

**Elements of State Health Reform:  
Individual and Employer Requirements - Part 1  
NGA Center for Best Practices  
April 17, 2007**

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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 Governors Association. These interactive web shows look at the 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. Today we are looking at state initiatives to require individuals or employers to pay for health insurance as a tool for expanding coverage. Many of you in individual mandate is the only way to guarantee universal coverage and with employers already covering the bulk of Americans, it is not surprising that some states are looking to business as a source of financing for extended coverage, yet such requirements have triggered opposition on both philosophical and fiscal grounds and there is legal uncertainty over whether states are able under the federal ERISA law to impose financial requirements on employers related to health coverage.

I'm joined by a panel of state and national experts to look at various approaches for achieving universal or near universal coverage. Mike Smith is secretary of administration for the state of Vermont, which is aiming to cover at least 96% of the population through its catamount health plan. Richard

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Figueroa is a health care advisor to California Governor Arnold Schwarzenegger and a long time leader on health issues in Sacramento where he is joining us by phone. Phyllis Borzi is a research professor at George Washington University, after serving for 16 years on Capitol Hill. She is widely recognized as one of the nation's top legal experts on ERISA. You can reach our panel by e-mailing your questions at any time during the show to [ask@kaisernetwork.org](mailto:ask@kaisernetwork.org) and thanks to all of you for joining us. Mike Smith, who is joining us by phone from Vermont, let's start with you.

**MICHAEL SMITH, M.A.:** Okay.

**LARRY LEVITT:** So your aim is to get at universal or near universal coverage in Vermont but not necessarily within individual mandate, go through the main elements or the main building blocks of getting to expanded coverage there.

**MICHAEL SMITH, M.A.:** Sure, when we looked at this we sort of put this in a comprehensive package to look at how do you increase access or near, as you say near universal access, how do we contain costs and how we improve quality, and although there are a lot of elements in the legislation that we passed to look at a comprehensive package, two of them I would like to focus. One is called the "Catamount Health Plan" which is a comprehensive health care plan that is based upon sort of an average comprehensive plan here in Vermont and what we do,

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we finance it through several mechanisms including increased cigarette tax, the employer assessment and I will get into that a little bit later, and premiums from the people who access this. In Vermont, we have basically just under 10% uninsured so we have about 62,000. What we found is about half of those are eligible for medicaid so we are going to do an outreach program. The others, about half of those that are remaining, are between 150 to 300% federal poverty level so we really focused in on there and devised an affordable plan with the revenues that I talked about that really gives a comprehensive package. Now, we shied away from the individual mandate and let me tell you the reason why. We looked at it and it is still an option if we don't get to 96% participation or people insured in Vermont, but when we looked at it we thought well, right now in Vermont we have people who are required to have automobile insurance and yet what we have found was that we haven't had a 10% non-participation rate or non-coverage rate with automobile insurance, even though we have a mandated requirement to have automobile insurance, we still don't have everybody that does it, so we wanted to try sort of this way of an outreach program to capture those people. On the employer assessment, basically what it says is that if you don't cover employees then you are assessed a buck a day, about \$365 dollars a year, for each employee that you don't have coverage

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for so that in a nutshell is what we have done in Vermont and that is really quickly a real quick snapshot focusing on the two areas that you talked about.

**LARRY LEVITT:** Let me come back to the individual mandates, so you don't require people to buy coverage but you do have subsidies to make it more affordable for those folks up to 300% poverty?

**MICHAEL SMITH, M.A.:** That is exactly right and there are two types of subsidies that we do have. You are subsidized depending on your income from basically 150 to 300%. We have expanded medicaid here in Vermont so the target population we were trying to get at is above that expanded medicaid population that we have here from 150 to 300% so we have incentives and pretty good incentives in order to if you are uninsured to join catamount health in terms of premium assistance. We also have premium assistance that if you have access to your employer sponsored insurance, we will subsidize that as well if you are uninsured right now and need assistance to get on to your employer sponsored insurance. We make the calculation which is cheaper for the state for you to be on the employer sponsored insurance as long as it is similar coverage or the catamount health plan.

**LARRY LEVITT:** And to you, one of the arguments people make for an individual mandate is that it allows you to do

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insurance market reforms, allows you to require insurers to guarantee issue coverage, to do so without health status rating and you have those insurance market rules in place in Vermont. Are there any concerns that it will be difficult to sustain them without an individual mandate?

**MICHAEL SMITH, M.A.:** We don't think so but again we have this provision in our law that in 2010 we will revisit this to see where we are with the participation rate and see what needs to be adjusted including looking at the individual mandate but right now we think the approach and the subsidies that we are providing, for example if you are right about 150% poverty rate, federal poverty rate, we are estimating that your premium will be about \$60 dollars a month.

**LARRY LEVITT:** Got it and you mentioned the employer's assessment as part of the financing, a dollar a day or about \$365 dollars a year and that is obviously substantially less than the cost of insurance. I mean, that is a small fraction of cost of insurance, so this wasn't meant to give employers essentially an inducement to offer coverage but more to get some money into the system?

