ALLIANCE FOR
HEALTH REFORM

Updated Resources on the Uninsured and Health Reform
Alliance for Health Reform
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ED HOWARD: Good day to you. I'm Ed Howard at the Alliance for Health Reform. On behalf of Senator Rockefeller, Senator Collins, our Board of Directors, I want to welcome you to this program to look at the newest official estimates of the number of uninsured Americans and if I talk into the microphone maybe somebody in the back of the room can hear me.

Now the Census Bureau announced the results of its current population survey estimates of the uninsured last week and found that 46.3 million people lacked insurance in 2008, up somewhat from 2007. How accurate is that number? Well, you're going to hear a lot about that question in the next hour and 45 minutes. But here are some thoughts I'd like you to keep in mind as you listen to the analysts discuss the numbers.

First, and this is particularly true over time no matter what survey one consults, the number of uninsured in this country is rising inexorably. Diane Rowland and I were colleagues on the staff of the Pepper Commission 20 years ago and the Commission made recommendations to deal with the harsh reality that back in 1988, 32 million plus Americans lacked coverage. Now it's some small consolation that the percentage of non-elderly Americans without insurance hasn't really grown much since then from about 15-percent to about 17-percent now and the absolute number is almost 50-percent higher.

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Secondly, and it's so basic that we sometimes forget to repeat it and keep it in mind, coverage matters. If you look at the Issue Brief that the IOM put out recently, I think it's in your kits, you can see they're finding not only that lack of insurance impairs the health of the uninsured, but that the health of those with insurance in communities with high rates of un-insurance is harmed by that.

The third thing I'd like you to remember is that contrary to what we sometimes hear the uninsured can't and don't get the care they need in hospital emergency rooms. Hospitals can stabilize patients who present in their emergency departments. In fact, they're required to under Federal law, but they can discharge them and they do in many instances.

So as we move into this crucial phase of the debate over health reform with fights over spending levels and government involvement and bending the cost curve, let's not lose sight of the fact that moving toward covering everybody has major economic, social and moral implications.

Our partner in this briefing is the Kaiser Family Foundation. The Foundation obviously is deeply involved in the issue of the uninsured. They sponsor a commission on Medicaid and the uninsured. They're one of the most respected sources of information about the uninsured.

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They issued their annual report on employer-based coverage just last week and at this point, I mentioned Diane Rowland, let me call on her. She's the Executive Vice President of the Foundation and the Director of the aforementioned Commission on Medicaid and the Uninsured.

She's not only going to help moderate today's session, but she's going to set the stage for the discussion by laying out some of the basic findings from the current population survey and their implications for the reform debate. Diane?

DIANE ROWLAND: Thank you, Ed, and thank you all for coming to hear once again about the uninsured and once more about healthcare reform. I think there's a total that we need to tally of how many times we've talked about the uninsured and especially about health reform this year, but it's always useful to revisit the numbers and revisit the problem as we try and look for the solutions.

So today I wanted to share with you the findings from the recent CPS survey that was just put out which is our annual survey by which we track the overall number of uninsured in the country. It isn't the mostly timely of surveys: no survey ever gives us the statistics for today, it always gives us the count for yesterday, so I would warn you as you look as these to think about what the economy has been doing since 2008 and

what may have been the numbers for 2008 will probably look very different when we capture the numbers that reflect today.

So we're in, as Ed said, a constantly evolving environment in which the uninsured numbers grow and the one thing that unfortunately stays true though about the uninsured is that the composition of the population stays relatively stable so that I think as we look at these numbers, we can assume that they are still reflective of the population that is uninsured that we are looking at finding coverage for in the health reform debates.

I think the first and foremost thing to think about is that most people today do have employer-sponsored coverage and public programs provide assistance to many of the lowest income, especially the low income children. So what we're left with when we look at the non-elderly uninsured population, some 46 million, a little lower number than the overall census number which includes the elderly uninsured in it and this is just the non-elderly uninsured, we see that the predominant problem of lack of insurance is an adult problem.

We have done fairly well by coverage of children, here children under the age of 19 who are typically eligible for Medicaid or CHIP if they are very low income are only 8.1 million out of our total of 46 million.

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And again when we look at the numbers, we have to reflect on the fact that one of the things going on that made the number not grow as much as many had expected is that we have been making tremendous progress in coverage of children through our public programs as well as in providing a safety net for the lowest income population through Medicaid during these hard economic times.

So what you see here is that while the number of children from 2007 to 2008 on Medicaid increased by 1.7 million and the number of adults by 1.2, mostly parents of children often eligible at very much lower income eligibility levels than the children themselves, we had as a result a decrease in the number of children who were uninsured, the good news out of the census data that we just saw and the bad news that we have a continued growth in the adult population that's uninsured.

And going back you see that much of the problem with the adult population is that while parents can be eligible for Medicaid and covered, those income eligibility levels are far lower than those for children and childless adults are typically uncovered by the Medicaid program, not eligible for Federal matching assistance if the states elect to cover them unless they get a special waiver.

So the bulk of our uninsured population, childless adults and some of the parents and children are relatively well

covered. And as a result you see that what is contributing to our growing uninsured rate is the growth in uninsured adults and what has helped moderate that rate in the last year has been the growth in coverage for children and the reduction in un-insurance among America's children.

Now the second thing that we have to think about in health reform is where does the problem lie, who's not getting insurance coverage? We have an employer-based system of providing health insurance coverage. If our proposals that we're considering in Congress are going to continue to rely on employer-based coverage, where are the gaps occurring?

And what you see from this slide so clearly is that those who are low income, under 200-percent of poverty, are much less likely to have employer-based coverage than those at higher incomes. Also not always covered, especially childless adults by the public programs, by Medicaid and by CHIP and therefore much more likely to be uninsured.

So as we look at healthcare reform, as we try to figure out how to bring more Americans into insurance coverage, we have a problem in gaps, in employer offerings to the lowest wage workers, a problem of affordability when that coverage is offered for the share the employer asks the employee to pay and a problem of the lowest income people under poverty level not

being eligible for the major public program that serves so well now as a safety net for children.

So those are some of the challenges facing the policy makers as they try to look at the reform options. So I think I would ask you to take the three statistics in this chart away with you as the major piece of the problem that we need to see how different proposals will address. First and foremost, most of the uninsured come from working families. These are families with full or part-time workers and in many cases with two or more workers.

As we have seen our economy cause jobs to be lost we are also then now seeing individuals losing their access to employer-based coverage and if they are truly low income, needing to turn to public assistance for help. Those programs are being stressed and strained as I'm sure John will talk to you at the state level as we weather this economic recession.

But second, and probably most critical to the cost of any health reform proposal, is the fact that those who are low income make up the predominant share of the uninsured population. Two-thirds of the uninsured come from families below 200-percent of the Federal poverty level, about $22,000 for a family of four so that twice that is $44,000.

We're talking now about health insurance premiums in the group market from employers being $13,375 a year on average

so that we're talking about health insurance being extremely expensive, the incomes of the people who need it being extremely low, a very bad match that requires some way to help buy them into affordable health insurance coverage which leads to the Congress' concern about both the cost of insurance and about how to subsidize the premiums especially for the lowest income population.

And finally we're talking about mostly adults and so we're talking about covering the uninsured, a group that is not as popular as covering the children and unfortunately, it's also somewhat more expensive since adults tend to have some greater healthcare needs than their children.

