Alliance for Health Reform:
Exploring Realistic Coverage Options for the Uninsured
October 28, 2005

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ED HOWARD: My name is Ed Howard with the Alliance for Health Reform. Ordinarily we would tell you now to turn your cell phones or pagers to buzz or whatever it is that you need to do not as to disturb us. We don't want to take you out of the news cycle so why don't you keep them on, and let us know what is going on. [Laughter] Maybe we can take a break and get caught up to date on the workings of the grand jury as we talk about the unindicted. Oh, I am sorry, the uninsured. [Laughter]

I want to welcome all of you on behalf of Senator Rockerfellor and Senator Frist and the rest of our board of directors to a briefing that is designed to take a fresh look, I guess, at what actually might be doable to reduce the ever-growing number of Americans without health insurance. I want to take this opportunity to acknowledge the support for today'sbriefing from Merck and Company whose former CEO, Regan Martin, is a member of our board. Thanks to Ray and Nancy Carlton and the rest of the folks at Merck for allowing us to get back to what is actually the heart of the mission of the Alliance.

Most of you know that most of the Americans under 65 get our health coverage through our jobs. That arrangement is under a lot of pressure these days. Even the supporters of job-based coverage are raising some warning signals about the

sustainability of current policies. What are you going to recommend to policy makers to do about that? Now some think we need some sweeping change but of course those who hold that view disagree pretty strenuously what direction that sweeping change ought to take place in. And that leads you to the question of whether or not there is anything to be done to lessen the burden on those who are uninsured now and on the people who are providing services to them and residing in their families and households. I personally think the answer to that question is no. There must be some steps we can agree on that we can take while we are working on a broader approach. The panel that we have assembled today is charged with helping us to identify some of the approaches that might fit into that short-term agenda.

Real quick, a couple of logistical items that are similar to those of you who have been before. There are lots of materials in your packets, including extensive biographical information about our panelists to supplement the merger introduction I am going to give them. By the end of today, there will be a webcast of this briefing available through kaisernetwork.org. A transcript within a couple of days on both our website, which is allhealth.org, and the Kaiser network website and electronic copies of the materials that you have in your packets. At the appropriate time, there are microphones that you can use to get up and ask questions. There are

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question cards in your packet and there is the ever-popular blue evaluation form that you fill out before you leave so that we can improve these programs to make them more valuable.

To get at the question of some realistic coverage options for the uninsured we have assembled, I think, a really excellent line of speakers and commentators to help us understand these pros and cons of some of these options and their prospects for actually happening. And, as usual, we have built in lots of time for your questions and comments at the conclusion of the presentation. So, if I can, let's get us started.

First up is Bill Scanlon. Bill may not be known as a fashion plate, although some believe he is. He certainly however wears a lot of hats these days. He is a senior policy advisor with Health Policy R&D. He is a consultant to the National Health Policy Forum. He is a research professor at Georgetown South Policy Institute. He is a member MED PAC, and I have only just scratched the surface. He has been one of the country's premier health policy analysts for 20 years or more. We are very pleased to have him lead off this discussion.

WILLIAM SCANLON, Ph.D.: Thanks very much, Ed. And thanks for not mentioning that nobody wanted to take the risk of giving me a full time job. Let me first of all commend Ed and the Alliance for having this session. As Ed indicated it

goes to the core of what the Alliance's purpose is. I think that Ed deserves some of the credit—for of almost 20 years ago now of raising the consciousness of the uninsured through his work in the Pepper Commission. I think we did sort of raise our conscious. You might think of this as us being at an "orange alert" level sort of at this point in time. But as you know, orange alerts don't motivate us to do much these days.

The sort of sad thing of the uninsured over the last 15-20 years is that you probably wouldn't be too far from wrong if anyone ever asked you during that period of time how many uninsured are there and you said around 40 million. That is a lot of people and that number has been in the same ballpark for that period of time. That is not to say that we haven't made any progress. During that period of time, we have phased in Medicaid eligibility for all children in poverty. We adopted the state children's health insurance program. And if you look at our last recession while adults and children were losing employer based coverage due to the recession, the number of children that were uninsured actually declined, which is a very good thing. We also have the Health Insurance Portability and Accountability Act adopted in 1996, which has made differences in terms of issuing some insurance policies with preexisting conditions, etcetera. Put it in the private marketplace, a little harder to quantify what impact it may have had on the uninsured but it certainly has helped in individuals within the

individual insurance market.

But now we are at the point, as Ed portrayed the question, where are we going to go in the future, and what can we do? I would argue that it is a combination of will and willingness. That is going to be critical if we are going to make progress in the future. The will is that we have to be willing to confront this problem and say it is a priority among all of the other priorities that we have. Ed's issue brief laid it out quite well; we are facing a lot of problems today. There is no question that the uninsured is there among them but the question what priority are we going to put on it in terms of willing to make the kinds of trade offs sacrifices etcetera that are needed to deal with it.

The second thing I think in terms of willingness is that we need to be flexible about how we approach it. Because I think that is one of the things that has characterized that progress we have made in the past is that flexibility, the willingness to compromise. We may not be ready and maybe not be wise to deal with it in a broad and sweeping type of reform but to deal with it in what you might think of it as bite-size chunks. That empowers the reality that the uninsured is not a homogenesis problem. It is a series of different problems and, they may need to be addressed in different ways. We also need flexibility in terms of how we approach it philosophically with respect to the roles of the private and public sector. And this

is something I think that very often leads to impasses. And again, if you look at the children's state health insurance program, it is potentially an example of where there was a little give on both sides and we have something that happened.

I want to talk about two areas where we might think about taking a bite out of this problem. Namely low incomes of working age adults and secondly with the problem of the small businesses and insurance among small businesses. But what I wanted to first though is talk about some about the nature of the problem that we face because I have been hearing of late discussions that attempt to dissect the problem which I think is a very good effort to get a greater understanding of what is at stake here but often can be misinterpreted as trying to minimize the nature of the problem.

We talk about the 40 million uninsured. We also talk at times about the differences in survey results in terms of what the exact count is. It is not really critical to the point of what the exact count is because the surveys come to roughly similar sets of numbers. Numbers that are of a magnitude that they are important enough to worry about. It is true that when we talk about whose uninsured at the point of time of the survey that we get numbers in the 42 to 45 million range. But if we ask the question, "Were you ever uninsured during the course of the year?" we come up with 50 million. This is out in the health unit survey. If we ask who was uninsured from the

entire year we get 29 million people. This is perhaps the group of people we need to be most concerned about which you might think of as long term or chronically uninsured. Today's *Washington Post* tried to give you a prospective if you look at the first page of the business section and what $9.9 million worth of profit that our Exxon earned last quarter, meaning that they tried to compare it to other things.

Let me give a little prospective on 29.2 million people. If you take the population of the 50 largest cities in this country and you add them all up and then you exclude Chicago, Los Angeles and New York—the three largest—it is smaller than 29.2 million people. This is bigger than the population of 47, accumulative population of 47 out of the 50 largest cities in this country. It is a big, big number. Something that should motivate us.

There is another sense that a lot of the uninsured is due to the myopia of the young. You might call it the super hero syndrome. They are not going to get sick so they don't need to spend of any of their saved money on insurance. And it is true that 23 percent sort of involved the uninsured are between 18 and 24 but 26 percent are between 45 and 64. Age of life when you are vulnerable for developing health conditions, when you may have left the labor market and you may be discovering you are on your own in terms of trying to provide insurance and you discover the difficulties in terms of

underwriting, restrictions on benefits, etcetera. It is a problem that may become worse as we hear more and more employers restricting retiree coverage and that particular aspect actually may help promote interest in this issue in terms of dealing with the uninsured. Consequences of being uninsured are also quite significant. You have about 3-6 percent higher probability in terms of skipping treatment, not taking medicine, not getting care when you have a problem and while there are sometimes when I think that we potentially sort of underestimate what the significance of the responses to survey questions like these are. There is an interesting study that is in your packet that was in The journal of the American Medical Association by a group at the University of Minnesota that tried to get follow-up care to an emergency room visit. They contacted physician's offices, clinics, etcetera and said, "Would you give me an appointment? I have been told by the emergency room doctor that I have a very serious problem." And the answer was, if you were uninsured, and you weren't willing to pay the money up front, you had only a 25 percent of chance of getting an appointment at one of those physician's offices or clinics for your follow-up care.