**MICHAEL SMITH, M.A.:** Yeah it was more dealing with how are we going to fund a system and we looked at several ways that we were going to fund this system. I mean, quite frankly we had another health care bill a year prior that had a payroll

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tax on it and we rejected this, in the administration we rejected it, and the reason we rejected it is because it punished good behavior. If you were providing insurance, you still got taxed. Under this new sort of assessment, if you are not providing insurance you get assessed so it rewards good behavior. It asks employers to do the right thing, and also what we found is that if we are going, we also exempted employers over a time period. It starts out with eight FTEs or less, then it goes down to six over the next couple of years and then it goes down to four where we will exempt really small operations from the requirements.

**LARRY LEVITT:** Let me bring Richard Figueroa from California in to this. Richard, Gov. Schwarzenegger proposed a plan earlier this year that has some similarities to Vermont but some key differences as well, go through quickly the building blocks, how you get to universal coverage which is what the governor has proposed.

**RICHARD FIGUEROA:** Great thanks, Larry, basically the governor's plan has three main elements, the first being prevention and wellness, you know, looking at just making health promotion disease prevention and wellness a priority both with both short term and longer term payoffs. The second element is coverage for all and within that we have what we call shared benefits and shared responsibilities between

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individuals, government, doctors and hospitals health plan, and employers, and the third kind of key elements affordability, knowing that over the long term in order to sustain the health care system we are going to have to do something to lower the large increases we are seeing on the cost side. Specifically on the coverage for all, we have about 6.5 million folks that are uninsured at some point during the year and in any given month about 4.8 million folks that are uninsured and we are proposing to expand coverage through the individual mandate but much as Vermont and Massachusetts have and other states have undertaken, to do so in a way that provides subsidies for lower income individuals so if we can be expanding our medicaid or Medi-Cal as we call it here in California program to cover all persons under 100% of the federal poverty level and have kind of a purchasing pool above that in terms of persons between 100 and 250% of the federal poverty level and that is about 1.2 million folks that would be eligible for that and then above the subsidy level that is kind of where the guaranteed individual mandate starts to really kick in in terms of people having to purchase in an unsubsidized manner and there will be about a million or so folks that will be purchasing we expect or opting toward employer sponsored coverage without a subsidy. We basically decided on the individual mandate because for us at least it is the most effective way to achieve universal

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coverage. Without it, we believe people will continue to voluntarily forego coverage and therefore shift uncompensated costs to insured individuals and we call that the hidden tax. We believe it is about 17 cents on every premium dollar as part of the hidden tax, a good portion of that, 10 cents or so of that 17 cents are associated with folks that voluntarily forego coverage or otherwise can't afford it, the other 7 cents being our dramatic rate of underpayment in terms of our medicaid program as part of what we are trying to do here is increase our medicaid reimbursement at the same time so that everyone isn't bearing the cost of that. We are asking individuals to pay, even for the subsidized portion either 3, 4, or 6% of their gross family income and then for folks [inaudible] individual mandate, we are endeavoring as much as Massachusetts did to set a minimum mandated benefit at a level that is reasonable. For us, we think it is about \$100 on average for the average uninsured person, which is probably an uninsured person between 30-34 years old. That is kind of how we set those price points. We are asking employers to pay some as well and we have exempted employers below ten employees from what we are calling a 4% employer fee which is basically 4% of social security payroll. We believe an employer sponsored coverage has been an important part of our health care system since World War II and will continue to be an important core

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element of any system of universal coverage. The 4% social security payroll is basically going to go into a special state fund to help subsidize lower wage employees and beyond just being a financial, necessary financial component to our overall cost of funding universal coverage program. It also kind of helps to some extent level the playing field between offering and not offering employers because we don't want to have elements in our plan that provide incentives for employers to drop coverage.

**LARRY LEVITT:** Let me follow up on that 4%, and it's 4% of payroll so just for sake of an example, if an employer has an average wage of let's say \$30,000 so that is \$1200 per employee, which is substantially more than what Massachusetts and Vermont have enacted but still less than the typical cost of insurance in the market place today, how did you arrive at that 4% number?

**RICHARD FIGUEROA:** The 4%, it isn't exactly a pay or play kind of situation because that 4% is going to go into a special fund that just subsidizes low wage workers. It was more recognition, trying to level the playing field a little bit and not making it so high that it would drive businesses from the state or otherwise invite ERISA challenges which I know Ms. Borzi is going to talk about a little bit. It is more recognition that they had a role to play if they were not

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offering employer and at the same time trying to set it high enough that employers are not going to drop coverage and the way we have kind of set this, just to give you an idea, an employer if they have to pay 4%, if they have all low wage workers that would be eligible for the subsidy, yes that may be an enticement for them but for the regular, the average employer that has a wide range of individuals employed in that, if they were to drop coverage in favor of the 4%, those higher wage individuals would then kind of be on their own in purchasing coverage in the private individual market. The low wage workers, albeit eligible for subsidy, will still be paying 3, 4, or 6% of the gross family income which is higher than many of them pay right now as their share of employer sponsored coverage so if an employer were to drop coverage in favor of the 4%, they are exposing both their middle to high income wage earners to go and basically purchasing coverage on their own and even their lower wage earners from paying more than they probably do right now for employer sponsored coverage so that employer is not going to be very popular with their employees and again most employers do offer even now in a voluntary market so we are very careful to set it at a rate where we didn't think we really would be enticing employers to drop coverage in favor of just paying the 4%.

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**LARRY LEVITT:** Let me ask you more about the individual mandate, first, also part of the governor's plan are a substantial set of insurance market reforms that guarantee access to coverage, eliminate health status rating among individuals and was the individual mandate key in your thinking to being able to do that?

