The Massachusetts Health Plan: How Did They Do It?
Alliance for Health Reform
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ED HOWARD: Welcome, my name is Ed Howard with the Alliance for Health Reform on behalf of Senator Jay Rockefeller, our chairman, Senator Bill Frist, our vice-chairman, welcome to this program on that rarest of phenomenon in US Healthcare policy these days, a bipartisan actually enacted plan to achieve near universal health insurance coverage in a major jurisdiction.

Our partner in today's program is the Kaiser Family Foundation. We are very pleased to have Diane Rowland, the executive vice president of the Foundation, with us. Bipartisan cooperation on major healthcare issues is rare enough in this town that we are really please to be a part of this briefing, and judging from the response to our announcement of the briefing, so are you. The registration, as some of you are painfully aware, reached the room's capacity in just a few hours, and we had to take it down from our website. So, today we intend to look under the hood of this new Massachusetts law, both at the moving policy parts, which is in fact an intriguing mixture of mechanisms and the politics of how the parties got to yes. So, it's not just how did they do it, but what did they do that we are going to take a look at.

Let me just do a logistical drill before we get to the actual program. As usual, your packet has a lot of background information including slides from the speakers from whom we had them

in time to give them to you in advance and biographical information more extensive than I am going to give in the introductions. If you are watching this on C-span, you can follow along in the presentations by going to our website allhealth.org and click on the link in the Massachusetts health plan briefing description. By tomorrow morning you will be able to watch a webcast of the session on kaisernetwork.org and in a few days on that website and on ours you will be able to see a transcript of the discussion with copies of the materials as well. And finally let me just note there are blue evaluation forms that I hope you will fill out before you leave and a green question card that you can use to grill our panelists if you want to do that in writing rather than verbally.

As I have noted we have with us Diane Rowland of the foundation, Kaiser Family Foundation, who is not only the ex— executive vice president of the foundation but one of the country's top health policy analyst and we are very pleased to have her with us today. Dianne?

DIANE ROWLAND, Sc.D.: Thank you Ed. I'm very pleased to be and to be able to co-sponsor this event with the Alliance. I'm wondering if we are starting a trend here. Last year, we talked a breakthrough in that when we were discussing Medicare and drug benefits we were actually talking about a law as opposed to a number of proposals. So I am pleased that today on the uninsured issues we are here to talk about a law instead of some proposals and to really be able to assess what this bright spot on an otherwise fairly depressing set of progress on the uninsured really means for Massachusetts, for other states, and for the nation. It's also a

pleasure to hear universal coverage return as a concept. We have been talking for a lot of the last few years about incremental and the word universal is now back on the table, which I think is an appropriate way to began to talk about how to address our uninsured population. I'm interested to learn more about the individual mandate, the employer contribution, and how the bipartisan nature of this bill and the work between a governor and a legislative all came to pass since I think we need to learn a lot that on our national policy issues.

So today, I really hope the we will be able to explore how they did it, what they did, whether they predicted it will work, what they think the milestones along the way will be to seeing if they have achieved their goals, and critically, as always, how they have managed to put the financing together since we always know that the dollar is behind health reform have always been a major stumbling block and can others build on this, what would it take for other states to try and do this, and is this really a way we can move forward with the national debate as well. So, I think we have got lots of questions and a wonderful panel that I hope will provide lots of answers. So, I want to welcome the panel and I am anxious to hear the story from Massachusetts. I remember that they have launched the American Revolution so maybe now they are launching the healthcare revolution. Thank you.

ED HOWARD: Hear, hear. Well, let's not dally any longer. We are going to hear first from Tim Murphy who is in charge of making the Massachusetts plan work as the Commonwealth's secretary of Health and Human Services. The mask of HSS covers 17 agencies,

delivering something like 12 billion dollars a year worth of programs and services to more than a million Massachusetts residents. He came to HSS from his post as a policy director for Governor Mitt Romney and before joining the Romney administration Tim was a senior official with the investment-banking firm of J.P. Morgan and spent time back in Massachusetts as an analyst and aide in the state legislature. Those of you who have not gotten the new, improved Tim Murphy slide presentation; there are some more copies on the way. You should make sure you pick one up on the way out. It's very close to the one you have in your packets so you should be able to follow along. Tim thanks very much for joining us today.

TIM MURPHY: Thank you Ed and thank you Dianne for the opportunity to come down and speak before you today regarding the Massachusetts healthcare reform law that was signed on April 12th. What I am going to do this afternoon is to walk you through the law, how it works, the organizing principles around what we think is a truly a landmark piece of legislation.

Everybody knows that the healthcare status quo is unsustainable. When we looked at working on healthcare reform in Massachusetts, one thing that Governor Romney and the team is that what we always do is problem definition. What are we trying to solve? And when it comes to healthcare it's very apparent but I think it is important to note anytime you have any conversation is a situation in which you have double digits increases in healthcare premiums where you have a half of million people in the Commonwealth uninsured, where you have many businesses particularly small businesses dropping health insurance due to the costs, where you see

significant barriers to entry to small businesses and to individuals for the purchase of a very complex product, issues about part-timers and contractors and sole proprietors being kept out of markets, participation in contribution rate requirements from an underwriting prospective from insurers. These things keep people out of having health insurance. Limited information for consumers, a lot of conversations about HSAs and more consumer directive plans, you need to provide information so people know where costs and quality is in a very opaque system. Then finally hospitals with needs to provide care and they provide care on an emergency basis and we need to recognize that. So, leaving people uninsured puts hospitals and other providers in a situation where they necessarily need to cost shift those costs over to other players within the market whether they be governments or businesses. So that was our kind of problem definition and why we wanted to tackle this particular issue.

A little bit more about the uninsured in Massachusetts when you do this problem definition, many times when people speak about whom was uninsured they have a picture. And that picture is these folks must have just clipped off of the Medicaid program. So, if we would just expand Medicaid a little bit more we will capture these individuals. And the reality is that is not the case. It is not a monolith and what we did is through a survey work that we do in Massachusetts every two years, 5000 households in Spanish and in English, we went out and we asked very specific questions about why are you uninsured. And what we were able to find out and what we were able to do was then segmented those groups of about 500,000 people in our state that were uninsured. And we put them into three

segments. The first is about 160,000 or 20-percent of uninsured are actually eligible for the Medicaid program. They are just not enrolled in our program in this state. There are many reasons for that. There are actions that we can take administratively to fix that but you just need to recognize the fully 20-percent of the uninsured actually have insurance through a government program, they are just not in a program. The second group of folks are what I would call sandwich individuals. Those individuals earn too much to be on the Medicaid program but earn less than 300-percent of the federal poverty level. And when we looked at all the things that we could do to reform the insurance market and get more affordable products available to individuals even under those set of circumstances people earning less than 300-percent of the federal poverty level would find it very difficult to purchase on their own a health insurance product given their other monthly household budget considerations. So, we needed to come with a solution for those individuals. And then finally, you know fully 40-percent of the uninsured earn more than 300-percent of the federal poverty level. The reason why they are uninsured varies greatly. Many of these individuals are young and healthy, and they look at a regulated market and the prices that are being charged to them and say insurance is just bad value, why would I ever buy it. Other folks are just right on that cusp and said while they would like to have insurance, but if they are a single person making $30,000 a year and their employer doesn't offer it and their choice then is a five or six hundred dollar a month product on an after-tax basis. You could see how someone could economically be rational and say,

I'm not going to purchase that product. Many reasons why those folks are uninsured - the take away of this slide - is you need to recognize that the uninsured are very different and you need to craft policy solutions that address their particular needs.

Given our problem definition and who is uninsured, the way in which we approach this solution in Massachusetts was two prongs. The first one was insuring the uninsured, and we needed to look at our Medicaid, we needed to look at premium assistance, and we needed to look at more affordable products to be available to those individuals. We believe that you need to have everybody in the system to get to the second prong, which is how do you contain healthcare costs. By having everybody in, that allows you to have conversations about electronic health records and transparency and other program integrity aspects of our plan.

