# State Health Initiatives: What's Next?
# Alliance for Health Reform
# and Robert Wood Johnson Foundation
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**ED HOWARD, J.D.:** Hi, my name is Ed Howard. I'm with the Alliance for Health Reform and on behalf of Senator J. Rockefeller, our Chairman, Senator Susan Collins, our Co-Chair, and other members of our Board of Directors, welcome to this briefing on state initiatives in health care coverage. Our partner today in this program is the Robert Wood Johnson Foundation, which has a very long standing interest in this subject and you'll hear from Pam Dickson from the Foundation in a moment.

We're going to look today at an issue that's really central to the mission of the Alliance anyway and that is seeing that every American has affordable, quality healthcare. We're going to look at where the most serious action and debate on the issue is occurring that is to say, in America's states. Now in some states there are programs to reduce the number of uninsured that have been enacted into law and are being implemented. In others, the legislatures and the governors are considering them this very day. And while Congress and the President have spent much of the last few months focusing almost exclusively on Iraq and foreign policy issues, more states than you can count have really been proving [inaudible] in the context of health care as they prepare to act as the laboratories of democracy that he talked about.

As I mentioned the Robert Wood Johnson Foundation, which is also by the way the force behind Cover The Uninsured Week that many of you covered as a matter of fact, is co-sponsoring today's briefing. The Foundation focuses a lot of its energy in the area of coverage improvement at the state level. And representing the Foundation today and sharing moderating duties with me is the Deputy Director of the health group at the Foundation, Pam Dickson, whose many accomplishments are detailed in the biographical sketching materials. I will mention however that she has served at very high level positions in state government, so she knows something of which we speak. Pam, would you like to say some words?

**PAM DICKSON:** Thank you. Good afternoon everyone and thank you Ed, for the kind introduction. I'm delighted to be able to be here today and co-sponsor this briefing, especially since addressing American's lack of access to stable and affordable coverage has been an essential concern for the Foundation since our beginning 35 years ago. One of our key strategies at RWJ to accomplish coverage is to encourage and support expansion of health care coverage at the state level. Doing it is important for two critical reasons. First, the energy and passion that states are investing in coverage send a strong message to Washington about the absolute priority of

this issue across the country. Second, change at the federal level is often based on models that have been shown to work at the state level.

We believe that this is a national problem that requires a national solution. For example, many of the state plans you will hear about today will absolutely rely on a strong re-authorization of the SCHIP program to succeed. We hope that coverage proposals and policies being developed at the state level will lead to constructive discussion and debate so that workable federal solutions can be found. I will mention briefly four of our current initiatives that are aimed at state coverage. First, our flagship program State Coverage Initiatives represents a comprehensive resource center for any state who's considering a variety of different options to expand coverage and Enrique will tell you a little bit more about this program, so I will move on.

We are also supporting the National Academy for State Health Policy to help states understand the Deficit Reduction Act and take advantage of opportunities to expand coverage under it. On June 15th we will be announcing significant new program support the consumer role in advocacy for state coverage. And finally, we are funding the University of Minnesota to evaluate state reform efforts. And this will provide evidence to state policymakers about what really works.

Over the past 10 years we have supported the Covering Kids and Families Program, which has been the nation's largest single effort to enroll children in SCHIP and Medicaid.

Although this program has recently ended, for State and local coalitions working towards this effort are still ongoing with their work and we are very pleased to support them and partner with them in many efforts. One of those efforts is to support the re-authorization of SCHIP. Thanks to SCHIP millions of children have been able to get the care they need when they need, but 9 million more children are still living without health coverage. This year, Congress has the opportunity to cover these kids by reauthorizing and expanding SCHIP.

I'm going to end by putting in a plug for the annual back-to-school campaign, which kicks off on August 15th. The campaign takes place in August and September to get out the word to parents across the country that low-cost or free health care coverage may be available for their uninsured children. This year, the campaign will also demonstrate broad support for SCHIP reauthorization and expansion at the same time that they support these coalitions, which will conduct thousands of enrollment activities during back-to-school week. I encourage you to visit the website www.covertheuninsured.org for the latest information on SCHIP reauthorization, our coverage

efforts and the back-to-school campaign. Again, that's www.covertheuninsured.org. And now my cue. I'm eager to hear from our experts.

**ED HOWARD, J.D.:** Thank you very much, Pam. A couple of quick logistical notes. You have materials in front of you that include, among other things, biographical material more extensive than I'm going to have a chance to give to our speakers and a source last that mentions from all of the programs that Pam mentioned and some others, and there are also some websites, and believe we have www.covertheuninsured.org in there somewhere. So you can take a look at that. There will be a transcript available at this event within about three days that may be of help to you and firming up those quotes.

If you happened to be watching right now on C-Span, you can go to our website, www.allhealth.org. You'll see state coverage initiatives in a box and you can click on the words, read more and all the materials that are in the kits, the reporters have it in front of us, will be available to you to read along or to look at as we go through the discussion. So we had a distinguished lineup of speakers today. Both people actually involved in state coverage expansion efforts, and some high-powered analysts that are dealing with multiple states. And we've asked them to be very brief today said that the bulk

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of the time can be reserved for questions from you folks who have so many questions.

We're going to start off with Enrique Martinez-Vidal, it is the acting director of a project known as State Coverage Initiatives, that's funded, as Pam mentioned, by the Roberts Wood Johnson Foundation housed at Academy Health here in Washington. SCI helps states to plan and carry out health insurance expansions and improve the availability and affordability of health coverage. If you didn't get a copy of SCI's state of the states on the way and, you ought to pick one up. It's a valuable resource in tracking state coverage actions, and I should mention also that Enrique's had some pretty first-hand experience in state health policy and Maryland before he came to SCI. So thanks for being with us this afternoon Enrique and we look forward to hearing from you.

**ENRIQUE MARTINEZ-VIDAL:** Let me first start by thanking Ed and Pam for inviting me to participate in this forum and talk about this really important issue. I guess I don't need to tell you about state coverage initiatives, because Ed just did. But we really are out in the front lines, trying to provide technical assistance to these states working on this issue. And we do a lot of meetings; we have websites, publications, and all that Ed mentioned.

