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Matching Health Benefit Packages to Health Needs: Key Issues To Consider In Health Reform
Kaiser Family Foundation
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DIANE ROWLAND: I'd like to welcome everyone to the Barbara Jordan Conference Center for this briefing on health care benefits and health care needs, how do we match the two together as part of health care reform. It's a pleasure to have you all here on this rainy sort of miserable fall day when the traffic has been bad and I think that being here today, at least, we can maybe have some content that warms us up from the beginning of fall.

It's also great to have you all here to really talk about these issues because I think often in the health care reform debate, we keep talking about health insurance and we're not quite defining what it is or what it means to people with severe health care needs. That'll be the focus of our discussion today.

We have a number of reports that we're releasing, three reports today, that we hope will help

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inform this discussion. I want to thank the authors of the first report, *Children and Health Care Reform*, assuring coverage meets their health care needs with the lead author, Joan Alker and Karen Pollitz, Vicki Wachino and Jennifer Libster of Georgetown and Julia Paradise of Kaiser.

We also have a second report that looks at individuals with special needs and health reform, *The Adequacy of Health Insurance Coverage,* that Karen Pollitz, Jennifer Libster, and Molly O'Malley of the Kaiser Commission on Medicaid and the Uninsured co-authored.

So this has been a joint project between Georgetown and Kaiser and we appreciate all of the help, both from the individuals at Georgetown and here at Kaiser and especially want to also recognize Samantha Artiga who contributed to many of these reports.

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Finally, we're going to share with you something very special, in my mind, that we really need to keep in mind. As we talk about health care reform, one of the issues that is often left out is the need for oral health care.

We are going to share with you this morning a report based on the dental fair for uninsured adults that was put together by Michael Perry and Meredith Lewis of Lake Research Partners along with Julia Paradise of the Kaiser Commission staff and also a terrific video that will bring these people into our audience today that was put together by Jackie Judd and her staff here at the Kaiser Family Foundation.

So I think we have a lot of material that will be informative as we think about how to put together health benefit packages as part of health care reform.

I think we're going to both share some of those initial reports and findings with you first with

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Karen Pollitz presenting the adequacy of health benefits reports and then Julia Paradise sharing with us the oral histories and setting up our video presentation but we want to follow that up with a real in-depth discussion of what this really means in the ongoing debate over health care reform, what it means for the kind of coverage that people expect out of health care reform, and the kind of coverage people might get.

For that, we're asking Judith Palfrey, the President-Elect of the American Academy of Pediatrics, Meg Murray, the CEO of the Association for Community Affiliated Plans, and Chris Jennings, the President of Jennings Policy Strategies and, as we all know, the former Senior Health Care Advisor to President Clinton to really comment on the reports that we put forth and the issues that health benefits bring forth to the health reform debate and maybe to speculate a bit on

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where we might be going with the President's speech tonight and with the ongoing debate in Congress over how to shape health care reform.

So I'm going to ask Karen Pollitz to kick us off with some key findings from these reports and then we'll follow with the oral histories report and then the panel discussion. Thank you. Karen?

KAREN POLLITZ: Thanks Diane. Good morning everyone. I would like to also recognize the great team of people who worked on both of these reports and we couldn't even all fit up here but in addition to Joan Alker, I see Molly O'Malley and Jenny Libster here today, Vicki Wachino couldn't join us but I just wanted to thank everyone as well and Kaiser for their support for this work.

We're here today to talk about, in our two reports on health care for children and people with disabilities; we're here to talk about the adequacy of

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health insurance coverage. That is a fundamental issue on health reform, one that, so far, has actually not been the subject of extensive debate or coverage. So I'm really glad that we're here to talk about it today.

The reason we want everybody to have health coverage is so they can have access to health care but it's not as simple as that. Today already, we have more than 40 million people who have health insurance and who, nonetheless, are struggling with medical bills and medical debts that they can't pay.

So it's very important that when we talk about reforming the health care system in giving people coverage that we give them adequate coverage. That means health coverage that includes all of the benefits that they need for all of their parts of their body above the neck and below the neck and that doesn't charge very much money in terms of cost sharing, deductibles, co-insurance, co-pays that people have to

pay every time they go to get health care services and that also covers the providers that people need who are qualified to give them their care.

So we have millions of underinsured today and we need health reform to not only get people coverage but to give them adequate coverage. To do that, there will probably be a combination of expanding Medicaid, our safety net program for the lowest income, most vulnerable people as well as expanding private coverage and strengthening it so that it's adequate for everyone.

In our approach, we examined two kinds of coverage. We looked at basically two kinds of coverage. For an example of private health insurance, we looked at the Blue Cross/Blue Shield plan that is offered through the FEHBP that most federal employees have chosen, that many members of Congress like, and

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that has been pointed to as a plausible benchmark for generous private health insurance coverage.

Then we also looked at the Medicaid program and we compared those two kinds of coverage to the health care needs of two particular populations, children and people with disabilities and took a case study approach.

We interviewed the families of two children and then three individuals who had disabilities to find out what are their care needs, what kinds of services did they use in the past year, and then we mapped that against the Blue Cross FEHBP option as well as Medicaid to see what would be covered and what they would be left to pay out-of-pocket.

The Blue Cross plan is considered, by many, to be a generous health insurance plan. It's kind of interesting, as you see our results, to see what that word generous conveys and what we assume about

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constituting generous coverage like other private health insurance plans, the Blue Cross/Blue Shield FEHBP plan. I'm just going to call it Blue Cross for the rest of this because that's too many words.

It distinguishes between acute care and long-term care. It mostly doesn't cover long-term care but it does cover most acute care services that people would need including hospitalization, physician care, mental health care, home health care, dental care, rehab therapies.

So almost everything that you would want to see on the list of covered benefits is on there but lots of times or some of the times, these services are capped, in particular, rehab services, home health services, dental coverage is quite capped under this program. It really just reimburses a few dollars toward the expenses that people would incur even for routine care.

Then the cost sharing, under this plan, is really quite high. There's a $300 deductible. Co-pay's usually about $20 every time you go to the doctor, get a service, sometimes co-insurance of 15-percent for drugs. Prescription drugs, brand name drugs, the co-insurance is more like 20-30-percent depending on the drug.