So, the healthcare reform bill has many objectives, they are listed on the page, and the rest of my presentation will be structured around this. First, you need to start out, you need to take a look at your insurance markets to be sure that you can deliver affordable products to the market. The pendulum always swings back and forth and as you can appreciate in Massachusetts we probably tend to be a little bit more paternalistic than other states and it was time for us to take a look at what we had wrought with all of the regulations and statutory requirements that we have in our non-group market and in our small group market. And you need to fix it and you need to recognize that you know government cannot be basically prescribing what type of benefits and insurance plans

people need to get. Individuals are smart, they will figure out what they need for themselves.

Second building block is we need an ease of offer and an ease of purchase. If you are a small business purchasing health insurance is a complicated matter. It's not your prime focus from what you do day-to-day. That is the good of the service that you offer for your business. Buying health benefits or employee benefits is not your prime focus. And we need to recognize that there are aspects of our current market that really put large barriers to entry for small businesses and for individuals. You need to fix it.

The third is subsidies for low-income individuals. We have many financial structures in our state today that deal with the uninsured and how we compensate providers for the care that they provide. What we needed to do was to basically say let's stop coming up with these kind of makeshift reimbursement mechanisms and let's get to the root issue. And the root issue is an individual and their need for assistance to buy insurance. So let's come up with a program for subsidies for the low income. You need to eliminate cost shifting. We needed to create a culture of insurance and then we needed to make sure that we are particularly focused on how we have cost containment and efficiency strategies to make this sustainable going forward.

So, what do we do with our insurance market? We did significant reforms. And what this slides displays for you is the existing market in Massachusetts and the reformed market. Now I want to make a point. For many people in this audience who are in other states, your states would have less regulation in statutory

provisions than Massachusetts does today. So you'll look at some of things and say well my state already has it but you need to recognize we start from and then where we go. The first thing is that we did have a dysfunctional individual market so what we did is we merged our small group and our individual markets together, limited uptake of HSA products because of certain prohibitions and stature. What we did is we made HSAs more available under existing products in the Massachusetts market kind of any willing partner provide those within our current law or practice. What this bill does is it allows insurance companies to develop value driven networks. In addition to that, we had as I mentioned earlier, bad value for younger adults. There is no reason in Massachusetts if you are a young adult and healthy and particularly if your employer is not offering you insurance, that you would buy in our non-group market – very expensive buying on a post-tax basis. What we did is we came up with a 19 to 26 year old market for those who find themselves in that situation.

In the existing market, there are no consequences for your lifestyle choices. So, for the first time in Massachusetts we have tobacco usage now as a rating factor in our small group and individual market. Hard cutoffs for dependency, those of you who have children who are just coming out of college, finding their way in their first job, recognizing that they are without health insurance, we come combinations for that in this bill. Kind of a growing list of mandated benefits only really affecting kind of small and mid-size businesses, not large businesses under Iressa. What this bill does is put a two-year moratorium.

And then finally, optional smaller risk pools obviously can cause significant price increases within a market. What this bill does it reforms the market to having mandatory insurance coverage and therefore creating larger risk pools.

When you make these changes this allows you to talk about more affordable insurance products. What this slide demonstrates is if you take a look at Massachusetts existing small group market for an individual, the average price point is about $350. And if you take a look at the changes that we made within this bill, you will see that if you can create value driven, tier networks, networks that don't have any willing provisions in it, you can save 10 to 20-percent. In addition to that, by having HSAs and deductibles as opposed to first [inaudible] coverage plans that can have a variance on your monthly premium from five to 22-percent; more moderate co-pays, four to nine percent savings; and then if you have a more prescribed pharmacy benefit management, that is a one to five percent saving.

The point is this you can take an existing product today that is a Massachusetts product and as I said earlier, one that is first al carte rich and one that is pretty much an open panel and you can drive costs down into a range if you take the most aggressive stance down to $154, the least aggressive, to $280. We believe that this is the right place to start a conversation. What the bill didn't do because we just weren't able to get this through the legislative was conversations about mandated benefits. If you were to take certain mandated benefits out of these plans you could

save an additional four to nine percent. So there are other ways in which you can get savings within the current existing market.

On page eight, very briefly, the point that we would like to make here is this is not about you know having access to primary care, hospitalization, mental health, or prescription drugs. This is about just changing the financial relationship and the provider relationship of your insurance plans. And we recognize that this is kind of as I mentioned earlier a pendulum that goes back and forth and those who grew up in Massachusetts recognize that we were very early adopter of a HMO model and I think that a lot of the things that we are talking about here is just basically putting the consumer back in the driver's seat and letting them make choices on types of plans that they get.

One of the breakthroughs of this legislation is work that I did very closely with a speaker that you will hear from in a few moments, Ed Haislmaier, is to come up with a connector. And what a connector basically is as the slide says it is an efficient nexus between buyers and sellers. Why do we think that we needed to set a small piece of government infrastructure to help this market work better for small businesses and for individuals? As I mentioned earlier, small businesses have significant barriers to entry when it comes to purchasing insurance. And what the connector does is addresses those. It allows all the employees of small businesses now to purchase health insurance on a pretext basis. It will eliminate minimal participation and contribution hurdles that insurance companies now impose upon small businesses. It makes it easier for small businesses and individuals to buy insurance. I mentioned it

was a complicated purchase. Now there is a place to go which basically signals to the consumer or the small business owner that this is a good value insurance product and there is an ease of purchase.

What it also does is that it changes the choice to the individual, not the employer. The employer essentially is only going to decide what type of contribution they want to make on behalf of the employee. The employee will decide what type of product that they want to purchase. It was also a mechanism for reaching people who are typically not covered by insurance products. Those are part-timers, people working for multiple employers. Think about it this way. You could work for two companies today you could be making $40,000 a year. You are not part of their employee benefits plan. Now you can have an account as a connector, those two employers can have section 125 plans for part-timers. You can get prorated contributions by the employer. You can have your own account as a connector, all on a pretext basis and you now have choice of products to purchase. And then you also have to have portability. If your employers are part of the connector and you move job to job, you no longer have to recreate your health insurance purchase. You no longer have to recreate your physician relationships.

Page 10 is just a graphical representation. Again, it's really simple at its core. This is just connecting buyers and sellers. Your buyers are above, your sellers are below, and we think that this is the necessary grease in this system to make this work better.

I mentioned earlier there are about 150,000 to 200,000 folks that fall between a group of not eligible for Medicaid but earning less than 300-percent of the federal poverty level. What we do in this plan is create what's called a commonwealth care program. And what this fundamentally does is it redirects existing spending in our system on the uninsured away from opaque kind of bulk payments to providers and we go directly to the individual. And how we do this is the following: for those that earn less than a 100-percent of the federal poverty level, they do not have to pay any monthly premium. They will be subject to co-pays and some cost sharing. And they will get private health insurance. For those between 100 and 300-percent of the federal poverty level, they will also get private health insurance and they will receive a sliding scale subsidy from our existing sources of funds. There are no deductibles in these plans for the individuals that qualify in this income group.

These are private health insurance plans for the first three years. There is exclusivity. Our Medicaid managed care plans are the plans that typically deal with these groups of folks so they will be the exclusive providers of this insurance. If they do not reach certain benchmarks, they lose exclusivity and our other private market folks will be able to come in and sell these products. The connector, which I just walked you through, serves as the exclusive agent of this plan. We don't want people to feel that they are part of some type of government program. This is just about buying private health insurance and receiving some assistance. Their insurance is going to look like anybody else's insurance. In

addition, in the Massachusetts plan also has our SCHIP in insurance partnership programs, which we expand and those plans are also about premium assistance.

