Health Reform in Massachusetts: Lessons for the Nation
Kaiser Family Foundation
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DIANE ROWLAND: Good morning and welcome to the Barbara Jordan Conference Center for this session on Health Reform in Massachusetts: Lessons for a Nation. I'm Diane Rowland, the Executive Vice President of the Kaiser Family Foundation and we're very pleased to be able to bring to you today a panel of people who are from Massachusetts who have on the ground experience in health care reform while we in Washington continue to debate what it is, how it might play out and what some of the key elements should be.

I think we've all spent much of the last three years, since Massachusetts passed its legislation, looking at that state, watching how the design works, watching how the key elements are implemented, thinking about how they pull together, some consensus to even past reform while we continue to be challenged by that here in Washington.

But especially we wanted to learn today both what Massachusetts has done, how it is working, what

some of the key successes have been, what are some of the key elements that have not worked as well that they would recommend be tweaked or changed in any national reforms and to think a little bit about what three years of experience in Massachusetts in a real program on the ground means for the debates going on today over national health care reform.

I think we have an outstanding panel to share with their insights and experience from Massachusetts and we're going to kick it off by asking Jon Kingsdale, the Executive Director of the Commonwealth Health Insurance Connector Authority to give us an update on what has happened in Massachusetts, where they stand now after three years and what that may mean in terms of lessons and key issues for national health reform.

Following Jon's overview, we're going to turn to a panel, all from Massachusetts and all from individuals who are directly connected with the evaluation and understanding of what's happening in Massachusetts. We'll first start with Amy: Whitcomb

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Slemmer who is the Executive Director of Health Care for All, one of the main consumer groups that advocated for reform and has been obviously actively monitoring its implementation.

Following that, Michael Widmer, the President of the Massachusetts Taxpayers Foundation will give us some of the insights into whether the reforms have really broken the bank in Massachusetts. You have a great report from his organization in your packet and also to talk a bit from the employer perspective about what has happened.

Celia Wcislo is going to share with us some of labor's insights. She's the Assistant Division Director for 1199 SEIU, the United Healthcare Workers East and she also serves as a member of the Connector Authority Board.

And finally, Jim Mongan, the President and CEO of Partners Healthcare and one of the members of our Kaiser Commission on Medicaid and the Uninsured will give some wrap up comments from both a provider

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perspective and from Jim's experience here in Washington. I think he can give you a lot of insights into where the healthcare reform debate has been and may also be going this time.

We're going to really let you have some opportunity to raise your questions at the end. So without further ado, let's have Jon give us a kickoff so that we can move on to the panel and to your active involvement in discussing and learning from what Massachusetts has been doing on the ground. Thank you.

JON KINGSDALE: Thank you, Diane. Nice to see some friendly faces in the audience and to be here on this august panel, including one of the more active and helpful members of my board of directors, Celia Wcislo, who's here taking a break from her family vacation to be here.

So I've been asked to set the stage a little bit, a few key facts and let me start with why health reform, why questions, I'm fond of telling my children, who now know more than I do, are always complicated,

multiple answers and so why politically has very much to do with the great effort of our late, great Senator Kennedy, who has so many times over his long legislative career demonstrated a phenomenal ability to reach across the aisle, whether it's working with Mitt Romney or the Bush Administration, as in the case of this reform or on many other instances. We will certainly miss him.

Why from a policy point of view 600,000 or so uninsured in Massachusetts as of 2006 pre-reform, a lower rate than nationally, about 10-percent versus 15-percent nationally. But still if you looked at that nationally, that's estimated to be about 22,000 deaths a year, preventable deaths a year, among adults without insurance, for lack of insurance. So clearly the main reason is a moral reason to take care of people who are now being rationed care because they don't have financial access to it.

But also it's a fairly humane state and even before '06 we had a robust uncompensated care pool.

Unfortunately free care and, there's something like that in some degree in most states, isn't really free, it's paid for by cost shifting onto people who actually buy insurance and/or taxpayers and it isn't particularly good care.

It leads to very expensive emergency inconsistent care, there's lots of data that the uninsured don't fill scrips, 25-percent do not fill their scrips and when you get disease specific like cancer, they get diagnosed later and die earlier.

I am going to change the order of the slides because somebody mentioned to me that Washington has become a fact free zone on health care, so, I think that was Diane, I'm going to switch to a couple facts before I lose you about Massachusetts and I've learned in my three short years in the political arena that there are facts which are useful and then there are actually true facts. I think these are true facts, but you're going to get a chance to push back.

So after two years, under 3-percent uninsured rate, we call it near universal coverage, we have done this not just by expanding government programs but also by private participation in insurance, the most recent numbers suggest a little bit of a diminution in this 44-percent private pay because of the layoffs during the Great Recession has led to some more publicly funded and a little less employer funded.

But nevertheless, a substantial expansion of employer sponsored insurance and direct pay. Actually our non-group market has more than doubled in size with the reform.

We have done this, as many of you know, in part through a requirement that individuals, adults, buy health insurance if they can afford it. That's enforced through a massive new, by tax standards, a massive new compliance program including a health care 1099 form, et cetera.

And in our first year we had, this is an easy number for people in medicine to remember, 98.6-percent

compliance, meaning most of the four million tax filers got their healthcare 1099, got it in, et cetera, et cetera.

This is very popular in Massachusetts, that we have a number of different polls that are academically based or done by neutral, objective sources and they rate this, not only as high when it passed in 2006, but climbing in popularity as we've implemented it.

And finally, and I know Mike Widmer from Mass Taxpayers is going to talk more about this, the cost of adding the insured, the cost to government, has actually been fairly modest, about $350 million in FY 2010, the net new additional cost of state of government over pre-reform. That represents a little bit over 1-percent of our state budget.

It's not just about facts, though. Obviously it's about people and Jacqueline is a young woman who left her job as a schoolteacher in Norwood and so lost her insurance, felt a lump in her breast, didn't pursue it because she didn't have coverage and would have been

one of those early preventable deaths, in her own words, had we not done reform and she not gotten coverage and gone and sought treatment for it.

Let me turn now to the basics of health reform in Massachusetts, just outline for you how this works. There's a three legged stool. The first leg of it is shared responsibility, meaning that individuals, adults specifically, are required to have health insurance if they can afford it. We have a whole process for determining whether they can afford it or not.

Employers are asked to step up to the plate and make a fair and reasonable contribution if there are 11 or more employees. And government is pitching in as well for low income folks who do not have access to employer sponsored insurance or Medicare or Medicaid with a subsidy.

This is actually a pretty American idea if you think about. It's both individual accountability and community commitment. The second element is insurance market reform such that insurance works for the sick as

well as the healthy and this is basically we do guaranteed issue. If there's a product in the small group, non-group market that is out there, and somebody wants it, the carrier has to make it available.

They have to renew it even if the individual gets sick or the small employer rates go up, acuity goes up. There's adjusted community ratings so there's some cross subsidy between the young and the old and finally, there is this individual mandate which is not only a way to reach people, but frankly to make sure that the risk pool for this community rated set of policies is sufficiently healthy, that it's affordable.

And then the third element is, which seems to be everybody's favorite here in Washington so I'm waiting for the storm to turn in that direction, so far it hasn't but I'm sure we won't escape, is the idea of exchanges to make health insurance actually transparent and easy to purchase.

