

**Conference: 10<sup>th</sup> Annual Grassroots  
Conference: Health Action 2005  
Plenary Session: Covering the Uninsured:  
States Lead the Way  
January 28, 2005**

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[START RECORDING]

**KATHLEEN STAHL:** Let's get started. I think I can see you out there, with the bright lights. Hello, hello. Welcome. I know that you all need a little time to blow your noses and wipe your eyes—after our luncheon presentations, so many inspiring advocates and so few awards every year. I have a couple of announcements. Please turn off your cellphones, in the plenary sessions like this one and in the workshops. Put them on vibrate or have more fun, what the heck! Also, in line of fun thoughts, the snacks in the break after this plenary will be served upstairs near the rooms where the workshops are, as well as downstairs. That way you can grab a snack and move the workshop a little quicker while you're turning your cellphone on vibrator. So, everything you need, taken care of.

This is a workshop about those of us who want to keep looking forward but have to be a little realistic about how hard it is to do that in these tough times. Many of the workshops—and let me say who I am—Kathleen Stahl, and I'm with Families USA. I'm the Director of Health Policy. Many of the workshops and the plenaries here at our conference really have focused on the top federal fights that we're facing. You've heard a lot about the Medicaid fight at the federal level. You're facing your own Medicaid fights at the state level. We're also fighting very radical, radical changes to the

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healthcare system that will erode our private healthcare coverage for poor folks and for all of us. I think it's really not the sunniest of times, for those of us that are in Washington D.C. You know, I don't want to sound too pessimistic. I don't want to set that tone for this plenary, but I actually think of it as sort of a period of solar eclipse in Washington D.C. It's really quite dark here. The good thing, though, is, within the darkness in D.C., we can see some bright lights out there at the state level. I believe, and all of us at Families USA believe that state advocates never say never, never give up, and never, ever miss an opportunity, no matter how small, to push forward with healthcare coverage expansion initiatives in your states. You do it because you love the people in your state and you want to see people have healthcare coverage. You are the best. States are now, and will continue, at least for four years, to lead the way in expanding coverage for the uninsured, and you're going to expand comprehensive coverage—you're not going to give lip-service to something less, even in these dark times there are bright lights in the states. This session will highlight a couple bright lights and we're going to talk about the dark clouds too. We really didn't feel like we could be totally Pollyanna at this session, so we're going to talk about the positives out there and we're going to talk about the challenges.

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Our first speaker will be Alan Weil, and he's going to give us an overview of state efforts to expand coverage to the uninsured. And then we have two speakers, one from Tennessee, one from Maine, and they really provide a very contrasting tale of two states. In Tennessee, advocates are fighting tooth and nail, literally tooth and nail to preserve one of the nation's earliest and best model Medicaid expansions. I think the purpose of having the Tennessee story today in this forum today is to remind us that while pushing forward the front line, we have to continue to protect our foundation, and have the coverage, build our coverage expansions on a solid foundation, and that's often Medicaid and S-CHIP. From Maine we have a brighter story. The advocates there have passed the newest model law for other states. I cannot tell you how many times, Mike, that we are asked to give folks more details about what you're doing, so that they can try to do some of the pieces of what you package is. Right now, Maine is facing the challenges of implementing their model. It's innovative, and it's challenging to make it happen. And so Mike will tell us a little bit about how you pass it, and then the long road ahead of trying to implement it.

So, first Alan Weil. Alan is currently the Executive Director and President of the National Academy for State Health polity. Before becoming head of the Academy, Alan spent several years at the Urban Institute, directing the Assessing

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New Federalism Project, one of the largest privately funded social policy research ever undertaken in the United States. We at Families use your stuff all the time. Alan also served as Executive Director of the Colorado Department of Healthcare Policy and Financing, the cabinet position responsible for Colorado's Medicaid and medically indigent programs, and also responsible for health data collection and analysis, health policy and healthcare reform. People tell me he is not only one of the nation's greatest experts, but also, I have heard repeatedly that you're one of the nicest people to work with that there is. So I'm really delighted, and Alan, step up [applause]!

**ALAN WEIL:** Well, thank you. I hope my niceness exudes from my body out into the room, whether we're working closely together or I'm up here speaking. When I agreed to give this presentation, I had to give a caveat. I had a baby due, and I wasn't sure if I would be able to be here. She came five weeks early, so I'm a sleep-deprived new dad [applause]. I couldn't be happier, but you all will pay the price for my mumbling a little bit, and being a little less prepared than I like to be in a setting like this. The good news, thought, is that because I was out to talk about what states are doing and to give it a really positive cast so we can come out energized, I didn't have all that much to say [laughter]. That's really not true, and I think one of the most fun things about my

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current job with the National Academy for State Health Policy, and the work that I did at the Urban Institute before I went to NASHP, is that we do get bogged down in Washington with big ideological debates. Things move slowly. Sometimes we want them to move slowly, sometimes we want them to move one direction and we can't get them to go. And yet, every meeting I go to with state folks, there's always an agenda, there's always energy and activity, and particularly, I think the partisan battles that make it very hard to get things done here are less at the surface at the state level. I certainly wouldn't be naïve and say that they don't exist, and they certainly vary from state to state. But I work with a group of people who I think are generally more pragmatically oriented and they're looking for things that will work, no matter whose ideas they are. That said, of course, states have been working under some serious constraints. So, let me try to structure my remarks in a few categories. I want to talk about what states are doing in the area of coverage, but I also want to talk about some other things states are doing because they're having some trouble focusing on coverage for some obvious reasons right now, and maybe a few lessons to take away from both of those two categories of activities.

Let's begin with the sort of head-one question. What are states doing to lead the way in terms of healthcare coverage and covering the uninsured? I was thinking about the

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word lead. You know, when you're in a race you have to lead as long as you're ahead of the next person and everyone else. Well, when you're racing against the federal government in coverage right now, it's pretty easy for states to have the lead. One of the areas that I think is unfolding in a way that is still hard for me to see the long-run implications of—and it's actually where I'm going to spend the bulk of time, because it's where it think, with respect to coverage, states are spending the bulk of their time—is on something that goes by a number of names, but generally is referred to as something like premium assistance. The concepts of these programs are as follows: We have the Medicaid program out there that's accustomed to providing healthcare to the lowest income, the neediest populations. We have the private sector, that through the employer-based system provides coverage to the majority of Americans. We have a lot of people who are working for firms. We know that most of the uninsured are employed, and although most of those folks don't have an employer who's offering coverage—that's why they don't have it themselves—some of them potentially could get coverage through their employers. Some employers might be willing to participate in the employer-based market if they had a little help. And the idea is to try to bridge the gap between two systems that are quite well developed, but have developed completely independently of each other.