So as the Congress looks at moving forward and the President moving forward on health reform, one of the ways that we've tried to divide up the numbers, and we thank our colleagues both at — my colleagues at the Kaiser Family Foundation's Commission on Medicaid and the Uninsured, especially Karyn Schwartz and Cathy Hoffman, and the colleagues we have, Allison Cook and Emily Lawton at the Urban Institute for turning these numbers around so quickly so that we could look at them in the context of some of the health reform proposals.

If you look at this slide, we're talking in many of the health reform proposals at providing Medicaid coverage to those

below 133-percent of the poverty level. Nearly half of our uninsured would fit into that category and therefore would be covered under the Medicaid program as part of the major health reform legislation.

Above that, between 133-percent of poverty and 400 the proposals are looking at various forms of subsidies to individuals who would have to go into the exchange to purchase their coverage and they would need Federal assistance to do that.

So the level of those subsidies and who's eligible for those subsidies becomes the second critical factor in shaping the cost of the health reform proposals. And finally, we know that the Congress is made up of individuals from and representing states across the country and so the effect of many of these proposals, raising the Medicaid income eligibility levels and allowing childless adults to be covered by the program moving to subsidies to address the uninsured will have very disproportionate affects on different states due to the fact that our uninsured rates and the state economies are very different as well as many of the states have different levels of income eligibility for the Medicaid program.

So one of the other factors that is beginning to be on the horizon for discussion is what is the impact across the states and which states will be helped, which states will have

new costs, will the leader states who have been better about covering many of the uninsured through their state-based programs and Medicaid expansions be rewarded or will the states that have lagged behind get the new Federal dollars?

So these are many of the choices and challenges that are part of the health reform bills and I'm sure that both Len and Stuart will have many reflections on those. But with that setting out of some of the key statistics from the census report and its implications for the health reform debate, let me turn it back to Ed who'll then turn it over to our other speakers. Thank you.

ED HOWARD: Terrific. Thank you very much, Diane. Let me just do a little housekeeping here. You have materials in front of you including biographical information about our speakers. I will not do them justice in my introductions. At the appropriate time you have green question cards that you can fill out and pass forward and there is a blue evaluation form that we'd ask you to use at the end to help us make these briefings better.

And you should know that there will be a webcast of this briefing available sometime Monday on Kaiser Family Foundation's website, KFF.org. You can get there through the Alliance if you need to at AllHealth.org and there'll be a transcript available within a week or so and if you will – if

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you haven't already turned off your pager or cell phone, I'd appreciate you doing that now.

You've heard the basic picture from Diane and now as she eluded to, we're going to hear how one state is coping with the worsened economic and fiscal conditions it faces and how it generates problems for those worried about the uninsured and then we'll hear from a couple of expert respondents to both the numbers and the on-the-ground situation.

So first we're going to hear from John Colmers who's the Secretary of Maryland's – who heads that department of Health and Mental Hygiene which is responsible for among other things, Medicaid and CHIP programs in the state. John spent many years in Maryland state government. He's run private insurance operations, he's been a senior program officer at Milbank Memorial Fund and he's about to rush back to the office and figure out what to do about the H1N1 virus so a little thing like the uninsured shouldn't be a problem at all. John, thanks for joining us.

JOHN M. COLMERS: Thank you very much, Ed. Please cough into your sleeve and wash your hands when you're done. It's a great pleasure to be here and to give a state's perspective.

I'm glad Ed underlined that because it is daunting for those of us from state government to presume to speak for all

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states and as Diane's slide made abundantly clear, the states all are facing very different problems. So I don't presume to speak for all states, but will give you the perspective of a state, one just north of here that has a population of around five and a half million people.

We are a relatively wealthy state but a quite diverse state, a state that has taken some bold steps in health care reform over the years particularly in the areas of cost containment and more recently in the areas of expansion. So let's quickly go through this.

Beginning with the uninsured rates, we are looking here at two-year averages. When you get down to the state level, it's recommended by the Census Bureau to average information over a two-year period of time to deal with small sample size. But as you can see here, using those two-year averages, the uninsured rates most recently have been relatively stable and although the numbers are slightly down in 2007 and 2008, they are not statistically significantly different from those that had appeared in the two prior years.

They are however, both of those numbers, are different than what was the case in 2000 when it was only at 12-percent of the population. For the current year, that represents about 700,000 Marylanders who are uninsured. Over that same period of time, as Diane has identified, the Medicaid population in

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the state has increased. In part it is by nature of expansion efforts that we have been engaged in and in part it is driven by other circumstances in the economy as a whole.

Again the numbers for the two most recent sets of numbers are not statistically significantly different from one another, but they are different from the numbers in 2000. So we differ somewhat from the national number in that while our uninsured rate looks as if it is declining, albeit not statistically significantly so, our Medicaid numbers are increasing.

And for the privately insured, it is a dead heat in the two most recent reporting reports at 76-percent of the population who have private health insurance under the age of 65. And again, that's down, however, from the rate that was in the year 2000 and so you can see that the growth in the uninsured that has been achieved between 2000 and today is largely the result of the loss of employment-based coverage. It's been offset to some extent by Medicaid coverage but not in its entirety.

In response to these issues, Maryland took action in a special session of the legislature in the fall of 2007. Governor O'Malley worked with the legislature to enact the Working Families and Small Business Health Coverage Act in 2007 to directly go after that portion of the population that Diane

identified – low income population that Diane identified that we have historically been lagging in and that is for adults.

That Medicaid expansion began with expanding coverage for parents of children in the state. We are one of the wealthiest states in the country and yet we had income eligibility levels for parents that were abysmally low, 30-percent of poverty which meant that you needed to have for a family of three an income of less than $6,000 a year in order to qualify for Medicaid coverage, which even though the children would be covered by Medicaid in the state, at an individual policy we would be expecting somebody to spend virtually two-thirds to three-quarters of their entire income on healthcare insurance in order to get individual coverage, if they could get it all and did not have a preexisting condition restriction.

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We raised that to 116-percent of poverty and since that time, we have around 47,000 parents and caretakers who have enrolled in the program. For the childless adult population we needed to be more circumspect in how we expanded that and there again, while we had authorizing legislation to also expand it up to 116-percent of the Federal poverty level, that was going to be phased in over time based on the availability of dollars.

The state at the same time was increasing its tobacco tax, there was a change in the sales tax that occurred, but the

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legislature said, for this population we're going to take a look at the availability of money and gradually expand a very limited program we have for those childless adults which provides only primary care and expand that to other services eventually over a three-year period of time to include in-patient hospital services.

Needless to day, with the change in the economy, we have not been able to afford that increase yet. Graphically you can see what has happened to the Medicaid population over time. I recognize that this is a bit of a cheat in that the scale on the left side is truncated but it does highlight some of the differences that we have seen and I wanted to point out that it is the growth that we have seen in the Medicaid population in Maryland is being driven in part by the expansion population, but very much so by the growth in Medicaid generally, again, because of the downturn in the economy.

And so we have seen a considerable growth – 11-percent growth in our expansion population added from December 2007, just under normal circumstances and another 5.4 on top of that associated with the expansion that we have seen. The legislation also included a provision for small businesses, again with a focus on businesses that had not previously insured their population and those that have had low income workers.

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It provided a subsidy of up to 50-percent of the cost of the premium for businesses with between two and nine employees and we required certain requirements with respect to a wellness benefit and a requirement to have a Section 125 plan.

Again this program began right around the time that the economy turned south and so we have not hit the projected numbers that we would have hoped. It's only 200 businesses and 1,000 individuals that have enrolled in this program but for those businesses and individuals it has been a great benefit and we have learned an awful lot in how to perform those subsidies for businesses in ways that work as businesses gradually increase in size so that they don't fall off the cliff.