We actually have two different exchanges, one for subsidized coverage for low income uninsured and

another one for unsubsidized small group and non-group and they're beginning to overlap some more as we move forward and I think here in Washington the national proposals have been more about one exchange and see in them as not quite so differentiated for some interesting policy reasons which I'd be happy to be in Q&A.

We in Massachusetts started them off as very separate exchanges. So one's subsidized low income uninsured. In that exchange the exchange function's a very aggressive purchaser like any large employer and the other is more of an alternate distribution channel for small and non-group. The Connector, which is an organization that I direct, really does a number of functions so we run that Commonwealth program for low income and uninsured.

Secondly we administer the alternative distribution channel that I just mentioned and that we actually have to earn our membership. You can buy

exactly the same product through this exchange or directly from the carriers for exactly the same price.

So the only reason that half of the growth in the non-group market, which as I mentioned earlier as doubled in size in Massachusetts, why half of that doubling has come to the Connector is because people trust us, they find it a simple, easy way to buy and actually we have a breadth of fairly good values for them, although of course health insurance is always expensive.

But in addition to that, we also make a bunch of policy decisions, Celia and the other members of the board in particular, about what is minimum coverage that satisfies the mandate, what's affordable and we function in this regard as kind of a learning organization and I think some of the debate in Washington in Congress is back and forth about ho much to be prescriptive in legislation and how much to delegate.

I can tell you that we, over and over and over again, Celia and the other members of our board, have said, well we think this is the right thing but let's try it and see.

In fact we are running a pilot program right now for small business which we are evaluating and changing even as I speak. So it's very much, I'd like to say, legislation is nothing like a learning organization. And then finally, we do a lot of outreach.

The uninsured sometimes are nervous about insurance, anxious about it, but it's not just the uninsured. There are 190,000 employers in Massachusetts so you can imagine how many there are nationally who need to understand what their role is, how reform would affect them and six million citizens as well.

So let me finish by just suggesting the relevance of all this. This is obviously a Bay Stater's perverted view of the national efforts at

health reform, but we think, I think, that the model that's being discussed here in most of the serious committee proposals, proposals being considered seriously, really build on Massachusetts' reform model. Of course you all are arguing about how to pay for it which I consider a separate question.

But the model in terms of shared responsibility and insurance reform and exchanges really is based on something that has worked. We do not consider this an experiment any longer in Massachusetts.

We do, and Mike will talk a little bit about it, now have to turn our attention from the moral high ground of covering most people to the tough, tough issue of cost containment, and I think Jim Mongan is going to talk about that as well, but we have got significant success against the primary objective of the 2006 reforms which was to cover most people. Thank you.

DIANE ROWLAND: Jon.

AMY WHITCOMB SLEMMER: Great. Thanks very much. I'm going to echo some of what Jon said and just begin by saying from a consumer's perspective; the health reform law passed in 2006 has been remarkably successful for consumers in the Bay State. We have more than 400,000 people in Massachusetts now have access to health insurance who didn't prior to our reform law and for each one of those individuals it's made a huge difference.

Some of the lessons that we know are that the benefits package that is required has to be meaningful and I think you'll hear more about that, but the minimum creditable coverage that qualifies in Massachusetts includes access to very important services like preventive care, primary care, prescription drug coverage. It has to be meaningful for the folks you are requiring to buy into it.

It also has to be affordable and in Massachusetts we worked hard on an affordability schedule that would allow most people to be able to

access care up to, for folks who earn 150-percent or below the Federal poverty limit, they pay no premiums and they have very low co-pays.

Between 150-percent and 300-percent of the Federal poverty limit, we have sliding scale subsidies that allow people to buy into coverage. This makes a tremendous difference to individuals.

The other thing from a consumer's perspective that I think is vitally important to pay attention to is it's not simply passing a law that says we will reform the healthcare system.

There is a requirement to help people navigate the new system and understand what the responsibilities are that you've now passed. In Massachusetts, we made a significant investment in providing education and outreach opportunities to individuals.

So we sent folks out into the communities, we provided culturally competent information so that they understood how health reform was going to affect them individually. I think at the town hall meetings that

we're reading so much about, lost in the hyperbole about some of the extreme views that are expressed in these meetings, we're missing the conversation in the middle that I've experienced where there are individuals asking how will these proposals affect me in particular.

And in Massachusetts, we sent folks out into the community partnering with existing organizations to provide good, solid educational information and at Health Care for All one of the services we provide is we're able to actually sign folks up for coverage, to talk them through what plans they may qualify for and the connect them to their care.

At Health Care for All, we also have what's our help line, which has a dual benefit and I think offers some opportunities for the lessons to be learned for national reform. We take calls from anyone in the Bay State who has questions about their particular coverage, they've just moved to the state.

Right now we're fielding an awful lot of calls from folks who have actually lost employer sponsored health coverage for the first time ever and are trying to understand how they need to live into the mandate.

And we can not only answer their questions, but we can connect them to a particular plan. Importantly, this particular mechanism provides a feedback loop to the state so when we log calls that show us a trend, that there's been some glitch in our implementation of health reform, Health Care for All can feed that information back to the state that can then make adjustments to fix whatever the glitch was.

It's also provided an amazing opportunity for us to hear real life stories about people who have not health care coverage before. Jon mentioned one Commonwealth care member who has had an experience that saved her life. We hear from folks like that every single day, who without health reform would not have gotten the care that they need and are therefore living

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better lives because of the fact that they can go and access health care.

Again, I think it's an important opportunity for national coverage, for the national debate to think about ways in which you plug in the consumer experience so that you can continue to improve the implementation process. I'm very excited about the possibility of passing national reform.

I think we also need to make sure that we have some sort of mechanism to make sure implementation goes well because it really is, as Jon alluded to, it's a series of decisions, a series of choices that are made, policy decisions that are made and being able to implement them well with the easiest access and to the benefit of the healthcare consumers you're trying to help is vitally important. And I think the helpline and other outreach and education opportunities that the state invested in makes a tremendous difference.

DIANE ROWLAND: Mike.

MICHAEL WIDMER: Thank you, Diane. It's a pleasure to join you this morning. I'm going to try to touch on three areas briefly, the employer role, the cost to taxpayers and then the impact of the recession.

On the employer role, as in much of the reporting of the Massachusetts law, there's I think a misunderstanding of what that role is. The first thing I want to emphasize is the so-called fair share contribution which has gotten most of the attention around employer responsibility.

The $295 per employee per year is not an employer mandate, and that amount is tied to the cost of free care in Massachusetts and so this is a formula that was derived by the average cost per employee for those employers not offering health care coverage, the cost of free care per employee per year.

So it's not a mandate. On the other hand, the right has been arguing, well this is some form of employer mandate and this shouldn't be in the law. The left says, well yes, it's kind of a mandate but it's

woefully inadequate, $295 per employee per year. So this fair share contribution and aspect of the law has become a punching bag.

The reality is out of the limelight, the cornerstone of this whole reform, or one of the key cornerstones, is the intersection of the individual mandate and the high level of employer coverage in the state.

And as a result, many employees of companies that had previously and continue to offer health care coverage had turned down the offer previously, mostly they were young and healthy, so they turned down the offer. Now the individual mandate, they have accepted the employer offer.

So the statistics show that in the first two years of reform, employer coverage increased by 150,000 lives, no, excuse me, 150,000 individuals and so it's actually the number of lives is larger than that. So 150,000, much larger than anybody anticipated.

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In fact the debate had been that the fair share assessment would lead to a reduction in employer coverage and crowding out and a larger impact on the public purse. Just the opposite has happened and it's a key part of the reform.