**RICHARD FIGUEROA:** Correct. As we indicated before, shared benefits, share of responsibility, and on the insurer's side, yes they will have millions of more insured lives to which to market to and receive those revenues but they have a responsibility as well and that is to do, you know, guarantee issue. We really didn't believe that you can't have an individual mandate and then not have a place for people to go and we believe that choice is an important feature of the individual mandate and so has to adjust it as part of our proposal that it be on all products guaranteed. We also are suggesting that insurers not be allowed to vary their premium rates other than based on age, family, size and geography, so there wouldn't be any, not only would not there be medical underwriting, there wouldn't be rate bands or things like that associated with the individual medical risk of an individual.

**LARRY LEVITT:** I want to bring Phyllis in here a little bit, hopefully not put too much of a damper on things, Phyllis let's start off with some basics about ERISA and first, what in

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your view does ERISA clearly allow states to do so that there is little dispute about in the legal community?

**PHYLLIS BORZI, J.D., M.A.:** Well, I think the thing that clearly states whether or not there is the political will to do it or not is states could impose a broad based fee or tax on all employers. That is clearly not preempted by ERISA because ERISA only preempts state laws that relate to an employee benefit plan so requirements on employers that aren't specifically mandates to provide plans or specific benefits are not preempted by ERISA but it is a continuum as your question suggests and the problem with this broad based tax or fee is that is the no good deed goes unpunished government version of it.

**LARRY LEVITT:** So even employers who provide [interposing].

**PHYLLIS BORZI, J.D., M.A.:** Exactly. So states who want to create broad based programs with an employer financing component because that makes perfect sense from a policy and financial point of view, what they have been trying to do is craft ways to create credits against the fee or to tax for employers who provide plans and whether you go all the way to a pay or play program or something along the lines that the governor is proposing in California, the difficulty it seems to me is again because it is a continuum, you want to have the fee

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or the tax, not create an incentive or not be able to be characterized as something that forces employers to provide plans or not to create the kind of incentives that the governor in California is concerned about and all the other governors are concerned about which is for employers to drop their plans.

**LARRY LEVITT:** In terms of forcing or requiring employers to create a plan or offer coverage, that is an area that there is broad consensus would clearly not be permitted under ERISA.

**PHYLLIS BORZI, J.D., M.A.:** Even the Supreme Court in the traveler's case, which was the 1995 case that marked the turning point in the ERISA [inaudible], even in that case the Supreme Court unanimously went out of its way to say that if you mandate benefits or benefit structures or interfere with plan administration it is going to be preempted by ERISA.

**LARRY LEVITT:** There is some confusion around because states do have historically mandated certain benefits in insurance plans, whether it is maternity coverage or mental health coverage and explain why that is done, why that is okay.

**PHYLLIS BORZI, J.D., M.A.:** The reason it can be done is because ERISA really has, I'm going to try not to sound like a law professor here, ERISA really, the preemption clause ERISA has three parts, the broad rule that says any state law that relates to employee benefit plan is preempted and the

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traveler's case and the kinds of things we are talking about today really deal with when a law relates to an employee benefit plan. The second part is an exemption because every good law has an exemption and it is an exemption for various kinds of state laws including state and insurance laws and the third part is an exemption from the exemption because goodness knows legislatures can't possibly do simple things and that is the deemer clause that you can't call employee benefit plans insurance, insurers in order to get out from under the basic relates to task. The mandated benefit cases fall under the insurance savings clause, the part of ERISA that says if you have got a law regulating insurance, it is not preempted by ERISA and that is why the key part of your question was that these are rules that can be imposed on insurers, not on ERISA plans generally.

**LARRY LEVITT:** So they have for employers that buy insurance on the open market they have the indirect effect of making sure that coverage has those mandated benefits.

**PHYLLIS BORZI, J.D., M.A.:** Yeah if you think about it this way, ERISA applies to all employer plans whether they are insured or self insured but employers who decide to purchase coverage for their employees through an insured arrangement are also indirectly subject to a second level of regulation and

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that is because the states can regulate the product they buy, not the plan that they offer but the product they buy.

**LARRY LEVITT:** But if an employer is self funding, not purchasing insurance, then [inaudible] the mandates don't apply.

**PHYLLIS BORZI, J.D., M.A.:** Right.

**LARRY LEVITT:** Let's go back to the pay or play idea, the idea that a state might try to create a system where employers either provide coverage or in effect pay some assessment or fee, thinking about that kind of approach what are some things recognizing there are no guarantees? What are some things some states could do or should avoid doing in order to protect those types of plans under ERISA?

