State Health Reforms Initiatives:
Are There Lessons for Federal Policymakers?
November 20, 2006

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ED HOWARD: My name is Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of our chairman, Jay Rockefeller; our vice-chairman, Bill Frist; our soon to be co-chairman, Susan Collins [misspelled?]; and the rest of our Board of Directors to a briefing - I guess you could call it a fresh approach to an old problem. The problem: too many Americans are without health insurance or access to adequate health care. The approach: efforts by individual states to try to deal with the uninsured on their own terms rather than waiting for some national solution.

Now, it is not as if states have not been working on a bunch of problems, including reducing the ranks of the uninsured, before this. It has been almost 75 years since Louie Brandeis [misspelled?] noted that a single courageous state can serve as a laboratory and try novel, social and economic experiments at relatively low risk to the rest of us. But some of these new state level efforts are creative and ambitious, promising and worthy of some further examination.

Now, last spring, the alliance looked at the emerging Massachusetts reform plan, which has the potential to reach near universal coverage. Today we are going to revisit that plan, along with those being tried in Utah and Vermont, to get a flavor of the kinds of approaches that are in the mix.

And we are looking for lessons to be learned, when and if a national effort to address the questions of the uninsured of cost and quality is mounted, as well as to learn what states can try emulating the efforts of other states.

Our partner in today's program is The Commonwealth Fund, a private philanthropy whose work stresses the need for a health care system that performs at a high level, especially for the most vulnerable segments of our society, including access to health care and health care coverage. And we are very pleased to have with us Anne Gauthier, who embodies that goal, actually, as the senior policy director for Commonwealth's commission on a high-performance health care system. And Anne, why don't I turn to you now and get your introductory remarks?

ANNE GAUTHIER: Thank you, Ed. I am delighted to be here and [inaudible]. I would like to just say a few words about our commission on a high performance health system. I think Ed has laid out his goals well. We [inaudible] United States and we are talking about the entire United States when we talk about health care system as opposed to some of the fine health care organizations in it. We talk about them too. But we are looking to improve better access, improve quality, greater efficiency with a particular emphasis on those who are most vulnerable.

Some of you - I hope many of you - may be aware that the commission has issued two major reports this summer and fall. We issued a framework statement that defines what we mean by high-performance health system for the United States, and a scorecard that measures our performance against the best that has been achieved.

We call for some broad recommendations for improving performance, including, importantly for this briefing, guaranteeing affordable health insurance coverage for all, increasing transparency and reporting on quality and cost, expanding the use of interoperable information technology, and encouraging public-private collaboration to achieve more effective change. States can and are playing a major role in each of these areas. And you will hear a little bit more about that.

The commission has conceptualized a high-performance health system, importantly, in our framework and our scorecard, we have defined it along ten dimensions that are lumped here into five key areas. The overarching goal is that we live long, healthy and productive lives, but the intersection of these shows the importance of not looking only at coverage, but wrestling with areas of quality and efficiency as well. And this is the states you will hear from today, recognize this and that is critical. Let me show

you, I cannot get away without some data, let me show you just one picture relevant to the coverage of focus today.

If you look at this picture, which shows the proportion of the uninsured in 1999-2000 and then again in 2004-2005 which is the latest data we have, I think if you were an epidemiologist, you would look at this and think we have an epidemic as we seem to lose states who have low rates of uninsured and gain states who have high rates. The dark blue states here are those that have 23-percent of their under-65 population that is uninsured and this is up from - there are 12 states today, this is up from just four states just five years ago.

Finally, I would like to peak your interest in the Commonwealth Fund State Innovations Program, which is designed to evaluate and promote the spread of best practices on all of these dimensions. I show you here some projects that are evaluations and other studies in progress. This is a work in progress. We are looking at Massachusetts, we are looking at Maine, we are looking across all 50 states at the policies and practices that would impede or promote high-performance, both.

And we have a quarterly, soon to be bi-monthly, newsletter, *States in Action*, that I encourage you to sign up for. Some of these projects are in partnership with the Robert Wood Johnson Foundation as well. And we seek to learn

from what my colleagues at this table are doing, and to provide that information not only to other states but to Congress, so that we can make some faster progress.

With that, I would like to turn it back to Ed to introduce our speakers.

ED HOWARD: Very good, thank you, Anne. Before I do that, let me just handle a couple of logistical items with which you will be familiar if you have been to many of our briefings. You see that the briefing is being webcast, it will be available tomorrow morning on KeiserNetwork.org, on both that Web site and the Alliance Web site all have dot.org. You will be able to get all of the materials that you find in your packets electronically. And you will find in those packets more extensive biographical information than I will be able to cover in the short time that I have.

And finally, blue and green, blue evaluation form, green question card, both very important. Please use them at the appropriate times. So, we have a distinguished line of speakers today, let us get started. And we are going to start where we left off in May, actually, with Amy Lischko.

Amy is both the commissioner of the Massachusetts division of health care finance and policy and its director of health care policy within the executive office of health and human services department there. She has been one of the key architects of Governor Romney's Reform Plan, now she is

charged with implementing the compromised plan that emerged from the negotiations among the governor and the democratic legislatures and the many stakeholders in that Massachusetts health system. And we are anxious to hear how that is coming. Amy, thank you for being with us.

AMY LISCHKO: Thanks Ed. It is a pleasure to be here. I was working on this presentation over the weekend, whittling it down from 29 slides, which are contained in your packet, down to about 10. And my 10-year-old son was working on a first oral presentation for school where he had to come up with two minutes of words on a book that he had recently read. And I said – I assured him that my job was far more difficult than his, coming up with two minutes.

What I am going to do today is give you a really brief overview of the Massachusetts Health Care Reform Bill and then provide you with some information and implementation updates, where we are right now and what we still have to accomplish.

I think most of you have seen many of the slides that are in the packet. This was the problem that we began with when Governor Romney came on board back in 2004. When we started looking at this problem, we had about 460,000 uninsured in Massachusetts and we were noticing double-digit insurance premium rate hikes, like everyone else across the country. Businesses were dropping benefits nationally. We

did not notice that trend in Massachusetts, but we knew would be coming across the country to us if we did not do something to prevent it.

It was hard for individuals and small businesses to obtain health insurance and we were noticing that people, even though they did not have health insurance, they were still getting care. This was not an issue of people out on the streets not getting the care that they needed. They were seeking care at inefficient settings like emergency rooms. And they were costing the state, it was estimated by the Urban Institute, about $1.3 billion dollars a year in the cost of this free care.

Two additional pressures that were on Massachusetts that really forced us to really take a closer look at this. One was that there were ballot initiatives that were due to come, actually for this election, that put pressure on the state that they would need to have health insurance for all residents, if that ballot initiative were to pass. And we also were pressured by the federal government, through a potential loss of federal funding through our IGT and DISH Funding mechanism, of about $385 million dollars. So there were both practical reasons for us to look at this problem and also, the governor felt the problem was small enough that we could actually tackle it in Massachusetts and be a place

to demonstrate that we could actually achieve the results that we wanted.

This was what our uninsured looked like. It was important to note that we really categorized people in three different buckets. There were people who were currently eligible for our mass Medicaid program that were very low-income, they just were not enrolling in the program, either they were healthy or they were choosing to seek care in emergency rooms and other places where they could get free care and were not enrolling in a program that was really delivering better, more managed care.

There was also a group of people who were actually fairly high income, they were above 300-percent of the federal poverty level. We call them middle income. About 40-percent of our uninsured fell into this category. This was a growing category. People that were making ends meet but they did not have a lot of extra for health insurance at the end of the day. These were people we wanted to make more affordable products available in the market and see that the market mechanisms were working properly.

And then there was people sandwiched in the middle that were not eligible for our public programs, but even if affordable products were available, they would not be able to purchase them. They were really the low- to middle-income and we needed to provide subsidies to them. So we

categorized them like this because it really was not one-size-fits-all. There was not going to be one simple solution. We needed to think really broadly about the problem.

The principles that we followed, and what we really wanted to accomplish were as follows: We wanted to stabilize the small group market and keep small businesses from dropping insurance, we wanted to introduce these lower-priced comprehensive health insurance products, we wanted to bring the young people into the risk pool, we wanted to have them know that it was important for them to have health insurance early on and get those healthy lives into the market, we wanted to create some sort of organizing principal or facilitator that would permit the pretax premium payment for people who are working.

There was an unfair— it was really an unfair ruling at the federal level that created this tax benefit for people who worked for employers and if people were buying in the non-group market, they did not have that same benefit. So we wanted to create that benefit, which was quite a nice savings for people and would make the insurance a lot more affordable if they could pay their part of the premium on a pretax basis.

We wanted to facilitate the purchase of insurance by part-time employees and people with multiple employers. That

was – when we looked at the data, that was who was falling through the gaps, people were working full time but they were doing this through cobbling together several part-time jobs. None of which the employers offered them health insurance. We wanted to promote a culture of insurance and personal responsibility. This was really important to get, again, those young people in and also just people across the board knowing that health care was not for free, that if they showed up in the emergency room, we were treating them, but that was not the best way for them to be getting their care. They really needed to have a doctor, they needed to have a place where they could get their care in a more efficient setting. And we also, very importantly, wanted to control costs so that the system would be sustained.

