and most employers are small firms, we're interviewing workers and most workers are in large firms. So we

don't have the sample size to look at the less than 11 firm size.

ED HOWARD, J.D.: Okay.

ANNE GAUTHIER: There's a question that came in that is technical aspect of a reform but it very much relates to the size of the employer and someone asked are ERISA plans under the same fair share requirements here and are the multi-state employers that were discussed earlier, both of those are ERISA plans and how did they fair and how does that play into the whole financing?

JIM KLOCKE: The answer is yes to both and this is another very big significant issue. We just dealt with it over the past few months. One of the questions, concerns people had as our thing was being negotiated three years ago was making it ERISA-compliant. A lot of time and billable legal hours were spent working on that issue.

It was an issue that was dealt with by the speaker and the Senate President with an ERISA attorney on the phone in the very final stages of hammering out the bill and people have been pretty confident that the bill we did in '06 was ERISA-compliant.

The issue bubbled up again a few months ago when the administration proposed those changes we mentioned earlier to the fair share regulations. The first version of their changes

did contain some things, which we and a lot of others thought were violative of ERISA.

Know there's a debate going on nationally. There is a circuit court decision pointing one way on one coast and a circuit court decision pointing the other way on the other coast but the people who we consulted, the attorneys we consulted back in '06 shared the view we had that this new proposal would really constitute an ERISA violation by really putting the state in the position of dictating health plan benefit requirements to all employers.

So for that reason, one of the major health care stakeholders in Massachusetts, Partners Health Care, which is the parent company of the combination of the Mass General Hospital and Brigham and Women's who had been a big supporter of health care reform all the way through, they joined us two months ago in testifying that these proposed fair share changes were probably or, at least, too close to comfort, likely to cause an ERISA violation, therefore raise the specter of the fair share part or maybe broader parts of the bill being thrown out if someone took it all the way up the federal court chain.

I think the administration made a modification to their proposal, which addressed, significantly addressed that concern. I don't think it's gone. I think our ERISA risk is 10-15-percent higher today than it was a few months ago but we're

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not in the position of danger that we were faced with back at the beginning of the summer.

ANNE GAUTHIER: Jim, is the concern being ERISA compliant or is the concern the requirement that employers are going to have to pay?

JIM KLOCKE: It's both. I mean we, as an organization, we are one of four business groups that took part from the start in the negotiations that produced the bill and we've been very involved in trying to help make it work over the past few years. So for us and for the other major groups, both concerns are there.

I think people will stand up and say well you're just concerned about protecting your members. We have to keep that in mind. That's part of our job but we want this to succeed. This has been a really productive law. This was something that was not easy to do but which breaks some new ground and the fact that it's had stable success over the past couple of years only increases our desire and the desire that I think a lot of the stakeholders have in Massachusetts to find ways to keep making it work.

ED HOWARD, J.D.: This actually might be antithetical to that expression of sentiment but we've had several questions that have come in inquiring about why the architects of the plan elected to preserve a public/private partnership, if you will, as opposed to presumably either doing nothing or going to

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an all public system. Was it to, as the speculation on the card goes, preserve the employer money that was in the system or to achieve broad political support or were there other factors as well?

JIM KLOCKE: That's a good question. There are a number of folks in Massachusetts who support and would think we would be best off with a single payer system. There have been efforts before legislatively to try to advance it but they've never gotten sufficient traction to get a bill passed.

I think the three political principles in '06, the Governor, Speaker, and the Senate President, none of them had support for a single payer approach. So when they sat down and said we want to do something on health care reform, they started thinking about various options, which led to the bill we got at the end of the day.

It was interesting to us that Governor Romney, Republican and a very vocal conservative Republican was the first one to propose the individual mandate. You can argue that that is, in one sense, expression of a Libertarian philosophy that says people have responsibility to take care of themselves. You could also argue on the other end that it's a pretty heavy government requirement imposed on individual citizens. We were surprised he proposed it.

Most of us are in the middle of political spectrum.

There are a lot of us moderate Democrats who work for business

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groups up in Boston but we would not have expected Governor Romney to propose an individual mandate.