**PHYLLIS BORZI, J.D., M.A.:** Let me focus on the things I think they should avoid doing because I will say another time it is a continuum. The more, if a state does a pay or play approach you want to avoid either the pay part or the play part, either prong. You want to avoid either of those prongs being characterized as forcing an employer to have a plan so let's start with the more obvious, the play part. What you want to do is you want to say an employer can either pay a tax or a fee. If I use tax I also mean fee, so they can pay a sum of money or they can provide coverage. Well, what you don't want to do in describing the coverage that they have to provide

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to avoid paying the fee or the tax is you don't want to be very proscriptive, you don't want to define the parameters of coverage. What you don't want to say, it is surely going to be preempted I think if you say you have to provide this package of benefits, you can only provide family coverage, you can't charge more than 20%, the more bells and whistles that you put on the play component, the more likely it is that a court will find that you are forcing an employer to have a plan that looks a certain way. That is really what you are going to try to avoid. Now, on the pay part, you might say to yourself well wait a minute, this woman started by saying it is perfectly okay to impose a tax or a fee, so why would that be a problem? Well the problem in structuring the pay part of this arrangement is if you tie the payment to coverage in a pool, a public pool or some other mechanism, to the fee that that employee pays for the employees, in other words here let me give you an example, suppose you say, now this isn't what I hear that the governor's plan does but suppose a mythical state was to say employers will have to pay 4% and that money is used on behalf of their employees to buy coverage for their employees in a pool, well even though you are imposing a requirement to pay, it still is an arrangement with respect to that employer's employees so you could make an argument, opponents of this arrangement would certainly argue that in

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that case, even the pay component was forcing employers to have a plan because under ERISA you have a plan when you have an arrangement in which you establish or maintain coverage for your employees so this is all about grafting and the way you conceptualize, the state conceptualizes its program.

**LARRY LEVITT:** And the way Richard Figueroa described the governor's plan which is employers or the Vermont plan for that matter where employers are paying an assessment but that money is not necessarily attached to that [inaudible - interposing].

**PHYLLIS BORZI, J.D., M.A.:** It's not tied to their employees. I think that is more likely than not to not be preemptive. Again, there are no guarantees.

**LARRY LEVITT:** Richard Figueroa, let me come back to you, if not for ERISA do you think, did ERISA play a major role in the design of the governor's plan?

**RICHARD FIGUEROA:** I believe we did and I think we are a mythical state, Larry. [Laughter] It did in fact, we were very cognisant of, you know, we had a pay or play bill a couple of years ago, a few years ago, called Senate Bill #2 which had, it was passed and signed by the previous governor but then was referendized out of existence. It was very clear that that bill was going to be challenged on an ERISA basis and this governor was mindful of some of the issues around ERISA. We

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were watching closely the court decision in Maryland and certainly the governor didn't want to be in a situation where, if we were able to reach agreements on legislature, would it be immediately challenged in court and would have to take several years to wind its way through the courts and there would be some kind of potential Supreme Court decision on all of this so he was very careful in designing this in a way that we believe would not fail the ERISA test or pass the ERISA test I should say in order that we have something that is actually implementable in the longer or in the short term and not have to worry about some court case in the longer term.

**LARRY LEVITT:** I want to move on to some of the questions I'm getting by e-mail. I'll start out with a very broad one which raises, I mean all of these plans that we are talking about here are predicated on private coverage whether that is employers providing coverage to their workers, coverage through a purchasing pool, or expansions in public programs like medicaid, and the question is what about single payer? Mike Smith, in Vermont, there is some history of a debate over single payer there. Is that still alive? Was that a consideration in designing Catamount Health Plan?

**MICHAEL SMITH, M.A.:** Well that was a huge debate here. Whether we should go to single payer or as the governor wanted to do is integrate the private market, in Vermont we were at

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least from our perspective we were a little leery of going single payer on our own. We thought we would, we've had and we have done well in sort of erasing a fairly significant medicaid deficit in the past. What we saw if we went to single payer that this thing could be a medicaid on steroids in terms of the deficit. We thought there would be an influx into the state. It could swamp the system from our perspective. The other thing that was really, how do you pay for a single payer and the mechanism is the income tax which is the easiest mechanism here in Vermont and we already, California may beat us by a little bit but the highest marginal rate, we are either second or first. I can't remember with California, we've got the highest marginal rate for income tax in the country so there is this ongoing debate but what we did, there was a big push in the legislature for single payer. What we decided to do was compromise with this hybrid sort of plan and use the private market and use a subsidy within the private market. For example, we will be, pretty soon the plans will come in now and there is prescribed comprehensive coverage in the plans. The plans will be submitted to our banking and insurance department here soon on those costs to those plans. We are estimating it to be about \$360, \$365 dollars a month with comprehensive coverage and then we can subsidize off that. For those people who don't have insurance can go directly to Catamount Health

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and for those who have substantial equivalent plans in the  
aside we can subsidize from there so we think we have reached a  
good compromise here with a viable funding source that doesn't,  
we just recently got Triple A here in the state of Vermont,  
that doesn't sort of compromise our financial underpinnings and  
go with something that we are fairly certain that sort of  
brings in both the private sector with sort of the public  
subsidy aspect here and really sort of gets to where we want to  
go which is our target of 96% coverage.

**PHYLLIS BORZI, J.D., M.A.:** You know, there actually  
are ERISA problems with single payer. I know this seems  
counterintuitive but there are at least two arguments that I  
heard raised about potential ERISA problems with single payer  
arrangements in the states, the first being the one that I  
talked about a minute ago with the tax, if you finance single  
payer in part through an employer tax there is question as to  
whether or not depending on how it was draft you would have to  
de-couple the payment of the tax or fee from coverage that an  
employer and employees take but the more interesting I think  
ERISA argument that I have heard is that a single payer plan  
would displace employer coverage and therefore that might be a  
law that related to ERISA plans not because you forced a  
company to have a plan but because you required coverage

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through a single payer program that therefore had some form of displacement or effect on ERISA plans.