This next slide is not in your packet and it really combines slides 6 through, say, 27 or so.

[Laughter]

It gives you the responsibility for the law. Key elements, who is responsible for really different elements of the law. We knew the government had to play a major role in this. There were a couple of different roles that government was going to play. From one, we had a small Medicaid expansion, mostly to children, and we also lifted some caps on programs and brought back some benefits such as dental for adults that we had excluded during tougher revenue times in

Massachusetts. We were going to be responsible for this subsidized insurance packet. What did it look like? What did the benefits look like? How much subsidy were we going to provide?

And the government was going to be responsible, really, for organizing that. They were going to develop and establish the connector, the facilitator for allowing this pretax payment of premium and allow for better functioning of the market. Government really had to do that. Government is going to have to do Uncompensated Care Pool Reform, they have yet to do that yet. But this is where people sought free care at hospitals and community health centers. It was government role to really move that along.

And then also the insurance reforms, that was going to governments responsibility. The health care system is not off the hook. They were going to be held to quality and performance standards through this new competitive market place. They were going to be held, as Anne mentioned, to new levels of transparency. There is going to be a lot more information on quality and cost information available in Massachusetts. They were going to be serving more patients that have insurance. So they were going to need to be more efficient and be able to deliver that care efficiently.

And there was also provisions in the law for pay-for-performance for the Medicaid providers. Employers, as many

of you have heard, have a number of responsibilities, probably the most important one is this mandatory cafeteria plan. They have to allow employers with more than 10 employees, have to allow for their prepayment employees to access that prepayment of their premiums.

There were new anti-discrimination laws that were put in place in Massachusetts, particularly affecting small companies that are not under the Arrisso [misspelled?] Laws. There was a fair share assessment, which is the 295 assessment that you hear about that was going to be placed on employers who did not offer fair and reasonable contributions to their employee's health insurance. And there is also a surcharge that is possible for employers that do not set up those cafeteria plans and their employees end up seeking care in the hospital, they can be charged for that care.

So all of these were the employers' responsibilities through the new law. And I think some people have said, we have not been tough enough on employers, but I will let you know that when we go out and we talk to employers across the state, they feel that we have been plenty tough enough with a number of these new laws.

Then individuals, the main responsibility on individuals is individual responsibility. They really need to be able to purchase health insurance that suits their needs, and use care more efficiently. And that is something

that we are working on developing exactly what that is going to look like for residents of the state. There is also, along with the responsibilities, there is benefits. And there is a lot of benefits.

For government, we get to constrain health care costs through this new bill. We are really hopeful that that will happen. We got to retain our federal funding which was important to us. We will have more transparency in the system and a better functioning marketplace. All important goals of the administration. The health care system has much fair reimbursement.

We increase Medicaid rates for both hospitals and physicians substantially through this bill and they need to provide better quality and a transparent data to us. But they also get much fairer reimbursement, which we hope will cause less cost shifting onto the private payers and employers and ensure better care for the residents.

Employers, mostly small employers, now have a more level playing field than they had before. They will be able to offer their employees more choice, more affordable options and they will also be able to offer their part-time workers to be able to come to this new connector for health care where before, they needed to provide one plan for their full-time workers and part-time workers. For individuals, we hope that they will see that there is more affordable options

available. That they can buy their insurance pretax and that they will also take – have advantage of that more transparent health care system.

So what have we done so far? This slide is in your packet on slide 28. The Connector's up and running, it has a staff of about 10. The Commonwealth Care, which is a subsidized benefit package for people under 300-percent of the FPL, began enrollment on October 1st, 2006, we already have over 8,000 people enrolled in that health insurance plan and we are hoping to enroll all people under 100-percent by January 1st.

The plan begins enrolling people on a sliding scale subsidy on January 1st. Our Medicaid expansions have been implemented. Our Fair Share and Freerider [misspelled?] Regulations have been completed and the education of employers has begun. So we have done quite a bit in the eight months since the bill was signed. But we also have a lot left to do.

One of the biggest questions out there for me and for the policy makers working on this is, what is going to constitute credible coverage for the individual mandate? Will many med plans count? Will high deductible plans count? What is that going to look like? What are people going to be required to have, what is the floor? There is a lot of debate about that and I am sure that is going to be a very

contentious discussion. The specifications for how – what the affordable insurance benefit packages look like for people over 300-percent of the FPL. The merge of the non-group and small group markets has yet to occur.

The rules for developing these section 125 plans for employers has yet to happen. Antidiscrimination rules and guidance has not occurred. So you can see, there is tons more to do and we have really just begun.

There was a recent survey done by Bob Lendon [misspelled?] for the Blue Cross Blue Shield Foundation, that tells us that it is pretty good news so far. About two months ago, I had heard that only about one in 10 had even heard of, Massachusetts residents, had even heard that we passed this new bill. But this recent survey said that 80-percent, actually, of those surveyed had heard of the law. And about a quarter of those that had heard of it, knew a lot about it. Good news.

We read the law – the surveyors read the law to everyone they contacted and after people heard the law read to them, 64-percent of them supported the basic tenants of the law. There is more support for Medicaid expansion, for kids, and for the business requirement to offer then there is for the individual mandate as might be expected. People do not like to be told what to do.

The support is really across all subgroups of insured and uninsured and even across socioeconomic status. There is some skepticism expressed about implementation, however. People do not tend to think that government can do this very well. They have Medicare Part D to remind them of things that can happen and they are nervous about it. There is also a lot of concerns for small businesses. Many people responded that they felt this was going to be harmful to small businesses and to economic development in the state.

There is continued support for this bill, will really depend on affordability, the premiums, and the ability to keep and constrain costs, which is clearly one of the biggest issues on the table. I will be happy to answer questions during question-and-answer time.

ED HOWARD: That is terrific. Thank you, Amy. Next up is Norm Thurston, who is the lead policy analyst for Governor Jim Huntsman's initiative on health insurance for Utah's uninsured. The goal of which is to cut the number of uninsured in half in the state over the next few years.

Norm came to the Utah Department of Health from the economics faculty at Brigham Young University and he has a range of health economic topics on which he has written and we are very pleased to have him with us today. Norm.

NORM THURSTON: Thank you. Today, what we want to

cover is evaluation of [inaudible] section 1115 waiver, also known as the primary care network. And you have to excuse me, I have a little bit of laryngitis, so I have to pause every once and a while to recover enough strength to keep going. So if I pause, it is not because I lost my place, I am just getting my voice back.

This goes back to 1993 when then Governor Michael Leavitt, now the secretary, created a program called Health Print. It was to find out exactly what was going on in the health care system in the state of Utah. As part of that process, they identified several specific populations who are having access issues. Most notably among all of those populations was low income working adults. He decided he wanted to do something to address those access issues for that population but it is difficult to do something in an environment that does not support Medicaid expansions.

So the solution was to provide low-income working adults with a limited benefit plan under a new program. The limited benefit plan would have no hospitalization coverage or specialty care and it would have limits on prescriptions. So basically, it would be a primary and preventive care type of an arrangement. The theory behind this plan is that some coverage must be better than no coverage. So this is a popular issue – and if you think about this, kind of put some faces on this, in Utah at the time, the homeless fellow

living under the bridge had basically no access to health care, other than relying on some charity care and some community clinics, did not have really good access to the system.

So the question was, can you take that kind of a person and put them in a system when they can actually get access to care? Furthermore, it was not just the homeless guy living under the bridge, it was also low-income working adults. People who, for whatever reason, were stuck in dead-end minimum-wage jobs and did not qualify for any public programs. How do you get them to get some access to health care?

So the program – the waiver program - created two new groups of Medicaid clients essentially, the primary care network, which was the new group, and the non-traditional Medicaid. Which these days, it is just as easy to call them the tanif [misspelled?] parents. That is pretty much a direct equation there.

The theory was that you could reduce the benefits slightly to the tanif [misspelled?] parents and use the savings from that reduction to fund this limited benefit plan for the new primary care network. Since the program began in July of 2002, we have had over 50,000 Utahans who have benefited from the primary care network. It is also interesting to note, if you believe in how markets work, we

are constantly having to close enrollment because we are very close to the cap. And when we do open enrollment, it does not last very long because people want to get on the program.

Just try to explain a little bit about what we hope to accomplish with this program, the basic idea is simple. Slight reduced benefits for some, not major, drastic cuts for some, just slight reduction of benefits, and use those savings to provide a significant benefit to low-income adults who would otherwise have no access to the health care system.

Following up on that, if you provide them, now you have to decide. You want to provide them with primary care or catastrophic care. The theory was that by providing them with access to primary care, that should result in higher quality health care. So they should be able to get preventive services which will keep them out of the emergency room, thereby reduce costs in the system. And it will also result in better health care outcomes.