We're working with creating a community of people that are working on this issue and try to network people together so that they are not out there reinventing the same wheel over in their individual state silos. So really in my mind there's two stories that are occurring simultaneously and their related, but they're different. One is that, and Pam, I guess it was Ed that mentioned earlier, there are some states that are in the process of implementing their comprehensive reforms, just a handful. And the second story is that states are continuing to work towards enactment of these reforms in their states.

So let me talk about the first story first. The implementation story and really it's basically three states at this point, Maine, Massachusetts and Vermont. Let me briefly talk about a couple successes and some challenges that they've had. There was a line of media coverage about working towards enactment, getting the bills passed, but now really comes the hard part. This is how to make it work on the ground. A lot of these bills were very general and what they required the agencies to do, the state to do, and now the agency folks have to really figure out how to make this work. And there are many unique challenges during the implementation phase.

So let me turn to Maine first, that was enacted in 2003. They were really the first state to take this on. They took on access and quality, cost containment at the same time.

There have been successes and cost containment. They did have some cost savings that they were able to identify. They've been doing some excellent quality work. They created the Maine Quality Forum. That's been doing a lot of work up there and they created a subsidized product with sliding scale premiums for low income people and they expanded their public programs as well. The public program aspects has been very successful, but the challenge for Maine has really been the sustainability of their program, both in terms of a funding source, and also in the political support that they garnered when they enacted it and it's been difficult to sustain.

So in terms of funding source, the original was the savings offset payment, we won't get into the details of that. But it was very difficult to work through how to really recapture the savings to the system and there are new governor recommendations on how to create a different funding source. And there was political opposition, originally, and it wasn't enough to derail the efforts, but it continues. They are criticizing the size of the program, and basically the response to that in my mind is its really hard, it's really hard to implement these programs, it's hard to go first. They're learning on the grounds. Like I said, the public program was very successful, but it's hard to make this happen in a voluntary system.

Massachusetts. You've probably read a lot about that. They have the connector and individual mandate employer requirements market reforms. A pretty broad reach across access issues. The challenge is basically the whole implementation of their commonwealth care program. Again, it was very vague and their bill; and they have to make this work on the ground. They have been very successful and transferring their uncompensated care people, sort of their safety net people and to this coverage program and now they're really facing challenges on the affordability of the product. The affordability of the product is linked not only to premiums and out-of-pocket costs, but how to balance that with the comprehensiveness of the product and also that the actual individual mandate is linked to the product being affordable. So it's really important for them to come up with an affordable products.

Another challenge, they have is the individual mandate itself. They need to do outreach and education to let people know that this is really on the books. And then there are sort of the enforcement problems. When you going to do if people don't sign up? That goes into effect July 1st so we really haven't seen how that's going to be handled.

In Vermont they did a program, premium assistance for low income people. Also, Cadamont Care which is a new

subsidized product. They have employer requirements. And then they did something very interesting which is to really focus on what some of the underlying cost drivers are to the health care system. And they implemented the Vermont blueprint for health. It had been a pilot project. They're now going statewide with that and it's really to focus on chronic care and chronic conditions.

The challenges there again, it's sort of similar to Massachusetts's affordability and comprehensiveness of the product. And how they can work with federal government is actually a challenge for them. ERISA issues getting a waiver to subsidize this. Washington State recently enacted a program, a comprehensive program, two weeks ago. That's the probably the next state that's going to be working on implementation.

The second story is that comprehensive reforms continue to be proposed. California. We're going to hear from Illinois. We're going to hear from Pennsylvania. Probably the next states in line may be Colorado, Oregon, and New Jersey. It's not clear yet how far and how fast they'll go. Many of these, if not most, are trying to address excess cost and quality improvement simultaneously. The open questions are will they pass and will they work? We could talk about the details at question and answer if you are interested in those.

I should mention that there are other state reforms, what we call sort of incremental or are maybe incremental with the vision trying to create the building blocks. Those states that can't go to the comprehensive level, but they're looking toward that and doing smaller reforms to create those building blocks. I guess a couple lessons that we've seen is that most states that have been successful have built on previous efforts and previous financing mechanisms. We saw that in Massachusetts and Vermont. Some of the needed ingredients that we see are leadership, the opportunity, readiness to act and some funding sources. Implementation takes a long time to make it work to initiate. And as I mentioned, the states are addressing access along with systems improvement and cost containment. There's a concern about long term sustainability of programs and also improved population health.

So in conclusion, I guess one question is why are states doing this? The answer is the issue is not going away. The uninsured numbers are up, employer sponsored insurance is going down. There are better state economic outlooks so states seem to be able to do this and there doesn't seem to be a federal solution, at least in the near term. States are very hopeful; they're looking towards the other states for lessons on success, especially in terms of implementation. There's lots of interest out there. Robert Wood Johnson's support for

states doing substantial and comprehensive reforms. We have a new program we're offering called The Coverage Institute. States are still in the process of applying for that, but we've had at least 20 states that are interested in this and we'll be working over the next year or two to work with states on a big initiative.

I should offer one cautionary note and I think it's probably unrealistic to think that all states have the equal ability to carry out these far reaching, comprehensive reforms without federal assistance. There's just too much state variation and that's a barrier. They have different tax bases, different funding resources, and different numbers of the uninsured. And I think that what we will see is that the state reforms are likely to inform the national debate on health care with the presidential race coming up. Thank you.

**ED HOWARD, J.D.:** Thanks very much, Enrique. Next we're going to hear from Joy Johnson Wilson, the Federal Affairs Council and Health Policy Director at the National Conference of State Legislatures. Joy's been with NCSL since 1978, although I should note she took a year off in 1989 to serve on the professional staff of the Pepper Commission where I was the counsel. She served with distinction with the commission, she's been a real pillar of strength for NCSL's

Washington presence, both before and after and a great joy to have on our panel.

**JOY JOHNSON WILSON:** Thank you. It's a pleasure to be here and I have to say that probably this is the most excited I've been in a really long time because the legislators out across the country, coast to coast, and all in between are just energized about health care. And we've had our challenges over the last few years and I think that certainly Massachusetts, but even the Vermont and Maine experience, have really energized other states to start moving forward undaunted by the challenges that still face us. And I think that it's important to note that even though single payer is still out there and has been out there, I must say throughout, that most of what states are looking are at builds on the Medicaid SCHIP employer based coverage model. And the focus now is how to sure that up and fill in the gaps that exist in our patchwork system.