Those cost sharing amounts keep piling up until you hit an out-of-pocket limit. That limit is $7,000 per year. It can be a little bit lower, $5,000 if you stay within a subset of the network providers that are designated as preferred providers. So if you use a lot of health care, you can really spend a lot out-of-pocket under this generous plan.

Compared to other employer-sponsored plans, the cost sharing is actually quite a bit higher under this plan. Typical out-of-pocket limit on cost sharing

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under employer-sponsored plans is more like $3,000 a year.

Medicaid, by contrast, is a very comprehensive program. the benefit package is designed for people who have very high health care needs and the cost sharing is designed for people with very low incomes. Basically there isn't any.

For children, the benefits are particularly broad. The early, periodic screening, diagnosis, and testing benefit is one that recognizes that children need the health care that they need on a timely basis right away without a lot of barriers so that they can develop and grow up healthy.

So EPSDT basically says children get screened and whatever gets found gets covered. Whether it's acute care services, long-term care services, dental care, educational assistance, anything that is considered to be medically necessary is covered. Then

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the Medicaid program is also our primary source of long-term care financing for the elderly and for the non-elderly.

So children, anybody here have kids? Anybody here used to be a kid? Children have unique health care needs. They're not just little adults. They are growing like weeds. So they need the care that they need and they need it on time. You can't put off health care for kids without taking a risk that there may be some long-term results. You don't want to let hearing problems or a cold kind of go untreated lest you end up with hearing damage and so forth.

Most kids are healthy most of the time but, as any mother knows, kids do get sick and you do use a lot of health care for kids. You seem to always be going to the doctor. Even for routine care needs and sort of minor illnesses and kids do have health conditions.

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About 40-percent of kids have allergies. Almost 10-percent have asthma. About 15-percent of kids have extensive special health care needs. Again if they don't get the care that they need when they need it, there can be problems down the road and for that reason, it's very important that they're not be barriers to care and in particular there not be cost barriers to care. We have many studies that show that cost sharing, even minor cost sharing, will delay or deter access to care.

We took a look at the specific needs of two kids and sort of the care that they used last year. Jacob is a seven-year-old boy. He's a healthy kid but, like many kids, he has allergies. He has pretty severe peanut allergies, also seasonal, hay fever allergies, and he has asthma, which can be aggravated by the allergies and other illnesses. He's also a kid who's cavity-prone. Usually when he goes every six months to

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the dentist, they find one or two cavities. He had four fillings in the last year.

So he's pretty healthy and his conditions are pretty easily managed mostly by prescription medications. He has four prescriptions that he takes every month and one over-the-counter medicine that his folks buy for him to manage his allergies and his asthma.

Then, as I said, the four fillings last year, he goes to the dentist twice a month. He only went to the doctor three times last year, twice when he was sick, once for his check-up but when he was younger, before they got his asthma under control, he did have severe asthma attacks and ended up being hospitalized, which is sort of the perfect example why it is very important that we manage the health conditions of kids. So that's Jacob.

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Isabelle is a teenager. She's 13-years old. When she was born, she was premature and diagnosed with cerebral palsy, which is a central nervous system disorder that impairs movements, in Isabelle's case, in her legs. So she has difficulty walking. She had two surgeries when she was younger to lengthen the muscles in her legs.

Now she uses a walker and a cane and sometimes a manual wheelchair to get around. She's also developed scoliosis or a twisting of the spine, which is a common complication of CP and last year, she had surgery to fuse her spine and insert rods to straighten it.

She also wears a back brace, and arm braces. There are two specialists that she sees to manage the care of her spine and her limbs. She has physical therapy every week.

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She's also got vision problems. She had surgery last year to correct that as well. She has difficulty using her hands to write. So as a result, she has specialized computer equipment that she can use in school so that she can read and write and communicate without having to use her arms. She's going to need that for the rest of her life. She sees an occupational therapist once or twice a week to help her get better at her computer skills, which she's also going to need for the rest of her life.

She has some anxiety as a result of her physical conditions and at this age, you know, lots of anxiety anyway. So she sees a mental health professional every week and she takes some medications to combat the anxiety. Sometimes her routine illnesses like colds can get more complicated because of her physical condition. She had to go to the emergency

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room one time last year. She also sees the dentist twice a year just for check-ups and cleanings.

Okay, so there's two kids. We mapped their care needs and what we learned that these costs against what the Blue Cross/Blue Shield option would cover. What we found was that the family's share of expenses for the care that these kids needed last year would not be insignificant.

In fact, it would be quite significant. Starting with Jacob, we estimated his family would have to pay just over $2,000 out-of-pocket last year if he'd been covered under this plan.

About half of that would be due to co-pays, deductibles, and co-insurance for the services that are covered and then the other half would be due to the limits on coverage, in particular, the dental care that he needs. Blue Cross would have only kicked in a couple of bucks toward that and his family would have

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had to pay most of that out-of-pocket and then also his over-the-counter drugs.

Isabelle's care is even more costly with two surgeries, she easily would have reached the out-of-pocket limit. We assumed $5,000 in this. We assumed that all of her providers would have been preferred providers but had that not been the case, which is entirely possible, that number could have risen even higher to $7,000. Then in addition, about $4,300 worth of her care would not have been covered, mostly her therapies, the Blue Cross plan limits rehab services to 75 visits a year with a $20 co-pay a piece and then her family would have had to pay 100-percent for the rest of that.

Then other costs that aren't shown on here, in particular her specialized computer equipment, she didn't buy that last year. So we didn't include that

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but she will need to update and upgrade that at some point before she finishes school.

That will be thousands of dollars more that her family would have to pay. Again this is out-of-pocket. This is what the families would have to pay for their share with the Blue Cross plan paying the rest.

Medicaid by, I don't have a graphic for Medicaid because it's just too easy, with the EPSDT plan, all of these services would be medically necessary. They all would have been covered with no cost sharing to the family. So it would have been covered 100-percent. There wouldn't have been out-of-pocket costs.