**LARRY LEVITT:** And ERISA in that sense is very broad. I mean, ERISA doesn't actually say you can't require an employer to do anything. It just talks about relating to it.

**PHYLLIS BORZI, J.D., M.A.:** You can't require them to do something with a plan.

**LARRY LEVITT:** Right. Richard, you are in a different situation in California since the governor's plan as a proposal hasn't been enacted and there is still a live single payer proposal as well in California, how do you see that playing in the debate?

**RICHARD FIGUEROA:** Well, as you know, we do have a bill pending in our legislature related to single payer. The governor actually vetoed single payer bill in 2006. We have almost unique fiscal requirements in California to pass something like single payer or really any bill that relates to budget or has a fiscal impact, we in our legislature have a two-thirds requirements to pass any bills that would appropriate dollars and neither party in California has a two-thirds majority so requiring or passing a single payer bill that actually has the funding to implement it and it would be very difficult in our legislature and so people have looked at this more about in terms of gee will there be some ballot

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proposition or ballot initiative which we are also very famous for, coming down the road to enact something like this because such a thing would not pass our legislature and be funding in so the bill the governor vetoed last year was more the structure of single payer but not the funding for a single payer. Gov. Schwarzenegger does not support single payer. He believes it is government run, basically take over of the system. That is something that he is not comfortable with, much like Vermont, believes that kind of shared benefits, shared responsibility model is one that is more acceptable and builds on the existing framework and people would believe that they are going to have their current systems of care disrupted in favor of more of a government organized and sponsored delivery system.

**LARRY LEVITT:** We have Mike Smith who talked earlier about some of the fiscal pressures that existed in public programs like medicaid previously and we have another question by e-mail which asks in plans like this, what happens to funds in established, existing state programs? Richard let me stay with you, in the governor's plan there are a lot of programs in California already providing coverage or access to care for the uninsured, what happens to those? What would happen to those under the governor's proposal?

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**RICHARD FIGUEROA:** Well, in the governor's proposal, we are basically trying to build on what we have. We have for example obviously a very large and vibrant medicaid program which covers about six million Californians. We basically would be adding about a million to that. We have an SCHIP program here called "Healthy Families" which basically runs like a purchasing pool. We would be adding an adjunct for adults onto our existing construct for SCHIP so that the parents of those SCHIP children as well as other single individuals that don't have children that are in the income range I discussed earlier, that 100 to 250% of the federal poverty level group would have access to, you know, it basically looks like private insurance coverage through a purchasing pool model so obviously we want to utilize every federal dollar we can and extending through medicaid, funding mechanisms or otherwise, more coverage to individuals. There would be things like our high risk pool, for example, which would not exist under the model we are talking about because we have guarantee issuance and other sorts of subsidies, you wouldn't need a high risk pool for uninsurable individuals because there would be no more uninsurable individuals under guarantee issue so some things would go away. We also have a large funding state county partnership where we give, flow billions of dollars to them to take care of the uninsured and

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undocumented, etc, and there would have to be some adjustments in that program as well so we are trying to make better use of the dollars we have, bring down federal dollars, emphasize primary and preventive services to kind of help keep costs down. We are also trying to, well there are kind of little nitch programs that have coverage, specialized coverage programs for children in one income category but not another or split families. Between public programs, we are also endeavoring to combine those families in a way that it makes sense so they all can be seeing the same provider and have the same health plan vs. these little nitch kind of things we have developed so we are trying to develop clinical bright lines between our different programs so that all kids above a certain percent of the federal poverty level are joined together in one program and adults can be joined together with the rest of the family, etc, and taking this opportunity to kind of make more sense of our currently pretty fractured system of financing.

**LARRY LEVITT:** Richard you mentioned earlier this idea of the hidden tax, that having medicaid or Medi-Cal rates that are below private rates right now and having a large uninsured population in California, those costs end up getting shifted to other payers and so your expectation is that universal coverage would eliminate or mitigate that hidden tax and create savings for presumably mostly employers now who provide coverage?

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**RICHARD FIGUEROA:** That is correct. We think employers are right now employees, not employees really, through higher co-pays, deductibles and premiums are bearing about a \$15 billion dollar burden associated with folks that voluntarily forego coverage can't afford it as well as our underpayment of Medi-Cal so one of our biggest cost containment so to speak features or elements of the plan is trying to eliminate or drastically reduce the hidden tax. Just today, Gov. Schwarzenegger as we speak is visiting an emergency room in San Diego County and that particular hospital has about a \$50 million dollar burden every year that they have to pass along to everyone else because they see so many uninsured and this is one thing that the employer community in California has been able to get behind in terms of because we have highlighted the large hidden tax that they are bearing as part of this so they have been very supportive of increasing our payments to our medicaid providers and in looking for ways to reduce the number of uninsured because they in fact realize they do bear that burden and that has resonated very well in the California populace once they understand gee, this isn't just an issue of the uninsured in a vacuum. I am paying as well and so if all the things that we have done, people get shared benefits, they get shared responsibility and they also have been very supportive of the notion of gee this is a hidden tax and we

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have all got to get in this together and try to figure out how to fix it.

**LARRY LEVITT:** Mike Smith, Richard mentioned making use or maximizing federal funds as part of the health reform plan, what role did that play in Vermont?