Additional reforms have included outreach activities that we have been engaged in making it easier to identify families who do not have health insurance and allowing us to reach out to them, that may be eligible but not enrolled in the Medicaid program. And simultaneously with the expansion we streamlined a number of important enrollment processes.

In moving to my concluding thoughts, because I'm mindful of getting to the broader discussion, Maryland like virtually every other state is facing serious budgetary problems.

The state budget has been reduced by the Administration. In the last year alone our general fund budget has been reduced by over $1 billion. In fact for the first time in recorded history, the general fund budget in the current fiscal year ’10 is lower than the fiscal year 2007 budget. So you have a three-year period of time.

The general fund budget is actually lower over that period of time. In part that’s made possible by the Recovery and Reinvestment Act dollars that have come into the state but we continue to face problems.

Yesterday the Board of Revenue estimates in the State projected an additional reduction that would be required of between $200 and $300 million in the current fiscal year and the budget picture for 2011 that we are in the process of putting together now is a budget deficit in the neighborhood of $2 billion.

The second important message is that significant reform at the Federal level is essential. The economy expanded access and an emphasis on outreach is essential for these programs to go forward and the states acting alone cannot do more.

We have stretched ourselves very thin at this point and it is essential that the Federal government help us move forward. And in that regard, we are very concerned in the process as it goes forward in terms of maintaining, because the

status quo is not acceptable with some of the debate that's going on now in Washington.

A state such as Maryland is concerned very much about maintenance of effort requirements and whether or not a state like ours, which have made significant investments to expand to the uninsured, will be penalized.

We are very worried about falling off the cliff next December when the Recovery and Reinvestment Act dollars disappear. In Medicaid alone for the state of Maryland that accounts for well over $700 million a year in addition enhanced match. If that money disappears halfway through our state fiscal year '11, you can imagine in addition to the $2 billion hold that we've talked about already creating yet another problem.

Cost continues to be a problem in the state, notwithstanding the activities that we're engaged in to contain costs through rate setting and other means. A large proportion of the population is spending a disproportionate amount on health insurance coverage and the uninsured constitute a hidden tax on individuals and businesses.

So this is one state's perspective. We know that we are spending in our state alone $36 billion on healthcare in 2007. That's about $6,000 per capita. We know that healthcare reform must be more than simply insurance coverage reform and

we are taking steps here to do that, but states can't wait for the Federal government to act. Thank you.

ED HOWARD: Thank you, John. Let me introduce our two commentators together so we won't interrupt the flow once we get started. We're going to hear first from Stuart Butler, who's the Vice President for Domestic Policy Studies at The Heritage Foundation. He's been around for as many rounds in the health reform debate as anybody in this town. He has a reputation for straight shooting and for collaborating with those from many points of view, ideologically anyway, to actually achieve something in the area of policy and we're happy to have him back on an Alliance panel.

And then we'll hear from Len Nichols, who is the Director of the Health Policy Program at the New America Foundation. He too is an economist, chaired the Economics Department at Wellesley at one time in his career and was an active participant in the Clinton health reform effort from his post at OMB. So, gentlemen, you want to have reactions to numbers and problems.

STUART BUTLER: Thank you very much indeed. Yes, I think Len and I have been working on these things for a very long time without a lot of success I have to underscore. However, I am reminded of Winston Churchill's definition of success, which is the ability to go from one failure to the

next with no loss of enthusiasm. [Laughter] So Len and I are very enthusiastic and we're also part of the PowerPoint free zone. So now they're all of a sudden using PowerPoint.

What I've done is looked at the census numbers that have already been discussed and also at the Kaiser Foundation's 2009 survey of employer health benefits which gives us not only a picture of the employment sector and what's going on, but also a longer term picture of what's happening in there and I think it's very important to look at these small changes in the current numbers in the white in the longer context.

And I think when you do that, some very important things emerge and I think help guide us as to what to do in the reform area. First of all if you look at the census numbers as has been said, you really just see a slight decline in private and employer-sponsored insurance in particular and you see a slight increase in coverage under government programs.

Kaiser shows also a tiny drop in coverage in large firms in the last year and a further significant I would say drop in the coverage among small firms, firms less than 200 coverage there in terms of people covered, percentage covers dropped from 42-percent to 49-percent.

And for smaller firms, 43-percent to 39-percent, some significant fall in just the last year. But then if you look at the whole decade from 2000 onwards, you see I think a trend

which is very disturbing. Coverage through the place of work for people who are in smaller firms significantly falling. For those between 25 and 50, dropping from 63-percent to 54-percent. From those that are smaller, from 50-percent to 39-percent, an 11-percentage point drop on a much smaller base.

So I think when you look at these kinds of numbers in context, you do see some patterns that I think should make us think very carefully. First you see of course a public coverage sector and I include in terms of total insurance of course both Medicare as well as Medicaid and other programs slowly growing but continuing to have long term problems, huge unfunded obligations particularly from Medicare of course.

But you've heard from John Colmers in terms of the challenges in the budgets for the Medicaid program. Medicare has a present value shortfall if you look at the unfunded obligations now of about $37 trillion.

So there are significant problems in those areas. The payment rates for physicians and hospitals in those areas and what that means in terms of the availability of good quality in the Medicaid program and also in the Medicare program.

And I would just say here that, as an aside, there's I think an irony in this. I spent a lot of my time looking at the long term fiscal situation, traveled around the country with people from Brookings and others on that. A year ago the

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argument that we got in push back was you don't need to make big changes in Medicare, in the structure of Medicare, because if you get healthcare reform right, then it will automatically reduce your problems I Medicare.

Now, the argument is we've got to make changes and reductions in Medicare in order to finance healthcare reform. So it's ironic now that we've got a complete change in the argument there, which I'll just leave on the table for you to think about. Also we're seeing a situation I think secondly where we see the larger business sector still reasonably stable but also issues and concerns clearly increasing in that area. We see lower paid people in the larger firms finding it harder and harder to afford coverage for themselves and in particular for their dependents.

We see inequitable tax subsidies continuing in that sector where people at the top end, in the board room, and higher paid people get much larger tax breaks than people who are lower paid, people have to get COBRA or people who don't coverage have other problems of course, but the tax system is still a mess even in the large business sector. We see benefits squeezing out cash income. The long term trends of pressure on cash earnings and cash earnings stagnating because of this.

And we continue to see of course affordability problems that we are all concerned about in healthcare reform that people can move and do move but then big changes occur and sometimes they lose coverage and become uninsured. And then thirdly we see what I would say is a collapsing coverage system among small business.

I think these trends show we see very high levels of un-insurance among people who work in small firms and their dependents of them. We see in the service sector, in particular, we see minorities, Hispanics who are cheerfully in the smaller business sector and in service, high levels of uninsured.

We have a catastrophe in my view in the small business concept of coverage in America. But what does that mean in terms of how we might move forward in thinking about healthcare reform in its broader sense? I would say three or four things come from this. One is, in my view, at least that as we think about Medicare and Medicaid, but particularly Medicare, it's very important not to raid that program which has got so many structural problems and financing problems for the long haul in order to finance reform.

If we're going to make savings and we should in the Medicare program it should be to sustain that program over the

long haul in my view, diverting that into dealing with the working age population uninsured should be unacceptable.

Secondly, looking at adding new taxes to existing coverage, not just for people at the high end and so called Cadillac plans, but particularly the various fees and taxes that some are proposing in the Senate on insurance generally and on providers in this system will in my view further erode the problem and add problems for lower paid people in this country and jeopardize the coverage that is hanging by a string at the moment for many of those people. It'll squeeze cash earnings more because it will simply be passed through to employees.