This next slide just give you a sense of what an illustrious sliding scale will look like for individuals. These numbers will be worked out by the connector board but these are based upon financial modeling that we had done as we compared this legislation and got it passed. So just as an example, if you are someone making $19,600 a year, you would have to pay about $46 a month to have good private health insurance. The state would pick up the remainder. On an early enrollment basis, it's about a $300 a month plan so the state is picking up about $254 a month.

Anytime you have a premium assistance program and government is going to become involved in the private market for the purchase of insurance, you get concerned that well will employers just dump their lower wage employees and have them go take advantage of a government subsidy, we were very thoughtful about this. We recognize that employers remain the cornerstone of health insurance offering in our state and so what we did is we obviously can take advantage of existing Iressa and IRS provisions about you know dumping of certain employees. We also beefed up our state laws for non-discrimination. In addition to that, what we also required employers to do is to have what are called Section 125 plans for all of their employees that kind of fall through the cracks of an employer based system. There is no financial contribution required by the employer by setting up a 125 plan however if they choose not to set up a 125 plan there is a penalty and if we see a kind of

excessive use of pre-care by their employees, they can be subject to a surcharge for that usage.

The final part with employers is a part that Governor Romney had vetoed the legislative just recently overrode it. And it is an uncompensating careful assessment on companies not offering employer based health insurance. And basically, what this is is it is tied to [inaudible] care use by uninsured employees. It is a maximum assessment of $295 per employee per year. And the definition of an offering employer is something that my agencies will be doing over the next couple of months.

We needed to address cost shifting within our market. I think this field goes a long way to get at this. We did increase Medicaid rates to hospitals and physicians. We do after year one say that there needs to be pay-for-performance matrix associated with those increases. As I mentioned earlier we had about 106,000 folks that were eligible for Medicaid but not in the program, over the last 12 months we have enrolled 77,000 of those individuals. That goes a long way to end cost shifting of the uninsured. We reformed our uncompensated care pull mechanism such that our expectation of that mechanism will decline year after year. The section 125 plan requirement gives people more opportunities to have pre-tax health insurance and then finally personal responsibility. And I am going to speak to that in the next slide.

We believe that we have fundamentally now set up a system that given Medicaid, premium assistance, affordable products that all citizens will have available to them affordable insurance options. In the new environment, people cannot remain uninsured or

not pay their healthcare costs. And what personal responsibility means to us is that everyone should be insured or have the means to pay their health insurance, and what we did was a first in the nation in which we then say that health insurance becomes the law in Massachusetts. So starting on July 1st, 2007, all residents of Massachusetts will be required to have health insurance. The way in which we will enforce that mechanism is through our income tax system. If you do not have health insurance for the last six months of 2007, you will lose your personal exemption on your Massachusetts tax form. And for 2008, there will be a fine equivalent to 50-percent of the cost of an affordable insurance product.

We spend an awful lot of time about getting people insurance but equally important is having strong cost containment strategies. And this bill includes that. There is a cost and quality council that is set up which will provide consumers information about the type of care that they are receiving and the cost of that care. That allows for real consumer engagement as you try to popularize HSAs and higher deductible plans. In addition to that, we have an electronic medical record strategy in this state funded very generously by the Blue Cross, Blue Shield Foundation of Massachusetts in which that is going on right now in three communities. We see great value in that approach. Computer physician order entry systems, there is a five million dollar grant in our plan to help particularly community hospitals and then also pay for performance strategies in our Medicaid program.

So in summary, we believe what we put together are sound organizing principles for a fully insured population. We keep small

businesses and individuals from dropping health insurance. We introduced lower price comprehensive health insurance plans. We create this connector that permits the purchase on a pre-tax basis. It gives more choices to individuals and to small businesses. We have the come along care plan, which deals with premium assistance for those who fall through the cracks. We are promoting a culture of insurance and of personal responsibility with a keen focus on cost containment and efficiency strategies. Thank you.

ED HOWARD: Thank you so much Tim. A lot of moving parts there, you did a very good job of cataloging them for us. Next, we are going to hear from Jim Mongan. Dr. Jim Mongan is the CEO of Partners Healthcare in Boston. And he is something of a one-person healthcare coalition. Here are just a few examples. He is a member of the Board of the Kaiser Family Foundation. He chairs the commission on a high performance health system for the Commonwealth Fund. When the Alliance ran its first retreat for senior Congressional health staff back in 1993, the keynote speaker was Dr. Jim Mongan. He is also here in Washington, been a key staff member of the Senate Finance Committee, a senior official in the White House, still pursuing the goal of broadening health insurance coverage while making sure that the Massachusetts plan didn't run aground because of its impact on various stakeholders. So, we are very interested in your prospective, Jim and thank you for joining us today.

JAMES MONGAN: Thank you Ed. I want to start by congratulating Secretary Murphy for his hard and thoughtful work, which supported Governor Romney in this very, very major

achievement. The governor's leadership was essential along with that a Senate President Tierney and Speaker Domenici all with the support and encouragement of Senator Kennedy. This legislation has deservedly received huge attention from around the country. And I thought today I might answer the four questions I have been most commonly asked by colleagues.

What did they do, how did they pay for it, will it work, will it be a model for other states? Well there are two important things to understand before starting. The first is that Massachusetts started from a better place. Only ten percent of people in Massachusetts are uninsured compared to the national average of 15-percent. I don't point this out to imply that the job was easy. But just to say we only had two thirds of the mountain to climb. Our lower rate of uninsured is due primarily to broader employer coverage and also to a broader Medicaid program. Second and equally important, Massachusetts has had for years a tax-funded, uncompensated care pool to cover hospital costs for the uninsured. As you can see, it's funded by a 160 million dollar surcharge on insurance payments, a 160 million dollar assessment for hospitals, and 220 million dollars from general revenues. So, we already have over five hundred million dollars in the system to address the uninsured.

To summarize these background points in the political vernacular, being a blue state made this legislation possible in Massachusetts. So the first question what did they do? Secretary Murphy has just given you an excellent summary and I will just focus on the three key elements, which lead to broader coverage. The

first, the individual mandate as Tim ably described. Second, significant subsidies, you cannot propose the mandated purchase of a very expensive product like health insurance with a straight face without proposing significant subsidies. Critically the governor stepped up to this plate while many in the past have shied away from making the necessary financial commitment. And third, affordable policies, one way to limit the huge need for subsidies is make affordable yet still adequate policies available. Now this is a work in progress. It's easier to hope for than to accomplish. There are some early indicators that policies costing about two thirds of a normal policy might be available with deductibles and benefit limitations which many might view as reasonable. However there would likely be much more significant limits on choice of providers though a wider choice than it currently available to the uninsured.

The next question is the most important of all. In my 35 years in experience, this debate has always been about the money, about the financing not about health. It's about how do you pay for expanded coverage. Progress on this issue has been essentially blocked nationally by the strength of the anti-tax movement, which has swept both taxes and employer mandates off the table as finance resources. So, what happened in Massachusetts? Well first, as I indicated our problem was only two thirds as large reducing the financing challenge. Secondly we had the very large 500 million dollar pool of tax funds, shown in blue, available which could be utilized to support insurance subsidies rather than paying directly to hospitals. This was a very important concept advanced by the governor. But addition revenue was needed so I have shown in green a

180 million of new Federal matching dollars, 125 million of state surplus funds, which were allocated to healthcare rather than tax cuts, and 50 million dollars from the modest assessment on employers who do not pay for coverage which though as you can see is a very small part of the financing package, was a critical part of updating political consensus. And finally shown in yellow is an attempt to illustrate the important role of the individual mandate. I illustrated the amount of money that would be paid by currently uninsured individuals towards the cost of purchasing private health insurance under the individual mandate. I have also illustrated how much would potentially come to the state as in penalty if people did not obtain coverage. The hope, of course is that they all will get coverage and it is a larger amount will go entirely to purchase coverage with none coming to the state although the employer mandate has been labeled as attacks by conservatives. The Governor's willingness to reframe the individual mandate with the support of the Heritage Foundation as personal responsibility rather than a tax increase was a critical conceptual breakthrough in achieving success.