These experiences of these two children remind us that even if everyone gets coverage as good as what members of Congress has, it could still be the case that families with even healthy, pretty healthy kids

like Jacob, could be left to pay hundreds of dollars if not thousands of dollars out-of-pocket for their share of the expenses that the kids incur.

For special needs kids like Isabelle, cost sharing could very quickly become burdensome and even ruinous at $5,000 a year with thousands of dollars more for the care that she needs.

On the spectrum between EPSDT and Blue Cross/Blue Shield, most families would have to pay more out-of-pocket if health reform ends up giving us a benefit that looks more like members of Congress as opposed to the EPSDT. As a result of that, I think it's fair to anticipate that a lot of families would delay or put off some of the care that their kids might need.

Quickly on our second report, we have another report on the health care needs of people with

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disabilities. We have millions of Americans who have disabilities or other special health care needs.

Many of them need what would be characterized as long-term care services such as personal care, help bathing, dressing, transferring but their disabilities also complicate their routine and acute care needs.

The people that we studied for this report are heavy users of health care services, lots of services, lots of different kinds of services, acute care, routine care in addition to long-term care.

The three folks we've profiled in this report, we begin with Scott, another seven-year-old boy. He was born prematurely as happens to about half a million children every year. He had a number of serious health and developmental problems that resulted. He has breathing difficulties. He has to sleep with an apnea monitor. He's very prone to respiratory infections.

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He went to the doctor a lot last year and was hospitalized seven times.

He also has a feeding disorder. When he was very young, he lost the ability to swallow. He eats through a feeding tube, a special nutritional formula. He goes to a feeding clinic. He's kind of learning how to eat again but relies still mostly on the feeding tube.

He has a lot of behavioral disorders. He has what's called a sensory integration dysfunction. That means that he senses space and pressure and heat and cold differently from the way most people do. As a result, he often behaves aggressively, and sometimes injures himself or others.

So he needs weekly mental health therapy and medications to manage that condition. Then he also needs a lot of personal care. Scott just needs a lot of help. So every day, after school, a personal care

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attendant comes and helps him with his homework, helps him with getting dinner, helps him get ready for bed, and all of the difficulties that are attending to that. So Scott needs a lot of medical care services.

Then we have two adults, Robert who's about my age now but he had a skiing accident as a young man and so for the past 25 years, he's been living with a spinal cord injury. He's paralyzed. He can't walk and one of his arms was also very injured and very weakened.

Aging with a spinal cord injury has given rise to a lot of other conditions, in particular, Robert suffers from cellulitis, which is a bacterial skin infection in his lower legs and it recurs and it can be very serious and even fatal if it's not treated. So he had to be hospitalized four times last year with that condition and then came home and needed home IV antibiotic therapy.

There's a strain on his arm from the wheelchairs. So he requires physical therapy to manage that. He needs daily personal care, about two hours in the morning and 15 minutes at night to help him get dressed and undressed, transfer between the bed and the wheelchair and so forth. He also has a specially modified car so that he can drive and because of this care and these services, Robert is independent. He's able to work. He actually has a very good job and he can support himself.

Then finally Erin, another adult, 45, like Isabelle, she was born with CP but she's grown up now. Her CP caused her a mobility disorder so she also needs a wheelchair and also a communication disorder. She has difficulty speaking and she has other disorders, mental retardation, epilepsy, asthma, hypertension, high cholesterol.

So she has very extensive medical care needs. She takes five prescriptions a month to control her seizures, her blood pressure. She needs Botox injection therapies to maintain her muscle tone.

She was hospitalized six times last year for a variety of reasons. Then in addition, she needs her routine care, her annual check-ups, and her vision care. She wears glasses, also twice a year she goes to the dentist for cleaning. Erin lives in the community. She is independent.

Her mother provides all of her personal care services at home. Then she works at the local United Cerebral Palsy Clinic in her community. There she gets a lot of services, occupational therapy, speech therapy, case management, and also daily personal care help when she needs to go to the bathroom.

The health care needs of these individuals are very high and very expensive when we map them across

the Blue Cross/Blue Shield plan. All of them would have faced very, very expensive out-of-pocket costs. Nearly all of them, they all would have met or come close to meeting the $5,000 annual out-of-pocket limit on cost sharing for their covered services. In addition both Robert and Erin would spend thousands of dollars more in each year for covered services that exceed the limits, their physical therapy, Robert's home IV therapy.

Then all three patients have long-term care service needs, personal care, and case management that private insurance typically doesn't cover and this plan doesn't either. Those would cost them another $15-17,000 a year. So very, very, very expensive out-of-pocket medical needs and needs and these will go on year after year after year. This is not just a one-time expense.

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We tend to make a distinction between long-term care and acute care and they have different programs and different committees of jurisdiction. Health reform may also treat them very differently but people who need these services don't make the distinction. They need what they need and their bills are high. The disability that generates the need for long-term care services also often complicates other acute care medical services that we typically think of health insurance covering.

By contrast, for all three of the patients with disabilities, Medicaid would have covered all of their care and it has. All three of these patients have been covered by Medicaid. Did I say Medicare? I meant Medicaid. Scott was on the program when he was born. He came off briefly when his mother went back to work. In those years when he didn't have Medicaid, she couldn't get a lot of the services that he need and he

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actually lost a lot of ground and eventually requalified for Medicaid under a waiver program. Now he is again getting all the care that he needs.

Robert was covered for several years by Medicaid when he was first injured and so disabled that he couldn't work but again because of these services, he is able to work. He is independent. He no longer qualifies for Medicaid but that means he pays thousands of dollars every year out-of-pocket for the care that his insurance doesn't cover.

Erin is on Medicaid now and has been for many years. She's very grateful for that care because, as her mother gets older and isn't able to care for her at home, she'll need even more personal care at home. That's going to be important.

The people that we've showed you today are living, breathing examples of how important health care is to growing up well and to living independently.

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When we talk about reforming the health care system, we need to make sure that people get the care that they need so that those outcomes can be achieved for every person.

Adequate health care means that the services that people need need to be covered. The out-of-pocket costs need to be low. Access to Medicaid is going to continue to be important for low-income populations particularly the EPSDT benefit for children but also for people with chronic and long-term care needs.