If they have chronic conditions, the primary care visits can help them keep those under control. So if they have diabetes, if they have asthma, if they have other conditions that would normally be difficult to control for somebody without regular primary care. By giving them access to primary care, you would keep their major problem under control, keep them out of the hospital and thereby give them better care and also reduce costs at the same time.

The question is, is does it work? Here are some of our key findings that we are – and, by the way, I should note, in your packet it is clearly noted that these are preliminary and we are still verifying all of these so you are essentially getting a sneak peak. So, you cannot really quote me on any of this because it has not been verified by the statisticians.

ED HOWARD: This is all off the record anyway.

NORM THURSTON: It is all off the record. Yeah, you cannot say things off the record to this many people and expect it to be the case but…but you should just note that there is a [inaudible] here, we believe these are correct but we are still going through the statistical verification to make sure the program is right.

Some of the things that we have found regarding access are that the average initial enrollment span for the primary care network client is 16.7 months, which was actually much longer than the typical Medicaid client. For [inaudible] receiving primary care visits in the first year is 76.3-percent and you will notice that my comments will not be subjective, I will simply make objective comments and let you decide for yourself what you are comparing that to. Because we are still working on figuring out how to establish whether this is a good thing or whether it is lacking in some

way. But 76-percent or primary care network clients were receiving primary care in their first year of service.

The average number of primary care visits in the first year was 5.6. Access is also another, in another sense, primary care network was meant to be a bridge. But it was something that people could be on while they were working to change their socioeconomic status. So they were working from one employment status to another or they were working on qualifying for Medicare or disability or other things.

In reality, of those who left the primary care network within a couple of years, 54-percent of them were leaving to some other form of insurance. Of those who stayed on the program, this is an interesting feature here, we have – we conducted a survey of those who enrolled in the first six months, and then we re-interviewed them after one year and after two years. If you compare the baseline, which is you ask them when they sign up, have you gotten the needed medical care in the past year. In other words, in the year preceding having gone to primary care network, 65-percent of them were already getting access to primary care network. So the question was, is, does the primary care network do anything for them?

After one year of being on the program, that number rises to 81-percent. So those were our key findings

regarding access. And I think there are more findings in your packets if you want to read through those.

Now let's look at quality next. One of the difficulties with this particular population is they tend to be sicker. So quality is a difficult thing to measure, especially when you do not know what you are dealing with. So we started by measuring who it was that was coming on the primary care network. This population had higher rates of arthritis, diabetes and heart disease, which were the only three measures that we actually had accurate statewide rates to compare them to for the same age group.

We also know, just from our experience, that we tend to attract sicker-than-average populations to this program. So they do have a need for primary care. Now, what are they getting in terms of quality care? What you would really like to know is does it have a health impact. Now I did not put anything here on health impact because of two problems. One, that even with an average enrollment of 16 months, it is hard to measure how much impact 16 months of primary care has on a vengeful [misspelled?] health outcomes. That is not a very long time frame.

The other problem is that you have a really hard time measuring heath outcomes anyway for this population. So we have not figured out a way of doing it, we are still working on it. But we do have one measure of quality that we believe

tells us something about them. We looked at primary care network clients who received at least three primary care visits, this was using administrative data, and half of the primary care network clients were receiving at least three primary care visits within their first year.

Then within those, who was three or more visits, we wanted to see how many of those visits were with the same provider or the same clinic. So of the half, 67-percent of those, that was the median measure of continuity, in other words if you just said, okay, what percent of your visits was with the same provider and then took the highest of all of those numbers, 67-percent was the median. So about half of them are getting two-thirds or more of their care with the same provider every year. Taking that one step further, what percent of them have at least half of their visits with the same provider, and that was 80-percent. So those are some interesting figures on continuity.

Another of our goals was to look at cost. Cost is something that we collect a lot of data on because we have, obviously, administrative to claims data to look at this. Our focus was primarily on emergency care utilization. The percent of primary care network clients receiving emergency room visit was 27-percent. And compare that to the non-traditional Medicaid population, which is 42-percent. The percent with the primary care visit before they went to the

emergency room, so this is in some sense a measure of appropriateness, so is the person just going to the emergency room before they ever see a doctor? Well, under a primary care network, only 5-percent of the clients receiving an emergency room visit had not seen a doctor before they went to the emergency room. In other words, they were relatively established in the health care system before they went to the emergency room.

We also wanted to look at the appropriateness of the emergency room utilization and here are some measures of appropriateness, I want to just focus on three of those. The first one is the percent of emergency room visits that is due to injury. Thirty-three-percent from the primary care network versus 19-percent for non-traditional Medicaid. In other words, that is an indication of more appropriate use, emergency rooms tend to be appropriate for injury than other things.

Using Dr. Billings' algorithm from New York University, we also categorize some of our emergency room visits. Those that were classified as non-emergent, was only 23-percent versus 40-percent. And then the bottom one there emergent but not primary care preventable, which is really why you think people should be going to the emergency room, for injuries and other emergencies that are not primary care

preventable or treatable. And on both of those, the primary care network clients were higher than the others.

Finally, going back to our survey, what percent of the clients are actually using preventive care or routine care? Baseline again refers to the year before they came on the program. Only 50-percent were getting routine care. After year one, it rises to 72-percent and it stays at 72-percent all the way through year two.

Finally, what is next? So we have the primary care network, we have been doing that for four years. But that does not answer all of our questions. Primary care network is a part of a larger effort to ensure all of you [inaudible] citizens as you heard earlier. Our goal is to have that number reduced by half by 2010 and then continue on beyond that.

In October of 2006, we had another HIPPA waiver approved which amends part of the primary care network 1115 waiver, to allow us to create a program called Utah Premium Partnership where health inferents [misspelled?] were up. This is a premium subsidy that will allow primary care network eligible clients and CHIP eligible children to use the state and federal funds. Instead of being on the government programs, they can take that money and use that as a premium assistance program through their employee-based health insurance.

So I wish I had more to tell you but it has only been operational now, today is the 20th, so we have 20 days of experience in. We do not have any data after 20 days. But it is an option there. And then finally, we also are proceeding to find a way to insure all of Utah's children and assist small businesses and so I think you heard what Massachusetts and for that, we are taking a look at those. Thank you.

ED HOWARD: Thank you, Norm. Up next is Jim Leddy, who is a state senator from Vermont and the lead sponsor in that senate of Vermont's Health Reform Legislation. That legislation is also being phased in as we speak. A big chunk of it started on October 1st as well. Now for 20 years, Jim Leddy directed the Howard Center for Human Services in Burlington, Vermont. Nice ring to that, Howard Center. That is not why we recruited him. Jim, thanks for coming and we are looking forward to hearing from you.

JIM LEDDY: Thank you, Ed. Can you hear me? Okay. It is a little bit intimidating, to come down here from Vermont. We do not even get the federal register in Vermont. [Laughter]

So, we may be ahead of the rest of you in that thing. You know where to begin is really a challenging decision for me because in some respects, I think of this and reflect on the beginning lines of Charles Dickens' "Tale of Two Cities."

“It was the best of times, it was the worst of times.” And if we look at what is happening in technology, pharmaceuticals, longevity, there are some very positive, very exciting, and very rewarding benefits that are occurring in our health care system today.

But at the same time, we have what could only be described as an explosion in the number of Americans who have lost their insurance, or underinsured, we have an explosion in disease management in the area of diabetes and obesity. Then our children and our grandchildren, we have a train wreck coming at us in terms of their health and their future and the cost of providing health care to them.

We each see our health care from our own particular lens [misspelled?], point of view. My lens is reflected through 30 years. Twenty years at the Howard Center, but 30 years of working with poor people. Working with people who had no insurance for the most part. Working with people who carried labels and stigma. Working with people for whom there was very little difference between good times and bad times.

So when I look at health care and change and reform, I think first of those people. Why shouldn’t they have quality health care and protection? But what I have learned is this, that no matter what my heart tells me, it is cost not justice, it is cost, not equity; it is cost, not access

that is going to drive change. And the reason is quite simple. Justice has never been as urgent a motivating principle as insolvency.

That is what we are facing. And I believe along with insolvency there is another more basic frankly more fundamental truth it is this. All health care is personal. No matter what our background, no matter who we are. We look at these challenges, ultimately sooner or later, from the perspective of our own personal experience, our parents, our family, those we know.

Increasingly for more and more people, when we do and look at this, it feels more like a lottery, with more losers than winners, it often depends on where you work. It depends on whether you work. It depends on your age, whether you are old or young. Many Americans have been reduced to what amounts to a variation of social Darwinism. Survival of the wealthiest, the healthiest, and lets not forget the luckiest. The perfect storm is on the verge, and more and more of our citizens are being thrown overboard without lifejackets. And it is in the sea of growing insecurity.

The fear of more and more Americans is quite simply this: Will I be next? Will my family be next? My view, it is a national embarrassment. It is a national embarrassment. Is the mic still on?

And it is from this perspective that Vermont reached the point where we simply could wait no longer. We could wait no longer for Washington to write to our rescue. For answers to come from elsewhere. So I created, two years ago along with the Vermont business round table, a coalition. A coalition of businesses, of labor, of health care providers, of low-income, of disability groups, of insurers, of doctors, of hospitals.