Now will it work? This legislation contains the elements for a very plausible pathway to much broader coverage. Whether or not it will succeed will depend on the interplay of three factors. Will the state economy continue to support adequate subsidies? Will the affordable policies be available and feel adequate to those affected by the mandate? Now if the subsidies remain adequate and adequate lower cost policies are available, the individual mandate

likely will be sustainable. If not, the mandate likely will be repealed.

Will it be a model for other states? Here I am more skeptical. The good news, and it's very good news, is that this legislation has already sparked a new dialogue in a number of states. The bad news is it will be much harder to do in other states. This is primarily because the financing issue will be much tougher in other states with more uninsured and no uncompensated care pool. There is no magic here. Achieving broader coverage in these states will demand additional taxes. In addition, achieving balance support from groups from left to right is critical and difficult. And finally, not all states have the committed, knowledgeable leadership on this issue which is absolutely critical and which brings me back in conclusion to my compliments to the leadership in Massachusetts from the Governor to the legislative leaders. Thanks a lot.

ED HOWARD: Thank you Jim. You raised some very tough questions. And our last speaker is going to answer all of them. It's Ed Haislmaier who is in his second stint as health policy expert at the Heritage Foundation. First as their senior analyst for seven years in the '80s and '90s, now as a research fellow Ed has worked on a whole range of health policy projects both there and in-between. He has written extensively on healthcare topics. Examples of his analysis about Massachusetts are in your packets. And he was one of several Heritage Foundation voices that helped to shape this final plan in Massachusetts. So we are really anxious to hear from you Ed, and thanks for being with us.

EDMUND HAISLMAIER: Thank you for having me. I don't think though in eight minutes, I can answer all the questions, but we will try. We will leave the audience something to ask.

What I would like to do with my time and I'm not going to do any slides. I would like to rather focus on a couple of key points that get to the last speaker's questions about whether it is replicable in other states, and I do believe it is because in fact it didn't start in Massachusetts. Maybe that is the place to start with this. Part of this did start in Massachusetts, of course, with Secretary Murphy and the Governor and their team. But we were invited up to speak with them as they were developing their ideas. And one of the things that we presented to them was some work that I had been doing for, well I guess 18 months here with the Commissioner of Insurance in the District of Columbia dealing with trying to rethink insurance markets. The genesis for that had been the closure of the George Washington University health plan, which was very popular. Many self-employed people purchased it, and they had had it for you know many years, and then the University for its own reasons decided they weren't going to do that anymore, and so they closed the plan. They simply ran out the contracts and folded up shop. Those people then went and tried to find insurance and of course, they were older and sicker and were being turned down. Now one of the things that you have to realize, contrary to what your perception might be, is the District of Columbia a: it is a state for purposes of insurance regulation and Medicaid programs, but b: it is one of the most lightly regulated health insurance markets in the country. In fact, there are fewer mandates than any in the

region. Maryland just across the border has more than any in the country.

So the Commissioner was asking me what do I do, and he looked in the statues and found that because the company didn't go insolvent he had no power, couldn't do anything. But it struck him as fundamentally unfair to people who have faithfully as he put it paid their premiums for years and now cant get a different plan once something happened to their other plan. So that started a journey to sort of rethink how this market works for people who have insurance. And that gets me to the first point. And the point is simply that in different states, you will have differences, and you will have to make adjustments. Those differences will come in three areas.

First will be the demographics of your population. If you tried to do this in say New Mexico, you have a situation with the Mexican immigrants that you do not have in Massachusetts or Maryland. You simply have to deal with that differently. Second is and Tim Murphy alluded to this, is the structure of your healthcare delivery and financing system. One of the things that I have learned about Massachusetts in the course of this is that it characteristic really, I think unique to that state is there is a greater concentration of branded providers in that state than probably any other state in the country. And those branded providers have gotten away with creating a public perception that they all deserve top dollar in reimbursement because they are all equally good. Nobody has actually measured that up until now, and I think that is one of the key reforms that had to be put in in Massachusetts, Secretary Murphy can speak to it, to start getting more provider competition

in Massachusetts by actually measuring cost and quality. Other states don't have that problem in terms of competition, and other states have other problems.

The third point on this is that where you start off from makes a big difference. That is, what is your current law, what has your state tried to do in the past, what is your starting point or your jumping point, and is the correlatory to that, what is your state politics. I will say they can do this in both blue and red states, but you will do it differently based on not only the politics but also the demographics and healthcare financing.

Now that said, I would like to give you four points to take away from what Massachusetts did about their approach. The first is that this is fundamentally in ways that we really haven't seen, at least not enacted in the last 20 or so years, a system focused reform more than a product focused reform. I make that point because both sides of the debate are equally guilty, if you want to put that way, of engaging in product focused reform. In fact, there is a long history of that in healthcare. By product focused reform, I mean we identify some group they are either people who are uninsured or people who maybe have insurance, but they were afraid it would cost too much or they might lose, and we then try to design a product to fit them. Now this has a great bipartisan pedigree. By the way, that's why oftentimes when we talk about bipartisanship I'm inclined to grab my wallet and hide the kids, but in this case, I think bipartisanship is a good thing. For example, everything relating to the current focus on high deductible HSAs and MSA plans is a really a product focus solution, similarly everything that was related in

the 1970's to the growth of managed care and in 1974, the Managed Care Act at the federal level is a product focused solution. Standardizing the individual market or standardizing the group market or small group market into a single plan those are all product focus solutions. They are messing around with the product.

There are some product provisions in here but if you look at the legislation, it's very broad. What they did is they simply widen the parameters to allow the private sector to create products that are somewhat different than is on the market but they did not attempt really to specify the product. The closest they got to this was the mandate light for 19 to 26 year olds but again if you read the legislation, it's very loosely written. They are not specifying in great detail the product. So the first point is it's a system approach not a product focused approach.

The second point is that it is a patient and consumer focused, not provider and payer focused. Too often or for too long, my argument is then that we have done too much where we start from the prospective of the payers and the providers. This is particularly true of the other half of the reform, which took what was essentially a provider safety net to deal with the uninsured who weren't going to get them covered. We were simply going to make sure that none of the hospitals went belly up from treating them. And we do that in all the states in the union, we just do it differently. I was down in Louisiana you know they have a whole different system and they are being forced to reconsider because their system literally got washed away in the hurricane and flood. But they have had that since Huey Long. But the whole point is is it was all

focused on the providers and not on the patients. I think that is what is fundamentally important is this is focused on patients and consumers. I say consumers because you know you are a consumer when you are buying health insurance but you aren't actually using it because you are sick.

The third point is that if you want to cover more of the uninsured first make sure that the system works better for those who are currently insured. That is where we started in DC. We were started dealing with the problems faced by the currently insured people. We have a balkanized [misspelled?], fragmented market of small group, non-group, large group, the risk of preempted federally regulated plans and et cetera. And for years, we have been beating the square peg of employer group insurance into the round hole of small business and we are not getting any further ahead. In fact in most cases, are falling further behind. So let's start by focusing not on those target populations who are uninsured but rather on can we make the system well for the people who are and then you have a platform in to which you are on to what you can build other reforms and buy people in.

Finally, point four is to focus first – when you are looking at the money and I do dispute whether you need more money in this, you focus first, I think this is what they did right in Massachusetts, focus first on getting more and better out of what your currently funding levels are before you automatically assume that you need more money. You know we have studies out the ears showing the slop and waste in this system and they are from all across this political spectrum. I think if you start with that

parameter that adding more money and adding a mandate are sort of the last things you do after you have done everything else, I think you are going be on the right road.