We calculated those additional 150,000 comes out to about $750 million in additional employee involvement participation in healthcare reform, very different from the picture that one normally gets in terms of the Massachusetts experience.

Secondly, the taxpayers talk about misinformation. There isn't a day that goes by that there isn't somebody, or many somebody's, in the national brass or some other group reporting about how the Massachusetts reform is unaffordable, it's falling apart at the seams, breaking the bank, et cetera.

That's simply not the case. That is simply not the case. If there's one message delivered today. Now you have in your packet a report we put out a couple of months ago which documents that fact.

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In essence what we concluded there, looking at the costs in fiscal 2006, the last year before reform, and then the projected cost in fiscal 2010, so over a four year period what are the additional costs in the state budget for health reform? And essentially $700 million in additional costs total, half of that reimbursed by the Federal government, so $350 million state dollars, which turns out to be about $88 million new dollars each of the four years.

So a very modest cost, very much in line with the anticipated cost increases around reform and it's another aspect in which the reform has worked and worked at least as well as anticipated if not better than anticipated.

One of the key reasons—two key reasons why the cost has been as minimal as it is, one is the high level of employer coverage and the other is the reallocation of a lot of the money in the so-called free care pool to pay for the subsidies, which are obviously required when you have an individual mandate.

Now I want to be careful, what's the lesson of that for the nation?

It isn't that the nation can get away with doing it as cheaply, if you will, as Massachusetts for a whole variety of reasons, certainly one of which is that it's a high level of employer coverage in Massachusetts and we had this functional free care pool that we could reallocate the dollars. So no, we can't conclude at the national level that the additional cost is insignificant.

On the other hand, it's not fair to conclude, well if Massachusetts with all of its advantages is breaking the bank, then surely this is unaffordable for the nation. That's just not at all a fair conclusion and it doesn't reflect the experience in Massachusetts.

Finally, the recession and the impact of the recession has further muddied the waters. Two aspects, one is on the employers, Massachusetts has lost about 100,000 jobs in the last 12 to 18 months as a result of the recession. Obviously with 100,000 lost jobs is a

reduction in employer coverage. The number, the 150,000 number that I mentioned in the most recent data, is approximately 100,000 on the net side, the net plus side.

So even taking into account the impact of the recession, we've seen an increase in employer coverage. But we've been through these cycles before, Massachusetts, presumably in other states as well in which there is a reduction of employer coverage.

Not in this case in Massachusetts employers terminating coverage, but there are fewer jobs. Therefore when you look at the total numbers, clearly there are fewer individuals who are receiving coverage through employers.

The other way in which the recession is having an impact is Massachusetts is experiencing a full blown fiscal crisis similar to most states. We lost about 15-percent of our tax revenues last year; it's the largest one year drop in our history.

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And as a result, every program across state government in fiscal 2009, beginning particularly in fiscal 2010 which began on July 1, virtually every program in state government is being cut in some fashion. So that's happening in health reform, particularly the issue around legal immigrants, compromises reached yesterday but there's some curtailing of services.

The important point there is states have to balance their budgets and when you have this kind of fiscal crisis obviously an addition to new tax revenues and we've increased the sales tax, there are going to be cuts. But it is totally unfair and incorrect to conclude therefore that health reform is unaffordable. On that logic one would say that every program in state government is unaffordable because every program has been cut.

So it's a result of a dramatic drop in tax revenues, not the unaffordability of health reform. Finally, one word on costs. Yes Massachusetts is

beginning to address that issue, access first and now how do control healthcare, the growth and healthcare costs.

But I want to emphasize that that's not actually tied to health reform because the additional costs to our health reform, either—I mean yes, there are additional costs to individuals and employers and taxpayers, shared responsibility, but that's small compared to the overall costs of healthcare in Massachusetts, pre-health reform, obviously in the public obligation mainly through Medicaid.

As a result, there's a lot of confusion that we have to control costs in Massachusetts in order to preserve health reform. I think that's skewed. We need to control costs in health care in Massachusetts because of individuals and employers and government that preceded health reform and would be facing us even if we didn't have health reform.

So yes it's a serious issue, but it shouldn't be confused with the implementation of health reform. Thank you.

CELIA WCISLO: I'm going to take a moment of personal privilege to say I notice Stacey Sachs from Senator Kennedy's office is here and because of the work of Senator Kennedy's office on the waiver, we would not have health care reform in Massachusetts today. We would not be debating nationally and I just want a moment of thank you for everything you all have done.

So, I'm always ending up between employers and providers while wearing a union hat and one thing I want to say about the Massachusetts employer community, they're really different and because of that, we've seen that 150,000 people buying insurance through work, we have not seen a drop, we have seen an increase of employer coverage and I think that speaks a lot to our employer community and the commitment they made to health reform at the beginning.

I would say on the national level not all states have the same kind of employers. I think there would need to be some kind of payroll tax or penalty to keep employers who are not as good from finding this as a way to dump their obligation to provide healthcare insurance. So I would disagree slightly. We have a remarkable employer community and I'm not sure that's true in most states.

I also think we need a public choice on any national reform. People say that Massachusetts doesn't have a public plan, but in many ways we have all the elements of it. We have a public board that Jon and I sit on.

We publicly define what subsidized care will be. We fund it with public monies and it's administered by health plans that have been doing Medicaid work for years. So there needs to be some element of public control and a public choice for people to really make it affordable and I think we've done a remarkable job.

Over the three years rates have only gone up 5-percent a year. This year alone, there was no increase at all in the cost of insurance. So it's sort of counter to what is happening in the private sector. I also think the individual was not as explosive as I thought it would be going and being on the board.

I was not a fan of the individual mandate, yet in fact three years out, even in a recession, that 69 to 70-percent of the population in Massachusetts can say reform is a good thing, that there is no major backlash, I think that's tied t the fact that we had an affordable alternative for them to buy into.

They could buy at work or if they didn't have access to that, they could have options for a plan that they could afford. So the individual mandate needs to be tied to affordability to avoid such a backlash. I also think the thing that's worked, and Jon mentioned it, we rarely agree on, we agree on a lot of things but we probably have some very strong 5-percent of disagreement.

And we've had a commitment from the beginning of the legislation that consumers, government, businesses would all try to make this work. And in fact, by accident we began to actually reach consensus on any decisions of our 10 member board because we had Republicans, we had Democrats, we had Liberals, we had other folks and it has worked, the concept of shared responsibility that we're all in this and that we try to reach agreement even if it means I have to back down on something or if somebody else has to back down because we need to find the common ground to move it forward.

I think that's critical for whatever reform because the bill is just a piece of paper with lots of lines in it. It's the implementation that becomes critical and because shared responsibility became our mantra and I think we really believe it, when there were cost problems we all chipped in. Consumers helped some, government helped some and the business community

helped some so getting through the initial stages or the rough practice requires shared responsibility.

I think you can't have an individual mandate without insurance market reform. I'm a union person, I'm used to group insurance, most of you probably buy it through an employer. The individual market, what happens to somebody when they're on their own, the fact that they can turn you down for insurance in many states, we were in the People's Republic of Massachusetts, I didn't know they could turn you down.

I didn't understand *Sicko* because I was like they can't do that. I think those limits on the insurance market are critical and you can't have an individual mandate without that. As a union person, but from SEIU, we think affordability is critical. We've done a great job in Massachusetts, but I think we'd all agree that we only go up to 300-percent of poverty. I'd say the gap between 300 to 450 or 500 is really a problem. These are hard working people who

have jobs but cannot afford what's being offered often out there.