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One is full blown public coverage, and the other is private sector employer sponsored insurance. And premium assistance models come in quite a number of forms. I won't walk through them. Seventeen states right now have one form or another of these programs. Many of them, I should note, are quite small. But the concept is to try to put together through a combination of public financing, generally Medicaid as a major contributor to the financing, some amount of contribution from employer, employee or maybe both to try to put together a benefit package that is real and meaningful for the enrollees. Now, the reason I say I don't know where this is going to go is because, as I say, most of these programs are quite small. There are battles between the states and the federal government right now over how they'll take shape, and how much Medicare financing can be used to support these kinds of programs. But we do have, I'd say, a lot of attention at the state level being placed on this notion and this idea of trying to bridge the gap.

The bad news is that because you're trying to cobble together different dollars from different sources, it's hard to come up with the financing to achieve a comprehensive, solid insurance policy. The good news though, is that I think there's a general sense among many elected officials in both parties around the country that having this gap group between those who obtain and receive Medicare coverage and those who

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are able to be covered through their employers and have the gap group have nothing is not appropriate either. And so, there is a great deal of energy in this area, and still a bit of a story to be told, but it's an active area for state governments right now.

A second area where states are moving the coverage agenda is in what I would call garden variety Medicaid and CHIP expansions. Now, for those of you, most of whom who have been defending against Medicaid cuts it might surprise you to hear me make any reference to Medicaid and CHIP expansions, and indeed if you look at the overall picture around the country, this has been a period of more contraction than expansion. But there are two things I would say, again, to keep with my positive theme of my presentation. The first is that we do have states that have been making efforts for expansions even during this time. Illinois stands out as having made a significant effort with some success and trying to go further. Colorado voters approved taxes to fund healthcare programs and the legislature is looking seriously at some expansions. Through a variety of waiver methods states are looking to use their CHIP funds, those that have some available to try to expand the program. So one thing to say is that even though so many states, as you know, are trying to minimize cuts, there are, even in bad years, a few states that are looking at Medicaid

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the way they have in the past, as a tremendous opportunity to expand coverage.

And the second thing I would say about Medicaid expansions goes to the core of how the program functions, because at least as of today, Medicaid is still an entitlement program, and we have gone through a bad economic period. We have observed throughout the country Medicaid enrollment expanding substantially. Mostly, not to things that are good. It's expanding not because the rules have changed, but because people's economic conditions have suffered and they've become eligible. But the good news is that because the Medicaid program exists as it does today, even holding the line on Medicaid eligibility and not expanding the groups that are eligible has yielded an expansion in the number of people that are covered by the program. And I think if we're going to take a view of what it means to take the lead in coverage, having a program in place that fills in the gaps that grow when the economy turns down and states being able to retain that program is a form of leadership, and indeed, just a couple of days ago, the former colleagues of mine at the Urban Institute issued a report on the cost growth in Medicaid, and enrollment is a primary reason for that. Some of that is because of eligibility changes, but most of it is because Medicaid is serving as the safety net it was intended to be, and that is a form of leadership in times of tight budgets. Did I convince

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you [applause]? If I didn't, let me just say it this way: If it weren't an entitlement, we had a fixed budget, we'd gone through an economic downturn, we would have seen something very different and therefore I think, even though it's hard to get excited about it as progress when you just hold the line and the enrollment grows because people need the program more, the alternative would be falling behind. So I think we should feel good about the positive side of that story [applause].

The third area where states are leading the way is a little speculative, but I think it needs to be said. There are a number of states that are seriously and in various ways exploring comprehensive approaches to healthcare coverage. Now, they're not looking to implement them next month, but one of the nice things about states is when they're seeing that times are tough, some of them and advocates within those states, keep healthcare on the agenda and basically force conversations to occur so that you're building the foundation for activities that may not be possible until the budget situation gets better. There are foundation led efforts, there are grassroots led efforts. I've been involved in an effort in Massachusetts. There's a foundation in Missouri that's working on this. I was up speaking with folks in New York just last week. There are efforts around the country to think, "Okay, we know the budgets are bad now. We know now's not the time to move a major agenda, but we also know that this problem is

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getting worse, and we need to be ready for a time that our leaders are ready to do more. And that again, is a form of leadership, because I think in Washington right now, when all the attention is focused on Medicaid and implementing the Medicare Prescription Drug law and all of those kind of things, there isn't a lot of energy in Washington to think about, okay, if we ever get a different emphasis on healthcare and if we ever get out of the budget situation that we're in, what will we do? And so, thinking and planning and building political consensus, doing economic modeling, all of those sorts of things are happening in at least a handful of states around the country. And if you thought I was stretching before, here's a big stretch, I'll just warn you: You know, there is work around the country going on on limited benefit packages, mandate-free benefits, health savings accounts and those kinds of things. There's a lot of leadership around the country at the state level on those issues. Now, substantively, you may not consider that form of leadership the kind of leadership you're looking for, and I would—I don't know if I would share all of your views—but I would certainly share your skepticism if you had it about whether or not that's a solution to our healthcare problems. But, in the name of looking for the light, but I think that that list of activities going on around the country and the amount of attention being paid to these kinds of options is a suggestion of a different political

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dynamic in healthcare than existed ten years ago, which is that no elected official, regardless of their political party or their ideology feels like they can ignore healthcare as an issue. No one can go out to the voters and say healthcare is just someone else's problem or the government doesn't have any role in helping people try to figure out how to get healthcare coverage. And even though there may be serious differences in perspective about what the solution is, the fact that it's on the agenda of both parties and that it's on the agenda in every state means that if we learn more, and as we gain more experience, and as we're able, maybe to learn from what works and what doesn't, it creates, I think, some room for moving forward. Not today and not tomorrow. Of course there may be movement in directions we don't like in the interim, but I think it's important to look positively at healthcare being on the agenda in a way that for many people it simply wasn't an issue that legislators felt like they had to pay a lot of attention to. So that's a form of leadership, wouldn't you say? It's all right. Didn't way it was easy.