Wherever it is that we stop with Medicaid in terms of the expansion and then move on to private insurance and strengthen that, we're going to have to make very sure that the protection from private coverage is nearly as good as what Medicaid offers. The adequacy standard can't just be a generous private plan like the Blue Cross plan that members of Congress

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has. It has to be better than that and it certainly can't be less than that. So thank you very much.

JULIA PARADISE: Thanks Karen [applause]. Good morning everybody. As the findings that Karen just presented demonstrate, gaps in covered benefits and cost sharing that doesn't take into account family income or extensive needs for care can result in heavy, sometimes staggering, out-of-pocket burdens for individuals and families.

When needed services are not covered due to benefit exclusions or limits or when costs are a barrier to access, the effect is similar to the effect of being uninsured. At this point in our briefing, we're going to screen a video that documents up close the human consequences of lacking coverage of one kind of care, preventive and primary oral health care. The video was shot at a dental fair for adults held over a

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weekend this past April on the Virginia Eastern shore. More than 800 people stood in line to receive services.

As you'll see, the inability to afford even routine dental services took many tolls on the people who came for care including pain, exacerbations of their other health conditions, difficult financial burdens, and the extraction of more than 1,200 teeth that decent access to care could have prevented.

While this video focuses on dental care, one class of benefits that insurance often excludes or covers poorly, the focus could as easily have been on mental health care or vision and hearing care or other services that are key to our health and well being. For that reason, I encourage you to see it as a larger documentary on the relationship between inadequate benefits and unmet health needs. Let's watch the video now.

[VIDEO PLAYED 00:27:05 – 00:33:53]

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DIANE ROWLAND: Thank you Karen and Julia. I think you've started us off with a lot to think about in terms of how health care needs exist in this country. Every time I see a video like the one we just saw or hear about the other, the RAM Project that brings people together, I think it's important to remember that there are people in America who do go without needed health care.

That really is what health reform ought to be all about. With that, we'll turn to our panelists for their reflections on both the imperative of adequate benefits in health care reform but also the materials we just presented starting with you Judy.

JUDY PALFREY, M.D.: Well thank you very much. First of all, I'd really like to thank, on behalf of all of us here and the panelists, the Kaiser Family Foundation. The leadership that you all show in bringing together this data and putting the faces on

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these problems is enormously valuable and many of us use your materials in our efforts. So thank you so very much.

I represent 60,000 pediatricians nationwide who are deeply engaged in this health reform discussion because of the things that we see every day of our lives. The children that you heard about today are the children that we see. I wanted to just reflect on a couple of things that we're hearing that are new in a way. The biggest one is that the recession really is affecting people day to day.

I was just with some of my colleagues from Michigan where the percentage of newborn children who are depending now on Medicaid has risen to 40-percent. Forty-percent of the children in Michigan are now depending on Medicaid. This is an astounding number.

The other thing that we hear from our colleagues is that the practice of medicine is becoming

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less and less rewarding. The hassles that people have to take into consideration, the fact that they're using different pharmacopeias for every one of the insurance companies.

The fact that they have to justify giving an immunization is just making it very, very difficult for practitioners, for dentists, for pediatricians, and so forth.

We know the benefits that children and adolescents need. We know them very well but the way in which the insurance companies now pay, particularly the private insurance companies now pay, is totally malaligned with the kind of benefits that we've heard about and the importance of them.

So I have a couple of comments on, specifically, on these presentations. The first is that while not all children have as extensive problems as you've heard about today and I would say that the

youngster with asthma had pretty extensive problems as well as the other. Most children do require standard well child visits.

These are extremely important for laying the groundwork for prevention so that some of the dental problems that you saw today actually could have been prevented by the fluoride varnishes and things of this sort, which are in the packages that we recommend for standard preventive health care, particularly the obesity epidemic that's occurring now there are preventives that we can do but we need to do them in prenatal care.

We need to do them in early childhood and certainly before the age of six. Some of the standards that are coming down now from things like the benefits for the Blue Cross/Blue Shield, say oh you can start at six. Well that's just plain too late.

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We are urging, through the American Academy of Pediatrics and others, the medical home model. This is because inherent in this is a provision to really have the pediatricians and the others who are seeing the children look at the population of children and adolescents that they're dealing with and determine are these basically well children? Are these children who were premature? Are these children who are the children of teen parents? Are these children with chronic health problems?

You've heard the differences that have been delineated in terms of the kind of care. So with the medical home model, we take some time to think about tailoring the particular care. Well it costs money to even do that tailoring of the care.

So that's why you're hearing from us how important it is to think about a medical home model

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where you can begin to say I've got 20-percent of this kind of a problem, 30-percent of this, and so forth.

I don't want to belabor the distinctions that have been pointed out between the benefit structures of the private/public pay because I think there've been really beautifully delineated but I think it's important that most people don't know there are those distinctions. Most people think benefits are benefits. We all get benefits and it's just fine.

The private insurance does not give as good benefits as the public insurance. That's extraordinary. We're very pleased that the National Business Group on Health has championed the full benefits of bright futures for all children, children on private insurance and children on public insurance because of all the things that have been said today but there is a key irony in all this.

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Although the paper on the Medicaid benefits shows how extensive Medicaid benefits are on paper. There are two big problems with this. The first is that the states don't have enough money to fund Medicaid and CHIP and particularly, as a result of the DRA in 2005, the states are suffering terribly. They are not able to provide the kind of benefits that are on paper.

The second thing, and this is really important to my colleagues around the country, is that access is severely hampered as you've seen here with the dentists. Why is it hampered? Well it's fine to say that Medicaid will pay but if Medicaid only pays 71-percent of what Medicare pays and that's already only 90 or so percent of what the privates pay then I might not be able to run my office. I might not be able to bring kids into my dental chair.

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So the truth is that while the benefits under the EPSDT and, by the way, the "T" is for treatment not testing, and it's a very, very important distinction, but while the benefits for EPSDT are on paper, the actuality is that in New York State, the payment for Medicaid is 47-percent. Here in D.C., it's 62-percent. In my own state, it's 82-percent but think of running your candy store and selling your candy for 40-percent of what it cost you to buy it. It just doesn't make sense.