That's a really important leap to make and secondly, we have many families because low income employees can't get into our product, they might be able to afford the individual coverage that they're offered, but they cannot afford a family coverage. In our nursing homes, if there's 200 of our members there, maybe three buy family coverage because it's totally unaffordable.

Those are things national reform has to address. I think we face the tension of getting—we had 60-percent of our uninsured were younger people. We've done a good job of that. We had the tension of how long do you bring down the benefit for younger people to get them in there, to make it affordable. I think any national plan is going to have to address that.

I think we started off doing reform in the right way, we rethought what Medicaid paid, we were putting money into increasing the amount of Medicaid

payments so that all providers and hospitals will take the newly insured. Because the economic recession has really backtracked, we're now back to 2006 rates. I do not think over the long term you could have reform that's universal or near universal without having better Medicaid rates.

I also think secondly there'll be a lot of people who have heard that stories about what's happened to Boston Medical Center or Cambridge Health Alliance in terms of ending of the subsidies. I believe that you cannot end subsidies until people are insured and you're paying in an appropriate fashion. We've also heard that made the headlines about our legal immigrant population that was recently thrown out but today there's an announcement of a okay to good solution but it's not an excellent solution.

I think we need to look at how we will always need a safety net. We will always need a safety net. How we pay for it and what we pay for it, I think has to be related to how many people are uninsured but to

think of short of a single payer system, to think we're going to get around the need for a safety net or we'll be able to pay for it less is not going to happen.

Finally, I do think we're starting to face some of the issues of primary care, but it's because we dumped 400,000 people quickly into a system. I think it's no different than any other state.

Some of us face waiting times, some of us don't face waiting times but I think the fact that we're bringing lots of people in, we need to pay better for primary care, we need to have better models and that's what we're trying to do now in cost and redesign of the system.

I think we're able to do it and I would go back to Jon's first point, that we started with AHCCCS. Once we got people brought into AHCCCS and really had people insured, there's a lot more goodwill to try to address the cost problem because we have a system now that we believe in. And that's going to be our step two. Thank you.

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JAMES MONGAN: Thank you. I'm pleased to be here with this group to talk with you all a little bit about Massachusetts. Being the last speaker I kind of wondered what I should focus my commentary on, but I think I would pick out one important lesson to my mind that comes mostly from my nearly 40 years of experience with this issue and I'd like to relate the Massachusetts experience to the current situation here in Washington.

My own background, for better or for worse, I've had the opportunity to participate in three national train wrecks on this debate, when I was with the Finance Committee staff on the Nixon bill dying, when I was at the Carter White House, so that bill died and somewhat consulting with the Finance Committee when the Clinton bill died.

So this Massachusetts thing was a real ray of light for me and I've been trying to figure out what made success possible in Massachusetts whereas we have failed so frequently nationally.

I guess to my mind the real inside story, and many of you probably know this, is that unfortunately this discussion has never been a discussion about healthcare. It's always been a discussion about financing and who's going to pay for it and that's how we've been stuck as a nation for the past 30 years.

And the reason we've been stuck is I would submit that the strongest political force over the past 30 years starting with the Regan revolution in California has been the anti-tax movement which has totally pervaded the country to the point that the Democratic Speaker of the House from the Liberal District of San Francisco says the only people you can tax are people who earn over $1 million a year.

So that there has been a thorough triumph of the anti-tax forces, now how do you deal with healthcare coverage, because you can't raise taxes, you can't do employer mandates because they've been defined as the same as a tax and you can only cut Medicare so far before the seniors start to speak out.

So that's where we've been stuck, unable to finance health reform. So what secret happened in Massachusetts? Well I would say the one significant and most major contribution of Governor Romney's, God bless him, was that he managed to put forth this idea of an individual mandate which had been put forth before in Washington by Senator Dole but quickly rolled back from because people said if an employer mandate's a tax, surely an individual mandate's a tax.

But Governor Romney said, no it's not a tax, it's a personal responsibility and people bought this switch in framing and rhetoric from its a tax to it's a personal responsibility and here is there the Governor had great luck because nobody can, with a straight face, mandate that people buy a product that costs $12,000 or $13,000 a year without having standing ready with very significant subsidies. So that brings you right back to the tax issue.

Governor Romney was lucky because in Massachusetts strong legislators over the 1990s had

passed some taxes to fund an uncompensated care pool. So there was a sum of money there along with Federal matching money that allowed the funding to be available to pay for the significant subsidies for the individual mandate. So if there was a real breakthrough in Massachusetts, the real breakthrough was kind of redefining the individual mandate.

So how do I link this to the national story? My fear is the national story is showing some signs of getting stuck again. The good news is, everybody has rallied around this concept of the individual mandate, both left and right can seem to embrace that to a certain extent, but the ability to provide adequate subsidies is very much in question at the present time as the Congress grapples again with the inabilities to tax, have an employer mandate or cut Medicare significantly.

I hope that some legislation will pass even if it's compromised legislation. I would alert people that that could lead to an unstable compromise, if you

will, and I think that we will undoubtedly have work to do as we go forward.

The reason I say unstable compromise is if you have an individual mandate but not adequate subsidies, then you'll have to have lots of exemptions from the individual mandate, hardship exemptions, and therefore it won't be a complete individual mandate and if it's not a real individual mandate, then is it possible to do all these insurance reforms that people also embrace and that gets you into a very difficult situation.

I think the best thing to do is to pass what we can pass but keep in mind that this won't be over for a number of legislative cycles if my prognostication is correct. Thank you.

DIANE ROWLAND: Well thank you Jim and the rest of the panel, but Jim always seems to manage to bring us to back to where I wanted to at least do one round with the panel and I think Jim's given you his most important feature.

But I'd like each of the panelists to just take one minute to say what they think the best thing about Massachusetts and its implementation and its enactment was and what one of the things you wouldn't do again if you had to do it. So Jon, why don't you start?

JON KINGSDALE: Well, one of the best things about Massachusetts and it sometimes come under the heading of bipartisanship, but I don't think that's actually accurate because we don't actually have a lot of Republicans in Massachusetts [laughter] is the commitment of the folks who make this system, non-system, work day by day to do reform.

So health plans, hospitals, doctors, community groups, government obviously, employers committed and as the guy who sort of rides the wave that they've created, my job's pretty simple, it's just not to screw it up, all the momentum comes from this tremendous breadth of support and I can think of literally a dozen

different times it could have all fallen apart except that folks stepped up to the plate and contributed.

So my lesson is I guess for Washington not necessarily bipartisanship but something that has the support of the broad set of groups each of which can during implementation actually block this from being successful. And I don't think there's anything I regret or would do differently.

AMY WHITCOMB SLEMMER: Thanks very much. I actually echo part of what Jon said, the collaboration that happens and continues to happen among the various stakeholders is vitally important to be able to continue the success of reform in Massachusetts. Obviously for consumers, the best part is that we've covered more than 400,000 people and that's just made a life changing difference to individuals.

The part that I think we've left as a challenge and an opportunity is there is a gap for folks who earn too much to qualify for subsidies but

can't yet afford either their employer based coverage or coverage through the Connector.

And I think there's an opportunity at the national level to look at what truly is affordable. In Massachusetts we define affordability for folks to pay between 2 and 12-percent of their income and again there is this gap still for folks who need subsidies but we have not yet figured out a way to do that in the states.

So that's one of the areas I think we've left absolutely for improvement. Thanks.