The second area that I want to discuss, and I'll do it much more briefly, but there's a lot going on in states that is not directly the coverage agenda. This is not about building programs, expanding programs, subsidizing people to obtain health insurance. But I think it's important to understand that this is the natural cycle of public policy, and it

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certainly plays out at the state level, where, because the states have gone through one of the worst budget periods that they've seen since the second World War, and they are just coming out of that trough right now, but they knew that they needed to be working. They did try to put more of their energy into initiatives that were oriented toward costs and building a better healthcare system for the future, with the understanding that that doesn't solve the healthcare problems of today, but maybe it sets us up better for the future. There's been a tremendous amount of effort at the state level on patient safety and quality improvement, and these efforts, I think everyone agrees that they need to be system wide in healthcare, and as we improve the quality of our healthcare system, we reduce costs, which makes it more accessible for everyone. There's been great work going on around the states, and I won't go into the details—you have much more detailed sessions—on long-term care and chronic care and how to better organize delivery of those services so that they better meet the needs of the people who need them, and then, because they better meet the needs they are more cost effective and enable us to free up resources, hopefully, over time, to put into other priorities. There's been a lot of attention, of course, to prescription reimportation, but beyond reimportation, there's some very creative work at the state level in states coming together to try to purchase for value and try to understand which drugs

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they need to promote and what they can do to have a more efficient and more effective drug system beyond some of the older, broader policies that have existed within the Medicaid system. Again, as states become more value-based purchasers, they hopefully over time are able to liberate resources that enable them to address coverage. So, again, these are not sort of head-on coverage expansion kinds of policies, but they are the foundation that's necessary, and they're the place that states feel safe to put some of their energy right now when they know they're having trouble with their budgets.

So let me just close with a few lessons from these times and again, just sort of keep us on the positive vein. The first thing I would say is this: There are a number of researchers—some of my colleagues at Urban have done this before I left and there are some others around the country who've looked at Medicaid in this time of tough budgets. And the consistent story around the country is that even in a period of declining budgets, Medicaid did better compared to its size in the budget than other state priorities. Now, that comes at the cost of education and other very important things. I don't mean to make this a rosy situation. But Medicaid has fared well, and although I'm sort of telling the story from today's perspective, if you let me tell the five-year story or the seven-year story, we have a lot going on at the state level. We have the CHIP program blossoming and reaching

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millions of children. We have states adopting the family coverage options within Medicaid. We have states investing in outreach and enrollment and simplification of eligibility. So many of these things in the last year, there's not much new good story to tell. We don't just live year to year, and I think it's important, even when I look out now, I don't see as much positive with respect to the direct coverage agenda as I might like, even if I expand my time horizon by a few years, I think there's a much more positive picture to tell about state leadership.

The second thing to keep in mind is that the governors, I think, are coming to understand the more complex role, the very complex role that Medicaid plays in their state budgets and in their economies and throughout their health systems and all the programs that they run. And so I think as we go forward, even though coverage initiatives are hard to pursue, governors are in a better position to defend and work to make the program effective and defend against some of the more significant attacks that may well, and we know are coming out of Washington. And much of that credit goes to you as advocates, but it also goes to the fact that Medicaid has grown and Medicaid is getting more attention, and I think that puts us in a better position for going forward. And I'll just close with this. Although there is a lot of leadership at the state level, it comes and goes. You get new governors elected who

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have health on their agenda and it's still a little too early for some of those to know how far they're going to go. The one thing I would also say: I talk to a lot of people around the country. The states know the even thought they can and must make progress on this agenda, they can't do it on their own, and we aren't in a world where there's this sort of crazy idea that Washington ought to just leave us alone and we can solve these problems. The states are really looking for help and leadership from Washington. They know they can't wait, and that's why they're acting, but there was a time when I think people who wanted to see progress on this issue were nervous about states moving forward because they wanted to see a national solution and they were afraid that too much state activity would actually detract from the sense of a national crisis and the need for a national agenda. Today I think there's a broad understanding that on the one hand, states need to keep moving because these issues are getting worse and the elected officials at the state level can't just sit by silently while the federal government figures out what to do. But at the same time, I don't hear from the states a sense that they want Washington to stay out of the way. So, the states will continue to lead, with some false starts, with some things that are good and not so good. AS the budget picture gets better, I think it will be a lot easier to give this talk next year or two years from now. But in the meantime, it is a very

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different picture at the state level than in Washington, where it does seem possible to talk about an issue for years and years and still do nothing. At least at the state level, we are seeing some progress. You're now going to see the good and the bad, and in many ways these two examples set the boundaries. I've described the big middle and now you get the nitty gritty of both positive and negative [applause].

**KATHLEEN STAHL:** Thank you, Alan. You know, we gave him a tough task, folks. We're going to hold questions until after all three speakers have completed. I wanted to touch on two themes, though. One is the accomplishment of having health on the agenda of this country. I, like many of you, care deeply about housing. We care about food security, and I think it is a credit to all of us that the healthcare agenda is at least part of the dynamic political debate today, and I think Alan pointed that out. Also, I think an important message is, we have to expand our horizon if we're to keep our sanity. We have to look out at a several year time frame and look at maybe the light at the end of the tunnel to keep pushing toward expansions. Something I remind myself, that it may not be this year that I'm able to do as much as I like, but maybe if we keep that longer timeframe in mind it helps.

The next speaker is Gordon Bonnyman. He is, as Alan said, going to tell us perhaps the tough story, probably one of the toughest stories out there. Gordon Bonnyman has practiced

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poverty law since 1973 and is currently the Executive Director of the Tennessee Justice Center, a public interest firm in Nashville, Tennessee. He was a key player and is an advocate for consumers in the design and implementation of TennCare, Tennessee's Medicaid managed care program. Today he is, as I said, fighting tooth and nail to preserve that program, which has really been one of our best models in the country. He's a leader in the fight to preserve Medicaid coverage for literally thousands of low-income Tennesseans. Gordon, you're a hero and no less than a true hero for us at Families USA. We honor you in our hallways every day and when we read the paper, it reminds us what you're able to do and what you face. I don't know what a vitriolic and difficult fight that Gordon has faced in Tennessee. You are a model of perseverance and determination, and you're a gentleman when your adversaries aren't always as gentlemanly. So, I'm delighted to have you here to tell the tough story [applause].

**GORDON BONNYMAN:** Thanks, Kathleen, and I'm always grateful to come to these conferences and go away with renewed spirits. I'm just so grateful, having come from a place where I thought we were in the middle of the nuclear winter, it's on a solar eclipse. This lifts my spirits tremendously. I just want to say, thank you very much!