So in addition to really looking at what these access barriers are, the payment structures are extremely important. I'm sure every one of those dentists in the video would have loved to take care of those patients if they had Medicaid and it would pay. I know that because I've talked to them but they can't afford to do it because they don't get paid for the

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work that they do. So they end up doing this two-tiered volunteer system.

So I want to, again, reiterate my thanks to the Kaiser Family Foundation and underscore how important these benefits are but they must be tied in with the access principles and the payment principles as well. Thanks so much.

MEG MURRAY: Thank you. Okay. Thank you. Well I wanted to thank Karen and Joan and the other folks who wrote the paper for pointing out the issues with commercial coverage versus the coverage you get in Medicaid managed care. To summarize what I heard was that the acute care coverage for the commercial package is what can be generous is very limited. There are high co-pays and there's essentially no long-term care.

I think those are important points for us to understand but there were four other points that I wanted to talk about that also underscore why Medicaid

managed care is a preferable model to commercial insurance for low-income kids and people with special health care needs.

The first has to do with the unique providers that you find in Medicaid managed care. Many states require that health plans contract with community health centers and public hospitals that many of the commercial plans don't contract with. Many low-income people prefer to get their health care from community health centers.

In fact in Massachusetts, they found that after the Commonwealth Care program was passed, community health centers saw an increase in patients, over 50,000 patients, after people had health insurance.

So people want to go to community health centers and it's the Medicaid managed care plans that contract with them. In fact, many community health

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centers, when Medicaid was first moving to managed care, found that the commercial plans weren't contracting with them and many of them set up their own health plans. That was the genesis of the association that I represent. So there are unique providers in Medicaid managed care that you don't find in commercial insurance.

Secondly, there are unique services in Medicaid and Medicaid managed care and Karen talked about some of them but other important ones are transportation and translation. Commercial insurance doesn't include taxi vouchers to get you to your health insurance appointment. That's really critical for people to make sure that they can get the health care that they need.

In addition, there are services such as translation and while most commercial insurance plans probably can hook you up to the AT&T translation line

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or their member services have lots of different speakers, community health centers again have not only, they have translation services there or they have providers that actually speak the languages. Then again, you would not find that in many other doctors' offices that the commercial insurance companies contract with.

The third area and really important one is the unique supports that you find in Medicaid managed care that you would not find in commercial insurance. This has to do with the Medicaid managed care plans have systems in place to make sure that people can get the health care they need. By this, I mean care management, case management, member services, outreach workers that ensure that people have access, that they can access the health care they need.

A good example is Santa Clara Family Health Plan in California actually sends out workers to

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people's homes for their most chronically ill patients. In one case, they found that one of the patients there needed refrigerated medicines but their electricity had been turned off.

So the health plan was able to get them help to get their electricity turned on. All of the health plans that are in Medicaid managed care have lists and databases of the social services that people need such as electricity help or heating assistance or food, getting on food stamps and WIC, all of those things that people need in order to be able to even get to the doctor.

So there's unique providers, unique services, and unique supports that make Medicaid managed care preferable for low-income people to commercial plans but the fourth point I also wanted to talk about are the unique plans that one finds in Medicaid managed care.

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I represent an association of safety net health plans and over a quarter of all the people in Medicaid managed care are served by these safety net health plans, which are nonprofit plans, many established by community health centers or public hospitals or government.

These health plans, their mission is to serve both the insured and the uninsured people and they are responsible not to their shareholders but rather to the stakeholders in their community. A good example is LA Care. They've given over $80 million back into community health centers and actually started an initiative to cover kids that were not eligible for MediCal.

They created the initiative and then they partially funded it. LA Care is not unique in that. Many of the other county-owned health plans in California did the same thing. They created a program

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to cover uninsured kids and then, in some cases, helped partially fund it.

So in summary, there's lots of reasons that beyond what, Karen's paper's wonderful in terms of quantifying the dollar impact on families but there are other additional reasons why, for these populations that are low-income or have special health care needs, that Medicaid managed care is a better model for them than commercial insurance.

CHRIS JENNINGS: Well good morning. I'm the Y-chromosome of the panel [laughter]. I guess I just like to say, first of all as all have stated, the work of the Kaiser Family Foundation on every element of health reform from beginning to end, is really irreplaceable and invaluable. I just want to thank you for all you do Diane and all your team. I just don't know what we would do without you.

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What I really liked about this panel and this presentation has been to put the face, what the health reform debate's really about. It's about people and to put a face on it. All too often we don't do that in Washington. It's a bunch of numbers and analysis and politics and process. That's what I get to do all the time. It's good to anchor us a little bit more on the humanity of the debate.

I have to say that the film was, I wish every member of Congress would watch something like that every so often. So Julia, I want to thank you for that and, as far as Karen Pollitz is concerned, she is just a crown jewel. She does this every single day. She reminds us that health care is really about sick people, that it's not really so much about healthy people.

The reason she was just on the air the other day talking about the insurance industry's claim, well

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80-percent of the people are satisfied with their health care. Well 80-percent of the people are healthy and they aren't going through the health care system. Until they need it, they don't think much about it.

That's what we need to do a little bit more, a little bit more thinking about what reform means to the people who need the care. I think this is what this panel has been all about.

I hope, by the way, that the President tonight does a little bit more of putting the face on the debate of health care and shows, and helps convey what this means to real people. I think part of that is our job too. We're all sort of backseat drivers. He should do that. He should do that, blah, blah, blah. We should do that. We should do that. I think I want to thank Kaiser for that.

Now just a few points. There really are four legs of the access chair that we have to keep in mind

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when we think about health reform now. One gets a whole bunch of discussion and that is insurance reform, blah, blah, blah. That's true. We can't have people underwriting and discriminating and applying pre-existing conditions and all the rest but the truth about access is it does come down to what the benefit is. that's the second leg.

The third leg is how you make it affordable, which is really the subsidies, the tax credits, the Medicaid coverage or not. The fourth, really, is the reimbursement. You really have to have all four of these legs to make health care work for the people who need it when they need it.

Now the unfortunate reality is that the debate that we're seeing on Capitol Hill today will not resolve all these issues adequately. It is also true that the debate that we're having today will help address some of the things that we're seeing. The

challenge to all of us is to make this policy as good as possible but to recognize that our desire for having and paying for health care seems, our appetite seems to exceed our desire to finance it.