Let's talk now about the issue to trying to deal with the components of the uninsured. And first of all this issue of the low income uninsured adult. As you can see about a quarter of the population who are uninsured and are working age adults

are in poverty and about half have incomes of less than 200 percent of poverty. It doesn't mean that they are not working because actually 60 percent of the uninsured work full time so the majority of these people are working. But they are not able to get employer based coverage. If you look at the uninsured and you look at where they worked, 67 percent are in firms that don't offer coverage and another 20 percent are in firms that offer coverage but they are in particular are not eligible. They could be part-time; they could be lower wageworkers. The reality is that the safety net doesn't work for a lot of working age adults because it doesn't matter how poor you are, you also in order to qualify for Medicaid you have to be categorically eligible for Medicaid coverage. What that means is you have to either be disabled or in a family with children. If you are a childless adult, it doesn't matter how low your income in including if it is zero, you are not going to qualify for Medicaid coverage. So let me put out here not necessarily with the sense we are ready to vote on in the Congress but as a discussion point, the idea of thinking about some type of coverage, something along the model of the SCHIP program from adults in poverty. The SCHIP was feasible in part because we recognized the significance of the problem and we were interested in covering kids. SCHIP was also feasible because we came to a compromise in terms of structuring the benefit. While there was interest on the part of some to expand the Medicaid

program and an interest on the part of others to say, “Let’s let the private sector do it.” This involved the melt of the two in the sense that while there is a Medicaid expansion option, there was also the option for great reliance on the private sector for slightly different benefit packages for some of the differences in cost sharing. These are the kind of things that maybe can bring people to the table in terms of a consensus to generate enough bipartisan support to secure passage.

Another critical feature of SCHIP was the fact that it involves greater federal financing and an increase over what the federal financing of the Medicaid program is and I think that is critical in thinking about sort of any type of future federal and state partnership. If you look at Medicaid and you look at the variation across states, you are struck by the fact that while there is differential matching of state Medicaid dollars by federal dollars, it is not enough to overcome differences in the ability for states to finance their programs or their willingness to finance their programs by a long shot. We have incredible variation in the Medicaid program. So, if we want to have a safety net that is relatively uniform across the country in terms of coverage for people in poverty, we are going to need to think about much stronger federal financing for it, in particular to provide that strong federal safety net during recessions. I mean we saw it during this last recession

the difficulty that states get in when your demand for the Medicaid program increases at precisely the point in time that your revenues are declining due to recession and if you are 49 out of the 50 states you have also a balanced budget requirement.

Let me talk now about the second bite, which is the issue of trying to help small businesses in terms of offering more affordable coverage. As you can see among the uninsured, a third of those uninsured working businesses of fewer than 10 workers and two thirds fewer than businesses of fewer than a hundred workers. Sixty-three percent of the uninsured are in those businesses yet only 40 percent of the workers are in small businesses. Small businesses have a number of different problems. For one, they end up when we look at the data, they end up paying the same premium on average but it is for a smaller package of benefits so they are actually sort of paying a higher price. And there is some myopia about looking at the average premium that small businesses are paying because we are only looking at those that actually ended up buying the insurance. We are not looking at those that were quoted a much higher price and said, “I am sorry. We cannot afford it so.” What prices small businesses truly face could be considerably higher.

Before I give you the option let me tell you about something else about the small business market, which is why we

are hearing a lot about employers and employers concerns about health care costs and their reduced willingness to offer health care benefits. So far among large firms we have seen very little of that but we actually have seen quite a bit of this phenomenon of firms reducing their offerings of insurance among small firms. There has been about a 15 percent drop in terms of the likelihood that a small business is going to offer insurance between the year 2000 and 2005 so not only do we have the issue of how the small businesses provide less insurance, we have to worry about the issue that the situation is deteriorating.

In terms of an option, what I would like to talk about is something that I am actually borrowing from Secretary Thompson. Last month, in a speech in Nashville, he talked about how we should deal with the uninsured for the small businesses and suggested that what we do in terms of relieving some of the cost pressure is to set up a reinsurance pool at the state level but finance very heavily from federal funds. The idea would be that in small businesses and their insureds by passing off the risk to the reinsurance pool could avoid some of the problem that are associated with experience rating. Because experience rating is particularly problematic for a small business when you have a single individual or some individuals within your firm that encounters serious health problems and then there is a need to—I am sorry, the insurer then responds

in terms of dramatic rate increases. Reinsurance would help stabilize premiums for individuals of small businesses. The subsidies would help in terms of reducing the overall premiums and how much they would reduce them would again depend upon to how generous the subsidies are but there is the potential here that we will be able to prop up the small business insurance market to some degree.

These I think are relatively modest proposals to put on the table. I mean, I don't know how big they are taking in terms of sequential measures. I am looking forward to hearing what the rest of the panel has to say because I think we need a lot of discussion and a lot of refinement of options before we are going to make progress. Now it maybe that we are not going to make progress until we have a year in which the last named storm begins with the letter 'j' as opposed to moving into the Greek alphabet. Thank you very much.

ED HOWARD: Thank you, Bill. Next, we hear from Rick Curtis, the president for the Institute for Health Policy Solutions. I think we are holding him to that as his task today. That is where he and his colleagues consult a whole range of both public and private entities on ways to improve health coverage for the uninsured. Some of you may know he directed health policy studies for the National Governors Association and what was then the health insurance Association of America. He was

one of the founders of the National Academy for State Health Policy and is as familiar with what is going on in different states to try to deal with this problem as anybody I know. He also has a suite of offices right next to ours so I can keep an eye on what he is working on, and it's very interesting stuff, which is why we have asked Rick Curtis to join us. Rick, thank you.

RICK CURTIS: I am actually going to talk about state policy incentives and not mention the word Medicaid but I do want to reinforce Bill's suggestions for low-income people below poverty. That painful and simple truth is that this is a population that will not be covered unless government finances it. The market cannot solve it. Working with the market without adequate subsidies cannot solve it. Some solution like he suggested is the only solution in my book.

That said, I am going to be concentrating on the working uninsured, and I am going to talk about two sets of things. One, initiatives now to reach the kind of small firms that Bill talked about and then secondly some of the movement toward of coverage of all in the states which is what we are concentrating more on now. First, I want to just make this point. Bill threw up a lot of data but if you go to the bottom line, if you look at the kind of firms that don't offer coverage, you can see that the workers that work for that firm

are preponderately working for a small firm. The kind of people that work for firms that do not offer coverage, for whom premium assistance can work to buy into existing clear coverage tend to be the ones who are working for the bigger firms. So this is something that people often get wrong. Don't try and reconcile these data with his first slide on similar issues or with his second. All of the three are from different data sources. What you need to look for is patterns.

Secondly, this is a terribly important point. If you look at the wage profiles of the small firms that don't offer they are much more likely not to offer. This is not surprise if you think about it but if the median wage or the majority of their workers are low wage workers this definition is majority making less than $9.50 an hour. So you can see that under size 10, 19.5 percent, 20 percent offer coverage if the majority of their workers makes less than $9.50 an hour; and, in fact, more of them who aren't in that low wage group offer coverage than the low wage employers in the next range and size, ten to twenty four, as you move on up. Not surprisingly, a number of states have tried to target that population and I am not going to try to go into details on all of this but I am just going to give you a flavor for some of them.

The newest is Montana. They had earmarked funding to do something about health and health coverage from a tobacco tax approved by the voters not long ago. Part of what they have

decided to do with that is provide subsidies for a purchasing pool for small employers. The funding is very limited; the federal government will be receiving a waiver application for them. They are providing some offsets to the premium contribution required to employers and then sliding scale subsidies to people based on their income within those groups. They are going to start enrolling January 1. This is at very fast pace. I will mention this very briefly; Bill mentioned the issue of selection and cost per person based upon health profiles and what a problem that is to small employee market. In a state like this that does allow health rating in their market rules trying to put up a pool where you can tell employers, what their price is going to be is a very difficult thing to do.

Massachusetts for some time now has had a thing they call the insurance partnership. There are federally matched that does include sole proprietors as well as small firms. Michigan you have probably all heard of this. They have a three share programs in a number of communities and in fact, some of them are four share programs but the idea is there is a subsidy, and there is an employer share and an employee share. Often there is also a discounted premium because providers are participating in a plan. At discounted rates, this often uses dish money—I said dish, I didn't say Medicaid. One noteworthy thing is here in communities where this is basically the major

initiative for the uninsured they have robust enrollment, like in you have probably heard of Muskegon. In communities where they tried to replicate it but they already have another program for individuals that is more heavily subsidized so that a small firm employer's workers can go get coverage at no cost to the employer over there only it is only front end coverage, not real insurance coverage. Guess what, the employer aren't willing to come into this kind of program and contribute. That is an important lesson.

New Mexico now has their long since approved waiver program up. Healthy New York does use a reinsurance program like Bill mentioned. I won't get into this now. I think you know this is partly a political solution. Some people are more willing to put money into covering sick people than people are means tested. Frankly, you need a subsidy somehow. I have real concerns about the system initiatives and cost containment initiatives and whether you need this kind of a thing if you are really moving toward coverages of all as opposed to a risk adjuster, which is more initiative, effective way to adjust for risks. Maine you have probably all heard of the Dirigo Plan. It is going well. It is controversial. There is some partisan disagreement about that. I mention West Virginia because it is new and some of you have heard about it. It doesn't really have subsidies but its an adjunct to the state employee plan and they are passing through the provider discounts safety nets

through Blue Cross and Blue Shield, which is the carrier and apparently got 20 percent under market rates for small employers, and they are getting some enrollment.