I'm from a state that in the early 1990s—which seems like a very, very long ago, far away era and place—we took our

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then populist governor, Ned Ray McWherter, took the state in a very different direction than what anybody's talking about now. Instead of taking public monies to buy into a fractured, dysfunctional private insurance system for those who are at the margins, he took the wisdom of wholesale purchasing, discounted pricing and community rating to make insurance available to those at the margins by buying them into the most efficient public system out there, which is Medicaid. But that was then and this is now. But it grieves me, it pains me to hear someone I admire like John Kerry yesterday say that he's looking at premium assistance to buy people into a totally broken commercial insurance system. But, and with apologies to those that I inflicted myself on at an earlier workshop by saying some of the same things. This may just be your cue to put your head down on the table for a little nap.

I'm reminded with the fate of where TennCare is now of Churchill's observation that in the long stretch of human history, humankind occasionally stumbles over the right answer, but manages usually to stand right up, back up and keep lurching along in the wrong direction whence it came. And I think we stumbled over some insights back in the early 90s, such as the notion that the way to tackle the problems of the people at the margins is to bring them into the public system where you can have efficiencies of scale and assure an adequacy of benefits and quality of care. We're turning our back on

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that now as people screw around with pretend-like solutions such as buy-ins into premium assistance.

The story goes that in 1994, TennCare started as an early waiver program. In January 1994, the governor was a lame duck with only one year left in his term, and so, as I like to put it, you know, we're big into Creationism in Tennessee. We don't believe in doing things by evolution, and if God could start the world in six days with one left over we could start TennCare at the stroke of midnight on January 1<sup>st</sup> 1994, which is what we did, and it was pretty messy. And there were a lot of bad headlines, but story goes that the governor got a briefing from his then TennCare Director about halfway into that last year with only a few months left in his term—and Governor McWherter is a person of considerable heft. He weighed about 250 pounds. He could have been cast as poncified [misspelled?] southern Sheriff in the Heat of the Night. You just put reflectorized glasses on him—anyway, Governor McWherter apparently swiveled around in his chair, propped his hand-tooled cowboy boots up on the desk and when he heard the report that 100,000 people had been enrolled, he said, "My program's got a constituency now [laughter]."

I say that because, since then it's been downhill, it's been a total fight. But to those of you that are wondering about whether its worth trying to expand coverage in this climate, I will just tell you, it is infinitely easier to play

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defense than offense, and if you can ever get a constituency through an expansion program, it's just hard as hell to take it away. That's why we still have more people ensured in Tennessee in spite of all of our problems right now, for a few more minutes anyway, knock wood, than most other states in the country.

And I think that we're all, in this world of Medicaid cuts, going to have to learn to exploit the advantages of playing defense, and I know I'm supposed to be putting the same face on this, but let me just talk to you a little bit about what we're now facing. We have a new kind of Democrat, a Zell Miller Democrat [booing] who comes out of having made millions as an HMO entrepreneur and who is bringing the insights from that experience into remake Medicaid into the model of his private HMO. He's been quite explicit about that as a goal. Part of that mean writing a definition of medical necessity, which amounts to an HMO entrepreneur's dream of what medical necessity would write, which means, the only medical services which are necessary are those which we, the management of the company, in our infinite wisdom, believe you should have without regard to any medical standard. It involves the self-infliction of a block grant in the form of setting an arbitrary locking in the present percentage of dollars spent out of the state revenue fund and say that we will not allow Medicaid to take more than that, which in the world of medical inflation

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means that we will cannibalize the program indefinitely in response to cost pressures. It means eliminating benefits, such things as whole classes of medically necessary drugs. ON the interesting premise that there are not drugs in those classes—I'm now referring specifically to antihistamines and gastric acid reducers, which there are perfectly good drugs that are available over the counter. I tried to explain to the millionaire governor that OTC does not spell F-R-E-E, and we are talking about poor people here, but it's a concept that seems to have eluded him. And we've moved over the space of the past few months from the Governor wanting to implement this new vision of an HMO private business type model. As he said, "The old Medicaid program is a dead dictator in a glass coffin." He wants something more American, and what he's describing is something more American in that there will be very few people covered by it, and the benefits will be inadequate [laughter]. He's now talking about eliminating coverage for 323,000, which will be the largest single increase in the rate of uninsurance, I believe, in the history of the United States. He is gonna cut off people in nursing homes. He's gonna eliminate the medically needy program. What's really interesting is that the figures that have just come out, and in some bedrock Republican counties—and he's really taken this issue away from conservative programs who've been talking about cutting the program—it turns out that the counties that

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will be the most seriously hurt are not the urban areas with large minority populations, but some rural Republican counties where as much as 40 to 45 percent of the population is on the program. As the former governor said, this program's got a constituency now, and it will really be interesting to see just how far some of these fire-eaters want to go with that effect on their constituents. It's going to have an enormous impact on rural hospitals and may lead to some closings, and I think some of those things are beginning to sink in now.

Some of the lessons that we've learned from this from the experience of the past 11 years with TennCare are, we're getting a little bit of traction now. The Governor has been extraordinary skilled and able at crafting a message. It's clear that the states, those that are wanting to cut the program and the Bush Administration are sharing their message points, such things as individual responsibility, choice, empowerment, and a lot of other euphemisms that all mask the enormous human tragedy. He's been very good at controlling the message on this. But we are coming back with some pretty simple, straightforward realities, which is, "It's about the federal money. It's about the federal money. Hello, hello, it's about the federal money. And we're beginning to get traction because, as Alan says ideology, partisan politics aside, the states have to balance their budgets each year, and they can either do that the easy way, which is to get the money

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from Uncle Sam, or they can do it the hard way, which is either make some painful cuts or deal with taxes at home. And so, we're beginning to get some attention there.

The other part of our message that we think is beginning to get through is, "Inflation. It's inflation. It's inflation. It's inflation." That's an important message to carry, because there's a tendency for states to think it's parochial, to think that it's their state their Medicaid program, something wrong with their Medicare program, be it TennCare or anything else. There's something uniquely wrong with the management or the level of cheating, or the stupidity of the advocacy committee, whatever they want to blame it on, and really, the underlying problem that keeps eroding health benefits in this country is the rate of medical inflation that continues to outstrip personal income, Consumer Price Index, state revenues, Gross Domestic Product, as it has for half a century, and as it is projected to continue to do. Just continuing to put pressures on that, and we keep trying to make that point, not only to help explain that TennCare has been a successful program and its problems are partly a result of externalities such as medical inflation that it can't control.