I think once he did that, that really set the table for a lot of the debate that followed. The speaker's proposal had what really looked in for all practical purposes, was an employer mandate with the payroll tax. The Senate President had a proposal, which among other things included a much more punitive version of that payer emergency room bill penalty that now applies to the section 125 requirement.

So none of those three principles came to the table as single payer champions and I think for that reason, we'll probably, my guess is we won't step into single payer country in Massachusetts, at least for a while, and not directly. One could argue, of course, that as government-provided coverage expands for more and more people, you'll get there some day.

We do have Medicaid expansions in this bill. We expanded Medicaid for people with low incomes and we actually provide free coverage for children up to now 300-percent of poverty, which was another issue the feds wanted to talk to us about in the waiver negotiations this summer but it turned out okay.

ED HOWARD, J.D.: And isn't it true that Governor Romney then former Governor Romney supported the extension of the waiver this year?

JIM KLOCKE: Yes, yes and he, I mean I think he and Senator Kennedy and Secretary Leavitt were all right in the middle of those negotiations obviously a few years ago. This year Governor Patrick and his team had the responsibility to get it done and they did an outstanding job. We know Senator Kennedy has always been a champion, has always worked it. Secretary Leavitt has been there from the start.

So we knew there would be some kind of waiver this year. The question really was, was it going to be in terms of dollars and terms pretty much the same as the one we got before or were there going to be some areas where the federal government said to us scale back significantly, make significant changes. At the end of the day, we didn't get to those places fortunately.

SHARON LONG: And an additional point on the single payer versus the mixed public/private system, the advocates for single payer were pretty strongly for this reform were they not?

JIM KLOCKE: I think most of them were, yes. They stayed involved. There was an effort, I'm trying to remember, whether it was five or ten years ago, there was an effort in Massachusetts to really get single payer put on the ballot and passed into law. That ballot initiative did not go forward.

I think frankly, the momentum for what became our health reform was one of, I say this for good reasons, it was

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one of the reasons that it did not. There was a health reform train moving. It had support. There was clearly some significant things going on and so there was a prospect for real progress there and we avoided a ballot fight.

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

CAITLIN MCCULKIN: Hi there. I'm Caitlyn McCulkin with NACHC, the National Association of Community health Centers. I think a couple of the panelists, a couple questions ago, answered a question and touched on the provider shortage issues that have been emerging as the implementation of health care reform has been moving forward in Massachusetts and we've heard both through press but also anecdotally from our members about that growing problem.

There's been kind of a patchwork solution that's been underway in Massachusetts by public/private partnerships with the Bank of America program and also the recent primary care component and the Senate President's legislation that the Governor set into law but what we were wondering is how does Massachusetts' experience with primary care provider shortages inform the national discussion?

ED HOWARD, J.D.: [Laughter] a question, by the way that has been echoed on several cards that have come forward—

CAITLIN MCCULKIN: One might have been from me so you could disregard that [laughter].

ANNE GAUTHIER: I don't know that anybody up here has the data or has the answer but one thing that seems to be clear in Massachusetts as well as in other states is that there is a maldistribution, for sure, of providers so that I think it would be difficult to say in the Boston area that there was a shortage of providers.

So I think getting a better handle on distribution and number and the organization of the systems that are providing care is going to be very important but I don't know that we have the answer for that at this point.

SHARON LONG: And I don't have any more information than that either but I would say in any state when you think about implementing health reform, it's always going to be building on what's in place in that state in terms of the private employer-sponsored coverage, the Medicaid program that's there, the health care safety net that's there. So all of those things will be part of the story of how transferable is health reform.

CAITLIN MCCULKIN: Absolutely. I mean what we have found anecdotally but we hope to have more data on this moving forward is that Massachusetts and Boston in particular may have had a higher proportion of providers to people seeking care than the average but the wait times have still grown and I think you had alluded to the wait for access to primary care appointments. So we're just going to be looking, moving forward, how that transfers to a national discussion.

