

**Elements of State Health Reform:  
Creating a Marketplace of Expanding Coverage: Part 1  
Kaiser Family Foundation and  
National Governors Association Center for Best Practices  
Washington, DC  
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**LARRY LEVITT:** This is Larry Levitt from Kaiser Network.org. Welcome to our new series, "Elements of State Health Reform," a partnership with the National Governor's Association. These interactive Web shows will look at growing momentum for health reform in the States and probe the key issues policy makers are facing as they develop approaches to cover the uninsured and make health care more affordable.

Many reform plans seek to expand the role of private non-group insurance, and in the case of legislation being implemented in Massachusetts and proposed by Governor Schwarzenegger in California, individuals would be required to buy insurance. Yet in most cases today, the non-group insurance market is not accessible to everyone, potentially excluding people with pre-existing medical conditions or subjecting them to surcharges. And it's not a market that allows for easy comparisons of benefits and premiums. Today, we look at what can be done to make individual private insurance available and affordable through insurance market regulation and purchasing pools, like the new connector in Massachusetts.

We're joined by a panel of state and national experts who have both studied these issues, and worked to implement practical approaches to reform. Karen Pollitz previously

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worked on the Hill and for HHS. Today, as a researcher at Georgetown University, she runs [healthinsuranceinfo.net](http://healthinsuranceinfo.net), a terrific source of information about state insurance rules.

Ed Haislmaier is a Health Policy Expert at the Heritage Foundation, who is often called upon to help policy makers develop health reform plans.

And Jon Kingsdale is the founding head of the new Massachusetts Health Insurance Connector, following a distinguished career in the insurance industry.

You can reach our panel of experts by e-mailing your questions to [ask@kaisernetwork.org](mailto:ask@kaisernetwork.org). Thanks to all of you for joining us, and Karen Pollitz, let's start with you. Tell us a little bit about the non-group insurance market today. What types of holes are there in that market?

**KAREN POLLITZ:** Well, I have to say, as an academic, it's the most fun to study things that are quirky and dysfunctional so I have a lot of fun studying the individual insurance market. I guess before I talk about what's wrong with it, I should talk about how you know when insurance is working well. And to begin with, it's important to remember - it seems obvious, but worth restating - we buy health insurance in case we get sick, not in case we stay healthy. And for insurance to work for you when you're sick, it has to meet what I call AAA test. So the insurance has to be available to you,

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it has to be affordable, and it has to be adequate to guarantee you the access to the health care that you need without leaving you with ruinous unpaid medical bills. And the individual health insurance market almost never gets straight As. It never even gets one A a lot of the time.

**LARRY LEVITT:** Some examples of how ...

**KAREN POLLITZ:** Okay, so there's a lot of things that happen in the individual market, and I should also mention that it is a different market state to state so some of this depends on where you live. But in most states, to begin with, the individual health insurance market is medically underwritten. And that means it's not available to you if you have a serious health condition. So if you have diabetes or cancer or heart disease or if you're pregnant, you'll be turned down every time in a medically underwritten market. And if you have even a mild health condition, like acne or hay fever, you might be turned down for that as well. So the individual market is pretty fussy about who they will sell health insurance to.

If you can buy health insurance, you also then need to know that the premium will depend on a lot of things, so there's not a single price for an insurance policy. It will cost you more if you're sick, it will cost you more if you're older. It may cost you more depending on the occupation you work in and other factors, based on your gender, too. That can

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affect your insurance premium.

And then in terms of adequacy, the individual market tries desperately to do better on the affordability thing to bring the price down, but their main trick for doing that is to limit what individual policies cover. So if you go out shopping, you may actually find lots of health insurance policies for sale in the individual market that are \$30 or \$50 a month, but they don't cover very much. They don't cover maternity care, they may not cover prescription drugs, they may have very high deductibles, \$5,000 or \$10,000 per year. So for all of those reasons, it can be a really really tough market to operate in.

**LARRY LEVITT:** And is fixing this market, from your perspective, as simple as telling insurers they have to take anyone, prohibiting medical underwriting and saying they have to charge a community rate, the same rate to everyone?

**KAREN POLLITZ:** Well, that's a beginning. You definitely need to do those things. You can't fix the market and make it work again for people who are sick unless you do those things. But in addition, you would need to throw in some pretty good subsidies, because this is a market that even when it's working well, is inherently expensive. It doesn't have the economies of scale of a group policy, so there is a lot of load. More of your premium dollar goes to pay to administrate

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the policy than to pay your claims. And it's not subsidized by definition, your employer is not helping you pay the premium the way they would for group coverage, and the tax benefits that would apply to employer-based coverage generally don't apply in this market. So you need to subsidize people pretty heavily if you're going to expect them to go into this market, because most people won't be able to afford it.

**LARRY LEVITT:** And Ed Haislmaier, would you share Karen's assessment with the way the market works today?

**ED HAISLMAIER:** Oh, yeah, because it's a holdover from basically a very different design and a very different era when health insurance and health care was very different. It's left over from a world in which health insurance was run like auto insurance, on the premise that we didn't know why people got sick or when they'd get sick, and when they did, there wasn't a lot you could do for them. So it was cheap, it was affordable, and today, that's no longer true. And so the system is dysfunctional.

The problem is that there's an inherent advantage to having the individual own the plan, because then you align the incentives in the system so that the providers, the plan, et cetera, works for the individual. I mean, the problem we have with health care in general is that the people who are paying for it, which is you and me - I mean, ultimately, one way or

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another, I don't care how you organize your system, we pay for it. All that money the employer supposedly pays is really our compensation. And all that government money, the government programs, that's all our tax dollars, you know. And ultimately, we're the ones who are getting the care. It's not the government or the corporation going to the doctor. But we're left out of the decision.

**LARRY LEVITT:** So you think it makes sense to move this market from employers providing most of the coverage to individuals [inaudible].