Instead in my view we've got to look seriously at restructuring the tax treatment of healthcare for people, the tax exclusion and other taxes and do this seriously and do it properly bearing in mind people's income. I would say thirdly we've got to move in a different direction when we think about or actually build up the momentum towards going in a different direction with regard to employer-based coverage, particularly in the small business sector.

It seems to me that we've got to look at the future of healthcare with regard to small business especially much like we've gradually done in terms of retirement savings and retirement plans where the place of work is the place that you

sign up and a lot of the paperwork is done but the basic decisions and the way we organize in the case of healthcare as in retirement savings should be outside the place of work.

I have a handout on that which talks about it which you can look at later. But that does mean, it seems to me, strengthening the place of work as the place of enrollment but moving towards a system through exchanges and through other steps and through pooling and through risk arrangements outside the place of work, particularly for small firms so that those decisions are made externally to the place of work. That is the way we must go and the reforms that we do this year must in view move us in that direction.

And then finally it's very important as I think the reasons almost that John Colmers said, I think this feel very strongly, that we've got to move forward strongly to empower states to make the kinds of decisions and to experiment with the changes necessary to begin to deal effectively with both the challenges of Medicaid and the other public programs and their financing and their organization and the problems of people who are lower paid in the current employment base system.

That means encouraging experimentation through such things as giving legislative waivers much broader authority for states to make changes in programs like Medicaid and other

programs and to experiment in ways that we're not doing right now. There is legislation that has been proposed to do that in both Houses with some very diverse people like Tammy Baldwin and Tom Price in the House, Senator Feingold and Senator Graham in the Senate. These are the kinds of things we need to do.

So in conclusion, I would say that when we look at this I think all of us on this panel and all of us who have been so laboring on this for so many years feel that we have a tremendous opportunity and an absolute need right now to make major and serious changes in the insurance system to get coverage that we all agree on.

In order to do that in my view we've got to some extent hit the reset button and think a little bit more broadly in a more bipartisan way and in a serious way about how to move forward. If we can hit the reset button with Mr. Putin, we should be able to do it with the Republicans if you are Mr. Obama. So I urge us all to do that and I think we can do this and can move forward. Thank you.

ED HOWARD: And when we set the reset button it'll say reset in English, right?

STUART BUTLER: Well it's in Russian, it should be correctly spelled. [Laughter]

ED HOWARD: Len.

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LEN NICHOLS: I would just like the record to show that Stuart Butler recommended using the Russian word, not me, but I like the concept. [Laughter] I like the concept. Thanks, Ed, for having me. I certainly appreciate the opportunity to talk about it and thanks to Diane and John for allowing Stuart and I to avoid the numbers because you all did a great job of laying it out.

I guess where I want to start is really it is a good time, believe it or not, to think about what these numbers mean for the reform debate because it helps us remember why we're doing this. What are we talking about when we talk about health reform in our nation? And it seems to me you can't think about this without asking what, for me is the basic question, who should be allowed to sit at our healthcare table of plenty. Who should be allowed to sit at our healthcare table of plenty?

I submit to you that's a question about what kind of community you want and I'm not going to go into a long religious lecture here because I don't have time, but I will remind you of Isaiah.

The historians tell us there really was an Isaiah, that the Allogians argue whether there were two, I'll leave that to them, but I will point out Isaiah was a real human who walked and he walked in the time of the divided kingdom between Israel

and Judah and he was worried about the physical survival the people of Israel. He was worried about it because the Assyrians were coming and he knew it. The Assyrians are what we would call the Arabs.

The Assyrians were coming and he wondered this, why will the poor fight for us if we don't let them share in the beneficence of Jerusalem? And that's partly why he formulated all those wonderful questions which I read in English, Stuart can read in Hebrew. He's more impressive than me, but I will tell you it's all there, it says take care of the widow orphan.

Why? Because he needed them to fight for them. So he was worried about the physical survival of the people but he was also worried about the spiritual survival. What's the point of physical survival if we don't maintain our covenant with our God?

I submit to you that's the question we should be asking when we think about what we should do in health reform. Now these numbers really tell us the trends are continuing and it's very easy to get caught up in the kind of, oh well you know it ain't that much worse.

So I went back to 2000 to compare what's happened just in the last eight years. We've lost three million people covered by employer coverage in those eight years and we've added 13 million to the Medicaid rolls and yet of course the

total number of uninsured has gone up inexplicably along that way, percentage points a little bit.

The point is this, we're on a path where our current structures cannot sustain it. Let's all say that one more time, it cannot be sustained. We are breaking the states back. So while I welcome Stuart's participation, by the way I would just say if you gave us three hours in true power we could fix this, but neither of those things are going to happen so here we are.

But I think the Federal government has to lead. The states cannot lead. The states must be partners, but they don't have the wherewithal, they're not going to ever get the wherewithal outside about 10 states to even think about it. so it's got to be Federally. Okay. So over time we've got this situation that no one that I know if is in doubt that the reason we're on this path is because healthcare costs are growing faster than income. That's the reason for all of this.

What's different today than was the case when we tried last time, '94, is that many more people are aware of just how unaffordable the current structure is so that the cost of doing nothing is far higher. In '94, trust me, the politicians thought about it hard and decided, hey you know status quo ain't so bad.

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Let's just go out there and say, we'll keep what we got for a while. Now you can keep what you got if you like it. Turns out a lot fewer people like it than would have liked it in '94, so I think they are highly motivated to try to do something and luckily, and I do think we should applaud Congress for this, when you think about it in sort of big picture terms, they are addressing the markets that are working least well.

The whole idea of an exchange is to extend to people without an employer offer and people in those small group markets, where Stuart's absolutely right, they are imploding.

Extend to those folks the same kinds of economies of scale and risk pooling potential that the big firms have which at least puts us closer to a level playing field and at least gives us sort of stopping of the hemorrhaging of the insurance coverage market. But we can't make that work without a big injection of money and herein lies all the excitement.

You know, I was somewhere among a bunch of docs and one of them reminded me of Wellington Mara, who I guess was the original owner of the Jets, right. And he said, when people tell you it's not about the money, it's really about the money. [Laughter] So that's where we are. I think we are in a place where we're arguing about money.

So let me just close by saying politics is hard. I could stop now, but I'll keep going, and let's remember a couple things. The opposition here to health reform that has manifested itself in all these multifarious ways, a lot — I can't quantify how much, but I would just say in technical term, a lot of it is not about healthcare at all.

It is about ideological opposition to an agenda that is about 160 degrees away from the person who was in the White House before on many, many, many, many fronts, and I say 160 as opposed to 180 because a lot has been learned about Afghanistan since the election.

But nevertheless, there you are, big world view change and you know, frankly the economy going through what it's gone through has legitimately scared a lot of people including yours truly.

So there's a lot of unease in all that stuff and in a way, the healthcare debate, even though the President and the Congressional leaders got us to this point faster than most of us in the business thought was possible, and they did it as absolutely fast as they could, it still came too late in the sense that a lot of people's ability to comprehend yet one more complex thing; we've reached the limit sports fans; they have shut down.

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And that's partly the burden we bare at the moment in taking this forward. Second, it's about the money. Cost is high. The simple truth is we waited too damn long so that now we have to subsidize people up to three, maybe even four times poverty to make it truly affordable and that violates a whole bunch of senses of oughtness. You know, how could you need to subsidize people that far above poverty? Something's wrong. Well something is wrong. Most people don't sort of haven't gotten there.