I will just use my last couple of minutes to then explain what I think are the key replicable elements of this reform in any other state. And as I said, I think you can do this in blue states and red states as well. The first is the connector piece which is essentially a mechanism whereby you create employer coverage plus. the beauty of this piece and this was the part that we and the commissioner in DC and I worked with federal officials on is to create a mechanism that says look for purposes of federal law when you go in the door, you are a part plan if you employer puts you in. that means you got all these protections and most importantly the money is tax free. But once you get inside the door, you then have a menu of choices that is essentially state regulated health insurance on an individual, personal and portable basis. So it's got all the comforts and familiarity of employer group insurance with the added benefit of being individual, personal, portable coverage and you have the protection of both federal and state law. Notice that there is no way for a fly by night insurer to get into that if every product has to be sold through a connector has to be first approved by the state regulator. That is I think particularly important when you look at longitudinal studies of the uninsured. There was some work that was recently published by Commonwealth and ***Health Affairs*** showing that over four years you have about 85 million people uninsured and when you subdivide that population you find that fully one third of them, 33-percent, cycle repeatedly in and out of

coverage whether it's public or private coverage, but they go in and out repeatedly. Another 29-percent has basically for the majority of that four years, i.e., two plus years, are covered but have one or more episodes where they are not. Then another 26-percent for the majority of those two years are not covered but do have one or more episodes where they are covered and then finally only 12-percent were without coverage for the total four year period. Now what that tells me is if you simply made the insurance stick to people instead of the jobs, you could probably solve half the problem nationally without new money.

In fact, that was exactly the conclusion that the authors of that paper came to. I mean not in so many words. They said ways of finding – either they mean one of the solutions is to find a way where an employer can sponsor insurance without actually having to pick and run the plan. And that is exactly what Massachusetts' reform is designed to do.

The other point that I would or subpoint that I would make in connection with the connector – boy, that is a tongue twister – is that it is important to understand what it is and what it is not. It is a clearinghouse. It is not a product regulator. In fact, this won't work if you make it the product regulator. The product regulator is the insurance department. It is also not a purchaser. This is not based on previous purchasing pool ideas where we get everybody together so we have large numbers to go beat up insurers and providers with. That is a procurement model if you will. That is not a patient choice model. This is a patient choice model. It is not purchasing the insurance. It is a clearinghouse. The best way to

think about it is it's like the New York Stock Exchange. They are not actually manipulating the trades; they are simply providing the service of clearing those trades. They are not buying for their own account, some members may be. The SEC is the place that regulates the securities sold through the exchange.

The next large point is about the premium support provisions. And I would simply make two points there. One, I think it's very important that you look at these as a way to induce sliding scales of subsidies as opposed to what I think is one of the biggest problems we have which is cliffs in our subsidy systems in healthcare where you get all or nothing. There has been some work in terms of either buying into SCHIP or Medicaid on a sliding scale basis or some work where you partially buy into private coverage. I think this takes a big step forward and I think that's the way to go. The other point, and again this comes back to money and focusing people on getting more out of the system and the money they have. This is a block grant. This is not an entitlement. The folks whom I know and respect just did a paper for the California Healthcare Foundation said it would cost nine billion dollars in extra healthcare spending if you did this in California. Not true. It's not true because if you look at the paper what you find is they take the illustrated subsidy rates and then assumed that they were an entitlement and everybody who fell into those categories got their money. Well, yeah, if you make it an entitlement, it will cost nine billion dollars but that is not what Massachusetts did. They said we are going to take the pot of money that we have got and we are going

to subdivide it as best we can to cover people and that's the way the legislation is written.

Finally, there is another element that is not included in the Massachusetts legislation that was included in the District of Columbia and in other states that have put forward some of their proposals. And that is a risk adjuster mechanism. I would say two things about the risk adjuster mechanism. There is essentially a trade off between community rating and by in large Massachusetts has modified community rating but it is a fairly tight community rating. There is a trade off between community rating and the need for risk adjustment. And the trade off is this. If your community – to the extent that your community rate, you artificially increase the costs for people who are better risk and thus you increase the chance that they will decline coverage. Hence, you might need mandates but you don't really need to risk adjust for when people are in the system picking between plan A and plan B to the extent that you as we did in the District of Columbia legislation, simply have you know age based rating, geography is irrelevant in DC as a rating factor as you might imagine. Age based adjusted rates, what that does is it means that price can be better aligned with perceived value for younger, healthier people and you will get them into the system without as much effort. However, you will probably need a risk adjustment mechanism. And then the final point is if you are going to do a risk adjustment mechanism, my preference is to do it in the back end rather than the front end. In other words, basically you put the insurers in a room together after the fact and say okay you sort out among yourselves and then if you feel that you know one

plan got a disappropriationally large share of the diabetics, you know or something like that, you sort it out among yourselves. It is essentially the same as the concept of a high-risk pool. The key difference is that and the funding mechanisms are the same too – the key difference is that by doing it on the back end, high risk people have the same choice of coverage that everybody else does and in fact what you find is once you get the insurers in a room and they start comparing notes, they probably aren't all that different and your experience with these risk adjustors has been then that it's not as big a problem in reality as people fear in anticipation.

I tried to get through a couple of high points on that quickly and I think we are going to move on to questions. Thank you very much.

ED HOWARD: That was good, very good. Thanks Edmund. Complicated stuff, very important stuff and now you get a chance to ask the questions that haven't been asked yet or in order to clarify the ones that have asked and answered. Dianne has some green cards that have already been filled out. If you have them, hold them up and we will snatch them from you and bring them up. There are microphones to my left and right where you can come to ask your question, if you prefer to do that. If you do that, please a: identify yourself and b: keep the question as brief as you can so that we can get as many in as we can.

And we have a questioner. Yes, go ahead sir.

KITCHIN PUTA: Hello, my name is Kitchin Puta [misspelled?]. I work for the Institute for the Advancement of Multi-Cultural and Minority Medicine. Mr. Murphy, thank you for explaining the program.

I wanted to ask you about two aspects. One, which you talked about in terms of the requirement or I believe requirement for pay for performance and then another that I don't think you mentioned about addressing healthcare disparities. I believe that I read that that was going to be a requirement of some sort on the plans. On pay for performance, are you thinking it will be like some of the proposals federally for Medicare that maybe quality providers would get paid like a percentage more, and they wouldn't get it if they didn't perform that well, is it something like that, small incentives? And then on the healthcare disparities, if you could please explain what type of requirements you are thinking of making on these people. How can these plans actually make sure that minority communities are better taken care of?

TIM MURPHY: With regard to pay for performance, the bill does reference that as part of our Medicaid rate increases in year two and three of the plan. I think as everyone in this audience recognizes, pay for performance is what you want it to be. There are many different flavors. You feel like you go into Baskin Robbins when people want to talk about pay for performance. What we plan to do is the following: we will work with our providers and our payers, and we are going to do this in a very methodical way, because what I don't want to have is ten matrix from the Medicaid program, ten matrix from Blue Cross, Blue Shield, ten other matrix from Harvard Pilgrim, and then all of a sudden you just basically have a situation where every doctor and hospital are just sitting there scratching their head. And it is not going to be worth enough money for them to care. So we are going to do this in cooperation, I think

initially what it will start off with is very process-focused type of pay for performance matrix moving towards quality. And will there be kickers for people who do better quality? It better be. There should be but this will take awhile. This is not something you just flip the switch. There is a lot of good literature and a lot of good experience on this matter. You've got some of our, you know, providers doing it today. So we will handle it in that way.

With regards to healthcare disparities, the bill does have a formalized council that builds on a kind of – I don't want to say it's informal today, but we have a healthcare disparity group that meets today. It sets up a 34-member healthcare disparity council which will be better be able to on a go forward basis articulate a certain kind of policies and vision for what both the state should be doing in its programs, what certain providers and hospitals should be doing. The Commonwealth has a long history with these types of programs. And you know we build on that when we work with them.

KITCHIN PUTA: In July 2007 when it begins will something be in place on this, regard –

TIM MURPHY: I think that it will actually be dependent upon what that group wants to do so it will I think premature for me to say what exactly will in place and not in place but as I mentioned there is a group meeting today so I am sure we will build off of that one.