And so, that part of the challenge is to stabilize the federal piece of Medicaid and SCHIP so that at least that part of the foundation is solid. The challenge of course for every state is how do you keep the employers participating in the system? But I think states are pushing the employer both large and small sector and saying you've got to be a player and we're willing to push really hard, we're willing to press buttons and do things that have not been done for a while. So you hear

about an employer mandate. You hear about an individual mandate. You hear about everybody must be in. And then the question is how do you make that happen? And that drives other questions.

If everybody's going to be in there has to be an affordable product or there have to be subsidies or there have to be subsidies and an affordable product. And if the product is going to be supported by public dollars the product has to be one that you're willing to stake your claim on and that gets hard. And that is a real challenge to find out what is comprehensive coverage? What is okay coverage that maybe isn't quite comprehensive but it's affordable? Those are all policy questions that legislators are now having to deal with. The other thing is who's not in now? And there's been quite a bit of focus across the states on who's not in. Children are not in. Try as we might with Medicaid and SCHIP, we still have lots of children who not in. So that's been a focus and this year a lot of states are looking at expansions in Medicaid and SCHIP to try and capture that group.

A group that hasn't been much discussed and that conventional wisdom said insurers would not be interested in covering what we call older dependents. Nineteen to twenty-four year olds to thirty year olds, who may be in school, may not be in school, who might still be covered on their parent's

insurance. Conventional wisdom was that insurers had no interest in expanding, in allowing people to keep their older children on their insurance. We have found though that states are successfully passing laws that say people can do this and the insurers are covering them. Anywhere from age 19 up to age 30. So that's something that's kind of been happening under the radar. An important gap category because there are a lot of 19 to 25 year olds that work for companies that don't offer insurance. So I think that's important.

Who else is not in? People with chronic illnesses. So there's an increased interest now in high risk pools and how do you make that affordable? Because the group of people who are becoming medically uninsurable is growing as insurance companies underwrite things like asthma and diabetes, which didn't used to be and medically uninsurable event. Small employers, part-time workers and self employed people. And this is where the Massachusetts connector program got people really excited because for the first time there seemed to be a mechanism to take someone who has three part-time jobs, they have income but no access to insurance and this allows them to pool that money from the three jobs, go to the connector and make it happen. And the small employers that they work for don't have to do anything other than set up the flow to get the money from them to the connector.

So it addresses one of the things that small businesses said, we don't have staff to run the health insurance program. We just can't do that. So this allows a small employer to do that and allows that worker to get coverage. So there's a lot of excitement about the connector or some iteration of that. And then finally on product. States are looking at all different kinds of products. Catastrophic health insurance with a prevention piece. Wellness, disease management, all kinds of incentives to get people to purchase insurance and to get the prevention things that they are covered actually participate in those things. So I think there's a lot of excitement, a lot of things to watch, a lot of mixing and matching of different things that have not been put together before and I think it's very exciting and I'm happy to take questions at the end and talk more about that.

**ED HOWARD, J.D.:** Thank you very much, Joy. Excuse me. One of the most far reaching but less noticed expansions being seriously discussed is the Illinois covered plan that was put forward by Governor Blagojevich. Krista Donahue is Chief of Policy for Illinois' Department of Health Care and Family Services and many of you may recognize her from her days in Washington, most recently as a health care and social security advisor to Senator Dick Durbin of Illinois, the number two democratic leader in the Senate.

We had Krista on the agenda. We lost her to the imminent deliberations in the legislature and then we reclaimed her this morning. So it's a special pleasure to have you participate. Thanks for being here.

**KRISTA DONAHUE:** Does that introduction count in my few minutes? I see his stopwatch, so and he's a very diligent timekeeper. So I'm going to talk fast and give you a general overview of the plan and I can give you more details in the question and answer period if you're interested.

Governor Blagojevich is very, very dedicated to health care. Since he took office, 560,000 additional Illinoisans have health insurance through state programs in Illinois. And we've been able to do that and at the same time limit Medicaid spending growth to just 1.4%. That was in FY 06. We have instituted cost saving measures in the program and expanded coverage at the same time and again have limited our spending growth without reducing provider rates or cutting eligibility. So Illinois Covered is actually a natural extension of what we've already been doing in Illinois to get affordable coverage to more people.

Like other states, we built on existing programs and existing systems and we have a sort of a diverse plan that recognizes that the uninsured are not a monolithic group of people. They are very different demographically. We benefited

from looking at other states and we also benefited from actually a bill that Senator Barack Obama passed in the Illinois legislature before he became the United States Senator. It was called the Health Care to Justice Act and it has set up an 18 month task force to make recommendations to the Illinois general assembly and the governor on how to cover all Illinoisans. And so, they presented their findings in January and the governor introduced the plan to the general assembly in March.

So let me just run through it quickly. Again, it is a diverse plan. There are 302,000 in Illinois below the poverty level who do not have access to Medicaid. They're single adults or adults who have children over the age of 18. We provide basically a Medicaid-like product to that group of people. The only difference it's funded with state money and it doesn't include long term care, but it's a comprehensive benefit package to people under 100% of poverty.

The next group is there are about 183,000 parents in Illinois whose children have health insurance through all kids, but the parents themselves don't have coverage. And as many of you probably know, it is more likely that a child has health care and goes to the doctor if the parents also have health insurance. So it's good for both the parents and for the children to stay healthy. So we do have family care expansion

up to 400% of poverty. Currently, in Illinois we have family care up to 185% of poverty. We also have an expansion of dependent coverage. There are about 500,000 in Illinois between the ages of 19 and 30 who do not have health insurance. And as Joy mentioned earlier, a lot of those folks could conceivably have access to their parent's insurance if it was allowed. And many parents obviously encourage their children to get health insurance, but when you're that age often you don't feel that you need it and may not want to pay for it, but the parents are often on the hook if something does happen.

So we're giving parents the option of keeping their kids – I say kids broadly because people up to 30 on their health insurance plan and we believe that there will be a significant take up there. In fact, legislators are already getting calls about that particular aspect of the plan. For people who are in the individual market or in the small group market who are struggling to keep up with premium increases or who can't get into the market because of pre-existing conditions or the cost prohibition of being in a small group, we created a product called Illinois Covered Choice. And it's a privately administered product. Insurers who operate in Illinois are required to offer a choice product. The state will offer a stop loss or a reinsurance subsidy on this

product. So right now we've modeled it at 40,000 and above. The state would pick up 80% of the cost.