The only group not represented was government. And I believe that the answer and the pressure had to come from outside our beltway and it had to come from the bottom up rather than the top down. And this coalition developed these six principles. And those six principles are incorporated verbatim in the preamble to our health care legislation. And by virtue of the work of this coalition, our legislation, I believe, was jump started by at least a year.

But let's get back to insolvency. For us to move forward, and this was a challenge, our overwriting goal had to be to contain the steeply rising costs of health care. We approach these goals in three fundamental ways. First we must cover the uninsured. And our numbers have increased by 50-percent in six years. Secondly, we cannot ignore or we will fail the plight of those with insurance, employers and those who have insurance. Finally, at the heart of our plan is we must improve the quality and the value of health care.

And the key here is follow the money. Follow the money. Seventy-five- to 80-percent of our expenses, as I am sure yours are, are caught up in providing treatment and care for people with chronic conditions, often multiple chronic conditions.

What we also learned is we were not doing a very good job with those folks. They were only getting the type and level in quality of care they needed about half of the time. So we built upon an initiative started by former Governor Dean and adopted and expanded by Governor Douglas. It is called the Blueprint for Health. We look at chronic care, we decided to really focus on that in a very organized way. The outline of what is wrong, you can look at it, you can agree or disagree. I do not think you can argue with where the costs are going. I think it is hard to argue with the outcomes or the poor outcomes that we are getting now.

One of the things that we did in our chronic care program, we built into our legislation, is we have no co-pays and no deductibles. We wanted to eliminate barriers for people that get help. For those that argue that high-deductible catastrophic plans will work, we say no, they will not. We cannot have more barriers in the way of people getting care that they need.

My view, the medical savings accounts type of plan work best when two conditions are satisfied, they work best

if you have money and do not get sick. We do not think that applies to many of the people that we need to reach. The co-pays and deductibles will be waived. We think if we cannot succeed here, and we are a very organized way with our medical society, with doctors, hospitals, insurance, the state, the Medicaid program, working in an organized way. If we do not succeed in making an impact on the quality of care and access to care with chronic conditions, we will fail. It is as simple as that.

I am not going to go over all of the gradients of our bill, you have them [inaudible] in substantial detail, and I think with a fairly good explanation in your handout. Our financing is tied to, we believe if everybody is going to be covered, if everybody is in, everybody should pay a fair share. We are using tobacco monies, increasing our taxes on cigarettes. We also have an employer mandate. We were not quite as smart as Massachusetts trying to figure out how to arrive at a number so we just came up with, how about a dollar a day? So ours is $365 dollars.

We would have gone with an individual mandate. Because I believe that is the only way we are going to get truly universal coverage. But quite frankly, we did not have the means to do it. Our plan and our law will trigger in three years. Individual mandate, if we do not achieve at least 96-percent coverage.

Finally – a couple minutes wow. I was worried. I would like to briefly make a couple of comments about what I hope can be lessons for federal decision makers. I know Alice is going to cover these but I just want to say, I believe if we are going to move forward, at the federal level you must understand the common denominator that all health care is personal. It is not just rules, it is not just benefits, it is not just a bunch of names and long legislation, all health care is personal. And our policy must reflect that.

Secondly, if it was Brandeis [misspelled?] who said it, I will agree with it, that the states are the laboratories of democracy, that is the good news. But we must make sure they are laboratories of empowerment and not abandonment. My fear as coming from a state, working with poor people and disabled people, our federal government needs to empower. The fear I have now is we are on the edge of it feeling just the opposite, that of being abandoned. One size does not fit all.

States need flexibility, incentives, we need the elimination of barriers and bureaucratic obstacles, and we need sustainable funding. I also think we need national standards. Who is covered and what is covered. We have far too great a difference of disparity, between eligibility and coverage between our states. I think that needs to be

leveraged and influenced by our federal government. The Holy Grail, which I would term another way to refer to Orissa [misspelled?]. It is a third rail, whether we can do anything or not, I think it needs to be examined. Medicare and Medicaid must be made more compatible. If they are not combined, they must be made more compatible.

We have a two-class system of health care operated by our federal government. One Medicare which is not means tested, which does far better, largely due to who the beneficiaries are. And the other Medicaid, which is quite a different program. The example, and worst example I believe, is the Medicaid Part D. My judgment is nothing more than a political fig leaf and I am in the landing pattern for Part D, I am 64 years old. If we do not recognize that in creating Part D, we created a donut hole, and we ignored the black hole of the uninsured, and we did nothing to deal with the issues of cost and the insolvency factor. A new benefit costing $600 billion dollars, at a minimum. As far as I know, did not extend coverage to one single uninsured person. It is unbelievable.

Let me conclude with this. The arch of the moral universe is long but it bends towards justice. Those words of Martin Luther King, are spoken probably 40 years ago on another occasion with other issues my judgments speak and [inaudible] as true to man as they do today, when it comes to

providing health care for each and every one of our citizens. So, thank you for having us here and I look forward to your questions.

ED HOWARD: Thank you so much. We are going to have one final panelist and then open it up for discussion among our speakers and for you to get your chance to ask questions. And that final panelist is Alice Burton, vice president of Academy Health here in town and director of the State Coverage Initiatives project and the Robert Wood Johnson Foundation. And she has operated out of Academy Health. Close contact with state level reforms and reformers across the country. And she is in a position to help us put reforms we have heard about so far into, somewhat, of a broader context. Alice, thank you for sharing your information.

ALICE BURTON: Thank you. Sitting here listening to Senator Leddy talk and I am thinking, oh, my, what a tough act to follow. And thinking back to Amy's comments back at the beginning where she talked about her 20-30 slides, talking about the Massachusetts plan, my challenge today is to talk to you about what 47 other states are doing. So I spent my weekend or last week cramming those slides down into six, which I have never accomplished before. We will see how that works. So I am going to give you a general picture of what is happening with states and their efforts on the uninsured. I think the first thing I would like to say is,

certainly, I have the impression, and I sense it in any state capitals and here in Washington as well, that states are raising hopes and raising expectations also that really action can happen on the uninsured. They are raising hope that bipartisan compromise is possible and, hopefully, that can be a model for other states to act as well as national leaders to act.

I will say that with bipartisan compromise, I would emphasize the work compromise and really I think states have lead the way in showing that working through the difficult challenges of crafting a bill is really important. And so compromise is an important part of that phrase. What is happening in the states that are moving forward on comprehensive reform or on less comprehensive, more targeted strategies, to specific populations.

I think several things, I think there are several ingredients there. One leadership, and that is somewhat obvious, and then in all of these states that we have talked about. But also an opportunity. And when I say that, I mean a potential – several forces have to come together. Whether it be the potential loss of federal funds that might create an impetus for let's get together and come to some agreement on this because we do not want to lose federal financing for a program. Or whether it be a maturing of a debate that has

occurred over several years. Or the coalition that Senator Leddy talked about. Or new leaders coming in.

There is some opportunity, some catalyst that makes reform possible in these states. And finally, and I think this is one that is often forgotten, particularly in this city which is filled with policy analysts on every topic and you have 15 different policy shops on every nuance. That is not true with the state level. The state level, there are few people in many states that do all the health policy work. And so to expect all states to be ready to act when there is opportunity, when there is leadership, I think we need to recognize we will need to support some states in doing that. That they really do need analytic capacity to be able to evaluate the options to move forward and be able to act on those things.

But certainly states are motivated to take on health reform and we heard Senator Leddy's comment about they are not waiting for federal action anymore before moving forward. But also the realness of this problem, the real and growing problem that is so immediate at the state level. And they are trying a variety of different approaches. Everything from these comprehensive approaches that really are market reforms and trying to reach a universal goal, or whether they are addressing a very specific and targeted population such

as working adults, working low-wage adults, or children or different kinds of targets.

What are the trends in state coverage initiatives? First, comprehensive efforts really do take time, these things do not happen overnight. I think if you talk to any of these folks, they would tell you that a lot of this work was in development for many years. They build off prior efforts often and they build off prior funding mechanisms. State does not wake up one day and say we have 25-percent uninsured and set a goal of having comprehensive coverage the next year and have that be realistic at all.

Really, all these states had done things in, many cases, to expand coverage for [inaudible] Massachusetts, Vermont and Maine which we have not talked about but is another state with a very comprehensive proposal. All have lower rates of uninsured prior to putting their reforms in place. And they all had prior expansions, many different efforts, but prior expansions of public coverage where they already had funding in place to address the uninsured – many uninsured adults but far beyond what many other states have in place. They were building those reforms on those efforts.

Most reforms, if not all, attempt to stem the erosion of employer sponsored insurance. Whether it is targeting small businesses and trying to help them to offer insurance, trying to find out what is going to be the right benefit

package, the right cost structure to make it possible for small businesses to offer coverage. Or to be putting in place an initiative that picks up the workers that are not able to access the employer-sponsored insurance or the dependents of people who are working. But they are all about working families, largely, and trying to stem the erosion of insurance coverage for that population.