KITCHIN PUTA: I would love to talk more about it. Thanks.

DIANE ROWLAND, Sc.D.: [Inaudible] some questions here from different individuals. Given that you are in Washington, they are

asking what the passage of S-1955 and several NC bill if it's going to be on the floor of the Senate this week, that present the pre-empt state regulation would do to the Massachusetts legislation?

TIM MURPHY: We have had conversations with the folks in the Senate with regard to the NC bills as currently crafted and there are aspects of it that would cause Massachusetts to go back and rethink various aspects of our plan because our plan is, as Ed rightfully points out, is about providing greater opportunities but it's greater opportunities particularly within our small group and our non-group market. So, the Senate 1955 does kind of get into that situation. So, we would have to see what ultimately the final bill is but we would have to make certain accommodations if it were to pass.

EDMUND HAISLMAIER: I know that is important. I want to jump in and make a point about that too. Essentially, when you do this kind of reform you can do it if you do think about it at the state level, you can do it vertically and create, and this is what Massachusetts is trying to do create what I call a single market in the insurance system within a state. You know get rid of the divisions within the market and that's what Massachusetts and other states are looking at doing that. Or you could do it horizontally at the federal level across states. And that is what Association Health Plans, which is again another product-focused approach, is trying to do. The concern that I would have – well, there are a number of concerns but the one concern I would have relative to what Massachusetts has done and other states have tried to do about S-1955 is the extent to which you create or creates room for selection

problems within the state. Because basically what I think the direction the state should go and Massachusetts is sort of halfway there, is they create this connector and they create what is really a blend of individual and group coverage. Because you can come in this as an individual and you get the ability, you solve that GW problem I talked about because if you come in as an individual and you have creditable coverage, you get the chance to change coverage once a year during open season. Right now it says you can pick up and drop coverage anytime that you want but then the insurers need to you know protect themselves, rate against you, to underwrite you. So this would regularize the market and you would allow in this small business to essential right that is going to be my health plan and go in there. What Massachusetts is doing is essentially, as of July 1, that becomes the individual market. That's it. Okay. And they have a study commission to say should we fold in the small business market. Now I can tell you that in the legislation that I helped draft and folks in Maryland who – and it got a fairly favorable hearing. In Maryland, they have a short legislative session; you run up the flagpole one year and then come back the next. But in legislation, there because they had already standardized their small group market, we drafted it in a way that said look and when it goes into effect, this becomes the individual and small group market. So you would still sell group insurance to groups of 50 or more but 50 and fewer that would be the one place where you would get insurance from the state unless an employer not only self-insured but self-funded. So, I can see that the S-1955 might disrupt that because essentially what it does is it allows

interstate sales of small group plans based on an entirely different model.

DIANE ROWLAND, Sc.D.: We have a question for Dr. Mongan. Will you say more about one of the key provisions affordability of policy? Why do you say that this is easier to hope for than –

JAMES MONGAN: Well, leaving administrative costs aside; there are only three ways to substantially lower premiums. You can limit benefits. You can impose large deductibles and co-pays or you can limit the choice of providers through networks, which accept lesser reimbursement. Now this connector idea that Tim and Heritage have worked on is a very good idea and it is a nice little vehicle. I give it an Ivy League A perhaps for solving some frictional problems in the health insurance market. It's a good thing. But it holds no fundamental magic that gets around and needs to make one or all of these three hard choices. And here is where the problem comes in. Fundamentally, scaling down cost is much easier for a commodity like a suit of clothes where you can get on second hand suit for $50 or pay $3000 for an Armanni or a car where you can a clunkier for a thousand or a Jaguar for a hundred thousand. And we don't care morally which choice you make or can afford. But making a much cheaper health insurance policy runs into tougher choices that society is less comfortable with. We are not going to allow are we only five days in-hospital coverage or a policy that doesn't cover surgery. No, we are not. These plans certainly don't envision that. About the only tool left are very high deductibles. And if you get to the point where you are mandating a policy that pays nothing for the first thousand or two thousand dollars you are going to run a

real backlash. Again, in your language down here think of the donut hole times about ten probably. So, this is a very serious challenge. I am absolutely sure that we can make some progress in getting policies that are somewhat more affordable than the current ones. But this is very heavy lifting.

TIM MURPHY: I agree that it is heavy lifting but I think that there are conversations that need to be had with the public. Those conversations are this, today most folks get insurance through their employer and they don't really think about the cost of that because it's going to be taken out of your paycheck. And therefore, as they go and they make choices about the type of provider that they see and the quality that they receive, there aren't the types of questions that get asked on other type of purchases that people make.

So, let me give you an example. We run a 7 billion dollar Medicaid program. Half of the discharges from acute care facilities are maternity in our program. I can show you a graph for the same quality for 12 hospitals in the greater Boston area and I'm paying $1800 to $5800 for the same procedure for the same quality. And we don't have a fundamental conversation about what cost structures are, some of them are legit, some of them are not, and how we pierce through an opaque system and make that information available to consumers to allow them to drive greater value for a very important purchase then we are going to get nowhere. And so I think what we have in Massachusetts is a recognition and a willingness by both payers and providers that we need to enter into this type of engagement and bring the individual into the conversation because

you know at 16-percent of GEDP and growing, you know two X, you know, our state's gross product every year, I don't know where we end up. So this is a I think a fundamental conversation that needs to be had and so that is part that I am particularly excited about.

EDMUND HAISLMAIER: I am going to jump in there too. There is a fourth option. And the fourth option has hardly been tried because we have been so busy beating up on the three that the good doctor just mentioned. And the fourth option is to seek value and a value is good quality and good benefit at a good price. The problem with the system is that the mechanisms for seeking value aren't there and that's is because value is subjective. It's in the eye of the beholder. And ultimately value and what matters is value to the patient/consumer. If you reorient the system to drive to providing consumers with better value then I think you will make some serious progress on it. Otherwise, yes, you are back to the other three of cut benefits, cut reimbursement, you know. That's the key to this. and the whole point is you got to involve the people who ultimately have the greatest interest in staying healthy and spending less because at the end of the day, it's their money. I mean either they can pay directly, they can have their employer withhold some of their money for tax advantages to pay for it, or they can pay it in taxes, you know in a single payer system. But ultimately it is people's money and they are the ones that are getting the treatment. And you need to reorient the incentiatives in the system so that the other players who have expert knowledge like the carriers, the insurance carriers and the providers, have incentiative and are rewarded for providing better value. You know the closest we got is

a system like this, which many of you are a member of, which is the Federal Employee Health Benefits Program. Again, it's not perfect but it is a system that is 40-plus year track record of doing better than the alternatives.

DIANE ROWLAND, Sc.D.: These are some followup questions that came early but they relate to this issue. First of all, Mr. Murphy, the question is what are some of the mandated benefits that people are most opposed to eliminating. What mandated benefits would you eliminate beyond the basic benefits and how skinny can you allow these health plans to get before people will really resist having to pay to buy them.

TIM MURPHY: Yeah. That is a good question. [Laughter] Bring it on. You know I think that – let's take a step back. Who do mandated benefits apply to? Ask that fundamental question. It doesn't typically to large employers because they are in Iressa and therefore they are pre-empted. So now, the conversation starts to come about, midsize to small businesses and individuals and what the state then deems what they should have or not have.

Now every mandated benefit has their constringentcy. Some mandated benefits in our state are things you would have in any insurance product. They only make sense. Others are ones that are kind of you know if you will, possibly lifestyle choices that are being asked to be funded by the rest of the risk pool. As I mentioned earlier in Massachusetts, we probably have about three-dozen mandated benefits. I am not going to go and pick and choose because I don't want to get the letters from people saying how could you say that.