MICHAEL WIDMER: In addition to agreeing with Jim's comments on the individual mandate as I think the cornerstone and the collaboration of all the stakeholders, one other area I would highlight is I think the incentives in our law are aligned in a very constructive way.

The example I gave in my comments was the intersection of the individual mandate and the high level of employer coverage in healthcare and many other

areas we often have the law of unintended consequences and we with good intentions actually end up creating more problems than we have solved because of the incentives are skewed or not put together in the right way.

And I think in many ways this law aligns incentives and I think that is very unusual in a broad public policy initiative of this scope, and one of the keys to the success on the downside, I've thought about this question, I guess I would wish we could legislate the abolition of recessions [laughter] because clearly we're struggling and in trying to keep health reform together both from the employer side as I mentioned and the taxpayer side.

We'll work through this but—and I don't how we can literally deal with that now or in the future, people say well we need a dedicated revenue stream, but there's no guarantee that revenue stream will stay healthy in the middle of a recession.

In fact it won't so therefore I'm not sure what we can do about it, but it is a part of the reality that we have to deal with. Thanks.

CELIA WCISLO: The brightest side I would agree with the other folks have said, the fact that we did it, we kept at it and it's successful today, that we had some common vision that we all bought into and we've been willing to fight and maintain.

I'd say on the downside, and it's tied to what Mike just said, the economic recession has meant that our rates for Medicaid coverage have declined dramatically. That is a problem for maintaining it over the long term and where Jon and I might disagree is I would in looking forward recognize that what we created was a public type plan for subsidization.

The difference between a Medicaid program and private insurance is like night and day in many ways. In many ways it's the same, in many ways the incentives are completely different and we've worked hard to create a glide path from being totally poor and in

Medicaid to employer sponsored coverage but it is a difficult glide path and people fall through cracks and perhaps by making it a more acknowledged public program, we would have been able to smooth that out a little more.

JAMES MONGAN: This Massachusetts program has to a certain extent ended the shibboleth that government can't work, government can't execute, in fact government can't get out of its own way. And I think this has proven that that's flat wrong.

Government can work, it can execute, these programs have been set up, they have been put in place. I would say a big part of the reason why government can work is because the various constituency groups want it to work.

So instead of being on the sidelines carping and criticizing and critiquing, they're all saying, hey we're part of this too, we want to make it work and that gets back to the importance of having as broad a supportive coalition as you can get.

Now unfortunately in the Washington world, that's a big of a cliché because you can urge bipartisanship but it's kind of like urging your son to date more and he can't get a date you know. [Laughter] Unless there's somebody on the other side, this is a little difficult. [Laughter]

DIANE ROWLAND: Thank you to our panelists. I think they've given you a lot of food for thought, but now we're going to open it up to your questions and as we do that, we're going to pass a mic around. If you would raise your hand and also identify yourself when you ask the question and if you are directing it to a particular panelist, do that as well.

But as we turn to questions, I'm reminded in a meeting I was in in Massachusetts. They talked about the fact that you need a campaign to enact legislation, but it doesn't stop when the legislation is enacted, that really you need the biggest campaign when you're implementing the legislation and keeping it going and

fixing it and I think our panelists today have so well reflected that lesson as well. First question?

CAROLINE POMPLIN: Hi. I'm Dr. Caroline Pomplin [misspelled?]. I'm a primary care physician. My question is, in the unsubsidized portion of the Massachusetts plan, does the Connector control premiums or have any say about premiums or are the insurance companies free to charge what they like?

JON KINGSDALE: Basically, the short answer is no. We are an aggressive purchaser when we're using our own dollars for the new commonwealth care subsidized program. We're basically just a distribution channel. We have some influence but modest and it's on 22,000 enrollees out of a population of six million. So basically no.

HANS KUTTNER: Hi. Hans Kuttner from Hudson Institute. It seems that there's a dog that doesn't bark here, which is the commonwealth care enrollment trends. So there's a recession. Incomes are down. You'd think there'd be more people who would be in the

income range of eligibility and there'd be more enrollment but at least and I haven't paid attention in the most recent few months, the enrollment doesn't seem to be picking up. Why isn't it picking up? Where are people going instead? Are the uninsured numbers, perhaps, going up, if you can give me some sense of the dynamics there.

CELIA WCISLO: You are now seeing enrollment starting to go up slowly. We also had the ARRA, so many people who were laid off were able to stay on COBRA and have it subsidized. So they aren't necessarily coming in yet to ComCare. There was a period where we were redetermining people like any Medicaid-type plan once a year, once every 18 months. They see what your job situation is, your income, so there was a period we were growing but we were also having people fall off the plan. So we saw a period where we sort of flat lined and now I'd say it's going up a couple thousand, Jon are you—

JON KINGSDALE: Going up about three or 4,000 a month actually in Commonwealth Care and also another thousand or two a month in our medical security program, which is a state subsidy for, temporary subsidy for the unemployed of low and modest income.

TONI MILES: Thank you. Good morning. My name is Toni Miles and I'm currently faculty at the University of Louisville, have lived in red states most of the last 20 years. You guys are really inspiring but I got to ask if you could pull back and look at the tension within the Medicaid population, I mean you've talked a lot about expanding it, in most states that is where the long-term care dollars are spent.

Expanding Medicaid would be a problem in most of the red states because it's long-term care. So how do you guys balance the tension that comes within the state budget? You pointed out you cannot run red in most of the states. So balancing the needs of the low-income population within Medicaid against the needs of

the long-term care population within Medicaid, that's a real barrier to health care reform in most states.

CELIA WCISLO: I believe some of the proposals that already passed committees recognize that for the states initially to expand Medicaid or Medicaid eligible populations was going to take significant other dollars. I believe many, for a certain number of years, it would be funded by the federal government. So in one hand, I think the legislation recognized that there was going to need to be state help. I think long-term just in our state alone, we had good funding sources. We tax insurers and providers to provide the free care.

I think there's creative ways of looking at those funding sources but I think we need to take on directly the cost, which we are just starting to do. I think moving people to more preventative models, long-term care looking at choice and whether people might be better off staying at home versus in institutions. There are ways to redirect the monies that are

currently in the system that could lead to broader expansion. It's really about a system delivery design and the willingness of the state and the industries to make those changes.

DIANE ROWLAND: Mike?

MICHAEL WIDMER: The question raises a related issue and that's the overall cost of Medicaid in relation to the state budget. One of the things that we've seen for more than a decade, decade and a half at least, is that Medicaid with the escalating health care inflation and therefore costs of Medicaid, the Medicaid program is taking a greater and greater percentage of the state budget.

This is sort of inexorable, this precedes health reform by a decade or more. So, as my comments earlier suggested, this is not really a health reform issue but rather cost of health care for Medicaid populations. So this is something that, as a state, we're struggling to address.

One of the ways we've addressed it recently is cut payments to providers, which isn't really addressing the issue long-term but we're seeing a major shift in proportion of cost spending or Medicaid versus other programs in the state budget. It's gone from about 22-percent a decade ago to about 30-percent this year.

DIANE ROWLAND: Could some of you though, in your discussion of the recession, comment on what has happened as a result of the federal stimulus funds and Medicaid? I mean have they made a difference is one question that keeps being weighed on people's minds here in D.C.?