This year, in particular, we have seen that reforms often expect some shared financial responsibility. And some are even beginning to recognize the need for mandatory roles, whether it be on individuals or whether it be on employers. That really, it is the mandatory nature of these programs that will get participation in the programs and there is only so far you can go in terms of universal coverage with a voluntary program.

Expansions in coverage often rely on private insurers delivered services. I think this is an interesting one. It has a couple of states debating this. Even the states that have Medicaid expansion that are doing something that is really a Medicaid [inaudible] often are doing that through a private managed care organization or are building it on a private platform or calling it something completely different and not calling it Medicaid. They may be using the Medicaid financing structure, but they are doing it through a very

private mechanism and marketing it and branding it a very private program.

We have seen, in a couple of state, moving forward and trying to do that, through private plans and trying to partner with private plans to hold the risk for these populations. But really a tension between an unknown population that we are trying to cover and the state may be needed to hold the [inaudible] some examples where states are actually using the private delivery system but holding the risk for the insured population.

Many state reforms address cost and quality in addition to health coverage. We have heard all of these previous speakers talk about the need to control cost. Most of the comprehensive reforms have different elements, a quality council, different initiatives to hold down our cost, chronic disease management, that kind of thing. Six voluntary purchasing polls with a standalone strategy are not likely to be sufficient to expand coverage. We heard Amy talk about the connector and that is a buzz in state capitals so lets put together a connector, let’s solve the problem of the uninsured by doing that. I think it is very important to recognize the history we have on these and to recognize what it is that Massachusetts is proposing.

Massachusetts, they are proposing a connector which will bring payers or purchasers together, but there is more

to it than just that. There is a subsidy structure, there is the section 125 plans which Amy talked about, which are reasons to come to that connector. And I think we have been through the experience, many states have been through the experience where they have tried just linking together payers to buy services, and there really needs to be a reason for them to come together. That subsidy is a very good reason.

So, looking forward. First, reforms take time and we need to evaluate them over the long run. I said that the beginning that we are raising hope and we are certainly raising expectation. The panel that we do a year from now, I imagine, will ask how many people are enrolled in all of these initiatives and I would encourage us to recognize that the hard work has just begun for these states. Now that they have got to compromise, they are now working towards implementation and that is really, really the challenge. So I think that we need to evaluate these reforms over a period of time.

Again when we have raised hopes, we have also raised expectations. And I also want to say, while there is a lot of interest in states, and a lot of states will act and will work on this energy for state reforms, I do not think it is reasonable to expect that all states will act. So and the variation in terms of the uninsured across the states, Anne had some very helpful slides at the beginning which point to

the real diversity of this problem across the nation. So it is not reasonable to expect that state by state, we will be able to solve this problem with 47 million uninsured Americans.

But what can we do from a federal level to encourage innovation and to see what happens at the states? I think we have heard it before amongst everybody that states will be the laboratories of democracy. So they will test ideas, both politically and practically. We will learn about what is acceptable, what compromise can be achieved and hopefully what we might be able to craft. But also, what works and what does not at a practical level.

Certainly these state models might serve as models for other states and other states will see pieces of what is working in these different states and take them to theirs and mold them to work for their own environment. But I also hope that they will be models for federal reforms. As many prior federal reforms have modeled on state efforts, I think there is an opportunity to do this. I think also we need to recognize that sustainable funding is essential for states to implement reforms.

We have been through a number of exercises where we give states some money to do some planning efforts and we say go solve the problem of the uninsured. But we do not follow through with implementation dollars. And I think we need to

recognize that for many states, the resources are such that if they are going to expand coverage and address the problem of the uninsured, there is the need for sustainable federal financing.

And finally, if we are going to pilot test a few things in a few states, we need to be prepared for them to be successful. And when they are successful, we need to be ready to enact those things. Because I think it is going to be challenging for us to have a few states leading the way with federal resources and moving forward on the uninsured and not helping the others to follow. So we really need to be prepared to follow through on the lessons that we learn from states and be able to act on federal reform. With that, I think we have questions, or turn it back to Ed.

ED HOWARD: Thank you very much, Alice, a good framing of the questions that arise as we hear from these states. Now we are at the point where you join the conversation. There are a number of floor mics, there are green question cards you can hold up and someone will take them from you. And I invite Anne Gauthier, as my co-moderator, to join in as well. Questions for any of the panelists, if panelists want to ask each other questions, they should feel free to be able to do that to. Anne, do you want to start us off?

ANNE GAUTHIER: Sure, I would be glad to. I think I will take us perhaps back into some of the interesting details that Amy did not have the opportunity to provide us with. You talked about as a critical theme, affordable coverage, and you talked about things that are being done structurally in the state but you also talked about regulations for what will constitute and affordable plan in Massachusetts. So could you explain a little bit more about what elements of the law are being put into place to make insurance "affordable" and how you see that playing out?

AMY LISCHKO: Well, a couple of clarifications, the individual mandate included in the law, a feature that it was only applied to people for whom health care was affordable. So if it was deemed that health insurance was not affordable for that particular person or family, then they were exempt from the individual mandate. So it is really important to us that we make sure to be successful that we make sure that the health insurance is affordable. The specifications for those affordable plans have not yet been determined. There is a council of the connector— the committee of the connector, it is made up of a board of 10, need to come up with the criteria and the specifications for what will constitute affordable coverage.

But I think that they have been clear in wanting plans to be very creative in coming to that and not just look

at the dials of increasing co-payments and increasing deductibles, but actually look at things like, tighter networks, look at things like disease management, look at things like behavioral issues, compliance with doctors orders, things like that. So that it is not strictly going to be, let's just turn the dials of co-payment and deductible to get to that more affordable premium.

The other issue that the state did take on is there were many councils developed and established through this law, 10, I think, total, which meet on a monthly or more frequent basis that keep all of us state employees very busy. But they all have established a Health care Quality and Cost Council which is made up of a number of people to look at developing mechanisms to make the health care system as a whole more efficient and better quality. So that will also be forthcoming.

MALE SPEAKER: Amy, can I just, following up, the council that you mention that is looking at the question of affordability, has the power to decide that question or does the connector board have that power or who?

AMY LISCHKO: It is the connector board, yes, excuse me if I said council, it is the connector board, which is a membership of 10. Five exophicias [misspelled?], and five appointed members that will establish that through regulation, there will be public hearings on it. We have

already heard from a number of people who have less comprehensive plans and are quite happy with those plans and want to keep those plans. And so I think it is going to be a really tough and difficult decision to come up with those standards.

ED HOWARD: Yes, and I ask questioners to identify themselves and keep their questions as brief as they can.

STAN DORN: Thank you. I am Stan Dorn from the Urban Institute. I have a question for Amy and a question for Norm. For Amy, I would like to know your thoughts about using what you hoped would be a large number of state residents covered through the connector as a means of leveraging lower premiums from insurance companies.

And then my question for Norm is, you talked about the tanif [misspelled?] parents who are losing some benefits and coverage to help fund services to single, childless adults. Could you tell us a little more about what those cutbacks were and what the results were in terms of your observation and evaluation? Thank you.

AMY LISCHKO: I think the connector – some people call the connector a purchasing pool and others stay far away from that terminology. So, I think it is a little unclear how that will play out and how the connector will exert a market force, because they have a number of lives on the plans to keep their premiums down. I think there is a lot of

pressure though on plans right now and so far, we have seen that they have come and met the levels of premiums that we had asked them to meet for the affordable products, for the products for under 300-percent of the FPL. They were well within the range that we were looking at pre-passage of the bill. So, we are hopeful that the connector will be able to exert at least some of that market pressure to keep the premium prices down.

NORM THURSTON: In terms of the reduction and benefits for the tanif [misspelled?] parents, it was thought that those should not get at the heart of medical care. So the changes in benefits were largely, the most important ones were, increases in the co-pays, but not by very much. For example, some co-pays went from $2 dollars to $3 dollars, it is not like we went to $25 dollars or anything like that. There is also some services that were limited. For example, vision and dental, under the new program, had limits. It actually is kind of an irony in a certain sense, because when those were written into the waiver, those were viewed as benefit reductions, but right after that happened, the regular Medicaid adults lost them entirely.

So within two years of the program starting, actually, the non-traditional Medicaid finance actually had better benefits for vision and dental than regular Medicaid. There were also some limits placed on - for example, we did

not cover or do not cover non-emergency transportation for tanif [inaudible] parents. Those were the sorts of benefits the…In terms of impact, it is really hard to know, those were the sorts of things that you do not observe frequently enough to tell. Our previous study basically showed very little significant results. But that may be just due to the fact that we do not have enough power to measure them very well as opposed to the fact that they did not have much of an impact.

One thing that we did notice was the increase in co-pays on pharmacy did result in a reduction in utilization rates for pharmacy, and that depends on who you talk to whether that is a good thing or a bad thing. So there may or may not be negative results from the tanif [misspelled?] population having their benefits reduced.