But also because that segues into a conversation about the looming threat of a block grant, and the foolishness in Tennessee's case of self-imposing a block grant, through this notion of just capping state expenditures and then

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cannibalizing the Medicare program year after year to stay within that arbitrary tab. If you can get people to realize that the costs are going to continue to inflate and you want that all to be borne by the state government with the federal contribution capped or fixed or locked in, it kind of calls to mind the old observation that nothing so concentrates the mind as the information that you're to be hanged in a fortnight. And so, talk about inflation in the context of what that portends for a block grant. It does tend to powerfully concentrate the minds of state lawmakers. We are talking, trying to put together messages about safe reform. We can't be against reform, we've gotta be for reform, but to do it in a way that is safe.

We're trying now to deliver a message which I think brings us to the position that we have in Tennessee where we're facing this massive cuts, but I fear other states even without an expansion are going to be going down the same path. People are gonna die. This is real lives. You're taking away something. It's not just that you're failing to address a festering social problem out there of the uninsured, but that you are now a government fiat, depriving people of health benefits upon which their lives depend. And I think Tennessee is going to lead the way in this area. Unfortunately, the Governor wants to lead the way a lot of states are looking to see, can you get away with simply cutting your way out of this

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at the level—can you get away politically at the level that we're talking about? And advocates are now driven back onto the most existential of questions. And we are talking about things like civil disobedience. We are talking about things that people talk about when they're driven into a corner and against a wall, and lives depend upon it. And we are doing that from a context of being able to defend something that is in place, which again, I think is an enormous tactical, political strong point to be working from. It's very tough. It's enormously painful, but I'm cautiously hopeful [applause].

**KATHLEEN STAHL:** Thank you, Gordon. You know, this really is intended to be an upbeat plenary, and you may be wondering. . . It's really a reverse psychology approach here. If you think it's bad in your state, you could be in Tennessee. And so we want you to see the brightness of your own state it's really hard to even joke about Tennessee, because I think it breaks our hearts to watch the fight you're waging, and I think our whole staff would be willing to join you in an act of civil disobedience, tomorrow morning, say [applause].

The next speaker really is going to give us some good, upbeat information. We've all been watching Maine. It's in the national spotlight. Mike Saxl—who I really enjoyed working with over the last couple of years—Mike is a Mainer first and foremost, and if you're from Maine, you know that the highest complement to someone from Maine is that they're a Mainer. I

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lived up there for a while, Mike. I know how that works. Mike went to college and to law school in Maine. He served as a member of the Maine House of Representatives for seven years, '95 to 2002. During his tenure, he was Majority Leader and Speaker of the House, and a leader on healthcare issues. After his tenure—It's a term-limit state—Mike founded and now is head of Maine Street Solutions, a public affairs and consulting firm that's working closely with advocates in Maine to advocate and make Dirigo a reality. As you all know, Dirigo, the Dirigo Health Plan in Maine. It's been in the national spotlight. But what's often not there is how hard folks in Maine are working to make it a reality now that they're actually starting to implement the program, particularly that component that will provide coverage to small employers and their workers. I honor you Mike, but I also must honor the team that you work with. I can't see because of these bright lights. I can't see well without bright lights, folks, but at my age that goes without saying, but is Joe Detray in the audience? Joe, if you are, [applause]—I don't know if he is, but Joe DE—Joe, stand up! I can't see. Joe, please stand up. Joe Detray [applause] is a leader in Maine. You know, Mike, you're a really lucky guy. You work with such a lot of cool people and really seriously dedicated people. I think there's a couple of others in the audience. Nancy Kelaher [misspelled?], Sharon Treat? Are you here, Sharon? Sharon was the Senate Majority Leader who

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sponsored the Dirigo Bill. David White I met at lunch today. What a team of people you have to work with! So really, Mike's here as the spokesperson, but he really represents all of our advocates in Maine [applause].

**MIKE SAXL:** Well, in the words of George W. Bush, "this is hard work," [laughter] so I'm gonna dig out my [inaudible]. Maine is an amazing place, and I want to tell you a little story. I've been traveling a lot. I've been doing some work on Dirigo, but I've also been doing some work on prescription drug affordability, so it's had me on the road a lot. And, a few months ago I was in New York City—and what I like to do when I travel is, I like to go to one place that's kind of a similar thing at every place I go so that I kind of get a feeling for where I am, and so right now I'm on a church kick—and so I went down to Saint Patrick's Cathedral and right outside in front of Saint Patrick's Cathedral, there's a gold phone, "Direct line to God, \$50,000." I was like, "Well, that's very odd." Went into the Cathedral, spent a few moments, enjoyed my time. Then about a month later, I was here in the Capitol City, Washington D.C. and I went to a church. I went down to the National Cathedral. There right in front of it, gold phone. "Direct line to God, \$50,000." This is very unusual, but I went into the church. It was beautiful, very serene. Finally, I got home and I thought I'd close the loop, and so I went over to the cathedral on Mudjoy Hill, in Portland

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where my old legislative district was, and there again, in front of the church, gold phone, "Direct line to God, 50 cents [laughter]." I couldn't understand it, so I went in and I saw the father there. I said, "Father, you know, New York, \$50,000. Washington D.C., \$50,000. Here in Maine 50 cents?" He said, "Here in Maine, it's a local call! [laughter and applause]." We feel like we're blessed in Maine. I call it the small state phenomena.

We have some people that are here. I know that Kathleen talked a little bit about Joe Detray. Joe Detray was one of the core people of a coalition we brought around Dirigo called Dirigo Health Now, our fiduciary agent, our fundraiser-at-large. Nothing would have happened on the political arm without Joe Detray. Sharon Treat knew the details and the politics. Nancy Kelaher, who's out in the audience, is on the Maine Quality Forum. David White is on Maine Quality Forum. We have people littered throughout the State of Maine working on Dirigo. And let me just refer back to yesterday. Michael Moyer was doing a great job in a plenary, in a session here, and he used a term I'd never heard of. He talked about the Iron Triangle of politics and in healthcare reform. He talked about providers, insurance and business, and how you had to break the Iron Triangle. Well, in Maine, we have a web of advocates that go through that Triangle, go around that Triangle and wrap itself around it all so that we can make amazing things happen.

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So with that, let me also thank Kathleen Stahl, who's part of that web of energy, Ron Pollack, the entire Families USA team. They have energized us to work in Maine, and have done an extraordinary job not just in saying, "Go," but in Kathleen saying, "We can't keep up with the Letters to the Editor. WE can't keep up." She's like, "I'll write Letters to the Editor from here!" And that's the way it is. No matter what the job is, Families USA has been an incredible partner for us, and I'm sure they've been an incredible partner for all of you, and I want to thank them or all the-[applause].