Now maybe that will change if we can really get people to understand this. Maybe we can really get a better sense about how little we're really talking about. We're going to be spending $35 trillion in health care over the next 10 years if we do nothing.

We're having a debate in Washington about how a trillion dollars is going to bankrupt us, right, over the same next 10 years when most of those dollars that we're talking about is reallocating the dollars that we're currently spending. I mean it's absolutely absurd but no one's talking that way. No one's like oh, gees, a trillion dollars. We're talking about reallocating dollars currently in the system to ensure a better system for people who need it.

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So we need to get a little bit better out of that messaging too or we're not going to even have close to a trillion dollars to reallocate to do something better. In fact, that will be probably the best that we can do. It still will be better than what we have.

Our job is to make this as good as it possibly can be and to continue to talk about the flaws and the shortcomings of the system and make it work. Our job is to make the policymakers think about who they represent. It's not just the so-called stakeholders who are the special interest and we hate them, the stakeholders, we like them. It's people.

We have a chance to make a big down payment to improving it but I can tell you that when you look at what will come out of this process, we will still have work to do and Karen will still be advocating. That's so we can all have full-time jobs until we retire

[laughter]. So I'll conclude with that and thank you very, very much.

DIANE ROWLAND: Well thank you Chris and all of our panelists for what I think is a wonderful way to start thinking a little broader about health care reform than just insurance reform and a trillion dollars to really help to put the faces of the people. The real focus of health reform is making sure that our health care system works for people who are sick as well as tries to keep other people healthier.

With that, we're going to give you your opportunity to ask the panelists questions and to please identify yourself when you ask the questions so that our panelists know they're talking to. If you want to direct it to a particular person, please do so. If you raise your hand, I think we have microphones out in the audience.

EMILY KATZ: Thank you. I'm Emily Katz with Care Oregon. This is to anybody on the panel but when we talk about high needs populations and high health care users, there was a population that I don't think we discussed much today and that's the dual-eligibles. I was wondering if you could talk about where care for duals comes into play and where Medicare comes into play especially in health care reform. So I was hoping really anybody could just address care for duals.

DIANE ROWLAND: I think that clearly the dual-eligibles, we know, are among the sickest of the Medicare population and also among those who use the most services under the Medicaid program. Clearly anything that can be done to both improve the coordination of their care between Medicare and Medicaid and to assure that they can remain in a community as long as they choose to remain is a real priority.

Clearly they are not the main focus of much of the debate going on now over health care reform but they point to a really high needs population just as you said that really does warrant more of our attention at how do we bring their costs under control by better coordinating their care.

So I think looking at better models for how to integrate their care and perhaps looking at the federal government easing some of those burdens on the states or swapping out some of the costs by assuming more of the responsibility for the dual population so that their care under Medicare can actually be more coordinated than having the joint responsibilities.

So I think it is an area where we might look at a realigning of federal state responsibilities but also an area where we really need to look at better care coordination to try and improve the outcomes for a very vulnerable and sick population. You're right,

they are a high needs population as well as those we've talked about.

WEIWAN NG: Thank you. Weiwan Ng. Does anyone have any estimates for how much it would add to private insurance premiums to increase the generosity of the disability benefits?

DIANE ROWLAND: A lot. I mean one of the points that we often make about Medicaid is since Medicaid takes care of some of the more disabled and severe, chronically ill, that helps reduce the requirement that private health insurance covered these individuals even under their current policies. So, in some ways, Medicaid is subsidizing private insurance premiums.

KATHY HESS: Hi. Kathy Hess with the National Academy for State Health Policy. The conversation this morning has been terrific and full of important information but it seems to me also that it doesn't

touch on all the components that feed into what we're talking about.

Chris talked about four maybe legs of a stool, I think it's maybe more of a table and there's a few other legs missing. I'm thinking just on the access issue, the issues with just having enough providers. I think the dental access issue is much more complicated than payment. Payment is a factor but it's only one and the shortage of providers is a major concern.

I'm thinking also with children with special health care needs and adults with disabilities, there are a host of discretionary grant-funded programs that also serve that population and in fact, subsidize some of those costs so that families don't have to pick up the entire bill themselves.

I'm wondering if the panel, anyone of you, would like to address some of the implications of what we're talking about this morning and how far reform may

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go for how these other components get addressed. I mean what will be the unfinished agenda and will we get to that or will Congress think we've taken care of everything and go home next year? Thanks.

DIANE ROWLAND: Judy?

JUDY PALFREY, M.D.: I'd love to try to tie in these two questions just in terms of expanding a little bit on the malaligned incentives. One of the real problems right now, at least in my field, is that we're paid per encounter. So you just have a lot of encounters for colds and discussion of things that are not as serious as they might be because that's how the payment structure goes.

I'm not sure we have to change the premiums at all in order to really shift the focus toward prevention and toward taking care of these problems. Right now, the insurers and the employers are paying for things that are not as valuable so that shifting

the presumption in terms of having more time to spend with the more complicated patients, having more time to use group well child care, for instance, and to use more creative kinds of ways of using our time.

Really we probably wouldn't actually have to increase the premiums but what we're paying for now with our premiums is really just what we call through-put, see a lot of patients, see a lot of patients, see a lot of patients. So we may be able to do many of these things in terms of the access with shifting our presumptions about what care actually is.

JACK BRESCH: I'm Jack Bresch. I represent dental schools and dental school clinics. I want to thank Julia and the Kaiser Family Foundation for that film. It was inspiring and commendations to Dr. Dickinson for the efforts that he and his fellow dentists in Virginia did.

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Chris, from your mouth to God's ears, on members of Congress seeing that film. Perhaps if they did, perhaps if they began to realize what individuals and families suffer through, relative to oral health problems, they would begin to see the importance and value of oral health. They are not seeing that. There is very little discussion of oral health in this health care reform debate in spite of some of the efforts that some of us are making.