**ED HOWARD, J.D.:** Forty thousand family –

**KRISTA DONAHUE:** In claims. No, I'm sorry, 40,000 in claims. Anything over 40,000 in claims, the state will pick up 80% of the cost. This reinsurance mechanism obviously lowers the risk for the insurer, but also lowers the premium for the end user for the consumer. So we think it will actually make it much cheaper for a small employer or a self employed person or an individual to buy this product. At the same time we are requiring insurers to participate in this program. So we do provide them some stopwatch protection.

The benefit package is determined by the Department of Health Care and Family Services, but the insurers themselves decide on the premium and the premium is reviewed by the Department of Insurance. Just to be clear, we don't make any changes to the current insurance market in Illinois. We have a robust private insurance market and we don't make any changes to that, we just simply require that insurers that are offering a product in Illinois also offer a choice product. The choice product will be a guaranteed product and insurers will be prohibited from rating on health status in that product. So small employers we think will see less of a variation in their premiums according to the health status of their workers. As

many of you probably heard stories of small business of 15 people, one person has a child who needs to go to the neonatal unit and the next year everybody's premiums go up 30%.

So that will provide some more predictability. And I can talk about more details if you're interested in that product at the Q&A. We also have a program called Illinois Covered Rebate, which is recognition of the fact that we need, as Enrique was talking about, the products to be affordable. And so we have premium assistance for families who are under 400% of poverty, which is $80,000 for a family of four. And the premium assistance is on a sliding scale. So if you're up to 250% of poverty you're not going to pay anymore than 3% of your annual family income on premiums and if you're up between 250 and 400 you're not going to pay any more than 5%. And again, that's to make it affordable for everyone and I can again give you more details.

I've just gotten the one-minute sign, so I'm going to leave you with the system reforms that we have in our bill and that is obviously going to benefit all Illinoisans. And we looked very closely at what Vermont did, which is they set up basically a statewide strategic plan for chronic care management. As we all have seen the studies, helping people with chronic disease better manage their disease, helping their doctors communicate does have an impact on health care costs.

And so we make some investments in electronic medical records to again, doctors should better communicate with each other and see what's going on with the patient and reduce medical errors. We set up a system whereby there can be best practices information disseminated around the state.

We have some consideration of more of a pay for performance type system. We have a task force in the bill that will come up with recommendations for the General Assembly on how to pay doctors for performance. And then we want to integrate all the disease management programs that are going on right now around the state. We have a program in Medicaid. We have a program in the state employees plan and most of our private insurers in Illinois have disease management programs going on right now. So we want to take the best of those programs and create a statewide strategic plan and I'll stop there.

**ED HOWARD, J.D.:** Great. Thank you very much, Krista. Donna Cooper's our last speaker. She's the Secretary of the Governor's, Office of Policy and Planning in Pennsylvania. And whether it's health care or education, transportation or some other proposal, Donna Cooper's in charge of looking at all of the fiscal and legislative and substantive impacts of those proposals. She previously served as a deputy mayor for policy and planning and the administration of Philadelphia mayor then

and now Governor Ed Rendell. So she knows what's going on and she has a good handle on all of the aspects of all of these proposals. Donna, thank you so much for being with us today.

**DONNA COOPER:** It's my pleasure. And to expedite the discussion, I will say that 90% of what Krista just explained is also the Pennsylvania plan. But it's interesting where there are differences and I think it's an issue really in sort of what's next and what's this debate really happening. Where do you subsidize to in state legislators? Pennsylvania seems to have less of a tolerance for going up to 400% than Illinois. So we're a state where $60,000 is considered rich enough to pay your own way.

Another interesting difference between our states is Illinois took a stop loss ratio approach to funding their health care package, whereas Pennsylvania, Massachusetts have tried to use their funds to underwrite the cost of the basic premium with intention or hope that better chronic disease management and pay for performance systems and decreasing hospital acquired infections will drive down the overall cost in the system. And again, I think they are – as we talk with our legislators and debate the Pennsylvania health care package, the question of why did we not take a stop loss approach, why did we go to 300% of poverty? Those sorts of small questions about where is the middle class? Where should

the burden of cost be born? Can we really drive down costs overall in the system?

They're the kinds of conversations that our state legislators are having. Very quickly, the Pennsylvania plan does have very strong expectations on the health care system around chronic disease management, pay for performance and the decreasing of hospital acquired infections. And decreasing of emergency room use in Pennsylvania, where high end emergency room users [inaudible] has a lack of access to weekend, evening, urgent care centers and rural access to medical care in general. So what's on our plate perhaps also in Illinois and other states, but we are a state where lots of members in the medical profession cannot practice to the full extent of their training, nurse practitioners, advanced clinical nurses, physician assistants.

One of our strategies for increasing access is really trying to make sure that those professionals can practice to the full extent of their training. So now we're having another debate, doctors versus nurse practitioners and what does that mean? And who knows more and who knows enough? The other part of our package is perhaps Illinois and I think their approach is very smart in not affecting the private market insurance place. Our package is also offered through the private market insurance place. But our private market insurance place has

very little regulation by the state in it. So we have extreme demographic rating. Extreme medical underwriting. And decreasing access for individuals and those in the small group market.

And so while most of the state health care packages find that it is difficult to build bridges with their hospital systems, because the more you insure the less you need uncompensated care, or our plan obviously sets up a set of conversations that might make doctors uncomfortable because of the expansion of the powers of nurse practitioners and others makes hospitals a little concerned around hospital acquired infections and chronic disease management for our managed care systems. We also needed to impose a set of new regulations on our small group insurance place in terms of decreasing the ability of those carriers to have giant spikes in the marketplace associated with gender, age and medical status.

So the things that are happening in our legislature, which is I think where you guys are sort of thinking what's the next thing you write? How many stories can you write about state plans? Well, we've a big debate in our legislature about should we tax free writers or not? Is an employer assessment fair? It's a tax on employers. And some states are taxing people who don't carry; some states are proposing taxing everybody as a little bit. But nevertheless, that question of

what is the legitimate role employers in helping cover health insurance costs if they're choosing to opt out of the system is a big tax policy question in our state and in many states as well. Many states that have relatively robust business tax systems, this will be rejected because it will be seen as another employer tax, but in fact many employers, and this is also getting played out in our legislature, are covering health insurance and aren't happy with their competitor in the state who isn't.