**MICHAEL SMITH, M.A.:** Quite a bit. First of all, like Richard, Vermont has a very expansive medicaid program right now and we have expanded our medicaid program as far as it can go. For example, we have about 14.5% of our population on medicaid right now up to 150% and what we would do is go from 150 to 300% in this area and use, we have what is called a global commitment to health. We have one of the first in the nation sort of 1115 waiver which gives us enormous flexibility and how we can use medicaid dollars. In return we have agreed to a rate of adjustment each year that is lower than our traditional growth rate but still we think we can maintain our programs under that but it gives us enough flexibility. We are in for another waiver here to use some of our medicaid in that expanded population from 150 to 300. One thing Richard said that is critical here and I'll just go back for a minute, the employer assessment, the employers really got this and they got the fact that if you ensure people and that if you can reduce the uncompensated care, that helps them. I mean, it may not be dollar for dollar but theoretically they knew intellectually

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that helps them and that helped us out a lot as we were putting this together because they knew that somehow in their premiums there was a cost shift charge and what they wanted to do is say as we try to reduce costs for everyone how do we do that? And, quite frankly the employer stepped up to the plate here and said yeah, this makes sense and that was a big selling point as we moved forward.

**LARRY LEVITT:** Richard, are you finding in California have you found some employer support for the plan?

**RICHARD FIGUEROA:** Yeah, as indicated earlier, I think the idea of eliminating the hidden taxes has really resonated with employers, our strong interest in increasing prevention and wellness packages that are available to them, like we call our health of rewards, healthy incentives programs, has resonated with them, you know, basically things that would help them urge their employees to take some personal responsibility for their health has resonated with them. When you get into things like the 4% fee, depending on whether you are offering employer, not offering employer, and how much you are actually spending, we have had variable views expressed on gee, it ought to be more, it ought to be less, I can't afford anything, you know, etc, so on that as soon as you get to the dollar figure amount and is 4% too high or too low, employers and employer groups are kind of all over the map on that one but again, you

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know, on some of the basic issues of shared benefits, shared responsibility that resonates well on initiative prevention and wellness and really trying to gee, what can we do to lower that hidden tax because they know they are paying it, they get it, and the health plans are not very shy about saying hey, we have got to pay these, we have to pass these bills onto you and certainly doctors and hospitals are not shy about saying hey I've got to keep my lights on. I've got to pay my nurses. I have to keep my computers running. I have a lot of costs of doing business. They are not shy about saying they have to have those along either because at the end of the day they have to balance their own balance books at the end.

**LARRY LEVITT:** Right. Let me go back to our e-mails. We have an e-mail from out in California asking about ideas or suggestions for how local jurisdictions might extend authority to require and/or encourage employer participation in the provision of health insurance. Phyllis let me start with you, first just basics, ERISA, this isn't just a state issue, I mean presumably ERISA applies to local governments as well.

**PHYLLIS BORZI, J.D., M.A.:** That is true. I mean, ERISA defines state law broadly but presumably it would apply to local governments but one thing I would caution the local governments, city governments, whatever, is remember back to what your initial question to me, what is likely not to be

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preemptive? There is consensus that is not preemptive, is attacks, so if the jurisdiction doesn't have and I am not an expert in all the state laws, but if there is no taxing authority that the jurisdiction has, it has to be a tad more creative in trying to figure out how to get the employers involved in the financing component.

**LARRY LEVITT:** And have there been a couple of cities that have tried to [interposing]?

**PHYLLIS BORZI, J.D., M.A.:** The publicities and actually there is rival of the retail industry leaders association that sued successfully to strike down the Maryland Law also sued Suffolk Co. New York. There is a case, a lawsuit going on there, where the county did a similar thing, a slightly different approach. They did it structured like a minimum wage that a certain percentage of the hourly wage had to go to health but similar kind of approach and that is being challenged in the court.

**LARRY LEVITT:** And this Maryland Law, so the Maryland Law applied only to Wal-Mart, to one employer in the state.

**PHYLLIS BORZI, J.D., M.A.:** Although you didn't find that on the face of the law. It applied to employers with 10,000 or more employees in the state of Maryland but as a practical matter the only one, it applied to all these

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employers but the only one that it would have had an impact on would have been Wal-Mart, at least that was the allocation.

**LARRY LEVITT:** And it would have set a minimum threshold for the percent of payroll that such employers would have to -

**PHYLLIS BORZI, J.D., M.A.:** Yeah interestingly enough the Maryland Law was as clean as you could possibly want it in structure but I think when the court, if you look at both the district court and the circuit court opinion, what clearly was offensive to the court is an operation that only affected one employer and that wasn't broad based enough to survive.

**LARRY LEVITT:** And the Maryland Law is dead at this point.

**PHYLLIS BORZI, J.D., M.A.:** That particular law, yeah, but Maryland, like many of the other states, are looking at more broad proposals; however, the legislature being a Maryland citizen I can tell you that the legislature just adjourned without addressing this issue in a more comprehensive fashion in this legislative session.

**LARRY LEVITT:** Do you expect, I mean there is the Vermont assessment on the books, the Massachusetts assessment on the books, do you expect, are there cases underway challenging those or would you expect those?

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**PHYLLIS BORZI, J.D., M.A.:** As far as I know, there is nothing, there is no case, Mike is probably in a better position than I to talk about Vermont, I know there is no case in Massachusetts. I know that San Francisco was one of the jurisdictions that did an employer assessment and I heard at a program that I attended although I don't know for sure that the San Francisco assessment on employers is being challenged as well.