**ED HAISLMAIER:** If you're going to get a system that aligns incentives - because we know that a lot of health care services that are delivered are either unnecessary or in some cases downright harmful. I mean, I was just at the NCSL Conference where they had folks from Intermountain Health University of Utah, Professor James, and he's saying like half of this stuff is pointless, if not dangerous, and that's just an appalling record. I mean, not even our most incompetent industries do that bad. So the only way you're going to get there, you can't regulate your way to a better health system. What you have to do is you have to get everybody working in the direction of saying, look, I'm going to get rewarded for doing better and costing less. But to get that, you have to ultimately have the consumer in control of it.

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So the conundrum you have is you have a very dysfunctional individual market, but for reasons of policy, you want to move in the direction of consumer ownership and control. So what you have to do is you have to look at, how do you fix the market?

**LARRY LEVITT:** And do you - to get to that consumer control - are the regulations you think you need in the individual insurance market it to make it accessible?

**ED HAISLMAIER:** Oh, sure. Here's another point. We have a system that again - you're looking to say what's the underlying premise here. This is a system that's premised on the idea - and this is true of the employer group market as well as the individual - that the seller is going to go out and find customers. The seller picks the customer. Now, that's very different from a market in which you say, we're going to line up all the sellers and bring the customers in, and the customers get to pick what they want. So in a world in which the seller picks the customer - and again, this is true in the group market, it's just more pronounced in the individual market - there are some customers you don't want to sell to, right?

**LARRY LEVITT:** Sick people.

**ED HAISLMAIER:** Yeah, sick people, or whatever. But there are also some customers who you might not be avoiding,

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but they are a lot of bother to go after. So it's a lot easier to sell to the ones that are right in front of you that you just walk across the street as opposed to trying to make the sale half a continent away.

Well, the same thing in health care. It's a lot easier to sell to that employer with 100 employees and you say, well, wow, I get that lined up and boom, it's all done, as opposed to the pizza joint with five employees. And then when you get to the level, I mean, you can be the healthiest person in the world, but if you have one part-time job at Home Depot and another one at Wendy's, I mean, that's just a nightmare to try to make that work in the market that we have today. Because you have to change that market dynamic.

**LARRY LEVITT:** So is that where the idea of a connector [inaudible].

**ED HAISLMAIER:** Yeah, that's a lot of what's behind that is to say, look, this is about reorganizing the way it is delivered. And that's where it differs - it has elements of pooling, but that's where it differs from some of the pooling arrangements. The pooling arrangements that you had like in the California HIPIC [misspelled?], you know, these health small business pools were based - and I know you have Rick Curtis talking about some of this - were based largely on a variant of the existing model, which is well, okay, if we get

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1,000 employers with 10 employees each, then we'll have a group of 10,000 and then we'll go see if we can get somebody to cover them as a group. But again, the individual employee doesn't have a lot to say on the subject. That's kind of like the grocery buyer, somebody who goes out and looks at the farmer's produce and says well, I'll buy your tomatoes from your field and put them in my supermarket. And then when you and I go in there, that's what we get, as opposed to this sort of farmer's market kind of approach where again, you line up all the sellers and the buyers come in and they pick what they want, and that's difference.

**LARRY LEVITT:** Let me bring Jon Kingsdale into this, and Jon's joining us on the phone from Boston, and is obviously trying to make some of this work on the ground in Massachusetts. Jon first start by telling us a little bit about - you took over the Connector, founded the Connector - just give us a quick summary of what your responsibilities are. What is the Connector trying to accomplish?

**JON KINGSDALE:** Okay, I think I need to back up and give you some principles of our health reform here. So one is subsidized coverage for low-income uninsured and there's federal and state tax dollars to do that. The second one is under the rubric of shared responsibility, have employers do whatever they can to make sure they are offering insurance, and

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they are offering it on a pre-tax, payroll deduction basis, and that they're offering something, not only they but in the non-group market, that meets one of Karen's, I guess her third A, adequate coverage, so that at a minimum, that coverage gives people some access to preventive care and the kind of health security that you have with some caps on your exposure. So if, God forbid, you have catastrophic costs, your coverage protects you from medical bankruptcy.

So those are all PL and then the last one is the requirements that we're doing regs on just now to have everybody who can possibly afford it have to have health insurance. So government's stepping to the line, employers are stepping to the line and individuals are stepping to the line too to get that last 5-percent of our uninsured insured. There's a lot of responsibility involved in doing that. The Connector has a major piece but not all of it. The two primary pieces that we have are to develop a subsidized health insurance program for the low-income uninsured, which we call Commonwealth Care, and we launched that and November 1<sup>st</sup> was the first enrollees. We now, as of April 1, we will have over 60,000 newly insured people, folks who didn't have insurance and didn't have a routine source of care, et cetera, for years, and in some case, decades, will have insurance, and that's almost 50-percent of our target market for the Commonwealth

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Care program.

The second major program is what we call Commonwealth Choice and I would underscore choice, to go back to both Ed and Karen's points about the non-group market not having a lot of choice. And that is private insurance where we're basically organizing an exchange or a market for private insurance in which if we can lure the customer to the shopping mall and in health insurance, that's a whole lot more difficult than some of the analogies that Ed used, and we can talk some more about that. But this is very much a pushed sale, typically. But if we can get them to shop, they'll see seven different health plans at different levels of benefits offered. They'll be able to compare premiums, cost sharing, provider network, and hopefully make a very rational and informed choice of health plan that meets that minimum health security standard. So those are the two main programs, and then we have a whole bunch of other regulatory things that we have to do, but that's the essence.

**LARRY LEVITT:** And Jon, tell us what's been your biggest challenge so far in making this work.

**JON KINGSDALE:** [Laughs]

**LARRY LEVITT:** Pick one.

**JON KINGSDALE:** That's a tough one. I am fond of saying I have a list of 137 major anxieties about this. Let me

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put it this way, by way of context, Larry. It took three years, literally, to hammer out the compromise, and to sign legislation that unlike almost any other major health insurance reform that I'm aware of, was not energized by stigmatizing and rousing emotional anger at one, two or three parties. If we had picked out the insurance industry or hospitals or government, they actually were all in attempts, and it took three years to do that, which isn't surprising when you think that we're reforming 16-percent of our gross domestic product, or our state domestic product. And so the biggest challenge now is to keep that broad political support while we grapple with some of the major, major controversial decisions that frankly the legislature couldn't resolve and bucked to us, and to do it in a way that is on track, doesn't give dozens and dozens and dozens of critics who would love a chance to declare this a failure an opportunity to do so.