And so they're not so upset about leveling the playing field and imposing a tax. So we also have a debate in our legislature a round of free writer tax that's splitting the business community because of the potentiality of leveling the playing field. And that is not a situation that our legislature is used to having, where the business community is not speaking with one voice about what needs to happen. We also have in our legislature a big discussion about adverse selection and should the state be attempting to drive down adverse selection, buy our insurance reforms or should we be letting the free market do what it's going to do and the state take on all the heavy users. And that's a big discussion around insurance policy and what is insurance and then that bumps up against ERISA. And I personally believe more than federal funding – or I shouldn't say more, but equal to federal

funding, ultimately ERISA will be on the table as states approach this.

The other issues that get played out in our state and highlighted even more so today by the announcements of Candidate Obama is partisanship. Should we pass this? Does this help the democrats? Does this help the republicans? Now will this help Obama? Will it hurt him? Should we not do anything because the feds are? So there's a lot of political jockeying on around health care that has nothing to do with health care and more to do with the horse race.

Finally I would say the issue for us as we also expand to age 29 for those who can be covered on their parent's coverage, the invisibility of those who are uninsured is problematic. We have a cover all kids program. So our kids are not, we don't have that many kids uninsured, we're a very high insurance state for kids. They have access. And so now that you take the 29 year olds and you peel them off, the pool of about 500,000 out of 12 million Pennsylvanians. $12.8 million of uninsured is somewhat invisible and is lessening the crisis. So we have a political win that's lessening the crisis and our good efforts to expand coverage are making the pool of uninsured folks almost too invisible for the legislature to really the pain of.

So we have some debates about is there really a need? Who are these people? Why aren't they insured? Is there a level playing field conversation? How should employers be treated? How should insurance carriers be treated? And are the pay for performance and wellness expectations something that can reasonably be calculated and perceived as savings that will be passed back to all payers? That's the kind of conversation going on in our state legislature that hopefully will culminate this fall for a passage of significant, if not 85% of our health care package. That's sort of the timing up until today. I'm not sure what the presidential politics will mean in this state work.

**ED HOWARD, J.D.:** Great Donna, thank you very much. That's excellent framing of some of the important topics that we're going to be talking about. It's time for you to ask the questions that you've been very patient in holding back. Could I just follow up on something before we open it up to follow up actually on something that you mentioned explicitly and it was implicit in some of the other presentation and that is ERISA. Those of us who think it stands for every rotten idea since Adam may not understand every nuance of what that has to do – what it is and what it has to do with states trying to pass these coverage initiatives and I would welcome anybody who would like to explain that in 30 seconds or less. And talk

about how states are dealing with it, either in general or in specifics the way you were eluding to Donna.

**DONNA COOPER:** I'll just take a stab at what's happening in Pennsylvania. ERISA is, as you all know what ERISA; it says in the large group market that the state cannot regulate the product. That's the short hand. And so we would for instance exempt people from our free writer tax if they offer a health insurance product. But our ability to gauge whether their product is comparable or decent could be undermined by ERIS because we're not allowed to judge the large group market and product. So if we say their product – let's say they offer a product that has a $10,000 deductible, can only be used if you fall a ski slope. Let's say that's what they offer as their health insurance. Well that wouldn't count to get out of our free writer assessment or common sense that wouldn't count.

But the question of that judgment of whether you're able to exempt that individual large group employer from your market, your free writer tax, is up for debate in terms of are you violating then ERISA requirements. The second issue is in the case of Maryland, when they pass the 8% payroll tax on Wal-Mart, the court case determined that you could not judge how much Wal-Mart would have to spend on health care, 8% may have been more than they should have paid given that they were a

large group employer. It wasn't the right role of the state to be making that judgment. And for us our free writer tax is 3% of payroll. Are people who are eager to stop our efforts to expand health insurance whether it is in fact ERISA problem or not are raising that ERISA red flag as a way to undermine one of our key revenue streams for funding the expansion of health care in Pennsylvania.

**ED HOWARD, J.D.:** Krista, what are you doing about that question in Illinois?

**KRISTA DONAHUE:** We face exactly the same issue. I think overall what you can say about ERISA is it does limit our options when we are talking about revenue sources and we too have a 3% tax on employers who are not offering insurance. When we're talking about how do we raise revenue here or there, it's very difficult to adjust that because our lawyers have told this is sort of where you can go up to. And so it does just limit our options in raising revenue.

**ED HOWARD, J.D.:** Yes, Joy.

**JOY JOHNSON WILSON:** I'd like to say one thing on the ERISA issue. Even Massachusetts has an ERISA problem and I think that's a space to watch because in the – the important thing about the Maryland case wasn't so much that they lost but that the court said that the association that sued, which was a national association, had standing to sue. So even if you have

all the companies in your state saying tax me, tax me, there still could be someone outside of the state that could file a case and your law could be overturned.

So I think that there's more of a issue than just getting your state together. It's a broader issue about the broadness of the ERISA preemption and we haven't talked about that in Washington lately and we probably need to have a conversation.

**ED HOWARD, J.D.:** The people asking folks at SCI about ERISA?

**ENRIQUE MARTINEZ-VIDAL:** Actually they ask about it a lot. And we actually have a few publication that are recent based on the Maryland case, but then it goes beyond that and talks about what the implications are for further state reforms. I think two things; one is what was mentioned here in terms of trying to find out what's going on in the self insured ERISA plans. And I know when I spoke with the folks in Vermont that said they had a problem with ERISA or that they were being challenged by ERISA was that they were dealing with it in terms of their premium assistance program. That any premium assistance had to be cost effective. And so then they have to do an analysis of what the employer program is and they can't get that information from the self insured employer.

So that was one aspect of it. And the other aspect of what ERISA is doing is more related to what happened in Maryland and Massachusetts. How much control does the state have on the employer's benefit plan itself? And that's where most of the time that is preempted, virtually all the time, and what states are doing to get around that is what Massachusetts and that's to apply a broad based tax which is not what Maryland did. And Maryland applied a very limited tax that only in essence applied to one employer and so that's in my min why they won that case was because it wasn't a broad based tax, which is why I think that Vermont and Massachusetts will actually withstand ERISA preemption lawsuit, although those always play out in courts. So it's hard to say.