As I mentioned you can save between four and nine percent on a monthly premium if you are able to take certain mandated benefits out. One example that we do use in Massachusetts, we are one of the few states that has an unlimited in vitro fertilization mandated benefit, unlimited, significant costs. I have had friends using in vitro and have beautiful babies and I an not suggesting that's inappropriate in the sense of – but I do feel that if we are going to have conversations about why certain people don't buy insurance and recognize that if you load products up and it's bad value for money, you have to go and fundamentally think about it because in the increment everyone sits there and says well my mandated benefit only costs 30 cents per member per month or 40 cents or a dollar. But then you go and you add up three dozen and find out where you are.

So we didn't get far in that conversation in Massachusetts but I take that back, we got far enough that we put a moratorium on them but I think it's something that is going to have addressed. And as Dr. Mongan mentioned when we start to figure out what's an affordable product and we see what the insurance companies come up with and we see what the prices we get, I think we will probably come and take a look at some of those.

JIM CANTWELL: Yes, I am Jim Cantwell of the House Budget Committee. I have a question for Secretary Murphy prompted by an article in the ***Wall Street Journal*** last week. The article states – it says the $295 penalty is small potatoes compared with the other obligations in the law. The employers are responsible for up a hundred percent of the cost of medical care. There is no cap on the

obligation. As if you have an uninsured worker get sick, you are on the hook.

TIM MURPHY: I grew up loving the *Wall Street Journal.* It's sort of page and now I find myself having challenges with it because they are obviously having some difficulty with our law. With regard to that particular provision, what the article failed to recognize is the following: all an employer has to do to avoid that provision is have a section 125 plan filed with the connector. That's it. No financial contributions required. And all the section 125 plan is doing is you're your employees is allowing them to buy on a pretext basis. We are just trying to level the playing field for part-timers, people working for multiple employers, and we don't think that's much of a challenge for businesses. We ask them to file certain corporation papers to just do business in our state. This is just a new filing. If an employer chooses to just ignore that, then what the law says is if we do see a persistent use of the free care pool over $50,000 per an employer, then the state can come back and make a surcharge payment but that is it. And I think it's a very, very modest request on behalf of employers.

DIANE ROWLAND, Sc.D.: We have a couple of questions here regarding the connector that maybe Ed, you could take the first stab at. One is please clarify the role of the connector in terms of providing coverage to individuals and small group enrollees. Will these enrollees be pooled? Does the connector serve as a pool or a broker? And how will non-group premiums be lowered? And then also the question that explain how the clearinghouse connector function

will know how to link people – what to link people to if it's not a regulator? Who decides what plans are offered through the connector?

EDMUND HAISLMAIER: Yeah. The way the legislative – Tim, correct me on the Massachusetts – the way the Massachusetts legislation is written is essentially it's an any willing plan. I think the connector does kind of play in on the good housekeeping seal of approval on some plans. The way this legislation has been drafted elsewhere – the original version in DC, did limit the number of plans but I think if they actually move that forward now, they would just make it any going plan. So the process would work as follows basically an insurance – but if the state would set up an exchange or clearinghouse or connector and wrote the laws in any willing plan, it would be mean that any insurer that wanted to offer a product through there would go through the normal pre-market regulatory review with the state's insurance commission or commissioner. Just like FDA approves drugs, state insurance regulators have to approve the insurer to do business in the state. They may have to approve each product it wants to sell, whichever market they want to sell it in in the state. So, this would be the same process.

Now the course of the legislation you might alter the terms of that approval but the basic concept is that the insurance agency in the state would do the pre-market approval that is normal for any insurance plan and that once a plan was approved that the connector would have to offer it at the next open season. I mean you would have some rules to you know you couldn't rush in at the last minute, you know it's timing and stuff like that. But that is basically the

concept. What does that mean? What it means is individuals would either go in as an individual, say a self-employed person or as an employer group. The big difference for them would be in the tax status. If you go in as part of an employer group, especially if your employer offers a Section 125, which was I think a very good innovation that Massachusetts added to that, it means that all the money that both the employer and employee pay are pre-taxed. You go in as say a self-employed person, you only get a hundred percent tax deduction. But you don't get the money off your payroll tax.

Once you are in the connector you have this menu of plans, open season or other out of open season times that you are allowed to do it such you know if you have a change in family status – you have this menu of plans to choose from. The insurance plans are rated on a standard rating basis. In other words, whatever applies in the state, in the case of Massachusetts or Maryland is modified community rating. In the state of Maryland, it was age and geography. In the state of Maryland, it was modified community rating C, it was aged adjusted. And they just say look, you know produce your table of rates based on whatever rating factors the state insurance law allows. Then people buy at that table of rate depending on who they are, you know if it is age, then it depends on your age. If it is geography, it depends on the geography. Those are the main factors.

There are a couple of advantages for insurers of doing this. One is that they get rid of payment risks. Right now, people as I said can pick up and drop coverage anytime they want in the individual group market. Essentially this guarantees the insurer,

you know you only get a body if you get paid and if you don't get paid, you don't get a body and you don't have to build this into your rates that you know you are going to pay commissions and then people are going to drop it three months later.

The other thing is this becomes continuation coverage. We did it in DC and I think you did that in Massachusetts too. You just say basically if you lose a connection and the way that these are written is that it is anybody who is a resident is automatically has a right to go in, anybody who is a nonresident but works there could be put in as part of employer group. If you then lose that connection, you can continue participating so continuation coverage.

MALE SPEAKER 1: This will be for Secretary Murphy. In view of the subsidies that are available for lower income individuals what is to prevent or discourage employers from dropping their premium contributions for those low-income workers.

TIM MURPHY: That is a great question and one that, as I mentioned during my presentation, we spent an awful lot of time thinking about you know businesses are economic, they are rationale and they should be. If someone is going to offer to pick up a cost then they are going to look to take advantage of it. we do recognize that in Massachusetts that we have, you know, three million people today who are currently for their employers and we didn't want a situation in which we saw dumping of low age workers into a government run plan because then our financial model would start to wobble. So what did we do? With significant provisions within our bill that basically said to companies in Massachusetts if you are looking to purchase insurance, you need to offer an equivalent

amount of money to someone who makes a hundred thousand or makes $20,000. You can't go make a distinguishment between the two and therefore go and send or drop people over to the exchange.

Now I am going to say we are going to get some of that wrong. Businesses are very creative. We did a small change in our unemployment insurance and we found businesses creating two and three different companies to deal with to get better ratings for certain set of folks versus other sets of folks. So we are going to have to come back and we are going to have to see if we have accomplished our goal, which is basically anti-private market crowd out provisions. I think we have taken the requisite steps. I think that there are some existing Iressa and IRS provisions that are helpful in that regard. I think we did beef up what we did in Massachusetts. If you take a look at our eligibility criteria for the premium assistance we are very specific. If your employer offered insurance over the last six months, you are not eligible. If your employer had offered more than 20-percent or 33-percent for a family under an individual plan, you are not eligible. Now you might make a petition to the connector saying can I take those dollars from employer and come buy a plan. And we would look at that. but we would say this the employer contributions goes to buy down the state's premium assistance first, not your contribution as an individual.

So, we took a lot of effort and time to think through the issue. I am not telling you today that we got it a hundred percent right because I am sure there are people smarter than me who are going to figure out how they might take advantage of the system. But

we will learn and we will come back and we will make adjustments because clearly we are not looking to destabilize that employer market. That is a very important foundation today in our market. Thanks.

DIANE ROWLAND, Sc.D.: We have a series of questions that go to the employer assessment. One is how did you come up with the $295 per employee. Second, do you think it's really sufficient as an incentiative to motivate firms to offer health benefits? And then to what extent does the financing rest on the assumption that this will effect offer rates among smaller employers? They ask hard questions here in Washington.