[Inaudible]

FEMALE SPEAKER: Norm, we have gotten a question here that I think follows that. Two questions, why has enrollment in the primary care network been so low? I think I know the answer with your caps, so I will let you get to that. But secondly, what happens to the enrollees in specialty care?

NORM THURSTON: Both very good questions. The so low is relative, we are a small state, 50,000 to us that is a big number. We currently have 300,000 uninsured. So 50,000 people is a lot of people. The cap was initially set at 19,000 people, that is how much money we had available

for the program. Typically due to, you do not always have enough money to fund it at 19,000. So the average enrollment has been closer to about 17,000 in any given month. Sometimes it is lower, sometimes it is higher. It just depends on where we are in the open enrollment cycle. So, but typically when we have open enrollment periods, it fills up within just a couple of weeks. Whatever cap we set, we would say ok enrollment is now open, we try to gauge it. And usually the open enrollment periods have been around two weeks.

We have had to limit those some times. Another strange thing is that we actually have two sub-populations. We have parents and childless adults. And we have to treat those separately because they have very different cost structures. So typically we have, the parents tend to cycle out a [inaudible] much more frequently than the childless adults. And so we are having open enrollment for them much more frequently.

The second question was specialty care. Specialty care is not a covered benefit. So in other words, primary care network does not pay for that. But we have some wonderful networks of donated care and we in fact we have two full-time workers in our office that help people arrange for donated or low-cost specialty care. We do not always get it. You do not always get specialty care. There are certain

specialties that are just very, very hard to get into. Neurologists being one of those, it is very difficult for anybody, even if you have insurance, to get into see an neurologist, which is even harder when you do not have insurance and you have to rely on charity or donated care. But for the most part, specialists' works on a charity care basis and it works reasonably well.

The one, I guess, there is a caveat there is, you just never know if you cannot get into a specialist, what is going to happen. We have relied very heavily on our family practice physicians. And that is sort of a concern that we have. Because sometimes we see the family practice physicians feeling responsible for providing care, even if it is a little bit beyond their ability and so sometimes you just get the family practice physicians saying, look, I cannot get you in to see a neurologist, but I will do the best I can and I will treat you the best I can with the skills that I have. And that may not be exactly the best for everything. But, by and large, people are getting, for the most part, care that they need to get.

ED HOWARD: Yes, Jim.

JIM LEDDY: I would just like to make a comment on the last reference to the importance of primary care. We absolutely believe that they are the foundation and will be the key to whether or not we are going to succeed. And we

have a challenge in our state and I think increasingly in the smaller and more rural states, if not throughout the country, of having a declining pool of primary care physicians. We need to address that and I think the federal government needs to pay some attention in terms of how support can be provided to students going through medical schools, for example.

My daughter just graduated from medical school. We call her Doc now. And she is doing her residency in Boston, she went to the University of Vermont, in-state tuition, we have a family foundation that provides $40,000 dollars over four years to Vermont kids going to medical school which is incredible. She came out with a six-figure debt, most of her classmates came out with $200- to 250,000 dollars worth of debt.

What that is doing is two things. It is driving them geographically where it is more attractive and is driving them into specialties that pay them more. And we doubled the loan repayment part of our budget, we think it is a step, but it is inadequate. We need to look at where our providers are going to come from and frankly provide subsidies and incentives to get them.

ED HOWARD: Very good. Yes, in the back, please?

CHRIS PETERSON: Chris Peterson with CRS. Question for Norm and Amy as well. Norm, do you think that enrollees in the new primary care program will consider themselves to

be insured? And the reason that I ask is I do estimates on the uninsured and I am just curious as to what the impact will be on those estimates as a result of that program and whether it is appropriate.

And then for Amy specifically, I would like for you to talk about your SCHIP piece of Massachusetts plan. If I am not mistaken, I think you exhausted your federal SCHIP fund for '06 and are predicted to do so for '07. I do not know if that is not too big of a concern for the state because you have Medicaid funds to fall back on when those SCHIP funds are exhausted but just wanted to get [inaudible] to talk about that.

NORM THURSTON: In terms of – we do a state survey of health insurance status and we specifically ask under the question do you have insurance, we say are you on Utah Medicaid, are you on CHIP, are you on a primary care network? So we do not really get an opportunity to see whether that person considers the primary care network to be insurance but, we count it in terms of – it is an answer on the question. Are you on Medicaid, are you on CHIP, are you on primary care network, et cetera? And so that is one of the categories that we do track in the surveys.

In terms of the individuals, when we have done the surveys of them, most of them view the primary care network as providing a significant benefit and a significant access

to what it does too. We do have a certain percentage who feel like they did not know what they were getting into, that they thought they were getting comprehensive care and they were surprised later to find out that they did not. And that is a marketing issue, just letting them know to look. And we have done some changes in the enrollment materials to let them know, in big letters, you are not getting this, you are not getting this and so that has been a marketing issue for us as well as helping people understand what the program does and does not do.

AMY LISCHKO: I cannot answer your question specifically. I know that there was an issue with that and that we had to reclassify some of the kids that were under our SCHIP, under our ordinary Medicaid program, I do not have the details on that, but I can get that for you. But it is not an issue moving forward.

ED HOWARD: Yeah, could we take one more question in the back, someone who was in line before the gentleman in front.

EVA DUGOFF [MISSPELLED?]: Hi, Eva Dugoff with Representative Jan Chikowski's [misspelled?] office. I have a quick question for Norm, which is, you mentioned that 56– to 54-percent of people left the primary care network for other insurance. Do you know why the other 46-percent of people left your program?

NORM THURSTON: We asked some follow-up questions for those that did not leave for insurance. There were just a mixed bag. There is not really one good answer to that, there was kind of even representation of, I did not feel like I was getting value for what I was paying, which was $50 dollars a year, so it is hard, someone was not getting value for their $50 dollars a year.

There were a lot of people who said that, there were a lot of people who said that they did not understand the re-enrollment process. So when we had that happen, we actually kept track of those survey respondents and re-contacted them at the next open enrollment to see if they wanted to re-enroll. So some of them may have actually come back on if they understood that it was missing.

We did have surprising number who said that the $50 dollars, coming up with $50 dollars once a year was a problem for them. And we do not really have a good solution for that because we feel like it is important for there to be some sort of participation. It is really hard to know how you pitch that in a way that does not cut somebody out. There is always going to be somebody at the margin and there were a surprising number that said that $50 dollars every year was a problem for them, coming up with that amount of money.

ED HOWARD: Yes, sir?

MATTHEW BLAKE [MISSPELLED?]: Thank you. Hi my name is Matthew Blake. I am a reporter with the *Capital Times*, Madison, Wisconsin. Referring to the title of this presentation, "Lessons for Federal Policy Makers," I was wondering if the panel does generally support the Baldwin-Price bipartisan Health care Reform Bill?

ED HOWARD: In case you are not familiar with that, there is a description in your packets and in the Senate, it is a Voinovich bill. Anybody want to take that on?

FEMALE SPEAKER: To give grants to states, to expand coverage as well as do some other reform.

FEMALE SPEAKER: I will start with that one. I am not going to take a position on the bill, I do not have one. I think there are key elements of what it takes for the federal government encourage reform in terms of states. And I talked about that a little bit, I think it is important to give them money for implementation and that implementation needs to be over a period of time. It cannot be a one-year pot of money with a cliff on the other end of it. For a state to be invested to develop a strategy, they need a sustainable funding source to be able to move forward on that.

And I think with that is the recognition that once those states are able to move forward, if they are able to move forward with those kinds of things, but a number of

other states will want to follow. So again, demonstrations of this nature can really help to show what different things can work. But I think there needs to be a readiness to act on what works after that is shown.

ED HOWARD: Go ahead [inaudible].

MALE SPEAKER: I do not have the detail, I have read through sort of summaries of what has been proposed. Again, I would encourage it but I would have caution. If it does not move beyond tinkering, I would question it. If it does not have incentives for state and other states to follow, but most importantly, it needs sustainable funding.

Since the early 1980s, when we moved essentially to block grant types of funds, increasing the federal government has found itself providing pilot projects, research oriented grants, three, five years and out. And what that does is it discourages states and others from applying because even if they succeed, they are faced with the incredible challenge of trying to find the ongoing funding. And so I do not have the detail but if these proposals offer those types of incentives, obviously, I think they would be positive and hopefully they would serve as examples for other states.

ED HOWARD: Go ahead, Anne.

ANNE GAUTHIER: If I could ask a follow-on as perhaps Amy might want to chime in here and Norm as well. To what degree would a bill such as a bill that provides significant

funding for some number of states help to break the partisan log jam that you have faced or you might face in moving ahead more significantly? To what degree would it impede or would it do nothing? [Inaudible]

NORM THURSTON: I think you are all aware that we do not have a partisan logjam in Utah. We have one party that controls the governorship and a veto-proof majority in both houses. So we do not have that problem, we have a different one.

We have an ideological logjam which is generally our problem, is finding something that is acceptable to all of the factions within that party. So…[inaudible]. I think I maybe would prefer to just comment generally. Our leadership in our state is very supportive of the concept of states being laboratory for democracy. Of finding ways – trying what works for different states. What works in Massachusetts may not end up working in Utah and vice versa.