There was a hearing last week up on the hill about ERISA. I know there were some state officials that testified in terms of trying to create more flexibility in the ERISA Act and there was a lot opposition by business groups to doing anything. I think some of the flexibility that was being asked for was actually addressing more of the data aspects and trying to open that up a little bit more for states to see what's going

**ED HOWARD, J.D.:** And for the record, it's the Employee Retirement Income Security Act, right?

**ENRIQUE MARTINEZ-VIDAL:** Yes.

**ED HOWARD, J.D.:** Yes. If you would identify yourself and allow a couple of seconds lag so that C-Span can get you on handheld mike.

**LAURA MECKLER:** I'm Laura Meckler from the Wall Street Journal. Just following up on that last point. I guess I don't understand how you avoid the ERISA problem, even with a broad based tax. You're still basically punishing employers who are regulated under federal law for not providing health insurance. So I don't understand –

**DONNA COOPER:** The court case isn't about the fact that they were punished nor is there any limitation on a state to impose a tax and to credit you back. A tax credit, if you offer something. The states have those rights and that's I think why Illinois and Pennsylvania are being very careful about what we're saying. This is an employer tax that is refundable if you offer health insurance.

So the federal law does not forbid that. Now the question is whether our ability to judge what you offer as health insurance is going to run into ERISA. Or is the 3%, the Wal-Mart case, 8% going to run to ERISA. But we have every right to impose a tax and to refund it if you meet certain conditions.

**KRISTA DONAHUE:** Well, in that case Massachusetts wouldn't meet that model because they don't have a tax that's refundable.

**DONNA COOPER:** Correct.

**KRISTA DONAHUE:** Enrique said that –

**DONNA COOPER:** Right. They're at per head for uninsured.

**KRISTA DONAHUE:** But you seemed to say that you thought Massachusetts would be okay.

**ENRIQUE MARTINEZ-VIDAL:** I think because that they would consider that as sort of a diminimus [misspelled?] tax that could rise above the ERISA preemption. But it could be challenged in court and be overturned.

**LAURA MECKLER:** Thank you.

**ED HOWARD, J.D.:** Yes?

**STEVEN LANGEL:** Steven Langel with *Congress Now*. I'm just wondering what steps are states taking to try to get changes to ERISA. And how receptive has Congress been to your efforts?

**DONNA COOPER:** I can tell you right now that internally in the NGA – the NGA has long had a policy that it feels that the federal preemption in ERISA is not in the interest of states and as part of NGA discussions right now that will culminate this summer, the governors are putting out a paper on

health care and it will speak to numerous ways in which the federal government can support and advance state efforts and ERISA is discussed in that. So I can only speak to what that is. I don't know about other things.

**KRISTA DONAHUE:** As a state we're actually – our number one priority is right now to try to work within it so that we can get a plan accomplished. It could be a while before there might be any amendments to ERISA. So we think that the plan that we have developed will withstand scrutiny and where a problem could arise is a) if we need more revenue and a larger employer assessment seems feasible but, b) also, we want to make sure that people have comprehensive coverage and so we can't really define what meets – we can't really set a standard in terms of we want an employer to offer this much coverage in order to meet our standards. We have to basically say health services would be – money spent on health services would be credited back.

I think a problem could arise if we see that employers are offering maybe a wellness program and some vision care, but not really a hospital or a major medical benefit. That could be an area where states want to try seek some amendments, but at this point we're just trying to work within the system right now.

**JOY JOHNSON WILSON:** We've had a longstanding policy on ERISA and how we feel about the preemption. We spend quite a bit of time watching encroachment in ERISA outside of state health reforms. For instance, when there was the big HMO reform bills going through, those would have expand the ERISA preemption. So we spend some time trying to keep ERISA from becoming even more sweeping than it already is. In those bills that are pending with state flexibility and waivers, no ones really talked about ERISA being one of the waiverable things, but would like to have that conversation.

**STEVEN LANGEL:** So is there any real concerted effort to make a case to Congress about amending ERISA at this point?

**DONNA COOPER:** I'd say not. That there's not any major effort underway right now. We were kind of waiting to see what Maryland was going to do about their Wal-Mart case. They've decided not to appeal. So that leaves us where we were before with a clear statement that ERISA is very preemptive and there are other states moving forward and to some extent we might want to wait and see how they do, how Massachusetts fairs. If some of these others come about. We have other more pressing issues, like Medicaid and SCHIP, quite frankly.

**ED HOWARD, J.D.:** Yes? Please.

**FEMALE SPEAKER:** [Inaudible] Health Care magazine. This question is for Pam Dickson. You mentioned that the

Robert Wood Johnson Foundation on June 15th was going to be announcing a new program involving the consumer and state initiatives. Can you elaborate a little bit more on what that's about?

**JOY JOHNSON WILSON:** I will elaborate to the extent I can, although for a sense it's embargoed into our announcement. But what this new program will do is recognize the important, significant role that consumers can play in both supporting and encouraging their states to play a strong role in providing coverage and also what that coverage might look like.

**JOEL FINKELSTEIN:** Hi, my name is Joel Finkelstein and I'm a freelance reporter. My question is kind of a general question in that I wonder – I know the [inaudible] the states have acted because the federal government has not, but I have to wonder how much that has backfired on the states in terms of now its given federal lawmakers the ability to say, well, we'll wait to see what happens in the state before we act.

**KRISTA DONAHUE:** This is actually – this isn't speaking for the Governor, but I used to work on Capital Hill and I think that it's actually had the opposite effect. I think more and more lawmakers see it as feasible to talk about health care. The past 10 years I think it's been more popular to talk about incrementalism because of taking on sweeping changes, some have done it in the past and it didn't work out so well.

So I think now that federal lawmakers are seeing states take on such sweeping changes it creates more political courage but it also creates, as Ed said, an incubator. Now we can see what works and what doesn't work and so you're taking less of a risk as a federal legislature if you can say, my plan has worked in these five states and there's evidence.

**ENRIQUE MARTINEZ-VIDAL:** I would agree with that and I think there are two case studies in point. One, when there was a lot of states passing children's health programs before SCHIP was implemented and that sort of gave momentum once a certain number of states hit this threshold. The federal government said, well, we should probably do this on national level.