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And third I would say the rhetoric around the opposition has made it particularly difficult to have what I will call, and I think Stuart would agree, an adult conversation which I know he's for and he's engaged in, an adult conversation about how to deal with our long term fiscal house and order and long term which we agree is basically about healthcare cost growth.

When you say any kind of Medicare savings is rationing and death panels and killing Grandma to pay for Pedro, whatever you say, you are – think about it, you're closing doors, you're making it much, much harder to talk about what we need to talk about if we're going to do this.

So when we say, well you can't tax people because you know they don't like that, and people don't like taxes, I agree with that, and you can't use Medicare savings because after all

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we got a Medicare problem. There's just not a whole lot left unless somebody's got a pipeline to Mars with oil attached. I mean I just don't see what you do here. So I will take issue a bit with only one of Stuart's points and that is that moving money from Medicare spending trajectories to covering uninsured should be unacceptable.

I would say take a step back. If we were able to just do Medicare reform, the whole point of getting that trillion dollar unfunded liability down is so we can spend some other place; all we're doing is directing it now because of the sense of urgency in our trying to address finally Isaiah's question, how are we going to make a community what we want it to be? So let me just close by saying the willingness to start over, to reset I think ought to be there. I'm totally in favor of having a real adult conversation about how to fix it.

Everybody on this panel knows the most, you know. I spent the last four years trying to find a way to create space for a bipartisan conversation. And it's not completely over, but you know my brother would say, well boy you failed again. [Laughter] But I would say, not yet.

But I would also say for that conversation to be meaningful at this point, that is to say the recent conversation where we had the big summit at Camp David or

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wherever, both sides have come to the table with the same set of goals about what is going to be needed for our country.

You can't say, on the one hand, I'm all for health reform but just don't spend any money or change anything. You got to say, you know what? I want to help you solve the problem. Now we both know a bunch of members on both sides who have tried to do that. In my opinion, they are the casualties of this rhetorical war. They're trapped in a bunker from which they cannot emerge without a whole lot of help. So to that, I turn to God. Thank you very much.

ED HOWARD: Thank you Len. Can I interject a couple of questions? I don't want to preclude, at all, but I'll just delay a little bit your entrance into this conversation. There are microphones that you can use to ask your questions vocally. There are green cards that you can fill out to ask a question in writing. Let me just ask one clarifying question and one more principled one if I can before we get started.

Both of you gentlemen talked about Medicare and the savings that are included in various bills that would then be used to finance expansion.

Bill Hoagland who was Senior Budget official with the Senate Republicans on the Budget Committee for the better part of 20 years said on a panel a few weeks ago that the net effect on the trust fund of the tri-committee bill in the House was to

extend the life of the part A trust fund for two years. Does that make sense? If it does, what's the big deal about making savings in Medicare that end up preserving the trust fund?

STUART BUTLER: Well I'm not familiar with exactly how he derived that and we're talking about part A and part B anyway and part B is the big driver in many respects. So I'm not exactly sure how to answer that question but I'm skeptical, I must say, and certainly the other things we see in terms of the, don't seem to jive with that. So I have to defer.

DIANE ROWLAND: Obviously the changes in Medicare though, put into effect by the legislation in terms of the reductions, for example, in the Advantage payments go on for some period of time beyond just the immediate period.

So the estimate is that it helps to reduce the actual spending in the programs. Some of the Advantage payments are coming out of part A. So it helps the trust fund. It doesn't necessarily change the overall spending under the Medicare program.

STUART BUTLER: Right. I mean I do think if we can agree then that if we make changes in the Medicare program to test, and maybe this is the Hoagland test, does this improve or leave altered the long-term, unfunded obligations of Medicare?

If there are changes made in reform that reduced the long-term underfunded, unfunded obligations of Medicare then we

can certainly talk about that but what I think is unacceptable is having savings that do affect the long-term ability of Medicare to provide benefits and use those savings or divert savings to other uses rather than reducing the long-term obligations of Medicare itself. That, to me, is the fundamental threshold question about Medicare.

Otherwise in my view, Medicare ought to be off the table for this conversation. It's a separate conversation about the long-term situation.

ED HOWARD: Go ahead Len?

LEN NICHOLS: I would say in some part of my philosophy, I'd like to agree that Medicare should be off the table, but it can't be because this is not just about coverage. It is also about cost growth reduction and the fundamental thing driving these coverage numbers are cost growth reduction. Cost growth reduction can only happen in a way that protects beneficiaries, which we both want to do if you make the systems' incentives far, far better than they are today.

The tool we have to deal with that incentive problem is Medicare payment. If we try to do payment changes across the whole health care system, we would be called Russians. We're going to be called that anyway, but the truth is we're not.

So it's about trying to use the Medicare program's incentive structure to incentivize a set of behaviors, which

we, I would believe, I do believe we have some evidence that it worked in the past and a lot of promising things that are going on right now in the public and private sectors around the country. I can give you that [inaudible] if you like but it gives us hope.

There is a way to change these incentives so that we can improve the behavior, improve the outcomes, and indeed lower costs both for Medicare and the system as a whole. That's what the cost growth reduction part of Medicare reform is about.

JOHN COLMERS: And I would just stress that we have 32 years of experience in Maryland that shows that if you are working on an all-payer basis to contain costs, it is far more likely to be successful than to focus exclusively on one portion of the market versus others and indeed, we are encouraged by portions of the bills that are being considered that would allow for greater state intimation in that capacity with respect to Medicare and hopefully all other payers as well.

LEN NICHOLS: I agree completely, politics is what's getting in the way.

STUART BUTLER: Well I'd certainly agree with that for Medicare for Maryland, and I also think you would agree that a similar kind of discretion and ability ought to be given to

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other states that may choose a slightly different path from Maryland to achieve the same objective.

JOHN COLMERS: Absolutely. Absolutely.

STUART BUTLER: In that case, we're in agreement.

JOHN COLMERS: Absolutely.

ED HOWARD: Yes. Let me just say folks who do come to the microphones please identify yourself and keep the question as short as you possibly can. Peter?

PETER MCMENAMIN: Okay. I'm Peter McMenamin, a health economist from Silver Spring, Maryland and also a beneficiary of Maryland's high-risk plan, which is another way of addressing the problem of the uninsured. I will try to make this brief, but I need to offer a sort of point of information about the current population survey, which would suggest that the situation is really worst than everyone is saying.

The CPS is a residence-based, family-oriented, multi-interview survey conducted by the Department of Labor. The basic question is did you have insurance at any point in time during the previous year? Now the bottom fell out of the economy towards the end of 2008.

So there's a good chance that the reason it didn't go up very much is that people truthfully responded to the questions. Well they did have insurance probably at the beginning of 2008 but they lost it as the economy went to hell.

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The numbers for next year are likely to be substantially higher than the increase we're seeing this year because they will have had a full year to work on it.

The other piece of information about paying for pay drill, not this one but is a lot of confusion, it seems, about what percentage of the uninsured in these numbers represents illegal immigrants. Now the real truth about the undocumented is they're undocumented [laughter]. You do not get into this survey unless the Labor Department has a reason to knock on your door.

If you're an illegal immigrant, and they say we'd like to do a voluntary survey and it will involve six visits back and you need to give us detailed information about all of the members of your family. I have a friend who recently retired from the Immigration Service, and I asked him did he think any illegal immigrant families would participate in the CPS. He said Peter, what have you been smoking?