But there may be some things that we find out that we all have in common and so if there is going to be some sort of federal guidelines, those probably should be widely tested in states first. Because otherwise, you end up taking something that may only work in a sub-set of states and trying to apply that to all states, and that ends up being worse than where you started, which was just allowing states to do something different on their own.

ED HOWARD: Yes, sir, in the back.

JOHN RIGG: I think this question is most [inaudible] at the smaller states geographically speaking…

ED HOWARD: And you are?

JOHN RIGG: I am sorry, my name is John Rigg. I am with the Committee on Ways and Means. This is more applicable to the smaller states I think geographically, not so much population. So specifically targeted towards Vermont and Massachusetts people, among the panelists, that is. It is a question more of geography, we have a number of small states that are highly urbanized or packed closely together and it is very easy to live or work on or near the border of one state. To what extent are you concerned about geographic variations for crossing state lines? If I work in Massachusetts and live in another state, to what extent are the Massachusetts health care regulations applicable to me and is that addressed in the law?

Secondarily, is there state, or is there a federal role in helping the states to regulate these sorts of things and what would you envision that federal role as being?

FEMALE SPEAKER: I think that is a really good question and we – the law as it pertains to employers, is for employers that are located in Massachusetts, for all of their employees, so they are required to test a fair share and free rider apply to all of their employees. And the individual

mandate applies to those residents that live in Massachusetts. But we had to make those decisions and we will see, there definitely is creep of both employers and residents across those borders. Particularly New Hampshire, Rhode Island, New York. So we will have to see if those are the right decisions. But those were specifically made in a statute.

ED HOWARD: Jim.

JIM LEDDY: We had similar issues and concerns raised. Actually there are some folks who thought that if we passed this law that the entire western shore of Lake Champlain would move, which is New York, would move to Vermont. We had some concern about that. The reality is that a state that leads, other states are going to follow. Our benefits in Vermont, in many areas, are decidedly better than our neighbors to the east New Hampshire. And we have seen no migration of folks from New Hampshire to come to Vermont to receive our benefits.

We have a – our second largest hospital in Vermont, serving Vermont residents, is in New Hampshire, Dartmouth-Hitchcock. They have 5,000 employees, 2,500 are Vermont residents. So there is a lot of movement back and forth. We think that if our program succeeds, other states will follow. We also think our businesses will regard this as an economic

benefit to them. Helping them recruit and retain workers. It is a question but we do not see it as a major obstacle.

ED HOWARD: Alice.

ALICE BURTON: I would just add that while we are seeing more state innovation happen right now and the potential for more variation. Even with the panelists today, we have tremendous variation across the states and what they are proposing to do. But we already have tremendous variation across the states that if you looked at a chart of eligibility levels in the Medicaid program, particularly for adults, you would see how very, very different it is across the nation.

So the question really is a national question. How much variation are we really willing to accept? And I think it also lends to how much, then, flexibility are we willing to offer? And is that flexibility for states to try new things with populations that have not previously been covered. Is that flexibility more acceptable than a different kind of flexibility? I think it raises really all of those questions as the federal debate happens, about how much of this will be encouraged at the state level versus a broader national solution.

ED HOWARD: Before we take your question, two things. One is remind you that that blue evaluation form is sitting right on top on the left hand side of your briefing materials

and I would appreciate it if you would grab hold of it here. We have about 15 minutes or so left of our time here. And this question that has recurred.

There are a couple, actually. The one I wanted to make sure got asked before we got too far along, addressed directly to Alice Burton, although if the other folks want to chime in, they can. Could you please describe the Illinois plan to cover all kids and talk about the progress of that plan?

ALICE BURTON: Sure, last year, I believe it was, Illinois passed legislation to expand coverage to all children in their state. And this happened on the heels of several other things that the state of Illinois had done. Again, building on prior investments in coverage. Illinois was one of the few states to expand their Medicaid program to parents at a time when most states were at least looking at reductions in a severe fiscal crisis.

So as they did that, that was a platform in terms of expanding coverage. This latest expansion was for all children building on top of the SCHIP program, essentially uninsured children in families with much higher incomes of any income, really can apply to coverage, they pay for that coverage on a sliding scale, so therefore, more likely we will have enrolled those that are likely to get a richer benefit from that.

Those right up above the SCHIP eligibility levels in the state. So Illinois was the first to do this boldly with the term All Kids is the name of their program. But several other states are talking about that. I think Norm you mentioned it in your state. Pennsylvania has at least passed budget authority to do a similar type program. And a number of other states have different kinds of strategies that are calling for All Kids types of programs. Whether they be explicitly building on an SCHIP framework or whether they be the goal of Universal Coverage for Children achieved through multiple different mechanisms.

MALE SPEAKER: Let me jump in there really quick. One of the reasons why we are including All Kids in our proposal Moving Forward is, it is affordable. We can insure all kids who are currently eligible for CHIP and Medicaid for around $12 million dollars more a year, ongoing funding. That is a drop in the bucket compared to the entirety of the problem. All that would leave us with kids over 200-percent of the federal poverty level, there are only about 12,000 of those. And again, it is doable, it is a doable proposition to focus on that group. It is affordable and you can actually get your hands around that size of a problem.

ALICE BURTON: I just had another thought on that. We have spent years also with years of SCHIP improving our outreach and eligibility. And really many of use recognize

that one of the components of reaching the uninsured was reaching those that are eligible but uninsured. That All Kids Programs makes that message so much clearer. It makes the message of enroll in our programs a lot simpler. So I think it builds on the point that Norm makes that it is an inexpensive population. But also it builds on the really great experience and great work that states have done to improve outreach enrollment in programs like that.

FEMALE SPEAKER: And I think most of the people in this room may know what one of major issues facing Congress next year is the reauthorization of the SCHIP Program and I think we are going to be seeing a lot of debate about whether to reauthorize as is or use it as a platform for potentially reaching more uninsured kids. So we will all be working with you to think through those issues.

ED HOWARD: Yes, sir?

HOWARD TUCK: Hi, my name is Howard Tuck. I am a physician in Robert Wood Johnson Health Policy fellow in town. And this is really a question for the state folks. With all of the flexibility and innovation, do you have enough of a mechanism and ability to evaluate the outcomes of the changes that are there? Can we learn from the state experiments adequately to really develop a greater understanding of the federal level? And is there a federal role for encouraging a more standardized approach to the

evaluations of the experiments in the innovations that you are creating?

ED HOWARD: Very good questions.

JIM LEDDY: I am not sure. We certainly took the issue very seriously and have built into our legislation a number of steps to evaluate various parts of it, including the outcomes of our Chronic Care Initiative. This very much a part of that overall effort. The investment in technology, which I did not mention, is key to our implementation of a program as well as the ability to evaluate it. I think that we are going to need help. We are going to need help from the government and perhaps from foundations. I think we need to have more universal forms of evaluation so that you can look, across states and come up with information that then can be replicable if they are working. But I think your question is a fair one. If we succeed only in expanding coverage without addressing the issue of quality, we likely will fail as well.

NORM THURSTON: I think our experience is similar. We found that it is relatively straight forward to evaluate participation and utilization when it comes to health outcomes, we have the same problem that every health services [inaudible] has. It does not go away just because you are looking at an experimental program. It is really hard to

measure the outcomes to start with, and it is even harder to associate health outcomes with the program.

FEMALE SPEAKER: With my foundation hat on, I will jump in. One of the reasons that we and other foundations have been asked to fund evaluations is because there is not state or federal funding currently available to ask and answer the types of questions. Not only about health outcomes but about how people lives are different, what is different in the care that they get and a number of other questions. So we have very small funding in comparison to the needs. Ideally it would be a federal role but money has been tight for such things for some time.

ED HOWARD: Yes?

GERALDINE DRAKE-HAWKINS [MISSPELLED?]: Hi, I am Geraldine Drake-Hawkins with the National Council on Disability. I want to commend Vermont because I heard that you, in your statement, are including people with disabilities in the work you are doing. My question to the other states would be, whether or not you have some kind of initiatives that will allow you to have data at the end that you could disaggregate in some way so that people with disabilities will have some notion of how things may be working in your states. There may be some lessons for us at the federal level.

Another part of my question or maybe another questions is, yeah, it is another question, whether or not, in any of the programs that you – the initiatives at the state level, anyone is looking at and collecting data around mental health. Thank you.

ED HOWARD: Alice or Jim. Whichever you would like.

JIM LEDDY: Well, mental health, obviously – Vermont's parody law, which includes substance abuse, it was passed in 1997, many folks would still look at it is probably the most progressive in the country and yet it is not as successful as we would like. The inclusion of folks with mental illness, and the whole area of mental health is a growing area that we are looking at in Vermont and I think across the country in terms of links to mainstream health care. I use that term because I cannot think of another one.