So keep everybody in the boat and move that boat forward with our eyes very much on the point of the shore we want to hit, which is 99-percent coverage of Massachusetts citizens.

**LARRY LEVITT:** You had something that you talked about your anxieties, and you had a bit of bump in the road recently as you were working to define the level of coverage and premium that would be affordable for people would be required to buy

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insurance. Obviously a difficult task, and you were, by many reports, quite successful in the end in getting the premium down from some of the initial bids from carriers. Talk a little bit about how you accomplished that. I think many people would be interested to know how that's done.

**JON KINGSDALE:** Okay, I'd be happy to, and I'm glad you brought it up, Larry, because the number you are referring to is \$380 and that was a slip of somebody's tongue at a board meeting that got picked up by a reporter, who then put it on the front page of the paper of record. It was then picked up by every would-be critic in the country and trumpeted as clear evidence that health care reform had failed. And the truth is we didn't get the number down from \$380 to \$175 - those are two very different numbers. The \$380 was, as I said somebody's quick calculation at a board meeting. We have three-hour board meetings that are really press conferences. And basically it was like having an incumbent office holder. We had to do a campaign to replace a false number that was virtually nationally accepted with a real number. So I can't even explain to you what the \$380 was.

What we did is we went back to the carriers who had bid, and we said sharpen your pencils, and let's have some exchange of information. What are you assuming when you put in your bid about the acuity of this population? What are you

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assuming about our ability to deliver a broad cross-section of risk to you, versus your worst nightmare, which as it so often happens in the individual market that you'll just get relatively sick people. And we had that exchange of information, we went back and forth. Some of those carriers lowered their bid significantly, but not from \$380 to \$175. I don't want to mislead anybody. But beyond that, we didn't pick all the carriers that bid.

Guess what? We picked the lower bidders. You know, big surprise. Not everybody has to pay the highest or the average price that in the end the seven carriers we picked were bidding. What they have to do is buy a plan, a plan that meets a certain standard. So we very appropriately focused on what is the lowest cost plan available to you in your area for the average uninsured individual, who is a 37 male in Massachusetts, what would be the price you would have to pay to get coverage? And that's the \$175. So it's a combination of exchange of information and negotiation, sharpening pencils, selecting from among the carriers that bid, the seven we wanted, and then recognizing that if you want - and our market research says 94-percent of these buyers will buy on price, they're probably going to buy a lower-priced plan among a spread of options.

**LARRY LEVITT:** Well, we were ready to anoint you a

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miracle worker, but it sounds like maybe you just asked some good questions of the folks in the market.

**JON KINGSDALE:** [Laughs] There are no miracles in health insurance.

**LARRY LEVITT:** I want to move on. We have a lot of questions that have come in by e-mail and want to move on to a few of those. Let me start with this one from Georgia, and this questioner writes that Blue Cross Blue Shield of New Hampshire recently announced a product that it is making available there called Tonic. It is designed for younger policyholders and has a monthly premium of \$130 for a 19-year-old. This compares very favorably with the recent public information on the second round Connector plan bids with the only plan available under \$200 having only 14 physicians in Greater Boston. The plan has a lower deductible, \$1,500 versus \$2,000. Wouldn't this lead one to believe that the power of the open market to control costs is greater than the government through plans like the Connector?

And Karen, let me start with you. This plan, Tonic, I think, is available not just in New Hampshire but elsewhere as well. And how do you think about when you're comparing a plan like Tonic and these market rates and what those might mean in a system where you have universal coverage and everyone's in the market?

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**KAREN POLLITZ:** Well, it's a great question, because health insurance is a word that means a bunch of different things. And Massachusetts is going to be the case that when you say health insurance, you know what it means, because the state has required this is what health insurance has to cover. In most states, that's not the case, so comparing Tonic to what will be sold in Massachusetts or what you would get at work is kind of like comparing a roller skate to a car. The roller skate's cheaper, but I wouldn't want to drive it to Chicago. I just wouldn't. And I haven't looked at the policy that they're selling in New Hampshire.

I have looked at the Tonic policy that's sold in other states and the one that I've looked at covers I believe four doctor visits a year, that's it. It doesn't cover maternity, doesn't cover mental health, doesn't cover rehab, doesn't cover prescription drugs, and so there's a bunch of stuff that isn't covered. And that's all fine if you're marketing at a young and healthy customer base, which is what Tonic is trying to sell to. But if you come down with cancer, you're going to go broke if you have that policy. So you're going to pay out of pocket for most of your cancer care, plus you will have paid the \$100 a month in the premium. So will have paid a premium for the price of still going medically bankrupt. So that's the difference.

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**LARRY LEVITT:** And Ed Haislmaier, in your vision, what level of standardization should -?

**ED HAISLMAIER:** Yeah, I think this is a difficult area, because the temptation is to over-standardize and you really want to avoid that, because it's important to have innovation in plan design as well as innovation in the medical care. I think we have a certain amount of standardization there already. I mean what we're really talking about is major medical insurance. Okay, now yes, Karen's right, different states will define that differently. But we do have some reference points for that in statute. Part of it is defining what is not major medical. That certain things like that the medical liability on your auto insurance, or limited disease or hospital only, or things like that, that's not, clearly, what we're talking about.

So in a state drafting this sort of thing, you can exclude a lot of that and you can really focus it. I think a good standard is what we have in federal law for what constitutes credible coverage under HIPAA. So it's not hard to work with these standards. You might adjust them somewhat. Clearly, you don't want people to face catastrophic expenses, etc. You just have to be sure that you don't over-standardize it to the point where you lose the benefits of flexibility. Because the thing to remember is different people have

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different preferences. And Jon was talking about how some of the target, 96-percent of them are going to be buying on price, and you know that's probably true for the first year or two. But then as people go on in the system, what we find is that price is only one consideration.