So I'm going to us a little POWERPoint here. We'll see how it goes. So, the most important thing is, what is Dirigo. Does anybody out there know what Dirigo is? Does anybody? What is it though?

**MALE SPEAKER:** [From audience] It's moving ahead.

**MIKE SAXL:** It's moving ahead. Is it the state motto? Is it an old Latin word meaning moving ahead, I lead? Is it a healthcare plan? Yes, all of the above! Dirigo is an old Latin phrase that's the motto of the State of Maine that demonstrates for us that we can lead—and what I think, I actually take from what Gordon and Alan were saying earlier is that—we're on defense now, and we should be on defense. I say, no, we should not be on defense right now. I say the thing we need to do as progressives in healthcare reform, we need to define the agenda that we want to see. We want people to see

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the future of healthcare reform. It can't just be about protecting against Medicaid cuts. It has to be about how we protect the uninsured and broaden access to the healthcare for all of us [applause].

So Maine needs reform. What's the big problem? Maine, you've got all those advocates, you must be doing great! But no, the answer is not that things are great. Mainers have been paying a higher percent of their healthcare than 45 other states. The cost of healthcare has doubled since 1994 to the present to \$7.7 billion, which is a considerable amount of money when you consider that Maine is a state of just 1.3 million. Family premiums have risen 77 percent during the six years between '96 and 2002, and the problem isn't just that the premiums rose that much, but that income could not keep track of those premium costs. So Maine needed reform. We have 130,000 uninsured, and if you look at the Families USA research, any time in a two-year period—I think it's 260,000—and remind your legislators that Maine is no different from your state. Eighty percent of those people are working people who work in small businesses in Maine.

Another big problem in Maine is our bad debt and charity care. In Maine, our hospitals are eleemosynary institutions. That means basically, that they have to take care of uninsured people when they walk through the door if they meet financial guidelines. But that also means that there

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may not be payment at the end of that care, and that comes to the tune annually in Maine of \$275 million in bad debt and charity care. That creates higher hospital in-patient and outpatient costs in our neighbors. According to a Blue-Ribbon commission in 1998 by then-Independent Governor Angus King, we were wasting a billion dollars, 20 percent of every dollar in Maine was being wasted. To give you a sense of the scope of that for Maine, that is just about equal to what we collect annually on the income tax. So, if we got rid of the waste and we got rid of the duplication, and we provided better healthcare services in Maine, provided better preventive care so that chronic care conditions were properly treated, we could probably do away with the income tax—not that I'm suggesting that.

So this is a familiar triangle, for all of you. In Maine, we decided that it was all about access, cost and quality. But what does that mean in terms of Dirigo? That means Dirigo Choice is the way we provide access to those 130,000 Mainers without insurance. That means a state health plan is the way we approach the issue of cost. That means the Maine Quality Forum is the way we preserve quality, to make sure that the healthcare delivery system is doing all it can. And as you know, access quality and cost, all three of those rely on each other. The Governor, Governor Baldacci calls it his three-legged stool. If you take and just do Dirigo Choice

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and just do an insurance product, then we aren't going to be able to address the issues of quality of the issues of rising costs outside of Dirigo Choice. We need to do all three every time.

So Dirigo Choice—What is Dirigo Choice? Dirigo Choice is the access piece, remember. Dirigo Choice is our public/private insurance product that we provide for Maine people who are in small businesses, self-employed or individuals. We put it out to bid, and the winner of the bid was Anthem Blue Cross/Blue Shield, and they are providing the product in collaboration with the state. Participation: It's a voluntary program we are not at pay-or-play at this time. But that has not been a barrier to folks participating. It's designed for small businesses, I said, and it's important that employers must pay a minimum of 60 percent of the premium.

But, it's important also that Dirigo Choice *isn't* what we're fighting against: Remember, you all are fighting against health savings accounts, high deductible policies and association health plans, and those things don't provide adequate care for people every day. We needed to have Dirigo Choice be a quality product. It has to have comprehensive coverage, 100 percent coverage for prevention, no pre-existing exclusions, it has mental health parity, so Congressman Kennedy should be very happy with what we're doing in Maine. And it has A Healthy Maine rewards, a way to encourage folks to do

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things like smoking cessation, participate in exercise and other kinds of other public health initiatives. So we have preventive and wellness care, immunizations, routine physicals, blood tests, pap tests, mammograms and the rest. Everything you want in a full-fledged health program is part of Dirigo Choice and you cannot compromise on that as you're rolling out your healthcare coverage. You need to make sure that healthcare coverage, what people are paying for makes a difference in their life.

The interesting thing about Dirigo, I think, is how we worked in and around Medicaid to provide coverage. Dirigo Choice provides coverage for people up to 300 percent of the federal poverty level. There's a sliding scale copay, so that means, a family of four making \$56,550 will be eligible for a 20 percent reduction on their employee share of their costs, and that can mean a very good return for them. If you think that for a basic family the cost is \$930 and that \$372 could be decreased by an additional 20 percent, that could mean real savings. In your state the prices might be different, and we hope that they're as low as they can be, and we're working to continue to lower those prices.

So how do we do it? It's not free, unfortunately. Dirigo is, though, to one degree, self-funded through employee and employer contributions. It is also up front funded by a one-time appropriation by the State, \$53 million to get it up

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and going. There's something called a savings offset payment which looks at the fact that we have \$275 million in this bad debt for charity care in Maine, and things about what that means to employers. That means 16 percent of the current cost of insurance is a result of bad debt or charity care. It's all about cost-shifting, so if Dirigo can insure the uninsured whether it's using MaineShare, our Medicare program, or a sliding scale deductible, or providing just typical employer insurance, we believe we can demonstrate to those employers in Maine that they are achieving a great savings in their premiums. We use the savings offset payment to capture some of those savings and share those savings with those employers.

As you know, we rely on federal matching funds and on Medicaid to help us fund this, and we are also looking at the other lines of this triangle, the other corners of this triangle. So, cost containment is a huge thing. Cost containment, we have an emboldened COM process, and something called the Capital Investment Fund. The Capital Investment Fund looks at all healthcare expenditures annually and over a period of time in the State of Maine, and says that the state cannot afford to grow healthcare expenditures beyond a certain point. What was really interesting was, in the first year we had a moratorium on all COM for major projects in Maine. The day it was release, something like \$260 million in new projects that they couldn't wait for. The COM process, the Capital

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Investment Fund is designed for a counter-weight because if we continue to build costs that we can't sustain, that will lead to more healthcare inflation.

We have voluntary expenditure targets. Our hospitals are living under a 3.5 percent voluntary expenditure target, and so far, so good. They're actually living under that target.