MICHAEL WIDMER: Well the federal Medicaid, the matching, the FMAP money, I mean it comes through Medicaid but it really becomes part of the overall revenue sources for the state budget and is essentially doesn't end up being directed to Medicaid per se though Medicaid obviously takes a significant share of the budget, as I just mentioned, but it has really been

absolutely critical because without those funds, the kind of cuts in programs that have taken place across state governments, state and local governments, would have been much, much more serious.

It's already been difficult enough. So I think it's had a major impact though it's difficult to tie it to Medicaid and health care per say.

DIANE ROWLAND: Since as we look at other states, the ability to weather recessions is highly dependent with states having to balance their budget on the federal government being able to provide some additional assistance both during the last recession and clearly during this one. John, did you have a comment?

JON KINGSDALE: Well just a gratuitous add, which is that most of the rest of the world looks at us and scratches their heads. They say well when people get thrown out of work, isn't that when you want to help them with some health coverage and how come, in

the United States, that's when they go without coverage?

So the additional monies for Medicaid, as I peripherally observe the budgeting process in Massachusetts, have been absolutely critical to try to preserve even with the cuts, that Celia referenced, as much coverage as we can.

DIANE ROWLAND: Okay.

GEORGE STRUMPF: I'm George Strumpf with Emblem Health of New York. Can you tell us how the Connector is funded, whether the participating carriers pay a fee and is there a role for agents and brokers?

JON KINGSDALE: Hi George. Well we have two different connectors really. That's not necessarily the way it's being discussed in some of the proposals in committee in the Congress but for a number of reasons, we really have two very separate programs. So brokers had nothing to do, basically nothing to do with non-group insurance in Massachusetts, which is not necessarily typical of the rest of the country and

certainly nothing to do with the subsidized coverage, which is 180,000 of our 200,000 or so enrollees through the Connector.

So 180,000 low-income, otherwise uninsured subsidized coverage, nothing to do with brokers but what's common across the two programs, the subsidized and the unsubsidized, which is about 22,000 people is that we are basically supported after an initial capitalization from the state appropriation in FY 2007.

We're supported by a surcharge on the transactions. In other words, if we don't fulfill our mission of enrolling people in insurance; we don't have any revenue to support the administrative costs of the Connector. That's a cost that is extremely scale-sensitive. Eighty-five-percent of our applications, for example, in the unsubsidized program come in over the Internet. We could serve 200,000 people for not much more than we serve 22,000.

The overall cost now is about a three-and-a-half-percent surcharge between the two programs for the

cost of outreach, education, enrollment, billing, contracting, etc. plus actually we have a lot of policy, if you think back to that slide, we have a lot of policy functions as well. So it's not purely selling insurance but with scale economies, I think we could get a national scale even if it's state by state but with some national infrastructure actually below three-percent.

That I would say compares with the cost, the transaction cost in the traditional commercial private, a non-group market and where all but about 200 people in our 200,000, are non-group. That compares with a cost that we don't have good information on but it's estimated to be somewhere in actually five to 15-percent of premium range for just the distribution costs of non-group insurance in the private market.

So there is the potential here to have significant savings in administrative costs that have nothing to do with health care just the cost of getting

health insurance into people's hands through these kind of state-based exchanges.

DIANE ROWLAND: Next question in the back and we have one right here. We can start here. One, two.

LYNN QUINCY: Hi. Thank you panel. This is Lynn Quincy from Consumers Union, the publisher of *Consumer Reports Magazine*. I have two questions for any panelist who'd like to address it. My first one is do you think there's any benefit to the consumer of having the ability to purchase coverage both outside and inside the exchange? If you would speak to both non-group participants and small group, that'd be very helpful.

My second question is if we get, for lack of a better word, a somewhat weak bill at the national level, are there features you would put in that bill to help states improve upon what the national bill does? Thank you.

JON KINGSDALE: The in/out question is fairly tactical. If it was about surgery or anything medical,

I'd certainly defer to Dr. Mongan but I'm probably the technician in the group here on health insurance. So there are a number of ways to structure these. There is no outside alternative for the subsidized insurance. I used to be in insurance. I've always wanted a monopoly and now it turns out there's nobody else trying to give away health insurance.

So we're talking now about the private unsubsidized market and there's some advantages to having an exclusive distribution channel that you get leverage. You have scale. You can do risk adjustments or you can get carriers to compete on value as opposed to risk selection.

But in the absence of that and that has many, many other issues attached to it, there really isn't much alternative but to having some sort of level playing field between in and out, buying insurance in the Connector or the exchange or the gateway, whatever you call it or outside at very similar terms.

Because if the two options are allowed to differ in significant ways, you set up an opportunity for consumers, brokers, and/or carriers and perhaps all three to arbitrage those differences and to take advantage of them and then typically stick the carrier or the Connector or the exchange with worst risks and make that part of the business unsustainable.

So unless your objective is to put one or the other out of business, you really need to have kind of a level playing field between the exchange as an alternative distribution channel and the other distribution channels. I can't even remember your second question at this point.

CELIA WCISLO: The individual market has grown, I think, predominantly because we reformed the insurance market to have the small group and the individual group market merged and because our small group market was so small as compared to our–individual market was so small as compared to the small group

market, it didn't have a huge impact on the small group market.

You see a lot of people coming in because their costs dropped dramatically the first year. It had been something like 350 down to 175 for a plan that was better than the one they were buying before for a 37-year-old, something of that nature and fairly dramatic. So that's why you saw that increase.

Back to the broker. One of the realities is that almost half of the people who are newly insured or 44-percent of them are buying through the employer-sponsored system or private coverage. So in fact, that relationship with brokers or fees and all that stuff hasn't changed for 44-percent of the newly insured.

DIANE ROWLAND: And Jim, you had a comment?

JAMES MONGAN: I wanted to address the second half of the question about role for the states. I must say I was one of those who, for many years, felt that this was a national issue that ultimately had to be

solved at a national level. I still really believe that.

I do think, as earlier speakers said, that there is a moral issue here and we are one nation indivisible and consequently, I think that ultimately you need a national solution but the Massachusetts experience has certainly shown me the importance of states trying to move the issue forward on their own and the kind of example that they can set.

So I would certainly hope if, in this situation, I don't want to say a weak bill but if a less than fully robust bill were to pass, I would certainly hope that there would be incentives for states to try and put in place various efforts to go beyond that.

Ultimately, I think we have to build off of those state efforts to get to something that's even better nationally but I think it's an important point that the question raises.

DIANE ROWLAND: Jon?

JON KINGSDALE: Can I? I can just jump in to second that comment. I would go further. I agree with absolutely everything you said Jim. In addition, I do think that medical care is local. Even health insurance can be fairly local and I reference before the Connector's learning organization. I mean we are literally running a pilot for small groups now, small employers. We are going to change the way we present that set of products and offering to the market as a result of what we learn.

I can't imagine doing that from Washington, D.C. for the country because Utah's different from Massachusetts from Mississippi from etc., etc. So if you want any kind of a market role, I think a local role for states is pretty critical even within a national framework, which I hope we get.

DIANE ROWLAND: And I assume you hope that no national reform will undo what you've done in Massachusetts.

JON KINGSDALE: Right.

REBECCA PERRY: Hi. My name is Rebecca Perry. I'm coming from the Maryland Healthcare Commission. Thank you so much for all of your input and views. My question is specifically related to the small group market particularly as it relates to the exchange in terms of people either choosing to be in the exchange, in the Connector or outside of it and how you give guidance to consumers who are looking for a viable health care options, as to where they should go and maybe how that's playing out in the pilot as people are getting into the small group market.