There are other considerations in there. The benefits, the form of the policy. I'm pretty agnostic when it comes to things like an HMO or a PPO or an HSA, because different people have different risk tolerances. If you're the kind of person who, when you go to buy a refrigerator or an appliance and they offer you the extended warrantee, if you take the extended warrantee, you probably want an HMO. If you tend to not take the extended warrantee, you may be more likely to buy an HSA. These are people's personal preferences. The nice thing about a consumer-driven market is you move away from a system where it's just cost, cost to cost as the decision element, and more of these things come into play. And we see that in federal employee benefits program and things like that.

The other point, just very briefly, and this is very important for other states looking at this is - I am constantly telling states, you're not doing Massachusetts. You may do your variation of the same basic approach, but you have to remember that a lot of what Massachusetts did is very specific to Massachusetts. And each state has its own problems and its

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own strengths and weaknesses. So for example, when you're comparing premiums, you have to recognize that one of the big problems they're going to find in Massachusetts, I think Jon would agree with this, is they've got among the highest underlying cost of care in the country. So that's just the docs and hospitals. So that's a very different issue. The hospital system is much less competitive than say, in the Northwest, in Washington or California. Those are just issues you have to deal with. So it's a little difficult to compare on a premium basis from state to state.

**LARRY LEVITT:** And Jon Kingsdale, let me ask you, aside from the question of the cost in Massachusetts, which you may or may not want to talk about, would a plan like Tonic, to the extent you're familiar with it, be something that people could buy in Massachusetts, or would the requirements you are setting out prohibit a plan like that?

**JON KINGSDALE:** Well, I'd like to make a couple of comments on it. So let me take your question first, but there's some additional assumptions in the questioner's question that I want to address. Tonic, as I understand it, not only has limitations, and I don't know of the New Hampshire underwriting rules, but in California, the primary reason that it's inexpensive, and it can be half of that \$130 in California, it it's medically underwritten. And I have friends

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in their 20s who have had allergies, mild allergies. They can't get Tonic. So you really need to look at value and availability when you want to compare price.

**LARRY LEVITT:** And is that Jon - I'm sorry to stop you, but just to clarify, and I don't think we set this out in the beginning. In Massachusetts, in addition to creating to the Connector, there are also insurance market rules that would prohibit medical underwriting.

**JON KINGSDALE:** Right, absolutely. And by the way, I agree with Ed about choice. I'm not saying Tonic is a bad policy. Tonic is fine, it's nice cheap insurance that gives some level of coverage if you happen to be pretty healthy. So it's fine for healthy people. It is not a solution to get most people health security. And that's what we're trying to do in Massachusetts. So it's a solution to a need that some folks in the market have, not a solution to the policy issue we're trying to deal with here.

But the other issue that's very very important, and the questioner really is off the mark here, and I want to speak directly to it - is this is market solution. We are setting up a shopping mall for insurance. Even the subsidized program creates competition between the plans to bid for access to our population and then additional compensation, organized market with 28 different choices of plan. Some people think it's too

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confusing, too much choice, of plans who we're going to standardize them to the extent that you don't have to read a 100 page EOC to find out that one plan covers 20 PT visits, and another plan covers 23 physical therapy visits. Because who cares about that? We're going to take some of that stuff out and allow consumers to focus on the six primary variables: price, cost sharing, network, drug formulary, which hospitals are in, those kind of important critical shopping variables. Because if you went shopping for a car, and you had to read a 100-page manual on the engine in order to figure out whether it runs, that's not a shopping experience. That's a legal exam. So I really want to be clear. This is very much market organized and competitive-driven, choice-focused reform.

**LARRY LEVITT:** Jon, let me stay with you for a second on that issue. We've got a lot of e-mails about why not expand Medicare to cover everyone, why not embrace a universal single payer system as in an e-mail from Washington state? I just want to get all your views on this issue, and I'll read one other e-mail. The e-mailer writes, "Excessive overhead related to the complexity of provider billing and collections and the insurance overhead and profit. Despite highly competitive insurance markets in the U.S. and highest out-of-pocket costs among OECD countries, we have not achieved better cost control or better quality of care or affordability of insurance. What

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evidence is there that the Connector as a regulated market will change the situation? What value does a myriad of insurers bring to the consumer?"

And Jon, I just want to stay with you to speak to that. I mean, stepping back a little bit - the idea, you talked about this being market driven. What, in your view, is the value of that kind of market-driven system over Medicare or a single payer system?

**JON KINGSDALE:** Well, first of all, I want to actually deny that despite that strong statement about how this reform works, that I would object to a single payer. I mean, it's probably shuddering, but there's a lot to recommend a single payer system. There's a lot of problems with a single payer system. Just like there's a lot to recommend a competitive market-driven system, and there are problems with it. You know, anybody who thinks one is the nirvana I think is just being a little bit naïve. So certainly, one of the advantages of centralized manufacturing in the Soviet Union or a single universal health plan is it's a lot more efficient, it's a lot clearer, you don't have the marketing costs, you don't have to regulate the market, and there are lots of advantages to it. There are real problems with it as well, and I don't think you want me to go into all those, but I'd be happy to if you want to.

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**LARRY LEVITT:** Well, we've got several hours, don't you?

**JON KINGSDALE:** Yeah, right. But you know, when it comes down to it, I'm feeling with what is, and I want to move from what is to something really much better. And we've been waiting for 70 years for national health insurance. We in Massachusetts are tired of waiting for national health insurance. We want to get almost everybody, if not everybody here, insured. I mean, there are 60,000 people in Massachusetts since November 1<sup>st</sup> who are newly insured, they have doctors. They have awful chronic diseases that they didn't know they had for the last three years because they haven't had a primary care visit. I want to move from 5-percent uninsured to less than 1-percent uninsured, and if I have to wait for a national health insurance plan to do it, I'll be dead before it happens.

So it's very important, I think, to recognize that improving significantly what we have is a real significant event. We had bids for our subsidized health plans. We took 15-percent out of those bids through competition. Now we have people who eligible, 60,000, they are picking among those plans. They have to think very carefully if they want to pick anything but the lower price of the four plans, because they have to pay the incremental premium for it. Some of them do,

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and that's their choice, and that's great.