So then, as we have looked at these things in the past, what are some critical determines of whether they work or not. They are common sense actually pertains. These kinds of employer groups cant afford healthy premiums, they cant afford to be in a position in that if they decided to buy coverage they might be a year from now left holding the bag because the subsidiary goes away or because experience rating increases the rate a lot. So, they need to know it is going to be predictable and affordable. Those are the first two rules.

Secondly they can't be in a position where they are suppose to know what family income is of their workers as close to wages. There are hybrid ways to combine these things but employer knows wages, they don't know family incomes. Workers generally don't want their employers to know family incomes for a range of reasons I could discuss that you could add to it. So those the critical characteristics, what doesn't work, getting the employer involved either in testing family incomes, or varying how much the employer is going to have to pay based on family incomes because the employer doesn't know what that is. It's real simple but it is true.

The employer contributions don't reduce their workers costs. I just gave you an example of that from Michigan. It is

just doesn’t work. The employer needs to know that if they are putting money especially this kind of employer that actually makes it more affordable for their worker the alternative is the worker can go get a free public program. The employer is going to say why should I spend money on this. Again, common sense pertains.

Now then, what does this have to do with really covering the uninsured? These things are something of a thumb in dike approaches. In Montana, they are only sure they can cover six hundred people in these kinds of firms, uninsured small, low-wage firms with their existing money. They hope to stretch that by getting a waiver but it’s, you know, a dedicated funding source. Some of these other programs are considerably bigger. There is no way any of them can be represented as coming close to solving the uninsured problem or even solving the uninsured problems among small firm workers. But they are important because they do cover some people and because they are developing structures that could work as those states are nationally removed and we move toward real solutions to the uninsured. One part of that is hybrid coverage solutions that don’t stick to—this is a public program with subsidies or this is employer group coverage or this is individual market coverage. There are a lot of interest groups here in town who think that only one of those is the way to go. Practically for these kinds of populations we have to find hybrid approaches,

get away from ideology, figure what works. And when I say a hybrid approach, it is an approach that reaches people through work where they can because the enrollment works effectively. The collection of their portion of the premium contribution works effectively. You do have some spreading of risk. When I say individuals because the individual gets to have the coverage, gets to choose the coverage, gets to keep the coverage over time. When I say public subsidy I mean you have subsidies based on income going to people that need it. And I don't care if that is a tax credit or it's through a public program that you are drawing federal matching funds.

If we are going to solve this problem, we need to get realistic about what will work and drop our idealogies and rigid predispositions about the model that has to work.

Now then, what can a state do to really solve the problem? They can—here are the ranges of things the states can. There are risks of prohibitions against the state directly requiring employers to offer coverage, as you know. They can do individual mandates. And then the question is that traditional individual marker, you have a more effective pool, and you don't have all of this health rating. What do you do to relate to employer coverage or do you blow it away and start over again? Hybrid approaches that is the kind of the thing that builds on these initiatives that I have told about where you say okay employers at least you have to offer maybe you have to

contribution a little bit of something. You set a floor on their roles and you make that an effective way to get some of these people into the system and then you work with the existing employer world as well. You combine these things, you cover everybody. Employer play or pay is the approach that if structured right can circumvent the ERISA constraints on states' mandates where you basically do or say employer you got to either contribute this much or we will waive that contribution requirement into a state pool or we will waive that if you are offer direct coverage and contribute at least this much to it. And then last on the continuing wall, while a state cannot mandate an employer to offer coverage or specify the benefits of that coverage, they can simply say hey we are going to have a fee, a tax on all employers. And we are going to use towards the pool.

Now then I going to voice—boy, is this going to be cryptic. Massachusetts you may know—the Governor Romney there has proposed an individual mandate, and he is proposing a pool-like thing he calls an exchange—that is the newest word for a pool—and through that exchange, there is sliding scale subsidies available for people up to 300 percent of poverty. This is a state with relatively high incomes. There is a low-cost lien benefit exempted from mandated benefits plan available for people above 300 percent of poverty through which they can fulfill the mandate. There is a lot of other fancy

footwork but those are the basics. In California, there was a bipartisan bill proposed this year by a Dr. Richmond and Representative Nation who by the way was a former RAND Economist Researcher. It died in committee. In California, you— many of you may know but this is important to get. It was enacted the previous the governor did sign it. It was highly political. It was a pair play; it was defeated as a referendum. It was defeated barely, 50.9 percent against 49.1 percent for. So this really resonants what people on all sides in California. They understand the electorate wants something here. This was because of some anominalities having to do with state law and restrictions through previous initiatives that some of you are aware of. It is very arcane stuff. They couldn't have any state cost associated with this without having a substantial bigger majority vote. So they are were no extra subsidies. So, we did an implementation analysis of this with RAND. Surprise, surprise there was a very disproportion of burden for low wage groups, employer groups, and low-income groups. This was a payer or pay proposal only for employer of size fifty. That is for political reasons. That is not where the uninsured tend to be. It covered about 26 percent of the uninsured and of those affected by this mandated only nine percent were uninsured. Those were RAND estimates.

You may know Vermont's legislation did adopt a payer or pay. It was a payroll tax of 3 percent of employers. It don't

cover all their workers and it was vetoed by the governor. These are all states that are eventually going to be doing something serious. In Wisconsin, there is a bipartisan proposed support, which is equivalent to the right hand side of that continuum I showed you before where there would be a payroll fee on all employer groups. It would be based—the structure would be based on the state employer plan with competitive choice and employees paying the price differences based on value and choice. Many of you know that Hawaii does have a mandate. There was an ERISA provision enacted for them. Many of you may not know that that split into stone that employer contribution cant be more than one and a half percent so guess what. The kind of small firms that don't normally offer coverage cant afford that. In fact many of them don't, even though technically they are suppose to be offering it. So, they have something like a ten percent uninsured rate. The employers that do comply when they are small on the wage end have a disproportion of burden they cant afford. And guess what? It pertains to about 20 hours a week and now they have a lot more jobs that are 19 hours a week so there are labor market dislocations as well as uninsured problems. So people there are looking at a combination of premium assistance where it is needed, some relief to these kind of small employers and individual mandates, some kind of a pool to make all of that effective so you don't have to pay the kind of loading factors

that you see in the individual and small group market for these populations.

Last point, when you think about states a lot of times you think about your matching formulas which are based on per capita income. California, Massachusetts, and that unnamed program, 50 percent each, they are both above national average on per capita income. Their unemployed rates are about the same as the national average. When you are talking about program like this that is where the similarities end. Percentage uninsured, take a look: 20 percent versus 12 percent. Look at the percentage of adults who are lower income. You have much more of an immobile distribution in California. The population by income than in Massachusetts. So you got half as many people here who are low income; and furthermore, if you look at this low income people, how many people are uninsured? It's way more in California than in Massachusetts, the percent. But if you look at above 400 percent of poverty, it is not that dissimilar. Why is that? Well, part of it is how many Spanish and Latinos, as you know. There are all sorts of issues around this but at any rate, their uninsured rates even adjusted for income are higher and look at that difference. Massachusetts seven and a half of the population, California 35 percent of the population. Then who works for these kind of small firms who cant afford to offer coverage? Seventy percent more proportionally in California than Massachusetts. So that goes

to Bill's earlier point that how you solve this problem is obviously has got to be somewhat different. Although there is strong interest in both states and the approaches being pushed in other states but boy, I will tell you the cost implications and coverage implications of any given approach are very different in two different states.

ED HOWARD: Wow. And he left a bunch of stuff out, I know. Thank you, Rick. There are a finite number of policy options despite what you might infer from Rick's presentation. The question is what is the likelihood that any of them is going to be able to gain any traction any time soon. So we are very pleased to have with us two imminently qualified policy analysts who have impeccable political credentials as well. In addition to which they now have the freedom to tell us what they really think because they are no longer on the Hill. We are going to start with Dean Rosen. Most of you know Dean. He has been the senior health policy advisor to majority leader, Senator Frist, our vice chairman. He has been a key professional staff of the House Ways and Means Committee and as of a few weeks ago, he directs the health care practice at Mehlman Vogel Castagnetti, a policy strategy firm here in Washington. In his spare time, I understand that he is going to be helping guide this new health policy analysis unit at Vanderbilt University as well. Now he is back in the private

sector, I am sure he is going to be brutally frank with us today about what we can do about the uninsured. Dean, thank you for being with us.

DEAN ROSEN: Thank you for having me. I appreciate you being here and while indictments or not indictments are being handed down, I appreciate you sitting here even more. In any event, let me again echo Bill and thank Ed and the Alliance and Merck and others for continuing to come back to this critical issue because it is a critical issue and a critical challenge. I am going to see if this works.

I am going to try to do four quick things. One sort of give you a current environmental impact analysis of where we are and be brutally frank. Then look to the future in terms of what political catalyst there might be for moving the issue of the uninsured and coverage forward. What vehicles there might be that would spur that along? And then quickly what some of the options are and obviously Bill and Rick have already touched on some of them. Liz will touch on others.