So there is some disconnect between above the neck and below the neck. There is some disconnect, as Dr. Palfrey understands, that oral health is very conducive and very important to good general health and that it is connected with many other medical illnesses. So if any of you enlightened folks have any idea how we can raise the profile of oral health in this debate, either publicly or privately, I'd like to hear your thoughts.

DIANE ROWLAND: Chris?

CHRIS JENNINGS: Well I just say that members of Congress are running from meeting to meeting to meeting to meeting and really all they're talking about is budget tables and politics and the latest poll and it is frustrating. I completely understand that.

I also would commend your work for or someone's work for getting Senator Baucus to really care about this. It's interesting that even when people know about these issues and it singes their memories about this. When 99-percent of the rest of your world is the numbers, process, politics, it gets lost.

I think that, as a general rule, I think that one of our problems sometimes in this culture of this city is we tend to excessively specialize on one particular area and sometimes you can get a rifle shout win and that's great but that it's short-lived and I

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mean, to me, this is bigger than just oral health. I mean even though it is about an adequate benefit package that really deals with the focus on prevention, wellness, and preventing and caring for the chronically ill populations of this country, which are the populations that drive the costs.

I mean we talk about it all the time but yet our policy does not reflect it. We talked about dual-eligibles earlier. I mean that is the chronically ill population and dual-eligible population. If you want to start talking about these issues, talk about how you prevent and care for those people. Part of that is dental certainly.

I think sometimes small approaches on like dental, you see more doable and more maybe I can get something done but frequently they also get lost because then other people say well what about this and what about this and then it becomes so overwhelming.

That's what I think what's happening in Washington right now.

If you listen to this presentation and you'd say well gosh, we need to have a benefit that's far better and more generous than FEHBP right? You said we need to subsidize it to make it affordable because otherwise, you can have them but you can't afford it, it doesn't mean anything.

We've got to have a fire network to serve those populations once we provide that. We've got to have adequate reimbursement otherwise people won't take these people. I mean I'm just going to tell you because I'm a numbers guy that what we just talked about was $3 trillion.

Now three trillion in a $35 trillion next 10-year doesn't even bother me. Hey pay for it but part of this problem in Washington is people are willing to talk about what we need but they don't back it up with

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how to pay for it. Now look, I'm for deficit. I'm for revenues. I'm for cuts. I'm for everything. There's nothing that I'm not for on health reform but someone else has to be for it too because, in the end of the day the members of Congress, like it or not, have decided that today is a pay-go world.

It's a pay-go world. We are paying for health care. we're paying for it because we have a huge deficit and we have a huge debt and that's what we're going to be doing. So part of our commitment to that cost means either through savings or through revenues, we're backing these politicians up. If we're not, we're kind of whistling in the wind. So sorry about that little lecture [laughter].

DIANE ROWLAND: I think another issue that's important to add to this is we have a lot of talk today about Cadillac benefits and what we've shown you today is that for someone who's really sick, many of the

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services are not Cadillac benefits. They're just adequate benefits to meet their health care needs.

I think that's important to remember when everyone's looking at how slim can the benefit package be and how much cost sharing can we put in it to reduce the cost, it may not be adequately meeting the health care needs of some of the people who, under an individual mandate, are required to have this kind of coverage. So we have a question in the front and then one in the back.

JOAN ALKER: Hi, Joan Alker from Georgetown. I had a question for Dr. Palfrey and really anybody on the panel. But I think one of the ways to drive the discussion that Chris is talking about in restructuring the way we think about health care is to influence with the employer community and you mentioned some outreach I think you all have been doing and to the extent that we've heard discussions about focusing on prevention

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and wellness with the employer community, I've primarily heard it about adults.

So I was just curious to know what you had heard on the pediatric side and what the Academy was pursuing in that regard.

JUDITH PALFREY, M.D.: Sure. Absolutely. Thank you. Just to pick up again on Chris and on you, if we look at the five cases that were presented today, there were several moments where prevention would have made a big difference and certainly in the dental situation and prematurity in a couple of the cases, we had a car accident in one of the cases and then obviously in the dental.

So in terms of the preventive aspects, we now have much more sophisticated ways of working on maternity benefits, on anti-smoking, on safety issues around seatbelts and so forth. So we have been working with a National Business Group on Health and they have

been really looking at these preventive benefits and saying this makes sense. We ought to be encouraging everybody to have them.

Also the PCPCC, which is the Patient-Centered Primary Care Collaborative, which is actually made up of a number of the Fortune 500 companies and led by IBM, have been really looking and saying are we buying for our people what we want?

When they've looked at it, they've said no. We're not buying what we want. When they've really gone and said I'm paying for things that are not worth the money that I'm paying and yet people are telling me there are other things they can have over here.

So that's the discussion, I think, is very important. We've been extremely pleased to be a part of that PCPCC and are working extensively with employers. Of course the big employers include such

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people as the DOD. They do include the government paid-for care such as Medicaid and so forth.

So really looking and am I getting what I'm paying for very seriously. The preventive services that can really decrease the number of problems even young people who have disabilities have by getting in earlier for the PT and OT and so forth.

DIANE ROWLAND: Okay. Question back here.

LINDA HAMBURG: Hi. My name is Linda Hamburg. I work for the Maternal and Child Health Bureau but my more important hat is I'm a mother of a daughter with special health care needs and a son with no needs. So my daughter's had 26 surgeries. You can only imagine the cost, most of which actually has been because the health plans, UCR, is far less than what the providers reimburse.

I also talk to families around the country and I know based on the conversation of the panel that

you're right. No matter what the benefit package is, there's such great needs both for the insurance side as well as the non-covered insurance. So for instance, my daughter when she had to go to specialized daycare, that was far more than regular daycare that other children would go to.

So my question is has there been any thought or discussion on having, just like we have now, where some kids have private insurance and then get Medicaid as a wrap, whether or not there's been any discussion on having a basic benefit package that would cover the majority of people with obviously strong preventative benefits and then having a Medicaid-like wraparound benefit for children like my child.

DIANE ROWLAND: Karen?

KAREN POLLITZ: Yes. I think there has been some talk about having some kind of an EPSDT wraparound for kids even those who might not qualify for Medicaid

and that's been discussed in some of the committees. That would probably be a very important way to strengthen coverage for kids beyond what even subsidized private insurance would offer.