By the way, there's a whole lot more than 14 doctors in that low-priced plan in Boston - that's totally wrong, I don't know where that came from. We've got seven options on the table now for the private insurance plans in our Commonwealth Choice shopping mall. Folks are going to pick on price as well as on network, and they are going to drive those health plans to bid even more aggressively next year to stay on the shelf. And I think there's a lot of value in that, because when you look at the alternatives in a highly politicized democracy such as ours, you depend on a single government agency to make wise choices and to cut costs for all of us. That's a tough challenge to lay before a bureaucracy, and it's not without its pitfalls. I actually find the market works better in that respect.

**LARRY LEVITT:** Ed, let me ask you. What would you say to a critic that says isn't a market system with multiple insurers just inefficient, that there's a more efficient way of doing it?

**ED HAISLMAIER:** Well, the answer is - first off, the question of whether it really is inefficient, and if it's structured the right way, it doesn't necessarily have to be. I think the point is you can structure a single-payer system in a number of different ways. I mean, the Canadian system and the

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British system, they're very different just like the VA and the Medicare system in this country are very different. Similarly, you can structure a market different ways. I think it's a measure of how dysfunctional our market is that people would consider a single government alternative as somehow superior. I mean, as bad as Detroit is with cars, I have yet to hear anybody say, well, we just ought to do away with them and nationalize and have one U.S. auto company to make cars. But people do say that in health care. What happens with these systems is they operate according to incentives and rules. And that's true whether it's a government run system or a market system.

So the question you have to ask is, are the rules and the incentives going to get you where you want to go? In other words, is the insurance company going to make money by investing in preventive care and keeping you healthy and keeping you out of the hospital, or are they going to make money by avoiding treating you? What do they do? Because in too much of the system today, and this is true in a national health system, the easiest way to save money is don't treat people. And the second easiest way is if you have to treat them, don't pay the provider. I mean, we run these programs in this country, we call it Medicaid. And I talk to state law makers and I say, I've got data that shows that the Medicaid

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population uses the emergency room at twice the rate of uninsured and five times the rate of the private insured and why? Well, in large measure because you pay providers so little that there's nobody else for them to go to. Now, have you really saved anything? What is your incentive here? Are you really getting where you want to go? That's the whole point.

A fellow that worked for PriceWaterhouse or one of those consulting firms and he did health care and he was in Britain and he was sitting with people running a national health service hospital and showing them how they could improve patient throughput, how you could get more people in, treat them, get them out quicker. And then he suddenly about halfway through, stopped and the guy said, but why would I want that? I live under a global budget. That just uses up my budget. So the incentive is not to treat people. So it doesn't matter whether there's a market - and the data is pretty clear.

The data - Brent James from the University of [inaudible] was saying this is the same in systems with single payer. They're wasting half their money too on things that don't work or are downright harmful.

**LARRY LEVITT:** The question is, how do you get rid of that?

**ED HAISLMAIER:** So how do you get the right incentive?

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That's what you're looking at in this. One of the interesting things that we do see consumer choice markets, we see some things that do tend to work in that direction. So for example, in the federal employee health benefits program, which is sort of a model for this and runs the same way, it's a large employer plan, but people get to pick once a year. And the government doesn't really standardize the benefits, it just has real insurance plans come in there, and the same companies, and offer benefits. Well, not only does it control costs, but what we find is that only 11-percent of people switch every year. And it's not the same 11-percent. What happens is people will switch and then they'll find a plan that they like and then they stay with it. So when you're talking about things like the incentive for a plan to invest up front in preventative care, well, why do that if the employer is going to replace you with somebody else next year, and the employees don't have any say in it?

**LARRY LEVITT:** And employees are moving from job to job to job.

**ED HAISLMAIER:** Right, right. And you have that, and so you actually tend to have people stay with a plan much longer in a system where they get to choose what they want. Now that's aligning the incentives to say look, this plan is working for the benefit of the subscriber.

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And the other thing I say to doctors and hospitals as well as the insurers - I say, right now, you have this business where you sort of club each other. The insurer says well, I'm going to get 100,000 people and you're just going to have to take my rate or I'll cut you out of my network. And these people are like sheep, they can't go to that doctor or hospital. Well, if you're in a situation where they can say like they will be able to in Massachusetts, well, wait a minute, if you do that, I really like that doctor or hospital, I think I'll switch to a different insurer, then the insurers and the doctors and hospitals have to get a lot more reasonable. Because on the doctor and hospital side, the insurer can say well, yeah, you can go there but it's going to cost you extra because they charge more and they're not delivering demonstrably any better than somebody else. So I think all of that works to the benefit of the consumer.

**LARRY LEVITT:** Karen, let me ask you - as it talks about aligning the incentives, what in your view is the - it's a hard thing to disagree with, I think - but what, in your view, is the right way to do that in a reform system?

**KAREN POLLITZ:** Well, either way, there needs to be a wise and considered role for government, whether we're just going to have government provided health care or we're just going to have a market. In the other markets that Ed has drawn

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an analogy to, whether you're buying tomatoes or cars, I mean, we have lemon laws, we don't give people the choice of buying a car that doesn't run and we penalize someone that tries to do that, or a tomato that will poison you if you put it in your sauce. So we need to make sure that the market is operating within permissible bounds, if we're going to have it that way or that the government program is working that way.

We also have to remember this is not like these other products. When you buy a tomato, you bring it home, it's a tomato, you eat it that day, it's done. Health insurance you buy today in case next week or next month or next year you get hit by a car, or you find a lump in the shower. So you're buying something today to protect you from something in the future, and you don't know what it is, and you don't know how much protection you will need. So I might feel okay if I'm feeling really good today about buying a policy that doesn't have prescription drugs, because I'm not taking any prescription drugs so I feel pretty good about that. And I used to feel pretty good about that before I got cancer and I had no idea what prescription drugs cost until I got cancer. They are expensive, and you really need them. You can't get through a treatment without them.

And I didn't know that as a 35-year-old woman. I really had no concept of that until it hit me. And I don't

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think we want this kind of buyer beware - oh, well, you picked the cheap plan with the crummy drug policy and the limited formulary and now you'll just have to die in chemotherapy because you can't get through it. So I think we want some of those - if the primary purpose of health insurance is to pay your bills, then we want to make sure that whatever your choices are, they're going to pay your bills. These other things that we want to achieve from our health care system are absolutely important. We want more efficiency in health care, we want better quality, we want people to get to doctors who really take good care of them and treat them like people, and we need all of those things. It's not at all clear to me that we can achieve all of that using just the tool of health insurance and how we design policies and who gets it. That's just the beginning.