The bad news we have got high deficients although not as high as the percentage of GDP as we did in the eighties and early nineties but we got high deficients. We got debt more importantly if you look at the recent testimony of the Congressional Budget Office; we got growing costs that are locked in because they are entitlement costs. And finally in

terms of the bad news and the barriers, we have a lack of policy consensus, and I would argue that there are two elements to that. For the first is, you have philosophical differences between the political parties that are fairly significant on the issue of health care and health coverage in particular, and we will talk about that a little bit more in a couple of minutes. Second, this something that Bill Scanlon, I thought, did a nice job of focusing on. I think we also have a lack of focus. I think if you look at the successful efforts in the past including SCHIP, if you count that as a success in terms of expanding coverage, or something that Liz worked on, the Trade Adjustment Assistance Credit. There was consensus in both of those examples about who we were trying to cover. But I have been to a number of these policy conferences as you all have over the last two years, three years, and you know there is a question. Should it be kids, should it be everybody who is low income, should it be low income working adults, should we focus on small business and etcetera, etcetera, etcetera? Or there are some folks who Stewart Butler and Henry Aaron and others have worked on this. That we ought to let the states go first and ought not do anything on the federal level. So, the third barrier I think is important to overcome as well. Not only philosophical differences that Rick talked about but also focus differences that Bill talked about.

Let me just highlight the second bullet really quickly

which is the entitlement cost because these are the things if you look at the testimony of the Congressional Budget Office and Doug Holdsek [misspelled?] and others are structurally built in which is we have a rising—we are not only a relatively large deficient, relatively large debt but we have growing federal government costs in the red bar is the entitlement spending and the mandatory spending. The little purple bar on the very top—I don't want you to memorize these numbers but just get a sense of where we are going—the purple bar on the top is the net interest on that debt and that is just going upward. So, anyway.

Now let me shift, and I don't mean to insult anyone by calling them stupid; it is really more me. But let me look at future political catalyst, which is the second part. Now that I have talked about the bad news—here are some of the other things. If you look at all of those bullets, the uninsured is at the bottom. The uninsured is a symptom I think of at least some of these. But if you look at survey data and polling data across this sort of political spectrum and you look at just what is happening out there in the marketplace, the General Motors announcement the other day, the other aspects is sort of shifting. Responsibility, as some would say costs, others would say to employer the fact that you have growing cost, you have got rising federal costs, you have got rising state health costs, you have got private sector costs, you have increasing

pressure on just on small employers but also on large employers, which puts pressure on unions and workers. Physicians in terms of the cost pressure. We talked about that if they don't get paid, they have got a lot of costs to deal with. And these are the things I would say that show up in the polls. The uninsured in the politicial polling does show up as a concern as well but then when you start talking about the costs would be to cover the uninsured, the support wanes a little bit. But I would argue as John Rother said in a panel that I was on the other day, that sometimes the politics of fear trumps the politics of hope. I am not sure I completely subscribe to that. But those top bullets are things that people fear. Just to pull out one aspect of that this chart is really sort of scary, I think. It should be scary to policy makers. This is the extend to which premiums, which are just one aspect of health care costs, are out pacing inflation and more importantly the bottom green line is workers earnings. And I would argue that sort of dealt with over time, you look at '04 and '05, is unsustainable in the future. And it is one of the things that if I were trying to motivate people on the uninsured and motivate people to look at costs, I would start focusing on because the anxiety that people will feel are going to come from that.

So the third point, what opportunities, what vehicles are out there? What kind of discussion are under way in

addition to some of the pressures that I have already outlined that are going to spur opportunities for policy makers to engage in this debate and again this is my own view, I don't subscribe this to anyone I just work for or anyone I currently work for. But one I think is entitlement reform. And I want to highlight that with a couple of slides in just a moment. Going back to where I was before looking at the rising entitlement costs and the impact of health programs there. The second is tax reform and incidentally there was a commission of bipartisan commission that sent their former Senators Breaux and Senator Mapp [misspelled?] just completed and reported on tax reform. You also have an ongoing commission that Secretary of Health and Human Services, Mike Livett is now working with looking at one important aspect of entitlement reform, and I am using entitlement reform broadly on Medicaid. And then third I think an entitlement reform there will be an increasing awareness I think in 2007 and Liz can correct me because of some of the cost containment trip wires that were put the Medicare Modernization Act on the cost of Medicare, and I think those discussions, even though some of the proposals that were in the Breaux and Mapp Commission were widely panned. I think those discussions taking place right now are vehicles where we might get into the uninsured. And they are naturals for reasons I am going to talk about in just a second. Then the political elections and I am just sort of a realist here, which is the

voters expressed themselves in elections whether you have a change in leadership or not and that is certainly not arguing for a change of leadership. I like the current Republican leadership. But when you have voters express themselves in the context of political elections as we saw in ’92 with Harris Walker’s election and others, that really catapults the issue—or maybe it was ’90 and then ’92. With thepresidential election, it catapults these issues onto the stage. So there are some vehicles coming up but let me just show some of the numbers again as to why I think entitlement reform is going to be one of these things that spurs it. This is the chart I just showed earlier looking at the major components of the budget and if you look at that red line which is the entitlements and the mandatories. This next chart just breaks down that red line. And if you look at it, it is Medicare, Medicaid and Social Security. There is two interesting things about it, I think which is if you look out to 2015, really I would say beginning in 2005 and then in 2010 it really starts to exacerbate when you get out 10 years from now. The red and the yellow, which are the health care components to that, are larger than the blue, which is Social Security. So if you are going to deal with these, the deficient, and you are going to deal with the debt and you are going to deal with entitlement growth, you have to deal with health care programs. And second, and I don’t think a lot of people understand this but why is

Congress now next week going to begin a debate in the context of budget reconciliation bill where what is on the table are some proposals to save money from Medicaid and the House and Medicare and Medicaid in the Senate because under the budget rules, you frankly can't touch Social Security in the context of a reconciliation bill. So one way or the other, entitlement reform is going to focus us the growing structural deficient of these programs are going to focus us on entitlements. And I mentioned not at just the federal level but at the state level. This is an example from Tennessee. And Tennessee has acknowledged an extreme example but this kind of thing in one way or the other is playing out at the state levels. So unlike Rick I will mention Medicaid but that red piece of the pie shows which keeps growing in Tennessee from fiscal year '83 and '84 to '93 and '94 to 2003 and 2004. That is the Medicaid portion of state spending is growing and it is crowding out other things like transportation and education, which are relatively stagnant or shrinking. So, it is not only federal cost pressure but also state cost pressure.

Then I also talked about tax reform and the Breaux and Mapp Commission is part of the catalyst too. These are 2002 numbers because it was the most recent pie chart that I could find from in lieu of an estimate. The numbers have gotten bigger but the percentage has not. And the point is that as you look at the current tax structure the majority of tax

necessitates right now, which I would argue are a place where you look for some potential reforms, are in the context of employment. So you see a philosophical push by some to provide more equity between the tax benefits we provide to people on unemployment based coverage and individual coverage.

Let me just finish out on sort of two slides and this is turning this now over to Liz a little bit but I am not going to answer the questions in terms of how to overcome these barriers or how to provide the right focus but I sort of lump coverage options into three different categories and reform broadly into four categories. In terms of the coverage options, you have the employer subsidy model, which is in part you can look at what was done in Medicare with the subsidy to employers to maintain their drug coverage, you can look at the reinsurance proposal that Senator Kerry put on the table in the context of the presidential campaign, which was really in a sense a subsidy to employers large and small. And others, those are examples. Government expansions again, Senator Kerry in a campaign, the democrats generally have called for SCHIP expansions. There is a bipartisan proposal a piece of which is actually in the Senate reconciliation bill that Senator Frist and Senator Bingham and others worked on for children's outreach and enrollment in programs not expanding eligibility but reaching out to people who are uninsured but not enrolled in programs. But there are government expansions. And then

there are a whole host, and it is no accident that I sort of put these on the right side of the page, of things that folks on my side of political spectrum are more likely to look at which is the tax credit model from the TAA or other tax credit model, expanded insurance deductions. The President proposed as a start I think to be people with high deductible health plans link of the HSS to be able to deduct above the line of portion of that getting back to some of the tax equity issues. Senator Frist and others have talked about broader risk polling and things like Healthy Mae which are not employers subsidies but look at spreading risks more broadly in the individual and small group market. Some of the things that Rick talked about and Bill as well. I think that and finally this exclusion, which I know that Liz will talk about a little bit, and I am not necessarily advocating but I think there is a lot of money in the employer exclusion if you look at the proposals to get rid of it, to modify it, to cap it and one needs to be extremely careful but that employer exclusion and the equity that the tax situation that I showed in the previous slide exemplifies shows that is something that probably ought to be looked at as part of the discussion. We spent a fair amount of money in the Medicare, the Medicare Modernization Act; let's just take the Congressional budget office at that time of four hundred billion, that was unpaid for. But it is my sense in the short term at least it is going to very difficult to have

another expansion of that size, whether it be for seniors or for children or others that is relatively unpaid for. So I we need to look at things.