**LARRY LEVITT:** Mike Smith, how much of an issue did ERISA play in the discussions there and have you had any threats or legal challenges?

**MICHAEL SMITH, M.A.:** No we haven't. We haven't had any legal challenges. We sort of did it a little bit differently than California but in the end it all came out where we needed to be, we looked at those three elements that we talked about, you know, quality of care, accessibility to insurance, and cost containment and we designed the program first around that. I mean, we have got the blueprint for health in terms of cost containment, how do we go after those chronic diseases and those sorts of things? Then, we have the insurance piece and how do we fit the insurance pieces in? And when we got to that design, then we started looking at the financing and then we started looking at ERISA sort of at the back end after we sort of had looked at all of the components

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of what we were trying to do and when we looked at ERISA, we were fairly comfortable that overall it is a funding source that is not a mechanism intended to be or likely to effect any employer's decision on whether to offer coverage or a type of coverage and specifically there is nothing in our law that dictates that employees offer coverage or anything about the coverage offered by the employees. The law is neutral about whether employers choose to offer coverage or pay the assessments. It does not contain any areas of regulation that are contained in ERISA and it does not regulate ERISA plans, benefits, and those things, and quite frankly the 9125 quarterly assessment for each full time equivalent does not, in our opinion does not meet the standard for imposing substantial costs so we sort of look at what do we want to do, how do we want to fund it and does it meet ERISA, in that sort of way.

**LARRY LEVITT:** I think we have time for one more e-mail and this is a question about federally qualified health centers and their role in employer individual coverage expansions and these are certainly places where many of the current uninsured get care and Richard Figueroa, let me come to you. What do you expect to happen with those kinds of traditional providers under the governor's plan?

**RICHARD FIGUEROA:** Well, you know, as part of our shared benefits, shared policy, one thing I hadn't touched on

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before is that we are assessing a fee on all physicians in the state equal to 2% of their gross patient revenue and 4% on all hospitals in terms of their gross patient revenue. FQHCs are exempt from that under the way that the feds allow us to use those dollars to match their dollars to provide additional assistance to states, so that's kind of on the revenue side. They are also going to see hopefully a lot of folks that come in on sliding fee scale right now will now have a more stable reimbursement stream behind them, you assume medicaid or because they will be enrolled in our purchasing pool. In our SCHIP program for example, we give people in our SCHIP program a premium break if they enroll in a plan that we call the community provider plan. That is when it's in the best job of including FQHCs, county hospitals, other public providers, in their provider roles. I think we would expect the board that is going to be managing the [inaudible] pool to kind of do the same thing to really encourage participating health plans and providers to enroll FQHCs and other public and not for profit entities in their provider systems so I think they have an important role in California now. They will continue to have an important role. Their payer mix may change as a result of this. They will hopefully receive additional resources. One of the things that is a little tricky about this is some FQHCs in California receive potentially higher rate than what they

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call the respect to payment system than they would private insurance plans so there is that concern among FQHCs that is particular to California but that may be also true of other states but generally I think we believe that all providers will benefit by having a lot more stable reimbursement systems than they have now so they don't have to pass along the hidden costs or in the case of FQHCs have to rely on the fund raising and additional federal grants and things like that to kind of carry them through at the end of the day.

**LARRY LEVITT:** Mike Smith, what are you seeing issues in Vermont with changes in the marketplace where people are getting care or do you expect those changes?

**MICHAEL SMITH, M.A.:** Well, in terms of FQHCs, they are integrated in our environment here. As you know, we are a fairly rural state. By the way, we have a lot of snow now so anybody that is thinking of skiing we will be skiing here until may as somebody just reminded me to pitch the tourism on your show here, but the FQHCs play a vital part of this whole sort of plan and what we did is actually they were very instrumental in sort of drafting the margining, the outreach program, for us here in terms of bringing people in because they see people uninsured every day and actually our key elements in our marketing [inaudible] plan, remember as I said in the beginning we have of the insured that we have, 50% of them are eligible

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for medicaid and they just haven't come on to our program yet so we really reached out to the FQHCs and secondly what we did in sort of integrating them is the ability to market the catamount health plan as well as we move forward so they have actually become a very critical partner in this whole process with us.

**LARRY LEVITT:** Well, we have to wrap up the hour soon. I want to give each of you an opportunity for some final thoughts and Mike Smith, let me ask you, you are in the thick of implementation now, give us a sense, looking ahead, of what milestones to look for, what over the next couple of years should we expect to see happening in Vermont?

**MICHAEL SMITH, M.A.:** Well, October 1<sup>st</sup> we go live so Susan Basiah who is the person in charge of implementing is really in the thick of things right now so we are looking at that as we move forward. At the same time, we have got to keep an eye on fiscal stability as we move forward through this. I think what we are hinging our fiscal stability on is something that I just briefly touched on is what is called the blueprint for health which sort of turns our care delivery system upside down and looks at how do we become more proactive in those chronic diseases that are really driving the cost of health care here and we have integrated in this state, because we are small, the hospital, the provider network, the docs, everybody

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into this process and we are implementing technology to provide care management plans, diagnoses plans, those sort of things that we are banking on that will really drive the cost of insurance down because right now we have an estimated 25% of Vermonters with chronic conditions that account for about 70% of the health care spending here in the state and only about 55% of them get the right care at the right time. What the blue print does and what the chronic care model does is really put that on its head and really go after it in terms of preventative, in terms of diagnostic, and in terms of care management after that and we haven't spent a lot of time on that but that is an integral part of what we are trying to do here in driving the increase in health care down so that is sort of my final thought and they have to go hand in hand as we move forward.