So I think we need to take a broader look, and make sure that health insurance does what it's supposed to do, which is pay your bills when you get sick, and then continue to address these other incredibly important issues through the way we train doctors, through public health, through prevention, through better nutrition, all kinds of things that we are going to do better - better research, better outcomes measures. That needs to get brought into bear regardless of what our system is. That's important for Medicare, that's important for people

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in the private market.

**LARRY LEVITT:** And Ed, and set a minimum standard so you think is reasonable.

**ED HAISLMAIER:** Yeah, I don't disagree with any of that. And the thing that is, I think, very good about the states doing this, and the more I travel around and work with the states, is there's a huge different not just in the geography but in the demographics. There's some states I'm working with that are very rural. They have issues Massachusetts didn't. I mentioned how Massachusetts has certain issues that those states didn't have. There's demographics, how your system is organized, how the money flows, the politics, all of this. And so this does give the opportunity for states to do different variants. I mean, my rule of thumb is yes, the government's there to set the rules, that is the proper function of government. As in any area, you just want them to do the least necessary. Don't over-engineer the rules, always try to make sure that you've covered all the possibilities, but do it in as predictable and streamlined a fashion as you can.

So for example, the federal employee benefits program, they only require coverage in basic categories, they don't spell out in great detail. Everybody has quality insurance in there and all the products cover catastrophic, they all cover

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drugs, et cetera. I would say that you have to cover docs, hospitals, inpatient, outpatient, drugs, mental health, and you can't do anything egregious like exclude a particular disease or something like that or have caps or something like that. Beyond that, I'm not sure how much specificity you need. Now, different states will do it differently. And there are trade-offs and that's the point that I make to states. One of the points that I made about Massachusetts is Massachusetts already came at this with fairly comprehensive standardization of benefits, with guaranteed issue and fairly tight community rating. Now, for whatever reasons relating to Massachusetts, they weren't going to move away from that too much. Well that's fine, but there's a trade-off. And the trade-off is that the issue of consumer market where people pick between plan A and plan B and plan C and D and then the plans are worried that they might somehow disproportionately get sick people. That's less of an issue with that kind of market because there's more standardization. So you don't really have to deal with some of the risk adjustment as much, and they didn't in Massachusetts.

The flip side is that you really have to make the young healthy people buy it, because they've overpriced the product, just because of the rating rules. So if a state does a different variation in rating, they're going to have to maybe

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have less forcing people in and more trying to adjust for risk.

**LARRY LEVITT:** Let me pick up on that issue of states and recognize that we are co-sponsoring this with the National Governors Association Center for Best Practices. We got a number of e-mails about the role of states versus the federal government, and one in particular was, how can truly comprehensive health reform be accomplished at the state level without waivers from the federal government? And that was from Washington state. Let me turn to Jon for a moment. Jon - this was a state-based reform, but you didn't do it without the federal government. What kind of help did you need from the feds to make this work?

**JON KINGSDALE:** Well, we needed financial and political help. Finances I think have been well reported that our Medicaid waiver, which covers a multitude of programs, and specifically close to \$400 million dollars a year in federal subsidies for our free care safety net program was in jeopardy and we were going to have it taken away as some states, including California, already have, if we didn't reform the way we were providing a security net for the uninsured. And this reform is very much focused on trying to move people who are income eligible and uninsured from massive block grants to safety net hospitals to give them episodic care into an insurance model where individuals pick a plan, pick a primary

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care physician, and the money follows them and their choice rather than large multi-multi million dollar grants in effect to large institutions to take care of the folks who happen to show up in their emergency or for hospitalization. So that was one way.

But it's important to realize, I think - and I stress this whenever I talk to folks from other states - it took three years for us to work this out, and I am convinced we would not have worked it out other than but for the embarrassment and the financial loss of not coming up with a plan that would keep that \$385 million dollars a year coming to the state from Washington, D.C. I can't emphasize how important the politics of not letting people just retreat to their second favorite plan, which is the status quo. So federal role is critical and it continues to be, because we operate under a waiver from CMS that has to be renewed.

**LARRY LEVITT:** And do you feel confident you can - I'm guessing the answer is yes - but do you feel confident you can sustain this at the state level, even if other states don't move ahead?

**JON KINGSDALE:** Yes, I do. Will there be some 21-year-old graduating from college who decides, to heck with this universal participant obligation here and I'm weighing two job offers, and I'm going to go out West or move somewhere else to

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avoid this? There probably will be a few of those. But so be it. For the most part, I think that this actually will - 95-percent of the people in Massachusetts currently have insurance, 94-percent before we started this reform. Most working folks look for insurance from their employer as an essential piece of the compensation package, and most employers find that if they can at all afford it, it's absolutely critical to attract and retain labor to offer insurance. So this is really only bringing the last 4- or 5-percent in. And of course, that's a critical difference when you look at a Texas or a California or even the national average state, with three times the uninsured level that we have. It's a much bigger challenge to get most of them insured than we face. So we're blessed with starting from a higher base, and that's not an accident. This is a state that's very reform-minded. After all, we did once before under Governor Dukakis pass universal health insurance, so it's not a foreign concept here.

As Ed mentioned, we've got a lot of market reforms, we've got a very tight rating band, so the oldest, sickest individuals cannot pay more than twice what the youngest, healthiest pay for the same policy under our rating rules. It's guaranteed issue, it's guaranteed renewal. So there's a lot to build on already in place.

**LARRY LEVITT:** And Jon mentioned the idea of

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Massachusetts starting at a fairly high level, higher than most other states. We got an e-mail from Kansas, also a state with a relatively modest number of uninsured compared to the national average. But this person also asked about the underinsured, and how the development of these state plans may uncover or are they uncovering large numbers of underinsured and is there a method through which states could make an estimate about the number of underinsured and how significant this population may be when developing a state health plan. Karen, let me ask you. How do we think about this? I mean, our main way of counting the uninsured is through Census, CPS data, that doesn't differentiate between what type of insurance people have. If the state is starting the process of putting together a plan like that, how do you think of people who are not just uninsured versus insured but underinsured as well?