In the final piece it is not just subsidies but I have heard more and more people talking about maybe not doing it all at once but getting back to sort of broader system reforms. There is an examples of these things now going on in a bipartisan way where there is an effort to move the Medicare program to more value based purchasing. There are bipartisan proposals on the health IT and other things. These things are not about covering the uninsured, I understand that. But they begin to deal with some of the cost structures and some of the underlying structures; insurance reforms, Association health plans, and I think Senator Anisey [misspelled?] is working some compromise legislation over in the Senate on insurance modernization. I think all those things will be part of the broader discussion too.

Let me just conclude with this thought. I think that it is going to take sort of six things to focus us on finding the solution. One, we do need I think a policy consensus on focus. As Bill said, whom are we going to start with at least? Is it going to be everyone to some subset? Two, I think we need policy makers with some gravitas to sort of agree on the third best option. This is, not to quote Ron Pollock but Ron Pollock says all the time, from Families USA, that you know everyone's

first best option is their option. Everyone's second best option is to do nothing. But I think that you know that people are going to have to be willing to sort of accept the third best which is probably a little bit from Column A and a little bit from Column B. Third, I think we need to think about some new tactics to raise awareness. I don't know what that is. But maybe we could get Hollywood involved or something. Fourth, I think we are going to need to deal with the cost of the current entitlement programs including the cost of the current tax structure. I don't think there are going to be very free lunches in terms of expansions in the next several years. So until you get the cost of those programs under control, I don't think you are going to make much progress as part of the effort. Fifth, I think you deal with the structure of those programs as well. One of the slides I didn't bring was one that I have titled "There Must be 50 Ways to Qualify for Medicaid." And the fact is I think we need to have a serious discussion not just about expanding Medicaid or cutting costs in the Medicaid but about reforming Medicaid to make the program more simple and reach some of the people who fall outside of the cracks. And finally, this is really link to the cost of the current programs, but I do think we need to find a way to pay off or offset the costs of expansions, or at least partially. I don't see the political dynamic changing on that within the next couple of years. And I don't see many more free lunches

unless we find a way to do that. So anyway, with those six concluding thoughts I will stop and turn it over to Liz.

ED HOWARD: —slow you down by making a long introduction, let me just make sure the people understand that Liz Fowler has moved from the Senate Finance Committee where she was the principle health policy advisor to the democratic members of that committee to Health Policy Alternates, where she is a principle. Most of you know her from her service on the Senate side. She has also been in the Executive Branch and the private sector as well. We are very happy to have her.

LIZ FOWLER: Thanks, Ed, and to the Alliance, and also to Merck for sponsoring the panel. It is a nice opportunity to be able to come back and I am glad you are still interested in my opinion. Moving off the Hill, you find that you have more time to make slides. I don't think I have ever made a slide show for a presentation that I have done when I was on the Hill. And I also even learned how to animate them so hopefully it doesn't all blow up in my face.

Let me recap my view of the positives and the negatives on this debate. On the plus side, in terms of a federal response to the uninsured, polls consistently rank the uninsured at the top concern among Americans. These polls are from 2004 and 2005. Sixty-two percent supports universal

coverage although there is no consensus on which direction to take to the policy. Seventy-five percent agrees in a poll that was sponsored by the New America Foundation that people should be responsible for having coverage in the same way auto insurance is mandatory. Covering the uninsured is a top concern among health policy opinion leaders that was polled by the Commonwealth Fund. And health care issues including rising cost in covering the uninsured consistently rank in the top two or three concerns among the voting population in this poll. This was taken before the election last year. It was tied with terrorism as number three behind the war in Iraq and the economy.

The second aspect I think that gives us all hope is that US business leaders are starting to really call for action on the uninsured. When I was on the Hill and had the opportunity to meet with or sit in on meetings with CEOs who came to meet with my boss. They would say, “Well before I get my to tax or trade or other issue, let me tell that the health care because it is a huge problem for us.” Actually, it is probably our number one concern. I think we are consistently hearing that and polls are starting to indicate that for American companies and as Dean mentioned, GM, this is a big issue.

Another aspect giving us hope the collaborative efforts like the Strange Bedfellows Group. I think generates a lot of

momentum for the notion that that maybe finding common ground is actually possible. That this group of dispirited interests trying together and come up with something. I don't know where that is at this point or how far along they are but just the fact that groups are meeting and trying to come to some consensus, I think is heartening.

At that time that we were debating the Medicare bill, a lot of us thought that good, you know once we get a Medicare bill off the table, the next thing we are going to turn to in health care, the next big thing is covering the uninsured. That seemed like that was impossible to do before Medicare bill passed due to some of the political pressures of where the voting population was at that time.

The last thing is and Dean mentioned this as well—that Medicaid reform could provide an opportunity to think about how the most vulnerable in our population get coverage and who is left out and how to fill the gaps. I think the gaps in coverage became particularly visible in the debate over Katrina when we saw how many people just did not have access to coverage because they were categorically ineligible and Bill talked about this as well. Although there might be 50 ways to qualify for Medicaid, it turns out that all of those 50 ways and all of the 50 states actually leave out quite a number of very, very poor people.

Well, there has got to be a down side to every upside.

I think the Dean started with the downside and then went to the upside. I will do the reverse but on the downside as popular as this issue might be in polls most Americans don't agree on a single solution. They also don't want to pay more taxes to cover the uninsured. And they don't want to lose the coverage that they have. And any sort of proposal that can charateristized as undermining the coverage that they have immediately generates opposition concerns and I think distrust. I think the other aspect is that while it is an important issue; it is not the number one issue in the voting booth so for those interested in covering the uninsured it is certainly not the driving factor in any election.

These numbers might not be the most current but as Dean talked about the federal budget deficient renders any new spending virtually impossible. Even before any spending on Katrina relief the budget deficient was over three hundred and thirty billion. That might not be the most current number. And expected to be 4 trillion over the next 10 years. I put this out there because I believe it and some may debate it but I think that covering the uninsured is simply not a priority for this administration or for the Congressional leaders currently. I think if you look for example at the President's tax credit, he has had the same proposal, I think since 2000, since he first ran in 2000, which would have been '99 in this advanced tax credit. I don't think it has changed much. He consistently

puts it out there but really no action or movement in that direction to try to get it passed.

Medicare is still an issue and it will continue to be an issue. I think over the next coming years especially as the drug benefit is implemented, we can expect a lot of proposals to modify it, reform it, improve it, whatever and to address solvency. Dean mentioned the triggers in the Medicare bill. A trigger as soon as Medicare spending becomes 45 percent from the general revenue pool that Congress is suppose to take some sort of action. Okay. If you read the language carefully, they are just suppose to have hearings but and not necessarily any mandatory action but nonetheless that trigger, it turns out is going to trigger in 2007.

Medicaid reform unfortunately is what is focused more on cuts and caps rather than improvements for the program despite I think the effort to try to look a little bit more broadly at what makes more sense for this program. It seems like cuts and caps are more the focus of the discussion. As Dean said, about the lack of consensus, if we cant even agree on Katrina relief which we are still fighting about and still tinkering with in the reconciliation bill, I don’t see how we can find common ground on a broader solution or a broader incentiative.

How we made any progress since SCHIP passed in 1997? Dean mentioned that the trade adjustment assistance program.

That program was never intended to cover the uninsured. It was created for a very specific population, those displaced by US trade policy and PBGC beneficiaries, that is the pension benefit that guarantee folks that lost their pensions when companies went bankrupt. I think we are going to see that pool as becoming an increasingly large portion of the TAA enrollees. Also less than a quarter of those who are eligible are actually participating in the program due to a number of factors, they either have other coverage, it is too expensive because it turns out a sixty five percent tax credit for your premium at a very high cost that is still a lot of money if you don't have a job. The 1,115 waivers, I think—a report I saw by Kaiser before I came over here showed that 426,000 new people were covered under 1,115 waivers and most of that in New York through one specific waiver. Dean mentioned Tennessee. So of the gains that New York has made were offset by a cut of 250,000 beneficiaries in Tennessee. Also I point out the waivers because I think the debate under these waivers have talked about or has focused on what constitutes coverage. If you look at the Utah expansion population, they only get a half of a benefit. They only get primary care, they don't get access to hospital care and they don't get access to specialist care. And actually, I think that was technically not a HIPPA waiver but is grouped in this general category. But the so-called half of a loaf approach to health coverage, I think we have really think about whether

that constitutes covering the uninsured if they don't have access to hospital care, that seems to be a half a loaf and not necessarily health coverage. Also, if you look at the way some of these are funded, it is as expensive as those who already have coverage.

Well, Congress and Administration has redistributed ERISA funding. I would argue that that is maintaining existing coverage and not new coverage. And I would also argue that outreach as important as it is, is aimed at getting those who are eligible enrolled and not necessarily covering new people and in addition, if you don't put any new money on the table to cover those that you are actually finding when you go and do your outreach, you potentially have created a problem for the states.