JON KINGSDALE: Interesting question. So my personal view is that we have a pretty robust, not a small group market in Massachusetts. We have a lot of carriers, particularly domestic and nonprofit carriers but national for-profits as well in that market, a lot of choice of product, a lot of competition.

Now I know the small businessman who has three employees and all of a sudden one is no longer the 27-year-old but now it's a 50-year-old and he sees a 30-

percent increase in his rates, doesn't necessarily agree with that but it's a fairly robust market. What it does not have is choice for individual employees.

So the small employer tends to buy to the lowest common denominator if switching to a less expensive plan or a select network or something else is going to make the CFO's spouse very upset, I mean you're offering the benefits just to retain and hire employees, you're not going to do that. I've been in the business for 30 years. I've seen it over and over and over again. There's a tremendous salutary impact on innovation and satisfaction frankly from choice.

So what we have decided to do is try to add not to compete with what's out there already, which is small employers buying directly a product from one carrier but offer choice. That's innovative. That's complicated frankly for somebody who's running a gas station and is trying to focus on what he needs to focus on to run it, which is not health insurance.

So we are slowly interesting people in that, learning how to make it simpler. Simplicity is absolutely critical but we're trying to provide something new to the market rather than just another way to buy a single plan from a single carrier for a small employer.

DIANE ROWLAND: Celia?

CELIA WCISLO: And to be honest, that's where our consensus model meant some of us who didn't agree with that model thought we should try it, that we needed to experiment with it. I was diabolically on another side on this question. On the other hand, there are not good models out there and we're attempting now to find out what the market, what small groups will put up with.

For me, as a labor person, having the young guy standing next to the older guy who might go in and get charged more for a plan versus the younger guy who's picking something else is not something I felt comfortable with.

On the other hand, we do not have models that have and we've, taken us two or three years to even get through all the technicalities to get to the pilot. So we're a learning organization and I think, next week, it sounds like we're going to learn some more at our next meeting about it.

RON HOLLANDER: Thank you. Ron Hollander [misspelled?] from Massachusetts. Hello all of you, now at Tufts Medical School. I wanted to come back to the comments I think Jon and Jim made about the importance of a framework nationally but also with some state flexibility.

One of the key things I think the Connector board, Celia, really wrestled with was the minimum benefit package. How important do you think it is, especially we wind up with state exchanges, for the federal government to set some sort of minimum standards beyond which, potentially Jim, the states could expand but is that a critical part, in your opinion, for that piece of legislation to contain?

JON KINGSDALE: Well given that that's the single most controversial difficult issue with which I've had to wrestle in the last three years, I'd like Jim to answer that [laughter].

JAMES MONGAN: I was looking for Celia to [inaudible].

JON KINGSDALE: I've heard Celia on that.

CELIA WCISLO: Do you want to go? Then I'll do it after you.

AMY WHITCOMB SLEMMER: I was just going to say, for consumers, it's vitally important to be able to have a minimum level of coverage and in Massachusetts, we define and these guys can certainly speak to how challenging it was to figure out, and continues to be, to figure out what actually qualifies as minimum creditable coverage but as we're talking about the opportunity for insurance reform, Massachusetts has just fined kind of a bad actor in our state.

We had an organization come in and provide very inexpensive health care coverage, sign folks up, and the coverage absolutely didn't meet the minimum standard. So these folks are being kicked out of the state for five years and fined. From a consumer perspective, that's vitally important because it was confusing.

People absolutely did sign up and think that they were going to be able to meet the individual mandate by paying very little and what they got back was almost nothing. So that being able to compare that benefit package is vitally important.

CELIA WCISLO: Jon is right. We are all about 20 years older though we've only done it for three years over this question. I think it comes to one we are mandating people. So we wanted them to have real coverage. We wanted to incentivize preventative care. So were they going to be before or after a deductible?

I'm a union person so I thought of it as a, you think of living wage, what's a minimum wage, well

what was a minimum health insurance standard that we needed to set? One of our biggest fights was over drug coverage. We had very many different issues. We probably, four or five times, people were driving in to vote against it, to vote for it and at the end of the day, we all voted for it because we really believed that that's how medicine is being practiced today. Without that, what did that mean?

So I think it's been important to create a floor for the state so that there aren't employers who are trying to go down so low that it doesn't mean anything anymore. For me, as a novice on this, I did not know there was no definition of health insurance.

You got to have health insurance just for cancer. You could have health insurance with a $15, $20,000 deductible. We needed to have clarity so if people were being told they needed to buy in coverage, they knew at least what the minimum is they could expect.

DIANE ROWLAND: Jim?

JAMES MONGAN: I might add just a word. I've been not in the middle of the fray like these folks but it does get back to this individual mandate, which sounds personal responsibility. That's good but if the government, imagine the government were to mandate that you buy a car, well it's pretty clear that you'd want to make sure that the car has brakes.

So there's going to be some minimum standards but you probably say gee do we really want to make sure the car has power windows? Well probably not but there's a lot of things in between brakes and power windows. That's the world that these guys live in. It goes along with the territory I think.

JON KINGSDALE: I'll just add one thing from a national perspective. I think we actually got to a pretty good place on this issue in Massachusetts but it's interesting, to me, to see the way the President's strong principle that if you like what you have, you can keep it has played out in many of the Congressional proposals, which actually takes a lot of the heat out

of this argument about what is minimum credible coverage.

Because the heat comes from well yes, that looks like a reasonable thing that insurance ought to cover whether it be drugs or whatever but wasn't the point of the law just to make sure everybody had some coverage and now you're going to what, penalize somebody who thinks they have good coverage for not having drug coverage?

Well I think the federal formulation has been, in effect, to grandfather a lot of existing coverage, which actually sort of deflates some of the tension over this issue about what is reasonable minimum coverage.

DIANE ROWLAND: In the back and then we have two on that side.

CAROLINE FICHTENBERG: Thank you. This is Caroline Fichtenberg with the HELP Committee in the Senate. My question is about the Connectors. I was wondering if you might elaborate a little bit on why

two were created from the start and you've alluded to the fact that they're kind of merging maybe. I wondered if you could just describe what's happened and what's happening?

JON KINGSDALE: Yes, they're not merging. They're beginning to overlap a little bit more just in terms of the health plans that we offer. So first of all, of all the folks on this panel with the possible exception of Amy, I probably have less to do with the construction of the law.

So I'm kind of reading into this but there was a set of health plans, non-profit, local health plans that serve Medicaid prior to reform, prior to 2006 called Medicaid MCOs, managed care organizations, that were the exclusive province given the exclusive sort of domain for three years of the new subsidized Commonwealth Care Program.

This was part of a glide path to make sure that the three largest of those four, which were sponsored and largely controlled by the community

health centers in Massachusetts, Boston Medical Center, and the Cambridge Health Alliance, so the three largest set of health safety net providers, that they would have kind of first crack at retaining access and continuity of care for their patients.

Those are not, in fact, two of the four weren't licensed as commercial insurers, couldn't even possibly if they wanted to, participate in the unsubsidized commercial insurance exchange. So it was really for reasons of accommodating the transition through a glide path for the safety net system that it was set up as two different programs.

Now actually one of the two is fully licensed as a commercial carrier. So one of the two safety net health MCOs, so it could actually serve the unsubsidized population and the three years having elapsed, we went out and invited additional participants including a national Medicaid MCO, which is participating in both programs and actually is going to be taking care, at least for the rest of fiscal '10,

of this legal immigrant population that we've had to disenroll from Commonwealth Care and put into an extension program. So that's what I mean when they're beginning to overlap a little bit.