In all likelihood, there are 9.5 million illegal, no excuse me, 9.5 million immigrants, not American citizens, who are uninsured. There maybe an additional seven million, which is what the number the Hispanic Center says but the intersection between the two is virtually zero. So the true number of uninsured is not 46.3. It's already more than 50 simply because there are illegal immigrants who, in all

likelihood, are not in this survey. So I say offer this as pieces of information, if that provokes additional comment, I'd appreciate it.

ED HOWARD: Len?

LEN NICHOLS: I would just say it makes a couple great points and Peter, I really appreciate you pointing out the prediction, which Diane opened with and that is, it's going to be a whole lot worst in another year because it's already worst because it's worst now but it drives home for me one of the big differences in 93-94 and that is how many more stakeholder leaders are in favor of health reform now than were then.

In particular, I've been struck by some of our hospital system leaders, and I don't mean the AHA. I mean the individual systems and particularly the one that affects me the most is Ascension Health and, for that matter, Catholic Health Care West but, in general, the Catholic Health Care Association. Why? Because they know those people are coming. They come to their hospitals, and they are frankly overwhelmed at the increase in the number of uncompensated care patients in the last six to 12 months.

They make it very, very, very clear that if you don't give us coverage expansion, you can forget about cost growth reduction because we can't do it without it. That's why, to me, these two goals are absolutely linked. Look, you know I

believe coverage expansion is a moral duty but it is also a necessary bribe to get our system the time to become as efficient as it needs to be and those hospitals drive that home.

ED HOWARD: Yes? Go ahead.

RITA JURGEN ADKINS: Yes, thank you so very much. My name is Rita Jurgen Adkins [misspelled?]. I write for Asian-Pacific American audiences. I would like to be able to just have a very quick follow-up of Mr. McMenamin, Peter McMenamin's question regarding the uninsured, the so-called illegal immigrants, which probably there are more than what meets the eye.

My question, my brief follow-up question is that there are legal immigrants who worry about not being able to access their health care even if they are legal immigrants because they are required to present a documentation about the fact that they are citizens.

Now that is a worry among minority immigrant communities, not only those who are illegals for obvious reasons but besides the legal immigrants who pay their taxes but if they have to access health care according to the new rules or the old rules, that would require documentation or proof of their being, of their status as citizens then they are

sort of in la-la land. Would you be able to comment regarding that?

DIANE ROWLAND: I think that you raise a very important point. I mean there is often, in a discussion, a lack of distinction between the undocumented population and those who are here legally who come and pay taxes and are part of the system, we already prohibit coverage under the Medicaid program for the first five years of individuals who are adults in that category.

The states now have some options to cover children in that category under the CHIP reauthorization but it clearly is an area that the Senate Finance Committee is going to take some additional action on as they consider the Baucus proposal. I think it's very important to recognize that John is going to go back and deal with the H1N1 flu.

We have to think about the fact, from a public health perspective, that viruses and flus don't seem to know immigration status when they attack, or insurance status. So I think that those are important points to remember.

I think they also bear on the issue of whether we still need a safety net because if we're going to leave a substantial part of our population out of being eligible for any kind of assistance to get insurance coverage then we're going to still need to look at how hospitals and other providers can at least

meet the needs of those populations for their primary care and hospitalization.

One of the other financing sources that gets tapped is the DSH, the Disproportionate Share Hospital payments, which if those are cut could really impact the ability of the safety net providers to at least address those populations. So that's a very important point to keep in mind.

STUART BUTLER: I do think this issue of the status of immigrants in the context of health reform, we all know, is a very emotional thing for Americans and for those who are affected directly as an immigrant and who has been documented, I think, from day one but still as an immigrant, I'm also particularly concerned about this.

I would also say Len managed to bring in religion. He brought in Isaiah, which is very shrewd because it works for both of us [laughter] but I would just point out in the Torah, it does say you should not stand idly by when your neighbor bleeds.

It doesn't say your documented neighbor as I recall in the original Hebrew but anyway, but nonetheless, nonetheless I think people do draw some distinctions that we just have to be aware of that leading is one thing. Bruising is another and so on and so forth that we do think differently. I think we can't ignore that.

There is a feeling among most Americans that people who quote, work hard and play by the rules, to steal one of Mr. Clinton's phrases, should be treated like everybody else. There are concerns about other people. So it's a delicate issue to deal with.

I think we just have to recognize that and be very careful how we deal with it but certainly clearly we live in a society, which thank God, believes that if you're knocked down in the street by a truck, it doesn't matter who you are. You should be treated. I think that is something that all Americans, in my view, share but then getting these gradations right is going to be difficult and it is going to be emotional. We've got to be serious and adult about it.

ED HOWARD: If I can, the folks who have sent some cards forward actually parallel the question that Diane and I were talking about before we started the Q&A period. That is I have seen on some websites assertions that this isn't really such a bad problem. There are a lot of discussions about illegal, undocumented immigrants but also people who have access to employer-based coverage and choose not to get it, are eligible for public programs but don't enroll.

They have $75,000 or more in income but choose not to buy it or they're only uninsured for a month or two and they get coverage back so what's the big deal. So is it a big deal

and is it a problem that is of a magnitude that we've been discussing or is it really a much smaller problem? I've seen numbers as low as eight million as kind of what we really need to aim at trying to deal with.

DIANE ROWLAND: Well I think that you can always look at numbers and parse them in different ways. One of the numbers is that many of the children who are uninsured are below 100 or 200-percent of poverty and should therefore be eligible for the Medicaid and the CHIP program. Well they're uninsured now. There's no question that they are but they're obviously eligible for coverage under programs but they may not be aware or their families may not be aware that they are eligible for those programs.

We know that their parents are probably not eligible and that when parents and children are covered together, you're more likely to get children to enroll. We know that we've cut back on some of the concerted outreach efforts that would have brought many of those children into coverage.

So part of why we talk about an individual mandate in the health reform legislation is that that would provide more of that incentive for people to sign up for some of these programs to participate so that while they are uninsured now, what we do know is that even if they're technically eligible for Medicaid, they behave and their health care status is much

more like that of the uninsured people because they are uninsured.

So there's still people who delay care who end up sicker and in our hospital ERs and in our hospitals with complicated cases, and they die more often and prematurely so that even if they have eligibility for a program, if they're not aware of it and signed up, they're not going to be reaping the benefits, which is why doing better outreach and employer and an individual mandate may be very critical to getting them in.

The second point, of course, is that on the employer side we know that the share of workers' premiums for many employers is extremely high. So affordability becomes a second issue when we ask people if they don't have insurance because they don't want it, the main reason that comes back is no, it's unaffordable.

If you think about $13,000 for a family policy through an employer where the employees' share may be three or $4,000 a year on an income of 20 or $25,000 a year, that employee is not going to be very likely to be able to say I'm going to sign up for that health insurance coverage because it's too steep.

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ED HOWARD: Stuart?

STUART BUTLER: If I may quite quickly. I think to some extent, this is an issue of how you perceive languages

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being discussed. It really is, for the reasons that Diane just said, you do have segments of the uninsured population where in a sense it's a relatively easy problem to think about solving. If somebody doesn't have enough money to sign up their kids for dependent coverage through the employer that provides it, that's a relatively simple problem of how do we deal with subsidies plus also how we might make the default that you sign up.

So ideas like auto-enrollment, we just know that people are, inertia works against you with coverage. If you change the default to you're in unless you decline, a lot of people who don't sign up today would be in. That's true of probably Medicaid as well. So we can sort of talk in those terms.