Health savings accounts I think some out there positive that HSAs will lead to coverage expansions and covering the number of uninsured. The other theory is that it will result in dropped coverage and more under insured as employers shift the cost burden to their employees. I put the little survey results there just to give an account of what is happening in HSA market. A 2005 survey found that only 2 percent of firms are offering health benefits or offering HSA-qualified plans. Of all workers who are covered under health insurance, 1.2 percent have HSAs and 37 percent of those covered did not actually receive a contribution to their HSA by their employer.

Current state of affairs, I take issue with those who are arguing that maybe the problem isn't as bad as we think it is. That really it is not 45 million, it is more like 36 to 41. In all fairness, I think some of the analyses that has been done by ASP has showing that that perhaps we are double counting or not counting folks who are eligible for Medicaid and folks who are in Medicaid we are counting those as uninsured and that is not right. The second aspect of our current state of affairs is that half a loaf is better than nothing. I think we should have a public policy debate about whether that is the case. Patients including Medicaid beneficiaries should be informed consumers who bear responsibility for the cost of their care and that we should more competition among private plans. I am just describing what I see as the current state out there. And I would challenge anyone who advocates these consumer driven plans to actually enroll in one.

Those who are truly sick can get their care when they need it. This is another myth, I think. That they go to emergency rooms or community health centers. This a very expensive way of delivering care, and by the way it is also not we are advocating for the rest of the population. What we are trying to focus on is protection, chronic care management, and actually ways of making delivery more efficient hoping that somebody goes to the emergency room in lieu of preventive care

or primary care is in the wrong direction. Also, I see the current state of affairs and Dean talked about this too, there seems to be a notion that only if we could find some way to cap entitlement spending. I think we saw this during the debate on the Medicare bill. I think we will find this in the debate as it continues over Medicaid.

Parting thoughts if we are serious about the uninsured I think that first we have to agree on the problem and that seems obvious but it just seems like we need to agree on who is uninsured and why. Then, secondly, we have to work together on a solution. I think that seems obvious as well. Any legislation to address the uninsured should be based on sound analysis and represent prudent and public policy. I think this was trying to get at the notion that Rick said that ideology has no place in this debate. You might have a theory, maybe it doesn't bear out but it certainly is a hamper to the debate, I think. A hindrance to the debate on the uninsured rather than an actual contribution.

In the meantime, at the very least, we shouldn't make things worse with proposals that actually undermine coverage. Dean talked a lot about some of the common grounds and I think that is true. I think there is a lot of common ground out there on re-insurance, on covering kids, focusing on quality of IT and efficiency. I think that the proposal that when Kerry was a presidential candidate last year put on the table, I think

there was some common ground and even overlap even with what Senator Frist proposed last year.

The last thing I want to talk about then if there is some potential common ground why can't we get there. First, I think it is easier to talk about big broad ideas without any details. Second, I think any proposal that goes to far in any one direction trying to outline details ends up upsetting some constituency. And number three why go out on a limb and upset those constituencies when nothing is going to happen. If the proposal next year to generate savings to the elimination or capping of the health benefit, the tax exclusion, I think that first of all regardless of what you think about that policy, I think all of us in the this room would agree as folks who work on health care that that money should stay in the health care system. The exclusion the annual benefit of the exclusion I think in 2005 was over a hundred billion dollars. Setting aside again whether you think that is a good idea or a bad idea and I know that there is a lot of concern about what any changes to that policy might do but if that is really on the table we would be in better shape if we had a proposal ready and waiting in the wings so we could actually come out with and put forward as a way to use that money. I think it would be a lot better than spending it on capital gains or the AMT reform or other issues on the tax side that generate a lot of controversary.

So anyway, I do believe if that is on the table then I

think we ought to take advantage of it if it is a serious consideration. Thanks. I would happy to answer any questions.

ED HOWARD: Okay. Thanks very much, Liz. Now you get a chance to talk at and talk back and talk at and have an answer too your question. There are microphones on the floor. There are folks waiting to snatch the green question cards out of your hands if you will just hold them up. And we will bring them up.

Let me just start while we are waiting with a question that was submitted in advance. Several people have mentioned the SCHIP program that kids insurance program. It is up for reauthorization sometime before the beginning fiscal year 2007. Is this an opportunity for a new incentiative? Is it an opportunity for a loss of what we have or somewhere in between?

LIZ FOWLER: Well, I think that gets to the debate about what represents adequate health coverage for some of the lowest income population. I know, or at least when I was on the Hill, there was a lot of talk about wrapping SCHIP reauthorization with Medicaid reform. I think that makes a lot of people nervous because I think at least on the democratic side we saw that as a writing on the wall for giving those who are currently eligible for Medicaid which is a richer benefit package, something less, in other words like an SCHIP benefit

package. So I think there was a lot of concern that any attempt to reauthorize that in the context of Medicaid reform couldn't necessarily spell good things for low-income folks. So, I don't know if that is answer to your question but there is talk of it and I am not sure it is up beat.

WILLIAM SCANLON, Ph.D.: Let me just quickly add that I think—I hope that both the SCHIP reauthorization debate and the Medicaid commission, despite some of the controversary about it provides, you know, an opportunity to really look at it. I think maybe the decision will be we'll just reauthorize the current SCHIP program with relatively few changes but I think Liz is right in terms of describing the fear of many in the democratic party in particular that you would somehow undo the Medicaid program or some aspects of the Medicaid program. But I think if you are going to look at some of the rationality of the our low income safety net in the country, that actually is helpful to have the discussion at the same time and sort of be looking at it because everyone agreed at the time to adding kids and doing more but it does raise some issues when it just kind of gets added on to the existing Medicaid program. I think if you are going to have a discussion about restructuring the program and where we are going, I don't think it has to be a negative. I think it can be a positive to have those things on the table at the same time.

ED HOWARD: We have people at the microphones. I would ask you to identify yourself and keep your questions as brief as you can.

JOEL SEGAL: Hi, I am Joel Segal with Congressman John Conners. I have been with him almost six years. This question is for Elizabeth Fowler and Ed Howard. I am formerly an uninsured person and someone who comes from a family with siblings who are uninsured and all who have serious disabilities and chronic life threatening health problems. They cannot get quality care. And often no care at all. It has devastating consequences to their health and to whether or not they can work. Because we don't have universal health care in this country. Someone who has been here for almost six years, I do not think that the United States Congress understands the crisis of the uninsured because we sort of live in a bubble up here. Covering the uninsured as Elizabeth Fowler just stated is really not on the Congressional radar screen because they really don't feel the pain and the suffering of the uninsured. The question I have is, with the Alliance for Health Reform and those on the panel support the idea of helping members of the House and the Senate and the staff to organize Congressional hearings on the crisis so that we can change the status quo.

LIZ FOWLER: Well, I think that is a great idea. I think and I share your concern over the plight of some many people who don't have access to health care and the consequences that has. I can tell you that the finance committee at least on the health side and I think this was a bipartisan interest. We did want to have hearings on the uninsured and we did put that on the agenda. Unfortunately, for us we compete on a finance committee with tax, trade, Social Security, welfare and a number of other issues and we always ended up seeming to get the short end of the stick. So, as much as the staff advocated going in that direction, there is a lot of competing interest out there. So I hear want you are saying and I agree with you. I think maybe at this point from the outside maybe we can all work together and try to push things in that direction from a different vantage point.

ED HOWARD: I should say from the Alliance's point of view we are very interested in promoting the kind of dialogue that would come out of those hearings. I don't want to be presumptuous enough to offer to plan congressional hearings for committee staff who are quite competent in doing that themselves. We do have lots of contacts with lots of people who can offer I think some guidance and some enlightment on this issue. We hereby make that offer to anybody who is trying to put together those kinds of hearings. There is also I should

mention, if you are not aware of it, something that Congress actually stuck into the Medicare bill, I believe, citizens, working group on health care and there is someone here who might tell us about that but Senator Widen and Senator Hatch on the Senate side put a provision in the bill to organize what will include some sound meetings, hearings in different parts of the country, and if you can tell us about it, maybe that is another outlet that you might point out to people.