**KAREN POLLITZ:** Well, it is a hard thing to measure, the underinsured, and there are some very smart people who've tried, and no one's come up with an exact number. Again, I think you need to go back to what is insurance for, this is in case we get sick. And as a rule-of-thumb way of evaluating whether insurance is good, you should line it up to a scenario where something really serious happens. So how much of your bill would this policy pay for if you found out you had breast cancer, or if you had diabetes, or if you had a heart attack,

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or if you got hit by a car. And those aren't so difficult to construct those scenarios. They don't have to be perfect. You can just ask a doctor what do you do for somebody who has breast cancer and make your little shopping list and then price it out on some fee schedule, it's all going to vary, but use Medicare's fees as a decent proxy.

**ED HAISLMAIER:** [Inaudible]

**KAREN POLLITZ:** Yeah, but you know. But one, okay?

**ED HAISLMAIER:** No, I mean, some of them you can treat with drugs, and some you don't.

**KAREN POLLITZ:** Right, so just pick one. Because again, back to my premise, you don't know what you're going to need this for. So pick something that's not too mild, and then hold it up. There are measures out there today about people who are spending more than a certain percentage of their income on out of pocket medical costs who have health insurance, and it's really scary. That number is going up. That and people are paying 10-, 15- or 30-percent of their income on their out-of-pocket medical bills because their insurance doesn't cover mental health, and they've got a kid with a really scary eating disorder, or because it doesn't cover drugs and they've got cancer, because it doesn't have an out of pocket limit on your cost sharing, and they have diabetes, and they don't have one big bill, but they have a bunch of little bills that just

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happen day after day after day after day - it never stops, and it adds up. I think you also have to look at health insurance. We buy health insurance one year at a time, which is so funny. I mean, we don't buy toothpaste one squeeze at a time, but we buy health insurance in these little kind of artificial increments, and most things that can happen to you will take longer than a year. A nine-month pregnancy, chances are that's going to land in two policy years, just the odds are. So you can't just look at what your out of pocket costs will be this year, it's what will your out of pocket costs be over the whole episode of care that you need. So I think we could begin to develop those measures. We really don't have them now, getting back to what does it take to make a market work, that's a very difficult thing to figure out, and if we could get policies, or high risk pools or the Medicaid program or whatever, to hold up that metric and say well, if you had diabetes and it looked like this kind of case, this would cover 40-percent of your bills versus 90-percent of your bills. That would be really helpful.

**ED HAISLMAIER:** Yeah, a couple of points on that I'm not sure - first of all, if you have the right innovation, you'll move in that direction anyway. One of the interesting things, for example, Switzerland has a similar system that Professor Herschlinger at Harvard Business School talks about

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it a lot, of universal required individual insurance. In fact, they just voted down the idea of single payer by about three to one. But they've developed five year plans where it is very comprehensive, it covers everything, and you go in and they actually do a personal workup and then you have goals that you work with them to meet on your health and staying healthy and getting healthier over the next five years. And depending upon how you come out at the end, you get large chunks of the premium back. Because what they're doing, they're using their expertise, sharing with you, to help you control the cost.

I think the other thing that's important to think about this whenever you're talking about subsidizing people is, Karen's right, you have to look at that total picture. But you have to do it without the bias to saying that somehow out of pocket is bad. Yes, it's part of the total picture. The question of whether you pay directly or you pay through insurance is to me, I'm agnostic on that question. Does it make sense? If it makes sense to do it one way, fine, if it makes sense to do it the other way. What I very definitely would like to see is that if you're essentially going to subsidize it, then you should be even in doing that. You shouldn't tilt the playing field one way or another.

**LARRY LEVITT:** In other words, you should be neutral in subsidizing premiums versus [inaudible].

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**ED HAISLMAIER:** Right, and in fact, I wrote tax credit legislation like that years ago in Congress, which is to say that the size of your subsidy would be related to the share of your income you had to spend on the total, out of pocket and insurance. Because we're going to find that it's oftentimes more efficient to buy some of this stuff out of pocket than to go through insurance. But again, you want a system where that happens for the people. I'll give you a good example of this.

Nutritional counseling for diabetes in Medicare, in this rule-driven, the patient's off there in the corner kind of world, and it's just a plan - whether it's a government or private it doesn't matter - the plan versus the provider. It says well, we'll pay for 12 hours. Well, this is nuts. If there's somebody who's a diabetic and I know them, who are motivated to control their diabetes through diet and not have to have expensive medical care, for heaven's sake, we ought to subsidize them to have more nutritional counseling. And if there's somebody that's not motivated, then that 12 hours is a total waste. But this is a provider-oriented system and that's when you need to move to more of a consumer-oriented systems. In terms of the numbers very quickly, a number of states have looked at - because a lot of the data is wrong, and we know that - have looked at doing their own sort of analysis. We know that nationally, it looks like the Census data

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overestimates the number of uninsured and underestimates for example the number of Medicaid recipients by about 10- to 20-percent, and that's been confirmed by a number of states. So a number of states have looked at doing their own, and I think some have also gotten at some of these other measures of well, is this really major medical.

And then, finally, there are clearly some cases where we know that are people who are getting care but who are not "insured." I mean, a number of states I worked in out West, their big problem is the Indian Health Service. Now, that's not insurance, it's a health care delivery system. But it's in theory 100-percent federally funded, but the reality is those people don't get what they need so they have to get it elsewhere, and oftentimes the state winds up picking up part of the cost through Medicaid. So it's clear that there are these people out there that have "something," but it's clearly not adequate.

**LARRY LEVITT:** And let me ask you - amazingly enough, we're nearing the end of the hour. As you talked about, you were talking to folks around the country, a lot of different states. Massachusetts, which I know you've written about as well, many people have pointed to that as an example of where left and right can join together, and Jon Kingsdale talked about everyone coming together around a consensus. Is that a

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political model that you see that can work in other states or is it [inaudible].