On the other hand, I think, as I tried to lay out, if you look at the long-term trends, it's not a simple problem. We do have to think about some structural changes in the way in which insurance is provided in America so that as we come back here to this place year after year, we're not just constantly going down the same road and having the same conversation. I do think that means that in the public conversation I think this is one of the faults in the conversation and quite frankly in the President's leadership on this.

Now there will be changes and there should be changes in the way we offer insurance and how it's provided in America.

To pretend that that isn't going to be the case and shouldn't be the case, I don't think helps. It certainly doesn't help when people then start looking at legislation and say just wait a minute, there's a big change here. Nobody told me about it. They said it wouldn't change.

So I think we've got to be honest. My experience dealing with going around the country a lot talking about Medicare in long-term situations, you level with people and talk about change, and why it's needed. You can have a conversation but don't pretend that to fix the long-term problem, the structural problem, that there isn't going to have to be change and just be honest and talk about it. It's what I think needs to happen.

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DIANE ROWLAND: I have a question here someone raised asking about what the average cost of $13,000 for health insurance means when someone else got a family plan on the individual market that costs $2,500 per year. The $13,000-per year figure is based on a survey of employers, 2,000 employers across the country asking what their most common family plan offered to their employees cost them as an employer and the employees and then we calculate out the share.

So those are policies that are relatively comprehensive though some have high deductible plans factored into it but

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it's the average across the country of a standard relatively comprehensive family policy under group coverage.

What is available in the individual market and what people can get when they go on eHealth and the web and shop for plans are plans that often have much higher deductibles. Many exclude maternity care. Many exclude mental health care. Those are some of the pre-existing condition issues that the legislation is seeking to address.

What you often find is that a plan that you can find on the web when you go to apply for that coverage may not be that price because of your age or because of your family composition or may exclude pre-existing conditions.

So that variation in premiums is yes, there but you're getting different products, and you often can't get unless you're a very young and healthy family, a reasonable priced policy in the individual market. You certainly don't get one that has the same level of benefits as many of these family policies.

Much of what this health reform debate is about is about how to change the rules in the individual market so that individuals who are sick can actually get affordable health care coverage if they go to the individual market.

ED HOWARD: Question from this person who says that they have heard and one of the speakers actually used this

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number and I know the President used it too that every day that we don't reform health insurance, 14,000 people lose their insurance and a little back of the envelope calculation makes that into five million-plus a year.

The census now tells us that the number of uninsured increased year over year by 682,000 or something less than 2,000 people per day. The question is how you reconcile those numbers, is it 2,000 or is it 14,000?

DIANE ROWLAND: Some of that relates to what timeframe you're looking at. So the number that the 14,000 comes from is the relationship between an increase and unemployment and an increase in the uninsured. So it captures a much more recent period than the change from 2007 to 2008 in the census numbers.

It is expected to be one of the indicators of where we may be going today that's been based on looking historically at during a recession what happens in terms of increased number of people both enrolling in the Medicaid program as well as becoming uninsured.

We know from some of the states that we've talked to that they are under very increased pressure for more individuals qualifying for their Medicaid programs and expect that in our next round of census numbers, we may be seeing something closer, but we'll have to check and see what the time periods show.

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STUART BUTLER: Yes, but I think it's also the turning factors, isn't it, that some people may endure a period of uninsurance and therefore both the at-risk and also in some case, actually endure it but a year-on-year number is what the 600,000 is about. So it can affect a lot more people than that year on year net change. I think that is what we're, that is a big concern.

ED HOWARD: So of the 14,000, maybe 10,000 get their coverage back?

STUART BUTLER: Yes. Yes. That's as I understand it.

LEN NICHOLS: Well that's right. What's interesting about the data in the most recent year is how many people gained Medicaid. It wasn't just kids.

DIANE ROWLAND: It was adults too.

LEN NICHOLS: So part of what's been going on here is that people lose their job, historically, they expect to get it back in a couple of months, and they're not. I think they're more likely to qualify and go through the trouble of applying for and getting on Medicaid because they know now that may be a half year to a year proposition.

DIANE ROWLAND: There are two other points that probably should be made. One is that we keep talking about this as potentially a jobless recovery. So in previous recessions, people lost their jobs. They were temporarily

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unemployed. When their unemployment ran out, hopefully they could be back in the workplace.

So what we're seeing now is with the loss of jobs and the economy with big firms shutting down and we talk about COBRA as a way for people to keep their health insurance coverage, but if your employer goes out of business so there's no group employer plan to buy in, you don't have a COBRA option either.

So I think we're seeing a very different kind of recovery that has some real implications on whether people can churn back into the workforce with job-based coverage.

The second thing in the census numbers that we didn't talk about that I think is particularly troubling is the increase in poverty rates and the increase in the number of people who are now in the very lowest income levels, which really adds more people to the potential population be covered by the Medicaid program, but also tells us that we have a much larger affordability issue than we previously had.

ED HOWARD: John, is that showing up in Maryland?

JOHN COLMERS: Absolutely. You saw the numbers that I showed in Maryland. The growth is driven not just by the expansion that we did but by the changes in the economy. My colleague on the cabinet who is in charge of human services are seeing huge increases in the number of individuals who are

applying for temporary cash assistance and other forms of aid including food stamps, which is also a pretty good leading indicator of what's likely to affect people in terms of their health insurance coverage and will stress again that the point is whether it's 4,000 or 14,000, many of these people are likely, without that insurance, may have a pre-existing condition.

In lots of states, they're going to find themselves in a position of not being able to provide coverage for themselves at all, delaying services and eventually a tax being borne by the rest of us when they end up going to the hospital are seeking care elsewhere.

ED HOWARD: Yes. Tony?

TONY HELSNER: Yes. Hi, Tony Helsner. Given the challenges of the reform bills are facing, I'm wondering if it makes sense to cover a certain percentage of the uninsured, perhaps not all of them. I prefer to have all of them covered, but if we had to make a draconian choice given the budget limitations that have been set, I'm interested in the comments that you have, what proportion of the uninsured, which groups would we cover and not cover?

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ED HOWARD: Diane, you want to go first?

DIANE ROWLAND: I usually start with help to the poorest of the poor and that when we are covering children and

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leaving their parents behind that that's a very logical group to begin to add better coverage for the parents so that we can cover whole families. Then I always look at the fact that a childless adult, unless severely disabled no matter how poor, cannot get on to the Medicaid program.

I think that's an area that we really need to move forward in but that in the minds of some is an expansion of government programs; we've got the building block there with Medicaid, but it is an expansion of government programs, and I think, as John points out so clearly, is one that requires the federal government to really help the states because in this economic environment, states are not at all in a position to absorb millions of additional new people onto their roles.

JOHN COLMERS: I would add also, just as Diane has said, is that as we've seen in the numbers this year and have repeatedly seen through the years, over the years, the uninsured is not a monolithic population. So you can identify ways of targeting people. Again, in our view in Maryland, we did start with parents because you're more likely to pick up the kids as well when you enroll the parents to get them engaged and very low-income childless adults, again I'll stress the point. It matters not what your income is in Maryland.

If you are a childless adult, you're not qualifying for Medicaid at all. I think, as a society, I think we ought to be

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in a position to say for those who are below the poverty level at the very least we ought to address that. I recognize that that is a more expensive approach to take because these childless adults often come with significant health care conditions.

Part of the reason they're not employed or making more money is likely that they are facing serious problems, either behavioral health or otherwise, but it seems to me that in terms of the cost to our society, the cost to our citizens, and the cost to our community of having people left behind is unacceptable.

My governor often says there is no spare Marylander. He says that as a way of saying that in order for us to get out of this, these difficult economic times, it's going to take everyone to help us to do that. Leaving people behind is just not acceptable.