We have transparency. All of our hospitals are required to post all of their prices for every procedure, or for a certain number of procedures, the common procedures. We have insurance reforms.

We've reinstated insurance forms regulation on the large group market so that rates can't change unless they're able to demonstrate a real need for those changes [applause].

We have a Hospital Study Commission, which Joe Detray champions often, which just came back with a 19-point proposal which includes some of these things, but also looks at regionalization and collaboration between hospitals, breaking down some of the anti-trust rules so that hospitals can't say they can't work together in order to target appropriate constituencies and provide efficiencies, and they've done an extraordinary job in setting expectations for hospitals.

And we have a state health plan. Can you imagine that? In the State of Maine we have a plan that tell us how we can improve quality every year, where we should set the Capital

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Investment Fund, what spending we need to have, and how are we going to improve the quality of healthcare in the State of Maine?

And, of course, part of cost containment is to end the hidden tax, which is providing insurance for the uninsured. We all know that those folks don't go away. They should get affordable appropriate care, which will provide better care for them and less cost for Maine businesses.

We also spent a long time on quality improvement and we now have something called the Maine Quality Forum, and I urge you all to go to [www.mainequalityforum.org](http://www.mainequalityforum.org). It is the vanguard of evidence-based medicine and best practices. It includes procedures, and both the costs, and looks at the frequency of different procedures at different hospitals in the State of Maine. So when they may be using a lot of episiotomies at a hospital in northern Maine, they may be doing a lot of C-sections at a hospital in central Maine, and they may have a different cost structure for both of them. When you are going to go to a hospital, you're going to have this information, you're going to be able to go to the hospital you feel best meets your needs and you'll understand where the trends are in healthcare. It allows patients to be better informed.

We have the state health plan, which we talked about before, and we pay for performance of public purchasers. So this is the website, and again, it's got great stuff - on

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surgery, on doctors, on the hospitals, on communities and other opportunities for learning a little bit more.

So what are the lessons we learned? The first lesson we learned is that you need—I heard yesterday, this is not partisan, but you thought needed to have all Democrats in the legislature and the governor's office, and as a Democrat myself, I accept that as a good suggestion, but it ain't necessarily so. We have great Republican supports as well, and what I think you need to do is find non-traditional constituencies and build new alliances. So not only was Joe Detray, who runs the Consumers for Affordable Healthcare, and who's been a known and relied-on health advocate a part of the team, but so is Dana Conners, who's the Chairman of the State Chamber of Commerce. So are businesses. One of our largest employers, Bath Ironworks was really worried about the cost of hospitals; so were small business groups in the Maine Small Business Alliance. They were all at the table together. Think about non-traditional alliances, as well as about cultivating legislative champions.

One of the things you're going to face if you go down this road is that there are tough choices. You know, the businesses don't want to have a savings offset payment now that they're achieving savings. They think that's money they don't want to spend. They want to spend it elsewhere, but without those we won't have Dirigo. You need to think about how to

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cultivate dialog around tough choices. We have three focus groups going around the State of Maine right now to help people understand what those tough choices are, and help them understand that these choices are to the state's best advantage.

And I'm about to get the hook here, so I'll just end with sustained leadership is essential. The most important thing perhaps is not just that we passed this bill, the question is, how are we going to keep hold of it? We now have—you may have heard of something called Alliance for America? Well now there's Alliance for Maine. You may have heard of the Heritage Foundation? Well now we have the Maine Heritage Foundation. You may have heard of Grover Norquist Taxpayer's Union? Now we have the Maine Taxpayers Union. This fight continues to be fought in Maine. You need to sustain leadership. You need to embolden your leaders, those people who made those difficult choices. Once you've got it done, it ain't really over.

Since Winston Churchill is apparently a healthcare expert, I'm going to end with one of my favorite Winston Churchills: "We will fight them from the sky, we will fight them from the beaches, and we will never surrender!" I say to you, pass your healthcare, expand your Medicaid to meet the needs of uninsured. Do things around affordability with Rx Plus and other strategies, bulk purchase, reimport, do what it

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takes. You should set the agenda for the states and bring the agenda to the federal government. Thank you very much [applause].

**KATHLEEN STAHL:** That was the upbeat part.

**GORDON BONNYMAN:** I thought I was the upbeat part!

**KATHLEEN STAHL:** Gordon! No, you were the hero. I'm sorry. You were a very upbeat hero in hard times, but, I think we have a few minutes to questions, not a lot of time, because you probably do need the break, being human beings. But we can take some questions. If folks want to come up, use the mics, identify who you are, and direct your question to one of the three panelists. Thank you.

**FEMALE SPEAKER:** Thank you for those presentations. It's very interesting. I'm wondering if both of you could talk a little bit more about what you think is behind the political will against both of these programs. I think we know a lot about what the right's agenda is on a national scale, but I'm confounded by what in those two states—the reasons for trying to undermine such programs would be. Thank you.

In Tennessee, all politics is local, and there are just some very idiosyncratic things, just happenstances of the state's misfortune. TennCare became a hostage in a divisive and ultimately unsuccessful fight to enact an income tax under the Republican governor who preceded our current governor. You've got medical inflation, which means that these programs

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all have tremendous budget pressures to force pressures on rolling them back. That's just there as a constant. But then again, we have a particular governor with a particular set of life experiences and temperament who is responding to those pressures in ways that I think are quite unusual, and so, it has a lot to do with just those kinds of things.

**MIKE SAXL:** I'd say the big deal in Maine are three things: ideology, politics and money. Ideology, I think there are just some people who are true believers and don't believe that government has a role in protecting those most vulnerable in our state and how that different ideological belief and how that free market is there to help save them, and Dirigo is really a blend of free market and private, and it's something they're not comfortable with. Politics, we have a Democratic governor, and he'll be up for reelection this next year, and we have set a national agenda, I think, to some degree, around Dirigo, and I think that some of those folks both want to not allow the Governor to have the success, and to not want to Dirigo to spread like wildfire. And three, money. I think that there's some industrial interests that have had it pretty good in Maine for a long time. Healthcare I sat 17 percent of the Gross State Product in Maine, and you know, hospitals are very safe and very strong, and they maybe don't want to go through a transition. The same is true for insurance companies. Maybe they don't want to have an apples-to-apples

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comparison with their policy and the Dirigo Choice policy. So I think there are a couple different things driving that in Maine.