**ED HAISLMAIER:** Oh, absolutely. And I tell people this all the time when I work with the states. I say, look, when I go in there, it doesn't matter if you're the governor, or one of the governor's appointees or a legislator. It doesn't matter, pretty much, what state you're in. And it doesn't matter if you're a Republican or Democrat or liberal or conservative. Your world looks like this. You have a state budget that in most cases you have to balance, and it's got three things in it, health spending, education spending and everything else. And the first one is eating the other two.

So the promise of what Massachusetts is doing, both the piece about reforming the insurance market, which any states could go on and start working on without federal assistance, and then the other piece, which is reforming the subsidies to say we're going to move from subsidizing providers to treat people that we haven't been able to figure out how to cover to using that money to buy people coverage. Okay, you do need federal waivers for that, but each of those pieces has a great deal of attraction to law makers at the state level, regardless of where they sit or what their party or ideology is, simply because it's saying look - here are some creative ways to try to do more with what you've got today in terms of resources and

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programs. The tools you have. The insurance piece, you regulate insurance. You don't have to ask the feds for permission. You can change your market, you can create one of these connectors. The money there, in many cases, you have some control or with the feds with a waiver you can do something.

Now, each state will be different. I mean, states like Massachusetts, Louisiana, they've got all the money in one place. Some states, I was in Montana, you know, it's not in the public money, it's in private cost shifting, but the cost is there. In Maryland, I was in there. They've got an all-payer hospital rate-setting system they've had from the '70s. They're very proud of it. Again, it's a state that could a lot, but their sticking point is that there's a sacred cow, this hospital rate setting commission, sitting on the money. You've got to move the cow off the money if you're going to get something done. So each state has these issues, but it's not really partisan. It's interest group, absolutely. Some of it's personal politics, you know, so and so wants to run for governor or this or that. But my impression has been - in Washington State, they had the Democrat chair of the committee and the Republican ranking member of the health committee, they each wrote two different bills on the same model, and then now they've compromised them. So yeah, you can do that.

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**LARRY LEVITT:** And Karen, you've worked at the federal level, you've spent a lot of time talking to states. Do you sense momentum happening now at the state level?

**KAREN POLLITZ:** Oh, absolutely. And I hope when Jon's done cleaning things up in Massachusetts, maybe he'll run for Congress and come here and tell us how he did it all. If you have any energy left after that. So I do think there's a lot of great creativity going on in states, and I actually live in Maryland and I was on the board of our high risk pool for a couple of years and spent some time in Annapolis. There's some fabulous people who are really devoted to making change and willing to put themselves on the line to do that. And that hospital rate setting system is very nifty, don't say bad things about it.

**ED HAISLMAIER:** Well, basically that's where the money it.

**KAREN POLLITZ:** Well, but going to the money - I think it's great that states are waking us up again, or kind of perennial - it's time to wake up to do something about our health care system. At the end of the day, though, I do think we're a nation and being sick is awful wherever you are, and we all want to be safe when that happens and the money is in different places. Massachusetts is always going to have more money than Alabama will, they just are. And at some point as a

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nation, we need to say this is important and this is the right and the moral thing to do, and make sure that this can happen everywhere. So I think there's also an important role for the federal government, and I hope soon they will step up to that.

**ED HAISLMAIER:** And I think they are. I certainly hear this in Congress, again on a very bipartisan basis. I mean it's interesting that President Bush, in the State of the Union, proposed tackling the tax treatment of health care, which is the single biggest subsidy in health care right now, and it's very perverse because it gives more money to people who earn more, and less to people - He proposed tackling that. Now that's something presidents have shied away from.

Including this one - he had an opportunity, I mean, he was being pushed on the tax reform commission a couple of years to tackle and he didn't push it. He dropped it then. Now he comes out and does it. And when you look at that, and what Senator Ron Wyden, the Democrat from Oregon, is proposing, they're different, but they're in the same ballpark.

**JON KINGSDALE:** Larry?

**LARRY LEVITT:** Jon, I want a word -

**ED HAISLMAIER:** I think it's because states are moving that that's happening.

**LARRY LEVITT:** We are over our time, and I want to give you a final word. Jon, let me just ask you one quick question

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- you've talked about some of the recent news coming out of Massachusetts and some of your recent decisions, and one of those was to delay a bit the mandate that people buy insurance meeting minimum requirements, and there's been some concern raised about that about whether it raises questions about the sustainability of the plan.

**JON KINGSDALE:** I'm glad you asked me about that, because I want to clear that up. You know, among the myriad of details that the legislature didn't have to and shouldn't have grappled with is the timing of phasing all these things in, and I've got 25 years of experience of health insurance and I didn't think about this until two months ago which is - people sign up mainly through their employer. Their employers have open enrollment, depending on which employer, every month of the year, and then you are in a plan for 12 months. So what we did is we said as of July 1, 2007, everybody has to have a plan. The mandate is not delayed, it goes into effect in less than 100 days. What we also said was that the people who get punished for not having minimum creditable coverage, which is what we call it, are the taxpayers, the employees. There is no mandate on employers. There is no mandate on health plans. There is a mandate and a tax penalty on individuals for not having minimum creditable coverage. So that means that somebody who is offered non-compliant plan on July 1, because

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his employer found out on June 14 when we finalized the regs that that's what we wanted, and he's already had his open enrollment in May, that worker on July 1 would be the one who gets penalized, because his employer didn't meet our standards. So what we said is starting at the end of 2007, four to five months after our plan regs are finalized, employers should start complying. We hope they will, we can't force them, we hope they will, so that employees as early as February 1, 2008 will have to enroll in a minimum creditable coverage compliant plan in order when the last month of their 12-month enrollment, which is in that example January of 2009, when that 12<sup>th</sup> month comes around, they will have chosen a plan back in February of '08 that is MCC compliant, because on January 1, 2009, across the board, no matter where you are in your annual sign up year, the minimum creditable coverage new higher unprecedented standards.

Nowhere else in the country are there standards like this. Those standards would go into effect the very first day of 2009, and they will catch anybody who didn't make a decision as early as February 1, 2008 to enroll in an MCC complaint plan. So I hope that's really crystal clear. This is not delayed, we are totally on track.

[END RECORDING]

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