But we have some real problems in Vermont. We are struggling with some serious issues of quality around the care of the mentally ill in our state hospital. And so that is getting particular emphasis but it is not directly related to our legislation. It is getting that emphasis because it should occur under and circumstances.

ED HOWARD: Alice.

ALICE BURTON: I would just actually tie your question back to the earlier one about evaluation. If you point it out, the large challenge of understanding how these

different initiatives work for different populations. It is one thing to look at them overall, it is quite another thing to look at how they affect discrete different populations of individuals with different kinds of needs. So it is an evaluation challenge in going forward. Your question about mental health, I would say that in most of the states that I have worked with in looking at coverage initiatives, one of the questions that often comes up it what will the benefits be and what will an affordable benefit package be and how to change that.

And clearly mental health is a part of the discussions in many of those states. And if not, if they are not included in a new benefit package, how are those costs covered? Are they covered already through the state general funds and really is that an efficient way to do that? So I think that mental health is very present in the discussions with state leaders about how benefits will be structured and how we will be paying for them one way or the other.

MALE SPEAKER: Can I slip in a couple of— actually it is a single question that was written in different ways on several different cards. And it has to do with Orissa [misspelled?] and the Massachusetts plan for requiring employers to set up section 125 plans. And I guess my threshold question Amy is if you could define 125 plans for us really quickly. But then explain whether or not those

requirements are being challenged under Orissa [misspelled?] if they could be, and whether employers were upset enough about the fair share requirements that they would challenge on that ground.

AMY LISCHKO: Sure. The section 125 plan is a part of the IRS code that allows for, at least what we were referring to was the part that allows for the pretax payment of the premiums to allow your employees to have access to that benefit. Because we are not requiring employers to contribute towards that, that requirement is just to set-up that plan. It is not subject to, at least our opinion is, it is not subject to an Orissa [misspelled?] challenge. It is possible we could get an Orissa [misspelled?] challenge on some of the other pieces of the law, such as the fair share. But we have not, to date, that I am aware of.

I think part of that is tribute to the way the businesses actually came together and worked through this law before it became a law and helped contribute towards it and felt that they were a part of it and felt that along the way, we have listened to them and tried to craft the regulations so that it was not too onerous or burdensome on employers. So, there still could be an Orissa [misspelled?] challenge to come but there has not been one to date.

ED HOWARD: Jim, oh, go ahead, Alice.

ALICE BURTON: I would also just point you towards a reference in your packet. There is an issue brief that the National Academy of State Health Policy and State Coverage Initiatives, the program I am involved with. Just commissioned with Pat Butler, an attorney, who does a lot of work on Orissa [misspelled?] and it goes through those issues and it talks about, specifically, the 125 plan exemption and that there is some Department of Labor ruling that the section 125 plans were essentially outside of the Orissa exemption. But I would encourage you to look at that brief. Much more technical than my answer here.

JIM LEDDY: I just comment that in Vermont on the so called employer mandate our experience was quite similar to Massachusetts. We had involved the business community. From day one, in terms of my establishment of this coalition 21, they really worked cooperatively, they did not like some parts of it.

What was interesting at the end is that while no business group came out in support of an employer mandate, on those not providing insurance, many of those providing insurance said thank you, quietly, thank you, at long last. One of the fastest growing areas of cost shift, in my experience, is between employers. And those that are offering good benefits, increasingly frustrated by carrying costs from those that do not. And if you have a husband and

wife working two different places, there is a choice being made as to where the benefits are going to be taken. And more and more employers are starting to define and limit the benefits offered to dependents. Largely because of the cost shiuft and the increasing burden on them.

So we really had, if not, support in a public way, we did not have any real opposition at the same time.

ED HOWARD: Very good. Yes, ma'am, you have been very patient.

MELISSA ANDELL [MISSPELLED?]: Hi my name is Melissa Andell. I am from the Academy of Managed Care Pharmacy, and question is for Senator Leddy. I noticed that you mentioned that there were no co-payments and no deductibles for the Vermont plan. And I was wondering if there were any mechanisms that you had in place or if there was any concern on your part about the financial sustainability of the program? I know several states recently have had to go from no co-payments no deductibles on their Medicaid programs to co-payments and deductibles because there were some waste and abuse in the system. And did you guys look at those states and do you have anything in place to prevent that?

JIM LEDDY: Well, first of all, the co-payments or the lack there of, and also of deductibles, applies to folks who are enrolled in a chronic care management program. It relates to that part of the care. And what we believe is

that we did not want to have obstacles to people getting care. And we believe that in many cases, with high deductibles, catastrophic types of plan, or even deductibles and co-pays, even more modest, for a lot of people those are reasons why they do not get the care. And we wanted to remove those.

We also, with our Medicaid population, for folks who pay premiums there, our studies indicate that about half of our uninsured in Vermont are people who are Medicaid eligible. And we believe that one of the reason is many of them might be healthy, young, but we also think another is might be the cost of those premiums. We actually, with our, Dr. Dinosaur program, which is our children's program, funded through Medicaid, we reduced the premiums by 50-percent there.

We reduced them for adults who were paying premiums by 30-percent. So we actually went the opposite direction. Because we were not afraid of people ripping us off. We want to eliminate where possible barriers to people getting care. And we feel that if they get quality care early and well, then we are going to achieve the savings in dollars and we are going to have a healthier population.

ED HOWARD: Do you have a question?

[Inaudible]

ANNE GAUTHIER: What we were talking about before with one proposal, I would ask any of the panelists here, what could Congress do that would facilitate the efforts that you are currently undertaking?

FEMALE SPEAKER: Aside from writing a check?

ED HOWARD: While you are thinking about your answer to that, let me just, I picked up a phrase from one of the pieces in your packets that was a one pager, an executive summary from the New American Foundation, asserting that state reform should be, here I quote “catalytic and exemplary to, not substitutes for, national reform.” So if you want to weave a comment on that observation into your response to Anne’s question, that would be a fitting way to bring this program to an end. Jim, do you want to start off? You look anxious to tell us what…

JIM LEDDY: Well, there is a couple of… First of all, encourage us. Encourage us, get rid of the barriers if you can, from our federal government. Look at the progress that states have made that generally, in my state at least, we have a Democratic legislature and a Republican governor. We had some very serious differences, I think we still do. But we made progress, the worst feeling I have ever had in my life in anything I have ever done, was to get down to the 12th hour on health care legislation and feel that I was

playing a game of chicken with the health care of it people Vermont.

And that has to end. That has to end at our federal level and it has to end at our states. We cannot polarize and politicize the health of out country and of our citizens by playing games of political chicken.

FEMALE SPEAKER: I know I should have an answer to this given the title of this whole meeting. I guess I would agree with Senator Leddy in that support for the states, not just financial but encouragement and also maybe some initial investment in helping us to evaluate our reform efforts, through either additional survey dollars or other dollars to help us take a good look at whether what we are doing is working or not.

NORM THURSTON: our experience has generally been positive that we have found very receptive. But sometimes you just run into strange requirements that are hard to explain. For example, with the premium subsidies, that they have to be – we have to write a check to a person, we cannot write a check to their employer and we cannot write a check to the insurance company. And the answer, that is just the way it is. There is not – it is not like anybody has any discretion to do that, but it is a problem for us in exactly doing things that we would like to do. And we appreciate the people in the federal government helping us work through all

of those issues. But there are some little things, just the legislative issue that…and it is very difficult to get things like that corrected in the federal settings. So I do not know how you do that.

FEMALE SPEAKER: I just add to this, I think that if we are at a place where we are expecting states to lead the way, if that is where we are and we want states to be doing things, then Norm is absolutely right, there needs to be flexibility on some of these administrative nuances which are not such nuances when you go to implement programs. They really can be barriers to doing things that make sense. So if that is where we want to be, if we want to be at a place where states are going to lead the way and do this, we need to be open to the flexibility that comes with this. We have all talked about the funding that is necessary for states to do this.

But again, I will end with while these states are raising hope, I think New America is absolutely right, we should not let raise an expectation that is state by state, we can solve this problem one by one state, and have any sort of uniform policy. Really there are some states that will not be able to act. I think that is partly why we struggle to answer this question a little bit here. Because there is some key ingredients that need to exist at a state that cannot with simply a federal grant program. There really

needs to be a broader solution if we really expect to solve it.

FEMALE: I would say amen to that.

ED HOWARD: I know you mean that in the most bipartisan way. Well, we have learned a lot of lessons in this discussion, both political and policy and in keeping with Jim's observation about the nature of health care personal as well. I know that this discussion is perfectly in keeping with the alliances mission of seeking solutions to the problems of uninsured and high costs in health care. Not necessarily along any ideological lines but with an urgency that is too seldom reflected in the discussion that we are sometimes part of here.

And with that, I would like to take this chance to thank Commonwealth Fund, both Anne and Karen Nelson and the rest of the staff. The Alliance Staff for putting together a wonderful program and materials. Thank you for being part of one of the more spirited discussions we have had on this topic in the last couple of years, and ask you to join me in thanking the panel for an incredibly rich discussion about what we might be able to do in the next couple of years. Thank you.

[END RECORDING]

[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.