DIANE ROWLAND: Yes Celia?

CELIA WCISLO: I also think it was the history of implementation that our first goal was to get to the uninsured, to build something that could capture them as quickly as possible. We had them in a free care pool. We knew who they were and we wanted to capture them quickly. I think the second one was something we, took us another year-and-a-half to get our heads around the technical parts and they, some ways functioned differently.

The premium payment system is different. How they relate to an employer, an employer's role versus the individuals buying it. People coming in through the Connector are coming in as individuals not as a small group. So it required some different structure just to even get it up and running once we had our

hands around ComCare and thought we'd maximized what we could do, that's when we really turned to the small group and individual market more.

DIANE ROWLAND: Okay, question here and then one in the back.

JIM ANGLE: Hi. Jim Angle from Fox News. One of the key points in the debate here in Washington has been whether you can increase the number of insured at the same time that you either reduce overall costs or at least reduce the increase in cost. What has been the experience with that and secondarily, are there any specific practices that you found that do reduce costs in a substantial way that could be replicated nationally?

AMY WHITCOMB SLEMMER: In Massachusetts, we made a calculated decision to separate the issue of providing coverage from the issue of reducing costs. So what you're seeing now is the success of the first phase of health reform in the state, which is providing

access to coverage. We have more than 400,000 people now have coverage.

We're now in phase two of health reform and, for those of you who are following this closely, you know that we just had a special commission on payment reform sum up their recommendations that will move us from our current fee-for-service system into, they've recommended we move into a system of global payments.

The overall purpose is to reduce costs and change, we will more change our health care delivery system. So we're in phase two. There'll be legislation this fall. Lots of us up here have different opinions about how that needs to happen.

I will say that given the experience and the success of providing access in such a collaborative and incremental way as consumers, health care for all is pretty optimistic about our ability to be able to move into a very different system of health care payment.

JAMES MONGAN: So a couple of comments about the cost issue, which is critical and crucial to this

debate. First, I do want to underscore Mike Widmer's very important commentary earlier that this Massachusetts program is not a program whose cost has gone off the rail by any stretch of the imagination. He's got the most credible numbers in the country on that.

A second point I would make, at the risk of sounding slightly defensive, is that we in Massachusetts and perhaps you here in Washington see headlines from time to time, as recently as last week, that premiums were higher in Massachusetts than any other state in the country.

First in the country, in the second paragraph of the story, it points out though that premiums, as a percent of disposable family income, ranked 40th in the country, 40th. So in a sense, the real story about health costs in Massachusetts is it's a place that costs a lot to live, housing particularly, utilities, etc.

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Having said that, the only point I'm trying to make is that there is not a unique Massachusetts cost problem. There is a significant national cost problem. I think it is important that Massachusetts, just like they tried leadership in coverage, tries to demonstrate leadership with respect to cost. There are people working on that. There is no magic answer.

I think even this latest proposal about moving from fee-for-service to global payment is an interesting proposal with some evidence that it may indeed be an important direction to go but it is important to answer at least three questions before plunging down that path. That's first, how do you structure organizations so you have somebody to give the global payment to. That's a very important question.

Second is how do you risk adjust that global payment? Do you pay the same amount for a sick person as a healthy person and are those risk adjusters adequate. Then thirdly, what are the very critical

implications for consumers because generally, capitation or global payment fits best with systems that lock consumers in to a system like a Kaiser or a Veteran's Administration. It seems difficult to imagine having your cake and eating it too. Global payment, no restrictions on choice.

So we have a lot of work left to do but I'm convinced that we can demonstrate leadership in this area just as we did with respect to coverage.

JON KINGSDALE: So Jim has already taken you down the rabbit hole of some of the issues that we get into because we are having a serious conversation in Massachusetts about cost containment, which is actually harder. Cost containment is harder, I would maintain, than coverage expansion but I want to bring you back to some very basic things and reemphasize what Mike said.

The problem with talking about cost is you're talking about different pies. There is a $60 billion pie. That's the health care spend in Massachusetts, all in, $60 billion pie. There is Commonwealth Care,

which is about a seven or $800 million spend. The increase in Commonwealth Care premiums per person covered per year, as Celia mentioned, has been under five-percent. It's been 4.7-percent.

This is phenomenally low compared with the rest of Massachusetts, compared with the rest of the country, compared with all sorts of things. That's not the issue when Jim's talking about capitation and cost containment. We're talking about the $60 billion pie that employers and individuals, now it was a problem before reform.

It's still a problem. I think it's a critically important issue and I can wax long on that one about why workers don't get real raises because it all goes to health, etc. but that's very different from the Commonwealth Care expansion programs, which have actually been very modest in their annual rate of increase.

DIANE ROWLAND: Last question.

CAROL PRYOR: Hi. I'm Carol Pryor from the Access Project in Massachusetts. Celia and Amy talked a little bit about a couple of groups that they have concerns about, folks over 300-percent of poverty, some of the workers who can't afford to cover their families.

One group that I've had some concern about is lower-income workers who are not eligible for Commonwealth Care because they have employer offer of coverage but they have nothing like the same protections in terms of out-of-pocket costs, cost controls that people with subsidies in Commonwealth Care have.

I understand why the state made the decision not to offer them coverage but, from a consumer perspective, I'm concerned about them. My sense is that the national legislation mirrors this issue. If you don't like the coverage, if you like the coverage you have, you can keep it but if you don't like the coverage you have, you may not be able to get rid of

it. So I just wonder what [laughter] your thoughts are about that particular group.

DIANE ROWLAND: Celia?

CELIA WCISLO: I think it really is a problem and it has been going on prior to reform when I look at where low-income workers, we have fall or whether it's our own Taft-Hartley's, we do a really good job on individual coverage. There are problems with family coverage, the fact that mostly women in nursing homes working who have families are picking individual coverage.

If Massachusetts wasn't the state it was, if we didn't have such a good SCHIP program, their kids could be uninsured because they can't afford it. I'd like to see some kind of circuit breaker or system where if what you would have to pay at work is a certain percentage that you would have the option to have your family members or yourself go into the plan, we thought about this on the Connector board.

Every time we try to discuss it, it's very clear that there's so many, you have to look at all the low-income folks in a state and you can't just have them bailing out of the employer plans because then you have what happened in Tennessee under TennCare. Everyone just dumps the coverage for those folks. They go into it and the government's expected to pick up the difference.

So I think there has to be some thoughtful approaches but getting up to 400-percent helps some of that group. It doesn't solve the employer-sponsored one. I think we need to have more conversation on it because if we don't solve it, we will never have universal coverage and then I'm back to single payer, what the heck? If you want to get everyone, we're back to single payer and it might be cheaper so.

DIANE ROWLAND: Well I think our panel today has clearly showed us that health reform is never over. It's a continuing issue. Even when a state has passed a

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monumental piece of legislation, there is always the challenge of implementation.

I think they've also shed a lot of light on some of the key issues including this one about what happens to those who are in plans they might want to get rid of or not be able to afford with their employer. That will have a great deal of influence, I hope, on the continuing discussions as we move toward national reform.

So I just want to thank them for sharing their experience with the Massachusetts, I would have called it an experiment but it's not an experiment anymore, it's a reality and to thank them for shedding so much light on the issues we struggle with here in Washington and across the nation. So thank you to all the panelists and best of luck to Massachusetts [applause].

[END RECORDING]

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