TIM MURPHY: Yeah. That's fine. As you know in Washington, the way once you get certain numbers is just through compromise. That number doesn't – let me give a little background. When the House of Representatives put their original healthcare reform plan, they had a very tangible kind of if you will pay or play financing scheme embedded in their plan which basically said depending upon the size of your business, you will pay five to seven percent of your payroll taxes in an assessment to the state. That would be offset by how much you then spent in health insurance. So, if you are company and you spend four percent on healthcare of your payroll, then you would give the state three of your payroll, and then we would obviously use that money to pay for these programs.

Senate President and the Governor were not interested in that as a plan at all. You know we deal with enough competitiveness issues in Massachusetts without making us an outlyer on that particular regard. But you know you needed to get a bill, and then

you get compromise. And so ultimately the $295 looked at our uncompensated care program which we referred to today a couple of times and basically did a calculation as volatile [misspelled?]. Take all of the uncompensated care that is associated with individuals who are employed but work for employers that don't offer health insurance. That is your numerator. Take the number of companies and their employees that don't offer health insurance, that is your denominator. And your quotient is if it's greater than 295, only charge them $295. If it is less than 295, charge them the smaller amount. The idea being is that more people get insurance, the less uninsured there are and therefore that number declines over time.

As you are all probably aware, the Governor vetoed that section. It was recently overwritten last week by the legislature. And one of the principle reasons why we vetoed that was the perception that the $295 if you paid it got your employees some type of state program of health insurance. It is not the case. There is no program for $295. We all know that. So you know that as a choice that was made in Massachusetts. It's one in which we will now have to implement through the regulatory process, and I think there is just more to come on that, so stay tuned.

Well, Dr. Mongan mentioned this earlier and we talked about the existing funds that we have today within our system that we are redirecting. We do already have a premium tax that goes onto essentially employers that do offer health insurance. So, we have 160 million dollar assessment on insurers and 160 million dollar assessment on hospitals. Well ultimately, who pays for that

assessment? Well, employers that offer insurance. So there was an element in this bill that they were just trying to level the playing field between offering and non-offering given that we did already have an existing assessment on offering employers.

DIANE ROWLAND, Sc.D.: Secretary Murphy in your discussion you talked about Medicaid enrollment getting 77,000 of those who were eligible but uninsured to enroll. The difficulty in enrolling Medicaid population is legendary and so they want to know what Massachusetts did to get that many people enrolled in such a short period of time.

TIM MURPHY: Well we did a couple of things. First just from a context prospective, as many of you know most states from a yield prospective have between kind of 60 to 70-percent of the individuals eligible for the Medicaid program in their program. Massachusetts has always been an outlyer in that we have had the ability to have probably between 85 and 90-percent of individuals who are eligible in our program. But what further steps did we take? Twofold, first and one that was something that was very much on the Governor's mind when he came into office, which was how can we better use technology to leverage what are our very large scale entitlement of eligibility programs. Over prior to the Governor coming into office our Medicaid program had run on a basically a pay for application. We had a number of different programs that helped people with their healthcare costs. And so, you have a situation where the intake officer could then make a determination of which program they were going to sign an individual up.

So what did we do? We basically started what's called our virtual gateway. It's just an Internet portal. On that portal is an online application. We consolidated all of our applications for various healthcare aid programs. And when we that, we recognized that a lot of folks were eligible for the program, Medicaid program, but were in our "uncompensated care" pool program. That coupled with some outreach frames that we did over the past 12 months lead us to a significant increase in our mass health program. So today, we are about a 1,500,000 people of a population of 6.4. I think we are yielding probably you know somewhere in the 94-95-percent range now those who are eligible.

So, those are kind of the nuts and bolts that we have done on this particular program. No magic. There isn't any magic but I think you got to make a better use of your resources, better use of technology. We are quite proud. We have had over 200,000 applications now come online since we started the virtual gateway. And we still have a couple of our largest safety net hospitals that need to fully embrace our new approach.

DIANE ROWLAND, Sc.D.: I guess the last question can be what are the lessons regarding what you did that we could, should, need to do nationally so that we can achieve coverage for all. You can make your final comments on –

TIM MURPHY: Sure. Data, data, data. If you can change the way people think about a problem, if you are willing to go and understand where the money flows, how costs are determined, how is uninsured in your state, I think that one of great insights to me in this whole process is people will tell you well the left thinks this

and the right thinks that and you can never have a conversation. And what we all just did was emerged ourselves in the information available and understood what were the levers that were being pulled or not pulled when it came to healthcare reform. And I think that the work that the House did and the Senate did and the Administration did was yeoman and sometimes tedious but always exciting. And I think it informed and inviewed the sense of what we were trying to get done because we focused on, you know, let's just get down to facts. Check your ideologies at the door and that made a big difference. And then the other part is and it's just anything in life. It's just a bunch — it's about hard work and it's willingness to kind of see what the end goal is and not giving up. That is why it took us two years. That's why I think we got a good bill. I think that is why mostly everybody is satisfied. We have tons of work still to go, and it will be that same attitude that will infuse how we get this to be successful going forward.

JAMES MONGAN: I would agree with everything that Tim said. It was a long list, they were all important. And again, I would congratulate him and his team's role in this effort. All of things that you have heard about are important. Connectors are important. Markets are important. Value is important. But never forget to follow the dollar. Subsidies are important in this area and that remains the biggest stumbling block nationally.

EDMUND HAISLMAIER: I would say — as I said earlier in my comments, I think the big, big, big lesson out of this is if we really want to tackle the uninsured we got to start not by thinking about the uninsured but by thinking about the insured and the system

that they are in because a lot of the data shows, as Tim said, that a lot of people who are uninsured use to have insurance. So, I want to know why they don't have it now. Because if you have a system where those people don't lose insurance then your residual problem becomes much smaller and much easier to manage. And I think it is instructive that you know the question was brought up about S-1955. There has been an association health plans and you know the House different version and what not but at the end of the day, this is the federal government fundamentally trying to fix something where most of the responsibility right now is the states, while they are ignoring fixing the biggest problem that is the federal responsibility and that is, we have a very backwards and uneven and unequal tax treatment of health benefits in this country. That is the single biggest subsidy system. It says that essentially unless you states come up with something creative like the connector, it says that well you can get a subsidy, a federal tax break that is double your mortgage interest deduction on a percentage terms. Because remember you are avoiding payroll tax, not just income tax but only if you turn over these decisions to somebody else to make for you. We should look at equalizing that across situations, you know self-employed should have the same whatever it is, and they are not saying keep the tax treatment that you got today. We propose by the United Health Right, you know a whole bunch of federal bills, left, right and center wrap some Senators to do all sorts of things with the tax cut. But they have the same common theme which is treat everybody the same and target those subsidies based on the people's

incomes not on who they happen to work for or what tax rates they happen to pay.

So I mean you have the situation where Congress is focused on that part which is not primarily responsible for while neglecting the part in my view that it is responsible for. And that is where I would start. Then the second point is with regards to the states is you know they are doing a lot of innovative things and not everybody will like everything that they do but it beats having one system that nobody likes, having 50 different variance that you could try and test. It does have its advantages. And this is why we are here today because one state did something different.

ED HOWARD: One state DID something. [Laughter]

EDMUND HAISLMAIER: Well, other states have done something. [Laughter] It may not be a success but –

ED HOWARD: Well, thank you all for those excellent closing comments. Let me remind you, we would very much appreciate you filling out those blue evaluation forms that are in your packets, so that we can improve these programs for your benefit. There are copies, I understand, of Tim Murphy's revised presentation available if you haven't gotten one. There are also some flyers about a program that we are running on Friday that has a little bit to do with pay for performance that came up a couple of times today, you may be interested in.

But let me just take a moment to thank – I guess we ought to start with the legislature and Governor Romney and his administration so that they give us something important and interesting to talk about today. Thank the Kaiser Family Foundation,

Diane [inaudible] and the staff there for their co-sponsorship and support. Thank you for your attentiveness and attendance. And ask you to join me in thanking all of the panelists for an excellent program that gives a lot of food for thought.

[Applause]

[END RECORDING]