**LARRY LEVITT:** Do you feel you have the pieces in place to address chronic illness in that way or do you think it will take some further legislation or initiatives?

**MICHAEL SMITH, M.A.:** Well actually about half the bill dealt with this initiative and it is tying in the health care plans throughout the state into this. Our medicaid office, for example, has started to implement the programs for chronic disease management and for the blue print so we have a very active and it has been great. I am sure we are going to have

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bumps down the road but we have a very active sort of collaborative team working with all the interest groups to put this together and at the same time we have the infrastructure being built in terms of technology that will fit right in to this.

**LARRY LEVITT:** Richard Figueroa, I am presuming you are not going live on October 1<sup>st</sup>, but give us a sense over the next several months how the process you think is likely to play out in California, the proposals are now in the legislature, give us a timeline of what you think might have or what you hope to have?

**RICHARD FIGUEROA:** Yes, in general the governor is very committed to doing something this year. He counts his polls on January, the democratic leader in the assembly has his own proposal, the democratic leader in the senate has his own proposal, the minority republicans in both houses have their proposal and that is the first time, at least in my memory, that was for 20-25 years now, that all four caucuses have a major proposal along with the governor so that speaks very highly to how important the issue is on the agenda this year. We have been, over the last three weeks, having some smaller group sessions with legislative staff and some of the major stakeholders to kind of walk through our plan to help provide kind of a sounding board or a table from which to discuss all

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these major issues next week, the head of the senate and assembly as well as the single payer bill will be up in front of the legislature in their first policy committees. I expect them all to be kind of voted out. The other major proposal besides the governors all share a lot of common elements in terms of trying to either do medical loss ratios on insurers or prevention and wellness. They all have major components of coverage, so there is lots of commonality on a lot of these different things. I think one of the big issues of course is going to be financing and ours is set up in such a way or constructed in such a way that there is no impact on the state's general fund. All the dollars associated with these various revenue elements I discussed earlier go in to special fund to fund the coverage and so funding is going to be a major issue, particularly as I indicated before. There is the two-thirds vote requirement for revenues in California so the governor is going to be engaging in the leadership of both parties and in both houses to figure out what is the best way to set up this table, given that there are bills moving into the legislature at the same time we have our own proposal on the table and what will that structure be? What will it look like? Our legislature leaves in the early fall and they aren't full time legislatures so we have a number of months to kind of complete our work this year but the governor really does want

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to do something this year. It's just a matter of trying to how do you set this table to deal with, which is a very large proposal on our part that includes the three elements I talked about earlier, in a fashion that gives people a sense of getting these issues to be aired completely, giving the public some input and at the end of the day come out to be something that is implementable. I would note that we have benefitted tremendously by the work of Vermont and Massachusetts and others that have come before us in trying to think about gee, how do you define what affordability means, what are some of the elements of medicaid expansions, what are some of the prevention and wellness kind of things that you can put on the table, so I would also like to tip our hats to those that have come before us in helping us to find these issues as we move forward.

**LARRY LEVITT:** Phyllis, you get the last word here. We talked about the murkiness of ERISA, any prospects for it becoming clearer any time soon or what will it take do you think to clarify these issues?

**PHYLLIS BORZI, J.D., M.A.:** Well, I think, you know, I guess I don't want states thinking about these issues to be completely turned off or discouraged by the Maryland decision, even though it is the first reported case, because I think what it will take if you are asking me if there is likely to be any

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federal clarification of this by congress, I don't think so. I still have the scars on my back from our attempt in 1993 to get some clarification when I was on the congressional staff but I think what it really will take is a number of states, important states, Vermont has already moved, Massachusetts has already moved, California, and I know a number of other states are thinking about this, to do comprehensive reform because I think the one thing we do learn about the Maryland court case is that it isn't going to work if you are just trying to do little bits and pieces because then for sure you are going to get challenged but if it is part of a comprehensive reform I think that is what it is going to take for it to get clarification for some one or series of states to do comprehensive reform with a part of an employer component of reform and we will see what happens.

**LARRY LEVITT:** In taking off your lawyer hat for a second and putting on your policy hat, I mean you spent a long time on the hill, if states do move ahead with these kinds of comprehensive reforms, some of which may push the envelope of ERISA, is that putting pressure on congress to do things?

**PHYLLIS BORZI, J.D., M.A.:** I surely hope so because I don't think that the answer here is for every state to have to reinvent the wheel and do it. This is a national problem. The escalating cost question, the uninsured problems, these are all

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national problems and if we had a commitment on the federal legislative level to do something about these problems and the states wouldn't feel like they had to do this step by step, state by state.

**LARRY LEVITT:** Well thank you. Thanks for the panel of experts and thanks to you for joining us. I am Larry Levitt and you have been watching Kaiser Network.org. We will see you next time for elements of state health reform and we will be discussing the issue of how to finance coverage expansions.

[END RECORDING]