I think on the other hand, sort of the reverse, I think some states in the early 90s, when there was health care reform being talked about at the federal level, they said, okay, we'll pull back. We'll wait and we'll see what happens. And when that project fell apart basically the states were still left holding the bag and I think that they're to the point where there might be a little bit of jadedness out there on what the federal government's going to do. And so these states are saying, we have to deal with our populations. They're our constituents. We need to do something about it.

And the government comes along looking at us as incubators for programs, then great, but until that happens we have to move ahead.

**DONNA COOPER:** Let me add one other thing. I think the nature of the governors that they're from both sides of the aisle that have put forward plans gives a little bit of cover to what Krista said, which is people are seeing it as feasible and it's no longer one parties issue.

**JOY JOHNSON WILSON:** Finally, I think if you look at all the presidential candidates, I don't think at the end of the day there will be one that doesn't have a health care plan because you can't be a legitimate unless you talk about health care. So I think that that reflects, that it's not just states generating air, that there's really something more going on.

**DONNA COOPER:** I know that Joy said that was the final point on this, but also in Canada they did start passing health care reform province by province before they did a national health plan. So there is a model out there.

**ED HOWARD, J.D.:** So that means we have only twenty-five years to wait? Yes, sir?

**JERRY GEISEL:** I'm Jerry Geisel of Business Insurance Magazine. My question is for both Donna and Krista. What do you think the likelihood is in your respective states at the

end of the day that is the end of this year your legislatures will pass a comprehensive reform measure?

**KRISTA DONAHUE:** In Illinois there is broad support for the health care plan. Obviously one of the sticking points is the revenue source and that is currently what's being negotiated. We've had very few amendments to the bill in the Illinois Senate. In fact, it got out of the Senate Committee yesterday with just an amendment to the revenue source. The revenue source is obviously what legislators are concerned about, no one likes taxes.

Our business assessment funds about one-third of our plan. Two-thirds of the plan was funded by a proposal by the governor that would have taxed gross receipts, which the governor considers a very fair way of taxing businesses because it doesn't allow them to take deductions based on expenses and end up paying $14 in corporate tax. So we are now looking at other alternatives for that other two-thirds of funding. Basically, every revenue source except for sales tax and income tax, are on the table right now.

So we're looking at closing corporate loopholes, at gaining at other sources of funding. But on the health care front there is recognition of the need for health care access. And again, our states have shown a great dedication to doing it, both by the governor and the legislature passing all kids.

**DONNA COOPER:** I think for us, again, revenue source is an issue. About a third of our program as well comes from the employer tax. The other balance does not come from any additional taxes. It comes from current revenues and redirecting of existing revenues and redirecting of federal funds. So the employer assessment will be a sticking point, but much like our Cover All Kids program, which passed last November, our believe our package will pass when it serves the greatest political benefit for the upcoming legislative elections.

I think that neither the Republican nor the Democratic Party could sustain a primary not having passed most of our package, including the universal health care part. So whether it happens this fall or next spring, because we're a May primary state, so there's a chance we'll bleed into next spring. But I think before the primary next year, Pennsylvania's package will be enacted. I would hope it's this year because we have more to do. We have to get this one done, go onto other things.

**ED HOWARD, J.D.:** You both mentioned federal dollars that are involved in this. How big, more generally in other states as well like California and Massachusetts, how big a role is the federal dollar flow that states are trying to tap

into as a part of the financing mechanism for some of these plans?

**KRISTA DONAHUE:** We have not budgeted for any federal money. We hope to receive a federal match on part of our family care expansion from 185 to 200% of poverty. And we're obviously going to apply for federal funding in other areas but we don't depend on it in our budget proposals because we want to be conservative about this. We want to make sure we're being good stewards.

**DONNA COOPER:** Pennsylvania has room in drawing down federal funds that are due under Medicaid that we currently don't draw down. So we envision about, if I remember correctly, 18% of our budget coming from funds that we currently don't draw down now. I think for folks in the room who aren't Medicaid experts or understand the state plans, nobody, I think, is building their plans on federal revenues that would require somebody going back to Congress and getting a Medicaid increase.

These are existing Medicaid dollars that are on the table and that aren't being full drawn down. For instance, in the case of Vermont or Maine, Pennsylvania, Massachusetts. And redirecting some of our existing federal funds. So it's about 18% of our overall package.

**ED HOWARD, J.D.:** Yes, right here.

**JULIA DAHL:** Hi. I'm Julia Dahl with *Salon*. I was wondering if you could talk about the reauthorization of SCHIP. What are some of the issues you anticipate coming up and what are you hoping for?

**JOY JOHNSON WILSON:** We're hoping for reauthorization before September 30th, which would be great. I think that would be the first thing. For a very popular program we're expecting a fairly rough ride, quite frankly. And I think that's important to note. Everybody loves the program but the devil's in the details and everything from how far we want to go in terms of the percent of poverty. Is it 200? Is it 250? Is it 350? Is it 400? Will we continue to have any adults in the program?

The formula is an issue. Everybody agrees the formula's not a very good one. That being said, when you try to change a formula you get winners and losers, unless there's enough money to make sure that doesn't occur. So we've got that issue. There are some benefit issues. Whether or not mental health parody, substance abuse parody, a dental mandate, EPST, which is the Medicaid provision that requires states to provide screening, diagnosis and treatment for children up to age 18, which is not in the SCHIP requirement.

So there are all these things that are under discussion. And of course, there's a little thing called the

money. We're in the budget. There is room for $50 billion dollars, but let's be clear. That doesn't mean there's $50 billion dollars available right now. That money has to be raised from somewhere. So that is another issue about how much money and what will it pay for. So we have a lot of issues that have to be settled within each house and then they have to conference and then there's really not that much time to get that done. So I think that's the critical issue, is the timing and can we get that done in the time we have?

**PAM DICKSON:** Could I add one thing to Joy's answer, which is I think, at least in the states in the conversations that we hear talking to other states, whether this is happening in Congress is another question, but we're having this debate about do you change the formula in a way that rewards the states that have stepped forward to expand health care coverage, like Illinois, New Jersey, Pennsylvania? Or do you leave the formula as is, which is pretty much predicated on how many uninsured kids you have. So the more uninsured kids you have, the more you get, which makes complete sense. But as it's being reauthorized also encourage a perverse incentive.

And that's a conversation we're having at the state level. I don't know if it's permeating the halls, but certainly an issue.