LEN NICHOLS: Ed if I could just?

ED HOWARD: Yes. Go ahead Len.

LEN NICHOLS: The only thing I would add to those very good statements is that if we do have to scale back our ambition in the short run, I would hope we would not scale back our ambition in the long run and that we might couple our triage or Sophie's Choice; however you want to describe what we're going through here as an exercise, which may be real

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pretty soon, we should still commit to covering all Americans by a date certain to be visited later because it seems to me, as John just put it, the moral question of agreeing to allow what the Institute of Medicine believes is true that roughly 20,000 Americans die every year because they don't have access to timely care, which they would have had, had they had normal garden variety health insurance.

You do the math. We stopped debating the Clinton plan in August of '94. Fifteen years have passed, 20,000 a year, that's 300,000 Americans we have tolerated being erased. I would agree, we don't have extra Americans.

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STUART BUTLER: I mean I think we're all in agreement here. I do think that Americans, in general, once you talk to them and have conversations, do tend to start putting some triage levels on people, children in particular as people for whom we have a responsibility as adults, I think, consider people who are low-income who cannot go see the doctor and get what we would think, what most people would think of as adequate coverage because of their income, needs to be addressed, people whose lives are shattered not just by illness but financially such that it makes it impossible for them because of their medical condition to get insurance.

I don't know any American who says that that should be allowed to continue. So I think that's important. I think we

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do have to, also I do agree with Len about we must keep our focus and commitment to the overall goal. The word coverage itself is a tricky word in the sense of meaning of what level, what degree do we really commit to and what degree of coverage now for somebody is adequate. I think that's also what this is going to turn on.

Is it everything? Is it comprehensive? Is it just everything except a small percentage of your income is going to be covered in some way? Those are things we're going to have to wrestle with. I don't think there's unanimity on that. That's not a big surprise that there isn't unanimity.

TONY HELSNER: Let me ask a follow-up question. Given that the states are saying they don't want to take on a lot of additional burden on Medicaid, of the bills, the various proposals out there, what are your thoughts about some of the better provisions for covering those that don't have any insurance right now without keeping the expansion on Medicaid kind of at a not extensive rate?

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JOHN COLMERS: I'm sorry. I may not understand the question. You're asking me which of the bills do I prefer from a Medicaid standpoint or leaving Medicaid aside, which of the bills I prefer?

TONY HELSNER: It's kind of a combination of that.

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JOHN COLMERS: I'm still trying to understand the Chairman's mark in finance. I don't think I fully understand it entirely of the financial implications for the state. Again, I'll go back to the points that I raised in my address. I think it's important for whatever they do on the Medicaid side to recognize states that have taken steps early and have expanded coverage and not to put us at a disadvantage that would speak for a higher and uniform expansion of the federal matching rate for the states.

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I think it's essential that they do something with respect to the cliff, the ARRA cliff that we're likely to fall off come next December. There are also issues related to the topic that we just talked about, which are the eligible but uninsured Medicaid population.

We have to take in some fairly extraordinary steps to try to outreach to those people using our comptroller to send letters to people who send in their tax forms who have incomes that make you believe that they might be eligible for coverage and giving them a letter.

We don't get the data. It comes out from the comptroller and tells them how to be in touch with them but there are a substantial number of people there and if you go to a mandate, individual mandate, it's going to place a burden on states. I happen to be somebody who likes choice. So I do

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like components of all the various bills as they relate to exchanges.

I think there are some exciting things that can be done there. I think there are things that you can look at for cross-border issues, but I still know that states have a great interest in regulating their insurance markets. So I think the finance bill looks like one that would give the states the ability to do it but not require them to do that.

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Finally, while access is important and coverage is important, I think we've talked a bit about costs. We have talked not at all about quality and improvements in outcome. I think that the bills, so far, haven't quite given us all the tools that are going to be necessary for us to address the cost and quality part of this.

ED HOWARD: Go ahead.

PETER MCMENAMIN: Let me offer a quick factoid that might unite the positions of our two Isaiahs on stage left [laughter]. Len asked what have we come to that we have to give subsidies to people who are at 400-percent of poverty?

The tax exclusions, the Joint Economic Committee tells us in 2007, came to a quarter of a trillion dollars, a few dollars short and 52-percent of that went to filers who have adjusted gross incomes of $75,000 or higher, which pretty much is four times the poverty rate.

So we're already giving more than half of the tax subsidies for health insurance to the wealthiest people in the country. Maybe it's about time some of those subsidies got diverted to the people who are only less than four times the poverty rate.

LEN NICHOLS: Well once again Peter, you've pointed out an amazingly useful fact, which you and I and 14 people actually remember. So the truth is we've got to spread the word here. In fact, that is part of the way that this debate has already and will continue to proceed.

When you show people how much we are currently subsidizing people above four times poverty, it does get their attention when they had previously said under no circumstances will I ever vote for a bill that subsidizes anybody more than X.

This note I will take occasion to applaud actually this convoluted excised tax, which Stuart appropriately skewered. At least it bought into the principle that we ought to do something on those high-end plans. I will point out very, very, very, very few low-income people are in those high-income plans, on those high-cost plans.

So it is a back door way, let's be frank, to get at the principle of the tax exclusion we all want to reduce or eliminate depending on the day. I would say at least the White

House signaled it could tolerate it. At least Democratic Senators have proposed it, and it's now in the Chairman's mark. So for the Democratic Party to do that, let's be clear, is an act of courage; they should be rewarded in courage.

Now once you accept the principle that you could tax high-end plans because you should then maybe we can move them to the rational kind of policy, which would be the one we would all design in five minutes, but progress is slow in there.

STUART BUTLER: Yes. It may be slow but I think it's very important that we speed up that particular bit of progress as rapidly as possibly. I totally agree with but for the reasons I mentioned that if you just put on a tax and it's not, as we know, it's not only to raise revenue from the high-end but plans generally but let's just focus on the high-end right now.

If somebody is a low-paid worker in a firm that offers a very generous plan and you tax that that hits the low-paid worker. That's a very different view of what we need to do in terms of moving tax money around than limiting the tax exclusion for people above certain income levels. That's why I think we've got to do it, but it's not only in order to move money around.

It is to make it visible to people, as you said, and that's why a hidden tax does not accomplish the other part of

the objective, which is to make people look at their whole compensation and say, do I really need $22,000 worth of health plan so I can go to the Mayo every day for the next week free of charge?

Maybe I ought to have a little bit more cash so that I can pay for the rent next week that we've got to bring that in because that in itself starts to change perceptions of the health care system itself, to challenge it, bring down the costs within the health care system generally.

So while I can understand what Len says about the tactical here, that unless you move quickly beyond that into visibly dealing with exactly the issue in a frontal way that you mentioned. I don't think we will see what should be the broad impact of disclosing that to people and having them begin to demand changes in the health care system to bring that down and push up their cash earnings.

DIANE ROWLAND: I would say that no matter what happens, we'll still be back here next year talking about the census report and the number of the uninsured because all of the health reform pieces that we're talking about won't be in effect. It won't influence the numbers that'll be gathered. So we can be hopefully, by this time next year, reflecting on what will all the reforms that we've enacted do to change these numbers, but we won't have changed them yet.

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ED HOWARD: Very good. Let me just add two things. One is on a blue note, would you please fill out the evaluation forms that would help us improve these programs and secondly, would you join me in thanking our panel for both really good questions and answers about numbers and really good answers about everything from economic philosophy to the Old Testament. Thank you very much [applause].

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