SHARON LONG: And I think some of that early experience under Massachusetts is that we can't separate what's, this is a new population that's never had health insurance before that's just now learning to approach the system versus there aren't enough providers. So there's always that period of adjustment. I think there still is some of that going on in Massachusetts as well.

ED HOWARD, J.D.: Go ahead.

JON GABEL: Well I would just say I think Massachusetts is a wonderful natural experiment, which validates a lot of the research, which has been done over many years. Not always did it come out as we thought but let me just note. It turned out there were more uninsured than surveys indicated and when people talk about the high cost of the program, it's because there were more uninsured than originally estimated.

We've said in research that people who are uninsured use about one-half as much services as people who are insured. Sure enough, we gave health insurance to a number of people and all of a sudden, they're going to primary care doctors and then we said there's a shortage of primary care doctors in this country. Now we observe it. So in a sense, this is just a reinforcement of research, which has gone on for many years.

JIM KLOCKE: Two footnotes, one on the provider question. My recollection is that we do have a great surplus of doctors relative to the national average but I think a lot of

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that is due to the folks in specialties, which doesn't help you on the primary care side.

Second on the question of increased enrollment, that was another one of the factors, which we were all focused on earlier this year. The states subsidized health insurance for individuals is called Commonwealth Choice. Our individual mandate has been on the books for a year and a half but the penalties for noncompliance only kicked in on January 1st.

So if you're a person, income up to 300-percent of poverty, you're going to be enrolling in Commonwealth Choice if you're trying to get health insurance.

All thorough last fall, enrollment in Commonwealth Choice went up at a very rapid clip, not surprising. The deadline's coming.

Folks thought, at the beginning of this year, that that trend was going to continue and frankly, if it did, we're going to have a big cost problem because the legislative appropriation for Commonwealth Choice was large but it wasn't large enough to contemplate a skyrocketing enrollment that kept climbing all the way through 2009.

What happened was that it climbed October, November, December, January and then February, it got to about 175,000 and it's basically been stable at that level ever since. So this funding problem we thought we might have whereby the enrollment keeps going up and the legislature needs to throw

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another several hundred million dollars at a time of a budget problem, didn't materialize.

Our own view is that we simply saw the result of the individual mandate penalties kicking in. Last fall, there was a lot of advertising and publicity. The penalty, those things have a way of getting people's attention and concentrating their minds.

So a lot of folks did say okay, now I need to sign up. I don't want to hit that penalty. January 1st, the penalties began and the way the penalty works is that it goes up every month that you are uninsured. So if you got insurance in April, you'll pay a small penalty but if you get it tomorrow, you'll pay a bigger.

The maximum penalty anyone will have to pay for 2008 is \$912. The penalties are scaled to income among other things. So you won't have that \$912 falling on people at the moderate end of the income scale but the fact that those penalties have kicked in and frankly that we have not had any significant political backlash against the individual mandate, I think, is very big news.

A lot of us had wondered when this was being debated, whether or not politically an individual mandate could survive once real penalties took effect. Our experience has been that it has survived. The penalties are set by the Connector board.

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They're very smart people. They also, they realize frankly that this whole effort is a fragile balance.

So I don't think we're going to be moving into the territory of immense penalties any time soon. I hope we never get there but thus far, we've been able to implement an individual mandate with some penalties and it has resulted really in a Commonwealth Choice enrollment, which as I say, climb, climb, climb and then once the penalties were in effect, stabilized.

ED HOWARD, J.D.: Okay. I think we have come to the end of this discussion. It is not the end of the controversy or of perhaps the lessons we might be able to learn from the continuing experience in the Commonwealth of Massachusetts.

Let me just take the opportunity to thank both the Commonwealth Fund for its support and participation in this enterprise this afternoon and the entities that helped support the analysis that we heard this afternoon, the Robert Wood Johnson Foundation and the Blue Cross/Blue Shields Massachusetts Foundation.

While I'm running on here, you should be doing as this young lady in the first row is doing is pulling out your blue evaluation forms and filling them out if you would so that we can make these briefings better for you.

Let me ask you to join me in thanking our panel for a very illuminating discussion [applause].

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