**KATHLEEN STAHL:** Question in the front.

**RAMONA SHEDROP:** Yes, my name is Ramona Shedrop [misspelled?] and I'm from Florida, and I have—since I didn't ask one this morning and it fits, I'll ask two. When the gentleman from Tennessee said that people die in this program, and I've always felt that way, but I've never heard that used. I feel that the people who take money away, as they are in Florida now, from people and the poor, healthcare and chronic illnesses and will die if they don't get care—absolutely will, and there's no question—people who've had organ transplants and other things. I think this is a death penalty, and I would like to know what right these legislators and these governors have of issuing a death penalty against people who did not commit any crime except being sick and poor? And the other one question I would like to ask is, we have something called the Homeland Security Program, which I don't like, but I would like to know if we will ever have Homeland Security if we do not have healthcare for everybody [applause]?

Yes. That's my answer. I would just say on the death thing, we have our University State Medical Center put out a bulletin a couple of years ago that just used the data that's out there in epidemiological journals and the Institute of

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Medicine Study on Uninsurance pulled together about the mortality risks of being uninsured in the United States. They took that and did a calculation which allows us to say that there will be a death every 20 hours if you remove 323,000 people from the TennCare program and consign them to the ranks of the uninsured. Which I mention just to advocates that people who do that often tend to be very apolitical and they just did this and hid it somewhere. Someone found it and has sent it to us, and we're trying to get it all over the place. But that really goes to the heart of the great myth that all Americans or most Americans subscribe to which is, sort of, the Robert Frost, "Home is where, when you go there, they have to take you in." The medical system will take you in even if you don't have insurance. Ultimately, you'll be okay. I was not defending the notion that we should allow retrenchments, I was simply saying that we need to exploit the reality that entrenchments are upon us in many places, to push this issue that no, that's a myth, that's a lie. We need to be adult, we need to embrace the truth, and we need to therefore confront the enormity of what this means, not only for the people who are about to lose their coverage, but for the people who never had any to begin with.

**KATHLEEN STAHL:** The Institute of Medicine finds that 18,000 people die every year because they don't have health insurance every year in this country. Gordon, I would call on

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you, maybe to share with other states when you have that methodology pinned down, on how you can equate cuts to their impact and families can share that with their—

**GORDON BONNYMAN:** I'll just e-mail it to you. It's just nothing innate to Tennessee, it's just, here's the mortality risks associated with taking this group of people, this population and rendering them uninsured. What does that do to the death rate?

**KATHLEEN STAHL:** So everyone can try to replicate that, which might be excellent for some media work. The question in the back there?

**ANGIE CASPER:** Yeah, I'm Angie Casper, and I'm here representing a small grassroots group called Montgomery Healthcare Action in Maryland. We work with the larger Maryland Citizens' Health Initiative which is trying to bring universal coverage, or at the very least, coverage for the uninsured in Maryland. You know, in our discussions with legislators and small business owners, and large business owners, for that matter—as you know it always boils down to, the bottom line is the bottom line. I wondered whether Mike could give us some insights that are the kinds of things that we don't necessarily read about, the sort of what did you do, and how did you deal with those questions when you worked to get the legislators on your side, when you worked to get small business owners on your side? How did you convince them that

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it was worth supporting and that they would be doing this not as necessarily a moral issue, but in fact, help save costs?

**MIKE SAXL:** I think that you have to know your audience, first of all, so to get the people in the middle, I think the Governor framed this whole issue not only as a means of fairness and justice, but one of economic development, that the opportunity to have healthcare that was affordable, accessible, of quality was the critical aspect of developing Maine's economic future, and he had some great allies in the business community who had been struggling to provide health insurance to their employees. These large employers, LL Bean, Bath Ironworks, UnemProvident Insurance Company, who were trying to find a way to make sure that hospital costs and other costs were controlled in the State of Maine, because they were struggling to continue—these great employers—to continue to provide insurance—and so they became our best ambassadors. You combine that with this fierce advocacy team that we talked about, Mary McPherson and Mary Henderson and Chris Estes at Maine Equal Justice, and Joe Detray and his team, and that kind of combination, we found to be extraordinarily fruitful. You always like it when the Chamber of Commerce and the AFL-CIO are going in hand-in-hand to strategize with the Governor.

**KATHLEEN STAHL:** I think we can take one more question, and then we really do need to take a break, because the workshops start at four. In the front.

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**JOEL SEGAL:** Good afternoon. My name is Joel Segal. I'm with Representative John Conyers' Office. You can applaud. He's also the Chairman of the 45-member Universal Congressional Healthcare Task Force that I coordinate, which is a great step forward, that there is a task force from the Congress. Here's what I have: What we're not getting on the Hill are real victims who've suffered through the healthcare system, either underinsured, or uninsured, and as a result of that, you have senior members of the Bush Administration, like Tommy Thompson, who said, "We really do have universal healthcare. You can go to the Emergency Room." Now, that's not true, of course. That's fallacious. What can you do as leaders of the state movements to bring your people into these offices—These members of Congress are not kings and queens, they're human beings—and let the members of staff know that this is a crisis that has to be dealt with now, not in five, ten years, not fifteen years, but now, because it's the life and death of a person. But what can you guys do?

Secondly, will you support an effort in 50 cities in the spring? It's a Congressional Town Hall Hearings where members of Congress are going to—It's non-partisan. Republicans and Democrats are going to listen to the victims. But would you also be willing to help participate in that effort? Thank you very much.

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**MALE SPEAKERS:** Yes!

**KATHLEEN STAHL:** I think we have four yeses, Joel. Let me just mention too, and many of you know this, that Families USA has a story bank effort, where we collect stories from around the country, including the wonderful story of a businessman from Maine, and to the extent that I could promote this, if I could end on a commercial, which is so like television, the extent that you all can help us identify the stories of real people impacted by their lack of health insurance and share those stories, we will work with you to place those in your local papers and we try to bring them to the members of Congress's offices. Too, in one other commercial break, one of the things that we're thinking about that addresses the woman who was at the mic before was the possibility of generating some numbers this spring. I'm looking at Ron, hoping I'm not going to go out on limb too far, but some state numbers that will show the impact on the premiums of folks who have insurance, of having uninsured people in your healthcare system. We suspect it will look quite impressive, so if you want to reduce premiums, don't go after your medical malpractice, go after the uninsured. And so, we hope to have state numbers for you sometime in the next six months that you can work with [applause]. I'm trying to lock Ron into a contract, here. It's really a subtle strategy of a report I want to work on! Thank you very much. Thank you

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to our three panelists. We have a break and then a 4:00  
workshop [applause].

[END RECORDING]