CARLOYN TAPLIN: Yeah. Though the timing may not be as quick as the other questioner would like. I am part of the staff to the Citizen's Health Care Working Group. As you said it was established in the Medicare Modernization Act. It is a 15-member committee with the Secretary of Health and Human Services as an ex-facto member and fourteen citizens named by the GAO and the committee was actually named in February. And the premise, which was the premise of Senators Widen and Hatch, was that health policy would benefit from an informed dialogue with the American people. And the legislation structured the steps that that dialogue would take. The first step was for the working group to hold hearings, which we had over the summer, where they educated themselves and addressed a number of topics that are all laid out in section 1014 of the Medicare Modernization Act. The next step was to prepare a report to the American people. That report was issued earlier this month and

is available on our website, www.citizenshealthcare.gov. And the purpose of that report was to lay out—and you have got a summary of it in your package—some of the key issues around health care so that when we move to the next phase, which is approaching, there would be a basis for an informed dialogue. So this is background information about health care in this country. We heard from a lot of people, Bill Scanlon was one of them, and we are moving into a phase of doing public meetings around the country. We are seeking opinion on our website. We have got kind of some starter questions there but we will be adding more questions as time goes by. The key to all of this that addresses the point the earlier questioner raised is that when we conclude our recommendations that get published in draft form and there a ninety day common period, then they get published finalized. After that happens, they get submitted to the President and the Congress. Five committees in Congress must hold hearings on them. So, the timing is such that those recommendations won't be done at the earliest by the end of this fiscal year. And I am not sure if Congress will be in session when they are actually done but either late this calendar year or early in '07, there are five Congressional committees that will have to hold meetings. While the working group addresses a whole lot of issues, the uninsured is clearly a major one.

[1] kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

ALLEN GLASS: Allen Glass for Senator Biden [misspelled?] Can anybody on the panel give us a rough idea of how much money we are talking about? How much would it cost say to provide all of the uninsured with—let's say a Medicaid-type benefit package or a GM type of benefit package or a FADHBP type benefit package? How much money do we have to come up with for these realistic options?

RICK CURTIS: What you are saying, sir, is a lot more complicated than multiplying 40 million or whatever. For an adult nationally you could take the average per capita, it is around $3,600 or $4,000 per person, and for a kid it is approximately half that much. But it is much more complicated than that because while we got away with it in SCHIP to basically say if you are already contributing coverage even though you are low income, and unable to afford it, tough, you are not eligible. You can't do if we are actually covering the uninsured. So, you also have to talk about additional tax and subsidies of some sort to the other low-income people who already had coverage. And there are sizable numbers of those at 200 percent of poverty of majority of people already have coverage. That is on the one hand, on the other hand if we ever got serious about this, heaven forbid I should say this, but that there are substantial subsidies now for people that don't need subsidies in the form of the federal tax breaks from

employment based coverage. If those were actually harnessed to be spent in a more progressive way for the people who need it the most, there are some substantial revenues there. But you have really got to turn to the specific estimates as specific proposals to get an idea of what the costs are.

ED HOWARD: Good point. Anybody else? I have got a question; it is actually a statement and then a question. If we are going to ask the public to accept tax increases or reallocation of funds for use by the uninsured, shouldn't we try to make the public aware of the problems? That is the majority of those I have questioned out side of the health care realm think the uninsured are the homeless, the unemployed, the poor. What is that we can do to increase the awareness of these myths, if you will, if I can read that into the question, among the general public? Certainly, the description Bill gave of who the uninsured are and some of the material in the packets belies the kind of assertions that the gentlemen are making in the question. I have heard those assertions made by a lot of people and seen poll data that reinforced them. Is that an important or immediate part of this task?

LIZ FOWLER: Well, that fact that—what is it seventy five percent of the uninsured are working is a significant number and as for getting that number out there I think at

least that number is known in health care communities. I don't know that it is known widely as the questioner points out. You know I think we really want to tackle this problem I really think it requires leadership at the national level. And for information to be get out there from our leaders in Congress and our leaders in the administration. And I am not sure like I said I think that is hard to do. When it is just simply not a priority, and it is not at the top of the agenda. You know, if you don't talk about it then people don't know. I mean, look at how much awareness was brought to the issue of Social Security regardless of what you thought of the proposal, a lot of people became aware of solvency dates, of benefit numbers; of what would happen under one scenario or another. Not all of the information is accurate, true or whatever but the public awareness given the national leadership bringing it to the top of agenda certainly made a difference and that is what I think it would take.

WILLIAM SCANLON, Ph.D.: I just respond and sort of have a slightly different tact which is there is this movie, I cant remember what it is about a political campaign and the press people from the Republicans and Democratics and in the election—probably some of you have seen this—end up getting involved in a romantic relationship but the subplot is all about how they are trying to get attention for their various

Senate candidates but the story the local news keeps covering is the fact that some loin or something has escaped from the zoo. That gets covered and finally the candidate that wins sort of figures out a way to insert himself into that story. Why do I tell that sort of funny story? It seems like it doesn't have any application on the uninsured but the point is I think it goes back to one of my slides which is I think the American people generally are very broadly concerned about losing their coverage, about not having enough money to pay for their health care increasingly in retirement. As you see some of these big stores, they are worried about increasing out of pocket costs. They are worried about some of their neighbors and I think to motivate people is going to take leadership in part from policy makers and others but I think it is also going to take—the questioner's point is very well I think stated—which is also going to take the ground people to focus on it. I think in part by finding a way to work your way into those stories, the cost, the impact, and raising awareness. It was in *The New York Times* story in the Sunday paper I think last week about the consequences of someone who even had insurance but the fact is most of the policy making elite—and I wont count myself among one of those—Most of the policy makers here are the conference understands what the problem is. I mean you all do and when as Liz referred to one of these polls, I think the Commonwealth Foundation did, the number one health policy concern was the

uninsured. But it is not the number one health policy concern of the general public. So I think how to make it that way is to focus on things that they do care about and make the link, which is often difficult to do and look at things in popular culture and other things to try to bring that home. I think you know whether it is—I half jokingly referred to Hollywood before but I think whether it is a evening show as we are now focusing on things like the *West Wing* and *Desperate Housewives* and other things that has an uninsured character and some other things. It is going to take inserting it more in the popular culture and showing that the uninsured are people just like me and you. And by the way, a lot of people who are really left out, who I think a lot of people are assumed are covered and Rick referenced this earlier, are very, very low-income that are not covered by any of the safety net programs currently. I think that fact needs to brought home too.

DEAN ROSEN: I say this at the risk of saying something foolish since I am not really sure I understand the political process but on an optimist side, I guess I would note with the SCHIP program we were in the midst of budget cutting when that passed. And it passed in part I think because the right champions on the Hill become interested in it. And they did start to use the data and the information that was available to really sort of transform the debate. In context to the BBA,

which is a significant budget cut, we have a new program. And you know it is the question of sort of what brings the stars into the right alignment to make this happen again, I don't know. But I wouldn't underestimate the idea that there is a possibility that information and information in the right hands on the Hill can make a big difference.

RICK CURTIS: Whether and when we reach a tipping which is sort of what Bill is alluding to here, but my own sense is this, actually I was on a panel in Hawaii about a week and a half ago, with a couple of other people that has been around this issue as long as heaven forbid, Bill, Ed and I—and a couple of speakers had gone before me and I succeeded her and she preceded her comments with these are the people on the panel have been working on this for decades. Decades and the problem isn't solved. I hope when I get to their age—well, I am one of those who have worked on it for a substantial fraction of a century [laughter] and along with my two colleagues here and while I am not a political expert, I have observed that a major problem every time this country gets serious about solving this problem is that suggested solutions are framed as what I call universally painless. And that when opponents and there are always opponents whose ox has scored somehow or other then find out how it is not painless for who and basically emphasize that. It is for that reason in part that I think we

need to look beyond the normal rhetoric here and the normal motivators here and also look at the notions of people have responsibilities to each other. There is individual responsibility, there is mutual responsibility, and it is not just the poor uninsured. And we have to worry about those. It is not just that you might be at risk. It is also that if you are 250 percent of poverty most of you have reduced wages and/or contributing out of pocket to coverage. And there are some who are given the opportunity, an affordable opportunity, and decline. They have a responsibility to you to participate. I think that has to be part of the message. What was encouraging to me in the last presidential election is some of the candidates actually said, “I am non-partisan, I really am non-partisan.” When you work for the Governors Association for nine or 10 years, you had better be. But it was motivating to me when John Edwards said with respect to kids and it was treated as completely non-controversial. He said in far more eloquent terms than I can and in terms that relate to the American public better than I can but he said we should cover all children. That should be a priority. That takes two things; parents have a responsibility to participate in coverage and contribute what they can afford to contribute. And government has a responsibility to make sure that it is accessible and affordable for everyone. I think that is the kind of combined message that can finally solve this problem. I am not the past

master to give it.

ED HOWARD: Not a bad imitation, though, Rick. That is a pretty good start. We have just time for a couple more questions. So, as we take these questions, I want to remind you about those evaluations and ask that you begin filling them out as we finish up.

SARAH DASH: Sarah Dash, I work in cancer research. My question is I would like to hear the panel address what are the costs of not insuring people. We have heard a lot about sort of the cost of various plans and entitlement programs. But I think there are monetary costs in terms of covering un-reimbursed care. There is cost to taxpayers who pay into that and so on. Could you address that? And also, some of the human possibility the IOM has estimated that eighteen thousand people a year die because of lack of insurance. And if that is not a call to action, I don't know what it is.