FEMALE SPEAKER: However, we have some concerns about that for maybe not so much for the higher-income folks but we know for CHIP, for those kids who are premium assistance that the wraparound and the shoe boxing and all of that doesn't always work that well in reality when families have to go out to get reimbursed for that. So there are operational concerns with that. That's why we prefer to see all those kids, the low-income ones in real Medicaid.

CHRIS JENNINGS: Can I? Diane one quick thing is that I think that there's two issues I want to raise. One is that I don't want to come across like I think that there isn't a lot of things we can do to alter how we deliver health care in the system and save

money and I worked for years and years and years on this and most recently with this Bipartisan Policy Center and Mark McClellan. You can't look at the health care delivery system and not see huge opportunities for efficiencies.

The provider community has to be completely engaged and invested and a part of that because when we have this conversation about okay, well there's money that we're spending that we don't need to spend, well they need to say and that's it. So you don't have to spend here and provide cover for that just as you need to invest in these areas.

So we really need to get a sense that that part of the debate, which is the hard part of health reform, delivery reform changes, workforce changes, allocation of people appropriate ways.

That issue is getting largely lost day to day in this debate because the debate in Capitol Hill is

about the individual requirement, the insurance reforms, the subsidies to pay for the coverage, and the financing.

If we do not have the infrastructure, if we do not have everyone in the health care system when we start off this debate, we will always have these incentives for people to spend money to avoid sick populations. We will always have a disincentive to cover people for prevention in chronically ill populations because in the end of the day, those are the people you want to avoid if you're an insurer.

So the reason why the fundamental framework of covering everyone is so important isn't just a moral one. It isn't just the right thing to do. It is a policy imperative to lay the predicate for what we have to do to change how we deliver health care in this country.

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DIANE ROWLAND: And we'll take the last question from the back.

CHRIS METZLER: Well thank you very much and thank you for this panel. Chris Metzler from American Occupational Therapy Association representing one of the tiny professions that should be a part of the whole benefit package but I, too, worry when people talk about Cadillac benefits and when people, policy makers, say well people should be able to choose what they need.

Well what you need before you get hit by the bus is very different than what you need after you get hit by the bus. I'd like comments from the panel about how the bills and the approaches on Capitol Hill toward finding the benefit package, actuarially equivalence, a national benefit determining body, how will those work? Is that the right approach to take care of the people when they're in the 80-percent who are healthy as well

as taking care of them when they go into either chronically or intermittently into the 20-percent?

KAREN POLLITZ: I think there's actually a fair bit of commonality in the approaches to defining the benefit package that we've seen in proposals so far. In terms of listing the services, there seems to be an intent to define some in statute and then pass off to somebody else to kind of fill in the list although I haven't yet seen anything that would constrain that panel to sort of hit a budget target or anything else.

So in terms of the list of services that's supposed to be kind of based on medical knowledge and science, which is a very positive thing. We've also seen, in statute, I think across the board that there shouldn't be any caps on the covered benefits, which is great. That was what ran a lot of these folks into trouble on their dental benefit, their occupational and

physical therapy benefits. Home health, you hit your limit and then that's it. You're not covered anymore. So that would stop and that's also important.

The actuarial value stuff that you see in the bills really governs the cost sharing that will apply. That possibly was meant to sort of give us a standard number to work with so you could see that 67-percent is less than 87-percent is less than 97-percent but it's also obscured the debate a little bit about what we're talking about in terms of cost sharing. The actuarial value of this Cadillac Blue Cross plan that members of Congress have has been estimated at 87-percent.

So at 87-percent, you could owe $5,000 a year if you really need a lot of care. A lot of what the bills that have been put forth so far, a lot of what they would provide for people with far lower incomes than what members of Congress earn would be a plan with

cost sharing that would achieve a lower actuarial value, which means they could owe even more money.

So the maximum out-of-pocket that's been discussed over on the Senate side is closer to $6,000 for a person, $12,000 a year for a family. That's not the premium. I mean that is the premium but that's what you would pay on top of the premium for out-of-pocket costs.

So that is just an issue we haven't talked about very much or we haven't talked about very well in the debate but I see the Congress in framing the issues so far this way in the health care reform, as kind of stepping off into the trap that the insurance industry has been in for a lot of years.

How do I make coverage more affordable? How do I make it cheaper? I'll just hike that deductible right on up there. I'll add some more co-pays. I'll

make the out-of-pocket go even higher and that's not going to work for people.

If we end up covering everybody and they still become bankrupted from their medical bills and we make them pay premiums for the privilege, that we won't have done the job that we need to do.

CHRIS JENNINGS: We tend to be seeing, on the Hill right now, very numbers-driven process and policy that the general approach by all sides is let's give better benefits and greater subsidies to lower income populations and, as we go up, we're going to reduce that.

Again you're two moving parts of, the cost of health care is the value of the benefit and the amount you subsidize it. That's health reform. Those are those two moving parts. That's the game that's being done on Capitol Hill.

What they've decided is gees, I'd like to subsidize people up to at least 400-percent of poverty and the Finance Committee, 300-percent of poverty and then after that in the way but boy that's expensive. Oh well my hidden way to reduce that cost is to lower the valued benefit. That's really what's happening.

Now having said that, a lot of those people who'd be getting that benefit have nothing now. So again, I guess put me in the camp of getting as much as you possibly can and setting up the infrastructure to build on because I don't think we're going to have a better chance than this year to get something meaningful done in the foreseeable future.

DIANE ROWLAND: Well I think, on that note, we can thank our panelists for both sharing with us the people that are really what health reform is all about, the issues that the Congress and the President are struggling with in terms of putting together a package

and the warning that goes back to make something that Uwe Reinhardt said at one of our Kaiser Commission meetings a long time ago.

When you look at a bill and you look at the price tag, the higher price tag, the more good it may be doing but unfortunately, when you reduce the price tag, you tend to have to sacrifice a lot of the comprehensiveness that may be there. So we'll be watching to see what happens but we thank you for joining us for this discussion.

We hope you're taking away some issues and concerns that will follow you through your following the debate. Thank you [applause].

[END RECORDING]

[1] The Kaiser Family Foundation 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.