**ED HOWARD, J.D.:** Krista?

**KRISTA DONAHUE:** We'd like to see SCHIP to continue and allow us to cover parents. We think it's really important to cover parents and a child's health as well. You can have healthy parents and healthy children at the same time. So we'd like to continue being able to cover parents. We'd like to see the income limit go up to at least 300% for kids. We're covering all kids, but that would obviously be great. And obviously it would be nice if we could amend the Deficit Reduction Act for the original documentation requirements. That's extremely difficult to administer. So we'd like to see that change as well. And of course more money.

**ED HOWARD, J.D.:** We actually had a question from one of the reporters listening in from Florida asking specifically about the proof of citizenship requirement and whether it was having much of an impact on Medicaid enrollment or participation. I would infer that the answer is yes.

**DONNA COOPER:** Well, it's just been a challenge to administer because lots of people don't have original documents so we're continuing to enroll people but struggling to implement that.

**JOY JOHNSON WILSON:** I think for us, we are not a big immigrant state. So I think that we've figured out systems and we have spent a lot of time and resources in making it possible for people who legitimately, per the DRA, should be able to get

MA and SCHIP. But I think if we were a state like California or Florida or Texas, I think those are much more enormous and real and ought to be addressed per Krista's suggestion around changing the DRA requirements.

**ENRIQUE MARTINEZ-VIDAL:** The twist on it that we've seen in a few states that are trying to create these public private partnerships. More so to the premium assistance out to support Medicaid eligible people that are getting their coverage through their employers. Previously they were trying to do that in a very transparent way so that it didn't seem like it was a government program and they were just buying their employer sponsored insurance. And now with the citizenship requirements, all of a sudden the government's right there in your face saying, show me this documentation. And it's very difficult.

**PAM DICKSON:** And I think another important aspect is people think that this only affects immigrants, but it doesn't. We have states that don't have a lot of immigrants that are losing a lot of kids in the program because their parents don't have – it's not just that they need citizen documentation, but they have to have identification documentation as well, which is separate from your citizenship. And some people have one and they don't have the other or they've got it for some kids and not the other ones.

So it's more complicated than being about whether you're an immigrant or not. And our hope is that somehow we can get this down to something that is workable for the states, because from the state perspective on an audit trail we have to show whether there's the requirement or not that the people are legally eligible for the service. So we have to figure out a way to do documentation that doesn't make it so difficult for people who are eligible to get on the program.

**ED HOWARD, J.D.:** We have about five more minutes I think before we have to let you go. Jerry I think had a question and then this gentleman here has been very patient as well. Jerry, do you want to ask a question. You've got a microphone there if you would use it. Would you use the microphone?

**JERRY BRAZA:** I'm Jerry Braza, a long time Washington Health reporter and still operating around as an independent because I can't leave it alone. And when I see these state plans and I see the presidential campaigns gathering steam and all of my experience tells me there will emphatically be emphasis on national plans for everybody. Ted Kennedy right is nursing a Medicare for All bill and Obama yesterday came out with a plan.

So what other states with their own plans are going to do if a national plan becomes a major happening on the Hill?

Are you going to fight this and say, no, our plan is better for the people of Pennsylvania or New York or wherever else? It's a national audience. I think that's going to be a big question if this comes up.

**KRISTA DONAHUE:** Well, it will be an additional source of federal money, which will be nice. We're going to try to obviously tap into federal resources. I believe Obama's plan was allowing states to maintain their current systems. The Governor feels it's very important to act to get people covered. If in the future there's federal resources for it obviously we're not going to fight that, but we just want to get this done so people have coverage now. No, fight for the federal funds.

If there's a piece of federal legislation, obviously we would want to use our experiences to impact the debate. We will have had some experience of implementation at that point. We can chare obviously. I think the biggest thing is it would be nice to have a source of federal funds. It's difficult doing this completely with state money.

**ED HOWARD, J.D.:** It's probably worth noting that when Congress passed the SCHIP bill 10 years ago, they grandfathered in several states that already had kids' programs in operation, it allowed them to continue in operation with federal subsidies that they didn't have before.

**DONNA COOPER:** I think that PA would basically stand up and applaud and actively lobby for the passage of a good federal plan. We think that's the most efficient way to do this, that there ought to be a national health care system. The only reason our governor does this is because the feds haven't acted.

Now it takes six years and we've built something and there's an infrastructure, that's another question. But right now we would put all our horses in Washington to get it passed.

**KRISTA DONAHUE:** Another example of grandfathering states in is when we did Medicare Part D; states were allowed to keep their state pharmaceutical programs in some form. Usually there's some consideration for existing programs.

**ED HOWARD, J.D.:** Yes, sir?

**MERRILL GOOSNER:** This is the proper last question. I'm Merrill Goosner and I'm a freelance writer as well as work at the Center for Science in the Public Interest. Several speakers mentioned prevention as part of their plan. I'm very curious to get any kind of details as to what you're talking about there because very often prevention programs, depending on how they're implemented, can increase costs not hold down costs.

And the second part is I'm curious if anywhere in the country any states are experimenting with, as part of health

insurance reform, public measures that might improve overall population health and making that part of the program?

**DONNA COOPER:** Public health measures are packaged. The prescription for Pennsylvania includes a smoke free statewide ban on smoking in public places. So that's the only, I would say, major public health part of that. There's some child obesity work that's already going on and that would be augmented with funds that we're asking our legislature to approve as part of our plan.

But for us, the wellness program is built in as a required element of the product that we would be purchasing. So if we're bidding a product in the private market, people are signing up. We will define a set of preventative health care appointments and wellness measures – we already do this in our MA program in terms of nature of visits and what's tested and when as a way to identify early illness. And you're right, it can increase outpatient costs, but our hope is that it decreases hospitalization costs.

So I don't know if that answers your question but that's the extent to which we've sort of addressed this in addition to better chronic care management.

**ED HOWARD, J.D.:** I think we didn't answer all of your questions and I apologize to those of you who sent emails and phone calls with questions. We just didn't have time to get to

them. Maybe you can catch our panelists before they escape and get your specific answers before they go.

**KRISTA DONAHUE:** Only if you give me a ride to Dulles.

**ED HOWARD, J.D.:** Thank you all for coming. Thanks to the Robert Wood Johnson Foundation for supporting and co-sponsoring this event and thanks to our panelists for really a lot of good answers to tough questions.

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