WILLIAM SCANLON, Ph.D.: You have certainly touched on a very important point. I mean, I was thinking when Rick was talking earlier about the potential costs of covering the uninsured we have to remember that there are the current costs of the care that the uninsured are currently receiving that some of those are borne by the uninsured themselves and some of

those are borne by sort of other entity providers of the public sector, etcetera, etcetera. But there is also the cost of care for gone which they don't get which leads to and I don't have a number for this but leads to exacerbation of conditions that leads to the kind of mortality increases that the IOMs have estimated and we should be taking those into account. They should be a part of our discussion in terms of this. There is no issue about that. I mean I think when I had that slide there about what people do in terms of not getting the treatment, not taking drugs, etcetera, there have been studies at the times of various sort of narrow focus which talk in detail about the consequences of that. Not getting your drugs for hypertension, what that means over a period of time. Not sort of getting good control over your diabetes, what that means over a period of time and we should be taking that into account.

RICK CURTIS: I think it is an important issue. I think it is a real issue. If Families USA, I don't know how accurate it is, but they did put some estimates of how much everybody else's premium has gone up because of the cost shift. In general, Bill is right from every thing I have said there will be savings, but there will be costs because they will get care that they don't get now so system wide it is something like fifty percent of the premium equivalent costs will be increase costs and something like 50 percent offset. The difficulty is

trying to capture the savings to harness to fund and a lot of smart people spent a lot of time trying to figure that out. As far as the national solution to that, I don't know. Maine has been trying to do. It is very controversial. But I think a more global picture besides of all these very important points about uninsured people die. They die. There is also the economic factor. If we have this whacky system where a lot of people's care gets to other people. And if we are going to solve this cost problem legitimately, the first, the first thing you have got to do if you are going to address cost problem is have accountability for cost. And with the kind of cost shifts that we got in this system you cant have that. I don't care if you want market based cost discipline or you want to have something that has more government decision-making and allocation involved. You can't do either with those kinds of cost shifts. So, I think that there is a bigger efficiency issue here and it is a very important one.

LIZ FOWLER: The only thing I would say I think that is an excellent point and I think that is why you are seeing businesses become more involved. I think that is why providers are a part of this debate. It takes a chunk out of their bottom line and I think as you are seeing more and more uncompensated care you will start to see more and more providers weighing in. I would say more on the institutional providers than the

physicians who can simply say no as Bill pointed out to someone who calls who doesn't have insurance versus the hospital which in some circumstances just can't turn someone away. But I think that is a very important issue. I have seen estimates out there. I can't recall them off the top of my head but I know that I have seen them, and I think it is an excellent point and should be part of the debate along with the cost to individuals of not being insured.

DEAN ROSEN: Just two quick comments. One is, I think you know—that obviously as Rick and Bill and Liz have all said—there is a broader cost in terms of the cost shift of premiums and lost work days in productivity and everything else you can even begin to get some estimate of what it would be by just looking at the Medicare and Medicaid funding every year for disproportion share, which is supposed to compensate some providers to basically take care of people who you know are uninsured and they get a disproportion share of those. And those are, you know, not insignificant costs, and that is a very direct cost. The other point I wanted to make which I think in part goes to your point and part goes to something that Rick said earlier about personal responsibility, which is there are not insignificant number of higher income people who are uninsured and probably it is not the largest percentage but a non-insignificant number of the children, the minors of those

parents who are uninsured. One of the things that Senator Frist proposed when I was there was not a broad individual mandate but was basically saying well maybe there ought to be something, maybe some kind of a tax incentiative, maybe some kind of a tax penalty if those upper income folks don't at least get themselves covered or at least their kids covered. Not only out of a duty and responsibility to the folks who you are suppose to care for and nurture but also in part of this issue of the cost shift. And maybe again starting incrementally and looking at folks who have the means to do it and maybe saying there ought to be an element here and not just a governmental or corporate responsibility but individual responsibility I think is important as well.

ED HOWARD: I should—nor can I conjure up the numbers but the institute of medicine did not only estimates of human costs, they did estimates of economic costs in another report. I know the savings that they estimated for universal coverage was in a range of $65 billion to $130 billion a year. The increased costs that they estimated were on the order of half of those numbers. The problem as Rick pointed out is that the savings often will not accrue the same people who are making these expenditures.

MICHAEL ZANMORE: Michael Zanmore [misspelled?] with

Congressman Patrick Kennedy. Rick alluded to this in his comments a little bit about and in talking about the Michigan experiences, but I am curious about kind of the intersection of employer-based care in individual care systems such as Medicaid, SCHIP and other alternatives. What we know from experience in modeling about the crowding out, and I am wondering if the panel will speak to the this question about would we sort of address bringing people in and instances that are not necessarily employer based without losing the employer contribution.

DEAN ROSEN: There has been quite a bit of imperial work now on crowd out and the long and short of it is again common sense pertains as you go further up the income stream with free or virtually free coverage, you will end up with more and more shifts from employer coverage. With just the SCHIP program it seems to be individual behave and not employer's dropping coverage so much. But I refer you all to a piece that was done a couple of years ago by the Center for Studying Health Systems Change by Cunningham where they segregated the states with substantial expansions from states with modest expansions. They had an overall crowd out rate for expansion of kids of—it is not inconsequential—I can't remember the number. It is only 25 percent. They didn't estimate it for the states that go further up but if you look at the table you can see

when you look at this changes and source of coverage it is much bigger. And that is not to say we don't need subsidies further up the income stream to cover the uninsured. We do but we need to do it in a way that is balanced and that you don't have employers who can afford to make contributions and people who can afford to make a contribution faced with disincentatives to do so. And a strong incentiative to eliminate those contributions unless people in this room really think they can raise the kind of public revenues that we would need to replace those private contributions. But I think it has to be much more even handed and much more conscious of the systematic incentiatives that are we talking about in broad expansions.

LIZ FOWLER: Well, it is a good point but I think there was a proposal that I had worked on when I was working for Senator Backus [misspelled?] that was introduced in 2002 and we used a lot of numbers that John Grouper at MIT had come with up. He had done a whole spreadsheet on size of firm, on income, and looking at the scale for who is covered and who is not and what sort of credit you might get. I think he did some of the original work on crowd out back when the SCHIP was debated. I think—you have to be careful that you decide that you can't do anything because you just don't want to crowd out existing coverage, and this was an issue when we debated the Medicare bill as well. If you are expanding a public program, you are

going to end up with some who had other coverage and who now shift coverage. It is just sort of an element of what happens. You try to minimize that to the extent that you can but I would just argue that it would be paralyzing to say that you want to minimize that to the point that it doesn't happen because I think it automatically will happen and you can take certain steps to avoid it.

RICK CURTIS: And there is good crowd out and there is bad crowd out. And many people calculating in the crowd out don't differentiate. So if a person is a parent at a 125 percent of poverty is spending all of their disposable income to cover their kid, and now they can enroll them in SCHIP. That is technically what an economist would call crowd out. Is that a bad thing? No, now the kid may have better food and shelter or clothes. But when it is somebody at median income—this is the other thing that we always forget here—median income for kids in this country is about 250 percent of poverty. So if unless we have got lots of money moving to that kind of level for free coverage, you are going to cause a lot of shifting from private contributions to public. That maybe appropriate but it is needs to be a consciousness decision.

WILLIAM SCANLON, Ph.D.: I was just going to add that I think there is also in parts of it a philosophical component to

it as well and in some ways, I would view it almost as a practical component, which is just as we are—the economy has really changed dramatically from the time that we set a lot of the pillars of health policy and health coverage in this country. In kind of the World War II and post—World War II era, you know there are Medicare and Medicaid and the current tax system to one where people bounce around a lot between employers and other things. I think that part of this is an answer to part of the crowd out discussion is an answer to a question that I posed earlier which is I think you can probably get more philosophical consensus around starting with you know lower income folks now who are falling through the cracks. I would think in part because it addresses some of the crowd out issues and very few people would argue that there isn't some kind of government role for people below fifty percent of poverty or hundred percent poverty because there are an awfully lot of those people are not covered. And second, this sort of philosophical component or again a kind of realistic component is in an increasingly global competitive marketplace where probably very few of us in this room have had the same for our whole careers, even if those careers have been just a couple of years. Looking at this as a component it doesn't have to be all or nothing. But looking at components of this they are giving the individual some control and some ownership over their own health care when they move and change jobs. We have tried to do

some of that but I think that is an important part of the discussion as well.

ED HOWARD: And that I suggest is a pretty upbeat way to finish a discussion that has had its ups and downs. I want to thank Dean and the rest of the panelists for bringing us to that point. Let me also just thank you for staying with it. This is not the last iteration of this issue. You will be hearing through the Alliance and it's partners and I hope that this kind of attention that you have been paying is a good indication that there is an interest in trying work on this issue despite the fact that we haven't made a lot of progress over the last couple of years. I want to thank the folks from Merck for allowing us to have the discussion and have those great Senate sandwiches available. I want to thank the Alliance staff, particularly Lisa Sqiroski [misspelled?] and some of the folks who have been working on these materials for putting them together,and ask you to join me in thanking the panelists for a useful, a very useful discussion.

[Applause]

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